United States v. State of Texas

Monitoring Team Report

Brenham State Supported Living Center

Dates of Onsite Review: April 1st to April 5th, 2019

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Table of Contents

Background

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

In 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, 15 of these indicators, including two entire outcomes, had sustained high performance scores and moved to the category requiring less oversight. Presently, one additional indicator in the area of restraint will move to the category of less oversight. One indicator in the areas of restraint will return to active oversight.

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

Restraint

Overall, the center-wide census-adjusted rate of usage of crisis intervention restraint declined over the nine-month review period and was the lowest since 2015; and especially so since initiation of the Safe Use of Restraints (SUR) and Ukeru in November 2018. This was a change in trend from the steady increase in crisis intervention restraint seen at Brenham SSLC over the previous five nine-month review periods. There was, however, some indication that not all data and restraint occurrences were documented.

Staff who were responsible for providing restraint were knowledgeable regarding approved restraint practices when interviewed by the Monitoring Team.

There were problems with restraint documentation. There was a lot of variability in the quality and content in the restraint documentation submitted to the Monitoring Team. Across the set of restraints, none had a complete set of IRIS documentation. There were missing entries and what was missing differed from restraint to restraint. For two consecutive reviews, the required psychiatry-related restraint documentation was not completed on time, or at all, for both individuals.

Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: monitoring individuals for potential side effects of chemical restraints; providing follow-up for abnormalities noted during restraint assessments; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and improving monitoring and documentation overall with regard to medical restraint.

One of the restraints was labeled as a medical restraint for healing. There was, however, no documentation (e.g., medical restraint plan, checklists). It turned out that this protocol was more so a protective mechanical restraint for self-injurious behavior (PMR-SIB) intervention than a medical restraint. The Center will explore this further and make the correction.

Two of the restraints were crisis intervention chemical restraints. In one of these instances, the restraint was unnecessary because the individual's behavior was no longer imminently dangerous by the time the medication was prepared. On the positive, the Center identified this occurrence and took appropriate personnel action. In the other instance, Behavioral Health Services was not consulted prior to the administration.

The Center's restraint review protocol needed improvement. The Center staff were aware of this, too (Indicators 16 and 17).

The newly-appointed Director of Behavioral Health Services (BHS) was receptive to feedback from the Monitoring Team, and appeared committed to improving the restraint management systems at the Center.

Abuse, Neglect, and Incident Management

Supports were in place to reduce risk of abuse, neglect, exploitation, and serious injury for all investigations selected for review (Indicator 1). This was good to see.

Incident Management Review Team (IMRT) meetings were well attended and were very interactive. Discussion continued until reaching a decision/end point. The Center Director and the Assistance Director of Programs (ADOP) were both involved in the details of the subject matter; usually they led the discussion. The Monitoring Team highlights the Center's good practice of using the Unusual Incident Review (UIR) Committee to review Center-only investigations.

Most incidents were reported timely and correctly (85%). Two were missing discussion or examination of the circumstances around the reporting.

For the most part, investigation content was acceptable, leading to logical evidence-supported conclusions. Half of the investigations identified factors contributing to the incident, but did not then include recommendations (or rationale for why no recommendations were needed). This is a change from past high performance.

Areas needing improvement should be relatively easy to correct. A new Incident Management Coordinator (IMC) was appointed since the last review. She was off-site at training during the onsite review week. She was experienced in the Incident Management department.

This was the third consecutive review with which there were problems with Adult Protective Services (APS) Health and Human Services Commission (HHSC) Provider Investigation (PI) timeliness in completing investigations (i.e., for this review, 75% were

not done within the required timeframe). In addition to not meeting the Settlement Agreement requirements, this has the potential to significantly compromise the Center's protection from harm system. For instance, in three cases, the investigation did not begin in earnest (that is, with the first substantive interview with staff) until 12, 14, and 20 days after the allegation.

- The Center reported that they had reviewed and discussed this problem with the investigatory office staff, with fluctuating effects. Given the seriousness of this issue, SSLC State Office should consider getting involved, too.

Other

Brenham SSLC was not meeting the requirements related to IDT planning for and as a result of the use of pre-treatment sedation.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.

Summary: Crisis intervention restraint usage decreased in the recent three months prior to the onsite review, corresponding with full implementation of SUR and Ukeru. This resulted in positive scores for many of the data sets in indicator 1. This was a change in trend from the steady increase in crisis intervention restraint seen at Brenham SSLC over the past five nine-month review periods. One restraint for medical intervention turned out to need to be more appropriately classified as PMR-SIB. These indicators remain in active monitoring.

#	Indicator	Overall Score	Individuals: 279	281	162	417	119	268	599	59	143
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	100% 12/12	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	1/1	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 (June 2018 through March 2019) were reviewed. When looking at the monthly data graph of census-adjusted rates of crisis intervention restraint for the nine-month review period, the monthly trend was continuing its ascending trend from the previous three or four nine-month review periods. This was evident through the first six of the nine months. Then, SUR and Ukeru protocols were instituted and the course of the trend line reversed and showed a downward trend. Overall, across the nine-month review period, the Center remained at the fourth highest in the state for census-adjusted crisis intervention restraints. However, the rate dropped to one-third after implementation of SUR and Ukeru. There were, however, questions about the accuracy of crisis intervention data recording. That is, whether all instances were correctly recorded. See comments about this in the restraint section of this report under domain 3.

The frequency of usage of crisis intervention physical restraint paralleled that of the overall usage of crisis intervention restraint because the majority of crisis intervention restraints were crisis intervention physical restraints. The average duration of a crisis

intervention restraint was under three minutes. There was infrequent usage of crisis intervention chemical restraint (zero to one each month) and no usages of crisis intervention mechanical restraint (though there was some confusion given the graphs presented to the Monitoring Team, but this was cleared up during onsite discussions). The Center reported few, and a decreasing trend in, injuries during restraint (though see the nursing-related restraint outcome and indicators below for more detail).

There was one individual who had protective mechanical restraint for self-injurious behavior (PMR-SIB). Though, a second individual's medical restraint were identified during the review as possibly needing to be more appropriately classified as PMR-SIB (Individual #149). The number of individuals who had one or more crisis intervention restraints was also showing a decreasing trend. The Center reported that new admissions were still occurring, but the usage of SUR/Ukeru reduced the need for actual crisis intervention physical restraint. Another individual, who no longer required PMR-SIB, continued to wear gloves, by his choice. See comments in Domain 3 under restraint.

There was low usage of non-chemical restraint and pretreatment sedation for completion of medical and dental procedures. The usage of TIVA for dental procedures remained about the same (about 45 individuals per year). There was little activity at the Center regarding assessing/moving individuals from more intrusive (e.g., TIVA) to less intrusive (e.g., PTS) interventions (also see pretreatment sedation outcomes and indicators below).

Thus, facility data showed low/zero usage and/or decreases in 12 of these 12 facility-wide measures (overall use of crisis intervention restraint; use of crisis intervention physical-chemical-mechanical restraints; duration of crisis intervention physical restraint; number of injuries during restraint; number of individuals with crisis intervention restraint each month; number of individuals with PMR-SIB), and use of non-chemical, pretreatment sedation, and/or TIVA for medical and/or dental procedures.

Restraint reduction committee met regularly. Minutes showed good attendance, review of center-wide data, review of data for various individuals, and focused discussion on outliers with recommendations.

Note: Crisis intervention restraint should be used when there are imminently dangerous circumstances for which the staff need to intervene with crisis intervention restraint to protect the individual and others from immediate and serious risk of harm. Although the Monitoring Team looks for decreasing trends in the usage of crisis intervention restraint, appropriate usage of crisis restraint does not prevent the Center from moving forward towards substantial compliance with the protection from harm restraint aspects of the Settlement Agreement.

2. Six of the individuals reviewed by the Monitoring Team were subject to restraint. Five received crisis intervention physical restraints (Individual #162, Individual #417, Individual #119, Individual #268, Individual #143), and two received crisis intervention chemical restraint (Individual #279, Individual #417). In addition, medical restraint for healing was reviewed for one individual (Individual #149). Data from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for five (Individual #279, Individual #162, Individual #417, Individual #119, Individual #268, Individual #143). Upon review by the Monitoring Team and discussion with the Center staff, the medical restraint for Individual #149 appeared to be more appropriate to classify as a PMR-SIB. The Center was planning to meet to make this change and did so, documented in an ISPA sent to the Monitor a few weeks after the onsite week. Given this, the Monitoring Team could not determine if the usage was decreasing. The other three

individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period.

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.											
Summary: There were numerous problems with the documentation submitted for the Monitoring Team's review of crisis intervention restraints. The Monitor allowed for subsequent re-submissions. These provided some additional information. Overall, the Center needs to better organize its documentation (electronic/IRIS as well as print-outs) in order to self-assess and to ensure that crisis intervention restraint is implemented and reviewed properly. These problems in documentation entries and documentation production combined with new leadership in behavioral health contributed to the low scores on these indicators. Those indicators currently in active monitoring will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	162	417	119	268	143	149		
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The restraint was a method approved in facility policy.										
5	The individual posed an immediate and serious risk of harm to him/herself or others.	44% 4/9	0/1	0/1	1/2	1/1	1/2	1/1	0/1		
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.	78% 7/9	0/1	1/1	2/2	1/1	2/2	1/1	0/1		
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	Not Rated	Not rated	Not rated	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.	67% 6/9	0/1	1/1	1/2	1/1	2/2	1/1	0/1		
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	71% 5/7	1/1	0/1	0/1	1/1	1/1	1/1	1/1		
Comments:											

The Monitoring Team chose to review nine restraint incidents that occurred for six different individuals (Individual #279, Individual #162, Individual #417, Individual #119, Individual #268, Individual #149). Of these, six were crisis intervention physical restraints, two were crisis intervention chemical restraints, and one was medical/PMR-SIB. 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.

5. For Individual #417 8/12/18, crisis intervention chemical restraint was administered when she was no longer demonstrating behaviors that were imminently dangerous. For three others, the description of the events leading up to restraint did not describe circumstances that were imminently dangerous (Individual #279 10/3/18, Individual #162 8/25/18, Individual #268 10/19/18). This might be because the situation was not imminently dangerous or because the staff did not properly describe the situation. For Individual #149, there was confusion over whether this was medical restraint or PMR-SIB.

7. For Individual #279 10/3/18, there was no information about the nurse checking for injury post-restraint. For Individual #149, there was no documentation provided.

10. For Individual #417 8/12/18, crisis intervention chemical restraint was administered when she was no longer demonstrating behaviors that were imminently dangerous. For Individual #279 10/3/18, it could not be determined if behavioral health services was consulted/contacted prior to administration. For Individual #149, there was confusion over whether this was medical restraint or PMR-SIB.

11. For Individual #162, the ISP/IRRF did not contain complete information. For Individual #417, there was no information in the ISP/IRRF. Although not part of the criteria for this indicator, the Monitoring Team highly recommends that the Center document that a meaningful discussion occurred regarding whether any risk factors, history, or diagnosed medical conditions were considered.

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

Summary: Given sustained high performance for this and the previous two reviews (all 100%), this indicator will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 279	162	417	119	268	143	149		
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 3/3	1/1	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.

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: Restraint monitoring occurred as required for five of the restraints. For two, it occurred but slightly beyond the time requirement. For one, documentation was incomplete. For medical/PMR-SIB, there was no documentation that addressed indicator 14 content. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	162	417	119	268	143	149		
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	63% 5/8	0/1	0/1	2/2	1/1	2/2	0/1			
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	0% 0/1							0/1		
Comments: 13. For two restraints, the restraint monitor arrived slightly beyond the 15-minute requirement: Individual #162 8/25/18, Individual #143 8/23/18. For Individual #279 10/3/18, the documentation was missing this information. 14. There was no evidence that this was followed for Individual #149.											

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
Summary: Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: monitoring individuals for potential side effects of chemical restraints; providing follow-up for abnormalities noted during restraint assessments; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and improving monitoring and documentation overall with regard to medical restraint. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	162	417	119	268	143	149		
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	0% 0/9	0/1	0/1	0/2	0/1	0/2	0/1	0/1		
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	44% 4/9	1/1	1/1	1/2	1/1	0/2	0/1	0/1		
c.	Based on the results of the assessment, nursing staff take action, as	0%	0/1	0/1	0/2	0/1	0/2	0/1	0/1		

	applicable, to meet the needs of the individual.	0/9									

Comments: The restraints reviewed included those for: Individual #279 on 10/3/18 at 5:15 p.m. (chemical); Individual #162 on 8/25/18 at 8:04 p.m.; Individual #417 on 8/12/18 at 12:19 p.m. (chemical), and 1/7/19 at 7:05 p.m.; Individual #119 on 11/28/18 at 6:57 p.m., Individual #268 on 10/19/18 at 5:15 p.m., and 11/27/18 at 4:07 p.m.; Individual #143 on 8/23/18 at 3:45 p.m.; and Individual #149 from 12/10/18 to 12/16/18 (for posey mitts for healing as a medical restraint).

a. through c. The following provide examples of problems noted:

- According to an IPN, dated 10/3/18, at 8:30 p.m., Individual #279 had two chemical restraints, including one at 4:38 p.m. of Zyprexa 7.5 milligrams (mg) intramuscular (IM) to the right hip; and another at 5:18 p.m. of Zyprexa 2.5 mg IM to the right hip, according to the Medication Administration Record (MAR). Documentation indicated that since the nurse administered the chemical restraint, the nurse made only one attempt to obtain a set of vital signs. The IPN provided, dated 10/4/18 at 5:16 a.m., only indicated that he was resting in bed, skin warm, respirations even/unlabored, and alert. The nurse did not note the individual's mental status, if he was calm after receiving two chemical restraints the previous night, if he became sedated from the medications, if he had urinated, status of his gait, any blurred vision or dizziness, and/or any issues at the injection sites (i.e., it was unclear why he received two injections to the same site). Essentially, nursing staff provided no status related to his response to the chemical restraints. Some information was cut off from the Flowsheet.
- For Individual #417's chemical restraint on 8/12/18 at 12:19 p.m., an IPN, dated 8/15/18 at 12:42 p.m., which was a late entry for 8/12/18, indicated that a Licensed Vocational Nurse (LVN) notified the Campus RN that the individual was exhibiting problematic behavior outside in the rain, and there was thunder and lightning. The psychiatrist ordered a chemical restraint. The note indicated that the Campus RN "told LVN to begin pulling up the Ativan and RN would be there shortly." The note indicated that the "LVN handed RN the injection. BHS [Behavioral Health Services staff] was present. RN doubled checked with BHS, asking you still want me to administer the chemical restraint?" The RN administered the injection. This scenario presented the following issues:
    - The nurse who prepared the medication needed to administer it. The note reflected that the LVN drew up the medication and gave it to the RN to administer. This is not consistent with standards of practice related to medication administration. In other words, the nurse administering the injection did not have first-hand knowledge of what medication was in the injection, because she did not draw it up.
    - Rather than assess the individual to determine if she needed the chemical restraint, the RN asked the BHS staff. Thus, the RN provided no clinical justification for administering the chemical restraint.
    - Information from the Flowsheet indicated that the individual was stating she wanted to die and had put a sheet around her neck in a suicidal gesture. Neither the RN nor the LVN completed a suicide risk assessment to determine if the individual still wanted to harm herself and why. An LVN IPN, dated 8/12/18 at 2:34 p.m., noted the individual made "creditable statements at 1120 [11:20 a.m.] about wanting to kill herself and wanting to die," which indicated that regular suicide assessments were warranted. However, they were not found in the documentation provided. Although the Flowsheet indicated that a suicide assessment was done, it did not reflect who did it and what the results were. In addition, chemical restraints typically are not given for suicidal ideation and gestures.

      In its comments on the draft report, the State disputed this finding, and stated: "Nursing BSSLC policy (attached) includes the following statements:

        - 'Nursing Responsibilities: a. Nurse will complete an assessment after the first credible suicidal statement/gesture.; b. If there are additional statements that occur within 24-hours after a credible suicidal statement/gesture, nursing is not required to complete additional assessments.'
        - According to section IV: 'Behavioral Services Staff Responsibilities include but are not limited to the following: "A. Within one hour of suicidal behavior, a face-to face assessment of the individual using the Suicide Risk Assessment in IRIS is to be completed by the Behavioral Services Staff/On-Call.'

    Also; included in the documents presented were 'Result Details' that indicated suicide assessment was done and this document was verified by Bradley-Shrick, Donna Jean on August 13, 2018 14:32 CDT. The Suicide Risk Assessment is also attached."

    Although the State referenced attachments, it provided none. In addition, the portions of the Brenham policy related to nursing assessments for credible suicidal statements/gestures that the State quoted were not consistent with current generally accepted standards of care for nurses working with individuals with psychiatric disorders. For example, the American Psychiatric Nurses Association sets forth "essential competencies for assessment and management of individuals at risk for suicide" (i.e., found at: https://www.apna.org/i4a/pages/index.cfm?pageid=5684). The Brenham policy, as quoted, does not reflect, and actually is in contradiction to these basic competencies.
  - Based on the MAR document provided, it was unclear which nurse documented the chemical restraint. This is important in this particular situation, due to the breach in practice noted above.

    In its comments on the draft report, the State disputed this finding, and stated: "Attached is a MAR document where it is clear which nurse documented the chemical restraint... Refer to: TX-BR-1904-I-VF.50.a-k_updated."

    Again, the State provided no attachments. Moreover, in its original document request, the Monitoring Team asked the State to provide: "For chemical restraints, the Medication Administration Record (MAR)." It is unclear why Center staff evidently submitted an incomplete MAR in response to this request.
  - No assessments of the individual's status or vital signs were found in the documents.
- For Individual #417's physical escort on 1/7/19 at 7:05 p.m., a nurse documented the individual's high pulse rate (i.e., 103) in IView, but did not retake it, or document the individual's mental status. In an IPN, dated 1/7/19 at 7:24 p.m., a nurse documented that the individual reported hearing voices. However, based on documentation submitted, nursing staff did not assess the individual further for auditory hallucinations.
- For Individual #119, nursing staff conducted a timely assessment, including vital signs and an assessment for injuries, but did not conduct and/or document an assessment of the individual's mental status.
- For Individual #268's restraint on 10/19/18 at 5:15 p.m., the IPN, dated 10/19/18 at 5:42 p.m., only noted that the individual was hostile and aggressive and refused assessment "x3." No other information was included in the IPN. Consequently, there was no status documented after the restraint episode. No respirations, mental status, injury assessment, or description of the individual's activities or behavior were included.
- For Individual #268's restraint on 11/27/18 at 4:07 p.m., Center staff did not submit an IPN. In response to document request #TX-BR-1904-I.50.i, Center staff submitted the following note: "Not entered into Power Chart 11/27/18-1607-physical." In

addition, according to IView documentation, the individual's pulse and blood pressure were elevated (i.e., 107, and 167/74, respectively), but nursing staff did not retake them.

- For Individual #143's physical restraint on 8/23/18 at 3:45 p.m., nursing staff documented an assessment in IView at 4:58 p.m., which was not within the required timeframe. The nurse did not document the individual's mental status. The nurse also did not conduct and/or document neurological checks in relation to the individual's self-injurious behavior (SIB), nor was follow-up for a potential head injury found.
- For Individual #149's medical restraint, Center staff did not submit a physician's order. The Center staff only provided IPNs for 12/16/18, which mentioned the individual had mitts on to prevent pulling out his mic-key button. Based on review of IView documentation from 12/10/18 to 12/16/18, nursing staff did not conduct any skin assessments. The only mention of the condition of the mitts was in the Flowsheet, dated 12/16/18. Based on the documentation submitted, nursing staff had not conducted and/or documented any circulation checks. In addition, in the documentation submitted, staff had not documented how long the individual wore the mitts and/or when staff removed them.

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

Summary: Documentation met criteria for all but two restraints, though one was the only medical restraint/PMR-SIB chosen by the Monitoring Team. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	162	417	119	268	143	149		
15	Restraint was documented in compliance with Appendix A.	78% 7/9	0/1	1/1	2/2	1/1	2/2	1/1	0/1		

Comments:
15. For Individual #279 10/3/18, documentation by nurse was missing. For Individual #149, overall documentation was missing or incorrect.

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

Summary: The Center's restraint review protocol needed improvement. The Center staff were aware of this, too. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	162	417	119	268	143	149		
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	63% 5/8	0/1	0/1	0/1	1/1	2/2	1/1			
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	0% 0/3	0/1	0/1	0/1						

Comments:
16. For Individual #279 10/3/18, the IRIS forms did not review dates (though there were review dates in unit meeting and IMRT minutes). There were differences across documentation about the number of restraints, the entry content, and whether the restraint

was identified as a crisis intervention chemical restraint. This was not identified by the Center's restraint monitoring protocol.

For Individual #162 8/25/18, the restraint was implemented for slightly more than the time allowed for in the crisis intervention plan. This was not identified by the Center's restraint monitoring protocol.

For Individual #417 8/12/18, there were no recommendations provided regarding the apparently unnecessary administration of the crisis intervention chemical restraint (or a rationale for no recommendations being needed).

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: Multiple medications were not used (indicator 48) and psychiatry follow-up occurred (indicator 49) for both individuals. On the other hand, for two consecutive reviews, the required documentation was not completed on time, or at all, for both individuals. Therefore, as noted in the last report, this indicator will be returned to active monitoring (indicator 47). Indicator 49 will also remain in active monitoring. With sustained high performance, indicator 49 might be moved to the category of requiring less oversight after the next review. With a return to high performance, indicator 47 might also be returned to this category after the next review.

Individuals:

#	Indicator	Overall Score	279	162	417	119	268	143	149		
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.	100% 2/2	1/1		1/1						

Comments:
47. The above indicators applied to chemical restraints for Individual #417 and Individual #279. The Administration of Chemical Restraint: Consult and Review form was completed for Individual #417, but not within the required time frame. The review form was not completed by psychiatry for Individual #279.

49. The medical record indicated psychiatry follow-up regarding the administration of chemical restraints in both examples.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
Summary: Supports were in place as per the four sub-indicators of this indicator for all individuals. This was good to see. The quarterly review by APS of individuals identified for streamlined investigations was slightly overdue at the time of this review. This indicator remains in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	417	162	268	143	203	147	59	599
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	100% 13/13	1/1	1/1	1/1	2/2	1/1	1/1	1/1	1/1	1/1
			549	107	380						
			1/1	1/1	1/1						

Comments:
The Monitoring Team reviewed 13 investigations that occurred for 12 individuals. Of these 13 investigations, eight were HHSC PI investigations of abuse-neglect allegations (one confirmed, four unconfirmed, one inconclusive, one unfounded, one administrative referral). The other five were for facility investigations of serious injuries (fracture, laceration), law enforcement contact, and a peer to peer aggressive incident. 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.

At Brenham SSLC, there were no allegations that were referred back to the Center as a clinical referral. Of note was that 120 of the 347 allegations in the tier 1 document were unfounded allegations made by three individuals (i.e., 35%).

- Individual #279, UIR 19-027, HHSC PI 47462890, unconfirmed allegations of physical and verbal emotional abuse, 10/4/18
- Individual #417, UIR 19-026, HHSC PI 47462250, unconfirmed allegation of physical abuse, 10/3/18
- Individual #162, UIR 18-331, HHSC PI 47416623, unconfirmed allegation of verbal emotional abuse, 8/31/18
- Individual #268, UIR 19-037, HHSC PI 47477525, confirmed allegations of physical and verbal emotional abuse, 10/15/18
- Individual #268, UIR 19-071, HHSC PI 47539127, unfounded allegation of physical abuse, (not streamlined), 11/30/18
- Individual #143, UIR 18-301, HHSC PI 47386980, unconfirmed allegation of neglect, 8/9/18
- Individual #203, UIR 19-042, HHSC PI 47494439, administrative referral of an allegation of physical abuse, 10/26/18
- Individual #147, UIR 19-068, HHSC PI 47532159, inconclusive allegation of verbal emotional abuse, 11/26/18
- Individual #59, UIR 19-074, witnessed and discovered, cuts lacerations swelling, 12/4/18
- Individual #599, UIR 19-043, serious injury, undetermined cause, date unknown
- Individual #549, UIR 19-053, encounter with law enforcement, 11/2/18
- Individual #107, UIR 19-047, choking incident, 11/2/18

- Individual #380, UIR 19-046, injury, bite on ear from peer aggression, date unknown

1. For all 13 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.
All 13 investigations met criteria for all four sub-indicators. For the eight allegations, there were no previous related history or trends to examine. For the five facility investigations, trends and prior occurrences were considered (sub-indicator b) and plans were in place such as a PBSP, PSP, or PNMP (sub-indicator c). Further, the plans were being implemented at the time of the incidents (sub-indicator d). In particular, the Monitoring Team highlights the Center's thorough review of the gait belt issues for Individual #59 UIR 19-074.

Three individuals at Brenham SSLC were identified for streamlined investigations by DFPS. The Monitoring Team chose two for review (Individual #268, Individual #145). APS submitted its quarterly review of its determination of the rationale for each individual to be identified for streamlined investigations. The document was from December 2018 and had not been updated for the subsequent quarter. For the SSLC, plans were in place to address the frequent false calling for both individuals within their PBSPs.

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

Summary: Most incidents were reported timely and correctly. Two were not rated as meeting criteria for reporting; both were missing discussion or examination of the circumstances around the reporting. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 279	417	162	268	143	203	147	59	599
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	85% 11/13	1/1	0/1	1/1	2/2	1/1	1/1	1/1	1/1	0/1
			549	107	380						
			1/1	1/1	1/1						

Comments:
2. The Monitoring Team rated 11 of the investigations as being reported correctly (85%). The other two were 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 #417 UIR 19-026, the UIR did not discuss whether it was <u>likely</u> reported by the individual or by staff. Nor did it

explore whether or not staff witnessed the alleged incident on the evening of 10/2/18 and, if so, why it was reported the next day. There was nothing in the UIR to explain this, offer a hypothesis, or even to explore it.

- For Individual #599 UIR 19-043, the injury was identified as serious injury and a resultant investigation occurred three months after the injury. The UIR did not discuss the circumstances around this timeline.

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: Indicator 3 will remain in active monitoring for possible review at the next onsite visit. Some improvement regarding ISP summary of incident and injury data for the previous year is suggested (part of indicator 4), but even so, indicator 4 will remain in less oversight.			Individuals:									
#	Indicator	Overall Score	279	417	162	268	143	203	147	59	599
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
			549	107	380						
			Not rated	Not rated	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. Indicator 3 is not rated if indicator 1 meets criteria. That was the case for all of these investigations.

4. Although still meeting criteria for minimal information inclusion, most ISPs did not reflect summarized incident and injury data that would presumably be more useful to an individual or guardian than a simple listing.

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.												
Summary:			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: Most investigations met criteria for indicators 9 and 10. Important investigatory analysis did not occur for one incident (Individual #599). For the other incident (Individual #107), one aspect of relevant evidence was not examined. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	279	417	162	268	143	203	147	59	599
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.	85% 11/13	1/1	1/1	1/1	2/2	1/1	1/1	1/1	1/1	0/1
			549 1/1	107 0/1	380 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)	92% 12/13	1/1	1/1	1/1	2/2	1/1	1/1	1/1	1/1	0/1
			549 1/1	107 1/1	380 1/1						
Comments: 9 and 10. For Individual #599 UIR 19-043, both indicators did not meet criteria. Regarding indicator 9, evidence/information was not collected to try to determine why this serious injury was not reported when first discovered. Regarding indicator 10, because of the extreme lateness of reporting, a primary focus of the UIR should have been to identify how/why this happened and to initiate improvement actions to reduce likelihood of it occurring again.												

For Individual #107 UIR 19-047, the Center's investigation did not determine if, prior to the incident, she had any dietary restrictions. This could be important data (evidence) in determining whether proper safeguards were in place and were, or were not, followed.

Outcome 7– Investigations are conducted and reviewed as required.

Summary: Investigations continued to not be completed in a timely manner by HHSC PI. This was also noted in the last report. The Center reported attempts to address this. It seems that support and intervention from State Office is now needed. The Center's review of the investigation should note if the investigation was not timely. If they had, an additional nine of the investigations would have been scored positively for indicator 13. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 279	417	162	268	143	203	147	59	599
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor/QA specialist (unless a written extension documenting extraordinary circumstances was approved in writing).	38% 5/13	0/1	0/1	0/1	1/2	0/1	1/1	0/1	0/1	0/1
			549	107	380						
			1/1	1/1	1/1						
13	There was evidence that the supervisor/QA specialist had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	31% 4/13	0/1	0/1	0/1	1/2	0/1	1/1	0/1	0/1	0/1
			549	107	380						
			1/1	0/1	1/1						

Comments:

12. Eight investigations were not completed within the required 10 days and/or did not have proper extension approval or content. Of these eight, five did not conduct the very first interview of relevant staff until seven, eight, 12, 14, and 20 days after the allegation was made. Two others did not have any due dates included in the UIR. One had inadequate extension content (i.e., it only said that the investigator needed to interview the alleged perpetrator; no reason was provided regarding this).

Special note: Many HHSC PI investigations at Brenham SSLC have not been competed in a timely manner for a number of review

periods. This has the potential to compromise the Center's protection from harm system. The Monitoring Team understands that the Center administration had tried to address this with the local HHSC PI office with partial/temporary improvement. It is likely that support and intervention from State Office is needed, too.

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.

For seven of the investigations, the Center's own review did not identify or detect that investigations were not completed timely. The form for this noted "yes" to the question about this. During the onsite discussion, the Monitoring Team explained that this resulted in a zero score for this indicator. For the investigations for Individual #599 and Individual #107, the review did not identify the problems described above in indicators 9 and 10.

Even so, the Monitoring Team highlights the Center's good practice of using the UIR Committee to review Center-only investigations. Furthermore, IMRT meeting observed by the Monitoring Team included relevant staff, interactive discussion with good participation, and discussion that continued until a logical endpoint.

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: Audits for significant injuries were done correctly for all individuals. With sustained high performance, indicator 14 might be moved to the category of requiring less oversight after the next review. Attention to the non-serious injury investigation system remained a need. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 279	417	162	268	143	203	147	59	599
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 12/12	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
			549	107	380						
			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.	58% 7/12	0/1	1/1	1/1	1/1	0/1	0/1	1/1	1/1	0/1
			549	107	380						

0/1	1/1	1/1	

Comments:
15. For five individuals, either non-serious injury investigations were not conducted for non-serious injuries for which a non-serious injury investigation should have been conducted, but wasn't; or the investigation did not indicate yes/no regarding whether abuse or neglect was suspected (i.e., it was left blank).

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.

Summary: Half of the investigations identified factors contributing to the incident, but did not then include recommendations (or rationale for why no recommendations were needed). This needs to be improved in order for indicator 16 to remain in the category of requiring less oversight after the next review. Given the Center's sustained high performance (i.e., 100% for the previous four consecutive reviews), the Monitor will keep this indicator in that category at this time.

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:
16. Five investigations identified factors contributing to the incident. But then, there were no recommendations regarding these factors (or a rationale for why not needed). On the other hand, for one investigation, contributing factors were identified and recommendations were made (Individual #143 UIR 19-301). For one other investigation, the late reporting was not identified (Individual #599 UIR 19-043).

17. There were five investigations that included a confirmed physical abuse category 2. In both cases, the employment of the involved staff was not maintained.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.												
Summary: This outcome consists of facility indicators. There was some progress in that some data were being collected and there was some commentary. Overall, the Center was at the beginning stages of working towards doing meaningful review of ANE/incident/investigation related data. 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. Four of the seven data sets were being tracked and trended. Data related to staff, location, and date/time were not being tracked or trended. This was an improvement since the last review.

20-23. The Center seemed to be at the early stages of gathering ANE/incident/investigatory data.

For instance, the Monitoring Team's tier 2 document request I.G shows 14 ANE confirms (eight physical) over the nine-month review period,13 investigations with inconclusive findings, and 20 serious injuries. These data were not evident in the Center's QA reports and, thus, no analysis, actions, or review focused upon these important data sets.

The Center reported that no plans were in place to address any issues at this time.

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	143	268	286	217	149	276	76	490	91
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/3	0/1	N/A	0/1	0/1	N/A	N/A	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. As 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, still needed to be expanded and improved. The submitted dental policies did not address the criteria for which the individual would benefit from a procedure under TIVA. The medical policy needed to be expanded and updated to ensure quality reviews are completed of individuals in preparation for procedures utilizing TIVA. The term "medical clearance" incorrectly implies the procedure carries no risk for the individual. Dental surgery is considered a low-risk procedure; however, the individual might have co-morbid conditions that potentially put the individual at higher risk. Risks are specific to the individual, the specific procedure, and the type of anesthesia. The outcome of a preoperative assessment should be a statement of the risk level. The evaluation also should address perioperative management, which includes information on perioperative management of the individual's routine medications. Given the risks involved with TIVA, it is essential that such policies be developed and implemented. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures.

For these three instances of the use of TIVA, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, an operative note defined the procedures and the assessment completed, and pre- and post-operative vital sign flow sheets showed nurses completed monitoring in accordance with applicable nursing guidelines.

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 for dental procedures.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. On 2/7/19, Individual #143 had the battery replaced in his vagus nerve stimulator (VNS). He received sedation/intravenous pain medication at an offsite facility. The offsite facility was responsible for obtaining informed consent.

However, based on review of IView, prior to his transport to the offsite facility, on the morning of 2/7/19, nurses did not document his pre-procedure vital signs (VS) to obtain a baseline. In addition, upon his return from the offsite facility, nursing staff did not follow the guidelines for post-sedation monitoring (i.e., the nursing guidelines, updated 2/1/19, require a "Full set of VS including SPO2 [peripheral capillary oxygen saturation] and document: q [every] 30 minutes X2; THEN q 2 hrs. X2; THEN q 4hrs. for a minimum of 24 hours"). The dates and times of vital sign assessments upon his return at 4:00 p.m. only included: 2/7/19, at 4:00 p.m., and 5:40 p.m., and on 2/8/19, at 9:30 a.m.

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: Brenham SSLC was not meeting the requirements related to IDT planning for and as a result of the use of pretreatment sedation. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 279	281	162	417	119	268	599	59	143
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	0% 0/5			0/1			0/1	0/1	0/1	0/1
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	100% 2/2							1/1		1/1
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.	0% 0/2							0/1		0/1
4	Action plans were implemented.	50% 1/2							0/1		1/1
5	If implemented, progress was monitored.	50% 1/2							0/1		1/1
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/2							0/1		0/1

Comments:

1. Based upon the documentation provided, it was determined that five of the nine individuals in the review group had required pretreatment sedation over the previous 12-month period.

For three individuals (Individual #162, Individual #268, Individual #59), one of these exams was an EGD for which it was standard

practice to sedate the individual prior to the exam. However, in no case was there evidence that appropriate consents had been obtained prior to sedation. Individual #268 had also been sedated for placement of a g-tube and cataract surgery. For the latter, it was noted that his behaviors prevented this surgery without sedation. Again, there was no evidence that appropriate consents had been provided for either procedure. For Individual #599 and Individual #143, there was evidence that they had received TIVA for dental work, including a deep cleaning. In both cases the need for sedation was reviewed at an ISPA meeting and was determined to be a support versus a restraint. There was no evidence of informed consent, although it was noted that both the QIDP and dental department had spoken with Individual #143 and his guardians and no concerns were noted.

2. As it was standard care for the procedures completed for Individual #162, Individual #268, and Individual #59, these individuals were excluded from further review. For both Individual #599 and Individual #143, there was evidence of a plan for regular tooth brushing in their IHCPs.

3. Plans for regular tooth brushing were not identified as action plans in the ISPs for either Individual #599 or Individual #143.

4-6. There was a review of tooth brushing in the most recent QIDP monthly report for Individual #143. Data indicated that this activity was not occurring as scheduled, however, there were no changes to address his lack of progress. There was no evidence that tooth brushing was occurring regularly for Individual #599.

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	272	167	76	90					
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.	25% 1/4	0/1	0/1	0/1	1/1					
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across 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	0% 0/4	0/1	0/1	0/1	0/1					

	across disciplines that require improvement.										
e.	Recommendations are followed through to closure.	0% 0/2	N/A	0/1	0/1	N/A					

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

- On 7/23/18, Individual #272 died at the age of 53 with causes of death listed as cardiorespiratory arrest, pulmonary edema, myocardial infarction, and pneumonia.
- On 11/25/18, Individual #167 died at the age of 61 with cause of death listed as acute pulmonary thromboembolism.
- On 12/3/18, Individual #76 died at the age of 36 with causes of death pending autopsy results.
- On 12/17/18, Individual #90 died at the age of 72 with causes of death listed as suspected aspiration pneumonitis due to hiatal hernia.
- On 2/28/19, Individual #440 died at the age of 74 with causes of death pending.

For Individual #272, and Individual #167, the administrative death reviews occurred more than 14 days from the clinical death reviews. For Individual #76, the clinical death review occurred more than 21 days from the individual's death. (The administrative death review was pending an autopsy, and an extension had been properly obtained.)

b. through d. Evidence was not submitted to show the Center conducted thorough reviews of medical and/or 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 some examples of problems noted:

- Individual #272 was transferred to a tertiary care/referral center, but the Center did not/could not obtain consults. The Medical Director should communicate/meet with the medical director of the receiving hospital setting, but the mortality reviews did not include a recommendation to this effect.
- A cascade of events started when Individual #272 received his tube feeding with the head-of-bed down. He then developed pneumonia/sepsis and the downhill course to his death occurred. The mortality review committee did not react to this finding. This left other individuals who have feeding tubes at risk. All nurses and direct support professional staff should have been retrained on what to do if they observe someone being fed by tube lying flat or in a position other than what is written in the PNMP.
- Based on information related to Individual #167's death, medical providers should have completed an in-service training concerning factors placing individuals at increased risk for pulmonary embolisms, but the mortality reviews did not result in such a recommendation.
- One of the recommendations related to Individual #167's death read: "retraining of campus coordinators on CPR [cardiopulmonary resuscitation] with regards to proper mechanics during CPR and not stopping CPR until the paramedics actually take over the CPR or physician has called the code stating the time of death." It was unclear whether or not the mortality review committee looked at the content of the current training, and/or the frequency of drills to identify the cause of staff not understanding these basic tenets of CPR.
- Although the Death Review Investigation - Nursing Services was not a comprehensive review of the six months prior to Individual #167's death on 6/25/18, a number of significant findings were included:

- Nurses had not documented notification of the PCP for all episodes of emesis (five episodes) on 11/24/18;
- On 11/24/18, the individual fell, and on 11/25/18, at 7:20 a.m., and 8:13 a.m., she fell twice, but the nurse did not notify the PCP since there were no injuries. However, the individual was confused in that she came to the nurse to receive her medications twice after she actually received them. There was no documentation indicating that the nurse called the PCP, even though the "Plan" in the Subjective, Objective, Assessment, and Plan (SOAP) note for the fall on 11/25/18, at 7:20 a.m., was to notify the PCP for confusion;
- For one of the falls (date and time not noted in the report), nursing staff did not document vital signs;
- A nurse's note at 6:00 a.m., on 11/25/18, indicated the individual had been up all night vomiting and her vital signs were stable. However, no vital signs were found in the progress note or IView, and the PCP was not notified of "all night" vomiting;
- The Campus Coordinator stood during administration of CPR;
- Notes did not indicate which PCP was called since there were two on call over the weekend when these events took place, and it was unclear if each PCP had the full history of emesis and falls during the weekend; and
- From a video review, during one of the individual's falls, the direct support professionals did not get up to assist her off the floor and to a chair. Rather she "scooted" herself to a chair.

- As noted above, Individual #76's cause(s) of death were pending autopsy results. However, on 11/13/18, the wheelchair clinic placed a raised cushion on his wheelchair, and extended or lengthened the seatbelt. On 11/27/18, PNMT documentation noted that the new seat did not allow the individual to access the floor properly with his feet. The seatbelt buckle could be stretched to allow his buttocks to reach the far anterior edge of the seat cushion. Staff reported that he would push himself to the edge of the wheelchair daily. This was not corrected prior to his death, reportedly because the final PNMT assessment had not been completed. At time of his death, the seatbelt was found across his chest with an abrasion/bruise to the mandible and ear. Reportedly, staff also had not checked on him for two hours. This death should have been considered a sentinel event, and the clinical death review should have, but did not require an interdisciplinary root cause analysis of these events.
- Initially, for Individual #76, Center staff provided the Death Review Investigation - Nursing Services report that a Quality Assurance Nurse completed. As noted in the Monitoring Team's previous reports, this did not reflect a comprehensive review of the nursing care and services provided six months prior to the individual's death. The report noted that the individual experienced significant weight loss during the past year. However, it provided no analysis of why this happened or what his IDT did in response. The report offered no recommendations.

  During the onsite visit, Center staff provided a second review entitled a Clinical Death Review by Nursing Services, which the same QA Nurse completed. This also was not a comprehensive review of nursing care and services provided for the past six months. The QA Nurse drew conclusions such as that the IRRF included his risks areas, and that the IHCP reflected that care plans were in place. The report included no analysis regarding the quality of these documents, and offered no information about whether or not the IHCPs met the individual's needs, and/or whether staff implemented them as written. It also resulted in no recommendations.
- For Individual #90, the Clinical Death Review by Nursing Services did not reflect a comprehensive review of nursing care and services provided for the past six months. The report indicated that the IRRF, IHCP, and annual nursing assessment met his needs. However, as findings in this report as well as previous reports from the Monitoring Team reflect, significant deficits in these documents continue to exist, and Center staff have yet to remediate the problems identified. The continued lack of

comprehensive and critical nursing mortality reviews and analyses of systems undermines the intent of the mortality review process and severely limits opportunities for education and improvement in services provided to the individuals the Center serves.

e. For the two individuals for whom recommendations were made, documentation was not submitted to show implementation of the full set of recommendations.

In addition, as discussed in previous reports, the recommendations generally were not written in a way that ensured that Center practice had improved. In other words, recommendations need to be designed to ensure that concerning practices have changed.

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, 27 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, three additional indicators in the areas of ISPs, physical and nutritional management (PNM), and communication 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.

Assessments

Regarding ISP assessments:

- None of the individuals had adequate behavioral health and/or psychiatric assessments completed prior to the ISP meeting. As a result, behavioral health/psychiatric supports were not integrated into the individuals' overall sets of supports and services.
- For other disciplines, assessments were submitted prior to the ISP meeting, however, assessments either lacked recommendations for supports, or recommendations were not used to develop action plans.
- These problems regarding assessment submission were identified by the Center through their own QAQI process. This was good to see.

Comprehensive psychiatric evaluations (CPEs) continued to be missing one or more items (for all but one individual reviewed). Annual evaluations were completed for most individuals and were submitted timely for about two-thirds of the individuals. The documentation was complete for about one-third of the individuals. Psychiatrists attended annual meetings for about half of the individuals.

In behavioral health, few individuals had behavioral health assessments that met criteria. About two-thirds of individuals had functional assessments that were current and complete. Across the review group, criteria for all three behavioral health assessment indicators were met for some individuals, whereas for others, criteria were not met for any of the indicators.

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 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.

One of the nine individuals had a quality annual medical assessment that included the necessary components and addressed the individual's needs. Moving forward, the Medical Department should focus on ensuring medical assessments include thorough plans of care for each active medical problem, when appropriate.

The ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. In addition, primary care providers (PCPs) had not completed any interval medical reviews for eight of the nine individuals reviewed, which was of significant concern.

Improvement was noted with regard to the completion of quality annual dental exams. More specifically, it was positive that for eight of the nine individuals reviewed, the dental exams included all of the required components.

For six out of nine individuals reviewed, nurses completed timely annual nursing reviews and physical assessments. For seven out of nine, nurses completed timely quarterly nursing record reviews and/or physical assessments.

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

Work is still needed with regard to the timely referral of individuals to the Physical and Nutritional Management Team (PNMT), as well as ensuring the PNMT completes reviews and assessments for individuals that meet criteria. The PNMT also needs to involve necessary team members in their reviews and assessments. The quality of the PNMT comprehensive assessments needs improvement.

It was positive that, as needed, a Registered Nurse (RN) Post-Hospitalization Review was completed for the applicable individuals reviewed, and the PNMT discussed the results. Given the Center's sustained performance in this area, the related indicator will move to the category requiring less oversight.

On a positive note, good improvement was noted with regard to the quality of Physical and Nutritional Management Plans (PNMPs) in addressing individuals' specific needs. The PNMPs for six of the nine individuals reviewed met their needs. With minimal effort and attention to detail, the Habilitation Therapy staff could continue to make the needed corrections to PNMPs, and by the time of the next review, the Center could make additional good progress on improving individuals' PNMPs.

The Center should focus on improving the timeliness of Occupational/Physical Therapy (OT/PT) consults when individuals experience changes in status. The quality of OT/PT assessments continued to be an area on which Center staff should devote considerable focus. As a result of flawed assessments, ISPs did not include a full set of strategies and interventions to meet individuals' needs. However, it was positive that ISPs included thorough descriptions of individuals' OT/PT functioning, which represented considerable improvement from previous reviews.

Significant work continued to be needed to improve the quality of communication assessments and updates in order to ensure that Speech Language Pathologists (SLPs) provide IDTs with clear understandings of individuals' functional communication status; alternative and augmentative communication (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 is objectively evaluated. This includes ensuring that individuals receive the appropriate level of assessment in accordance with their needs.

In skill acquisition, recommendations for skill development were evident in the Functional Skills Assessment (FSA), vocational, and/or retirement assessments for few individuals.

Individualized Support Plans

In the ISPs, there was not progress towards writing individualized, measurable goals that were aspirational and likely to lead towards individuals living and working in a less restrictive environment. There were ranges across individuals, that is, some individuals had as many as four goal areas that met criterion, whereas others had one goal area that met criterion. None of the goals, however, were written in measurable terminology, and none had regularly collected reliable data.

For the handful of ISP goals that were aspirational, action plans were not developed that would lead towards the accomplishment of goals.

ISP action plans were not consistently implemented. The Center had a Qualified Intellectual Disabilities Professional (QIDP) monthly review process in place. That is, reviews were occurring and being completed, but the process did not result in addressing barriers to implementation.

There was one half-time psychiatrist; he was designated as the lead psychiatrist. Other providers were locum tenens. There was turnover in the lead psychiatrist position and in the locum tenens providers since the last review.

In psychiatry, there was some positive movement towards the identification of psychiatric indicators for reduction and the creation of psychiatry-related goals. Much more work is needed. For instance, there were some goals for some individuals, but

they did not contain all of the required content and they did not appear in the ISP/IHCP. A positive observation was that in one of the psychiatry clinic sessions, the psychiatrist was monitoring goals that had been created over the past year.

In behavioral health, reliability of PBSP data was seriously problematic. Teams were not confident in the data being accurate, clinicians reported incorrect and uncollected data, and the Monitoring Team observed numerous occurrences of problem/target behaviors of which more than three-quarters were not documented or recorded. Correcting this should be a high priority area for the Center.

Several PBSPs included token economies and plans for addressing refusals. This showed some individualization of treatment programming.

Across the nine individuals, there were a total of 13 skill acquisition plans (SAPs), compared with 21 at the last review, and closer to 27 at many other Centers. This represented very limited planning for skill development for individuals who had multiple skill deficits.

The new BHS director had worked at the Center as a Board-Certified Behavior Analyst (BCBA) for several years. She was knowledgeable of the systems at the Center, had identified areas in need of improvement, and was open to feedback from the Monitoring Team during the onsite visit.

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.

It was positive the Center continued to perform at a high level with regard to describing in each ISP how individuals communicate and how staff should communicate with them. The related indicator will move to the category of less oversight.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.	
Summary: Overall, the number of personal goals that met criterion with indicator 1 remained about the same as at the last review. There were ranges across individuals, that is, some individuals had as many as four goal areas that met criterion, whereas others had one goal area that met criterion. None of the goals, however, were written in measurable terminology and none had regularly collected reliable data (or implementation). These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	268	143	119	59	490	149			
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	1/6	3/6	4/6	2/6	3/6	1/6			
2	The personal goals are measurable.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #268, Individual #143, Individual #59, Individual #119, Individual #490, and Individual #149. 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.

1. The ISP relies on the development 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.

At Brenham SSLC, goals were rarely aspirational and offered few opportunities to learn new skills that might lead towards living and working in a less restrictive environment. 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. However, each of the ISPs contained an individualized goal in at least one area.

Fifteen 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.

The personal goals that met criterion were:

- Leisure goals for Individual #59, Individual #490, Individual #143, and Individual #149.
- These leisure goals did not meet criterion:
    - Individual #268 did not have a leisure goal.
    - Individual #119's goal to operate her DVD player was continued from the previous ISP at her ISP preparation meeting. Her ISP noted that she already spent time watching DVDs. While this might have been a good action plan to support greater independence, it was not an aspirational long-term goal to expand her leisure/recreational skills. Because the team had a goal for her to move back into the community, a more aspirational goal would have been a goal that offered additional leisure/recreational opportunities in the community. The IDT also expressed the need for supports to

address her weight gain. A goal that supported her to be more active would also have been appropriate. In a comment on the draft version of this report, the State wrote that "although this goal and action plan were continued from the previous year, the lack of implementation should not discount that this goal is still appropriate for individual #119 and involves skills that would be beneficial when living in the community. Currently individual #119 requires staff's assistance to operate the DVD player. This goal will give her more control over her environment and reduce her frustrations of waiting on staff to assist her." The Monitor's response is to reiterate what is in the first part of this bulleted paragraph. That is, operating a DVD player to do an activity she already spends a lot of time doing might be an action plan to support independence, but did not show any long-term planning for Individual #119 and, therefore, did not meet the criterion for this sub-indicator.

- Individual #119's relationship goal met criterion. Individual #268, Individual #490, Individual #59, and Individual #149 did not have relationship goals.
  - It was not clear how Individual #143's goal to plan an outing with his peers would lead to new skill development. He already routinely took trips in the community with his peers. His greatest barrier to interacting with others appeared to be his communication skills. The IDT needs to focus on activities that improve his communication and interpersonal skills.
  - Individual #119's goal to make a friend on campus that would read to her did not describe what Individual #119 would do to make new skills. This appeared to be a goal for staff to complete.
- Work/School/Day goals for Individual #119 and Individual #143. Both had goals to graduate from high school.
- These work/school/day goals did not meet criterion:
  - Individual #59 did not have a day/work goal. He spent a majority of his day sitting idly, engaged in very little activity.
  - Individual #268 and Individual #490's work goals to earn money to purchase preferred items did not focus on the development of job skills that might lead towards more independent employment.
  - Individual #149's day goal to attend a meaningful day program did not focus on skills that might lead towards the development of employment skills. In a comment on the draft version of this report, the State wrote that the IDT had discussed finding day programming activities that fit individual #149's preferences in hopes of identifying potential plans toward the development of employment skills. Even so, the IDT should have done more than this. The IDT should have completed a comprehensive vocational assessment prior to development of the ISP. Goals should specify specific skills that training will focus on during the ISP year. To complete this goal as written, Individual #149 would only have to attend a day program. Past attendance at day programming had not led to identification of employment skills, based on preferences or otherwise. Furthermore, this goal did not reflect skill building.
- Independence goal for Individual #268, Individual #143, Individual #119, Individual #59, and Individual #490,
  - Individual #149's ISP indicated that the IDT would meet following the ISP meeting to develop a greater independence goal. There was no evidence that the IDT met and developed a goal.
- Living options goals for Individual #143, Individual #119, and Individual #490.
- These living options goals did not meet criterion:
  - Individual #268 and Individual #59's goals would not lead towards living in a less restrictive environment and were not aspirational.
  - Individual #149's goal was not individualized.

The Monitoring Team observed Individual #119's annual ISP meeting. The IDT planned to continue most of her goals from the previous year with little modification. There was minimal discussion regarding opportunities to learn new skills or experience new activities. The IDT's long term goal for Individual #119 was to move back into the community with or near her family. With this in mind, the IDT should have more so focused on goals that would increase Individual #119's independence in her home and would support her integration into the community. Aside from attending school in the community, her ISP did not offer opportunities for skill building or integration into the community. An additional area of focus for Individual #119 should be developing work skills that might lead towards meaningful employment in the community when she graduates from school.

2. When personal goals for the ISPs did not meet the criterion described above in indicator 1, there can be no basis for assessing compliance with measurability or the individual's progress towards its achievement. The presence of a personal goal that meets criterion is a prerequisite to this process. Of the 15 personal goals that met criterion for indicator 1, none met criterion for measurability.

- Goals did not include timelines for completion.
- Some of the goals also did not include measurable behavioral objectives. For example, it was not clear what Individual #143 would have to do to complete his goal to plan an outing.

3. Since none of the goals were measurable, this indicator was not evaluated. QIDP monthly reviews and SAP data sheets indicated that a majority of the action plans were never implemented. For those that were implemented, consistent data were not available to determine progress towards goals. In many cases, SAPs had not been developed when requested by the IDT. Thus, staff lacked guidance needed to implement action plans. Some examples included:

- Individual #119's action plan to operate her DVD player indicated that a SAP would be developed to guide staff in implementation. Her ISP was developed in April 2018. Her QIDP monthly review indicated that as of February 2019, the SAP had not been developed. Her SAP for operating a vending machine was also never developed.
- Individual #143's ISP noted that action plans would be developed for planning an outing after his skills were assessed in this area. There was no documentation showing that the assessment had occurred or that action plans to support this goal were ever developed. According to his QIDP monthly reviews, there were no data for implementation of action plans related to his recreation, day, or independence goals.
- The QIDP monthly review for Individual #490, indicated that there were no data for implementation of action plans related to her leisure and greater independence goals.
- None of Individual #149's action plans had data to support implementation.

As noted throughout this report, for all of the other goals, it was not possible to determine if ISP supports and services were being regularly implemented or to determine the status of goals because of the lack of reliable data and documentation provided by the Center. While some data were collected showing implementation of some action plans, there was not enough information documented to clearly determine the status of goals.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: Performance overall remained low across these set of ISP-characteristic indicators. In particular, integration of, and attention to, various clinical and therapeutic needs (indicator 13). Five of the indicators, however, scored higher than at the last review, thus, indicating that the Center has capacity to meet some of these requirements. This set of indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	268	143	119	59	490	149			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	1/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	50% 3/6	0/1	1/1	1/1	1/1	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.	50% 3/6	0/1	1/1	1/1	0/1	1/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	33% 2/6	0/1	1/1	1/1	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.	33% 2/6	0/1	1/1	1/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	1/6	0/6	0/6			
Comments:											

8. Fifteen of the personal goals met criterion in the ISPs, as described above in indicator 1, therefore, those action plans could be evaluated in this context (i.e., for this indicator 8). A personal goal that meets criterion is a prerequisite for such an evaluation. Action plans are evaluated further below in terms of how they may address other requirements of the ISP process.

The goal for Individual #59's feed fish had reasonable action plans that could lead to ultimately his achieving of this goal.

Most of the action plans were written as service objectives and did not include staff instructions or implementation strategies that would ensure staff could consistently teach a new skill or accurately collect data on progress. Many action plans stated what staff would do, but not what action the individual would take to show progress towards accomplishing his/her goal, thus, data often indicated how many times staff had implemented the plan instead of measuring specific progress towards the goal. IDTs still needed to focus on laying out a clear path of assertive action plans to meet each goal. Some goals had no action plans that were clearly related.

- Individual #490, Individual #268, and Individual #149 had no action plans related to goals with specific teaching strategies to guide staff in implementation. Individual #490 had a total of two SAPs, Individual #268 and Individual #149 had one; none were related to their goals.
- Individual #119 had one SAP related to her goals, thus, consistent implementation was unlikely.
- Individual #143 had SAPs related to his goal for dressing independently, however, his SAPs did not offer enough guidance to ensure consistent implementation.

9. One of the ISPs had action plans that integrated preferences and opportunities for choice. For Individual #119, choosing a movie and using a vending machine would facilitate choice making and preferences.

For the most part, goals and action plans were based on individual preferences, however, opportunities for making choices were limited. Action plans ensuring opportunities for work and day programming based on preferences and supported by exposure to new activities were particularly limited for those not attending school.

IDTs were generally not identifying preferences in a way that might guide the development of activities that would offer opportunities to learn new skills and build on developing a plan for meaningful days. For the most part, ISPs listed general preferences related to food, music, television, and activities routinely offered at the facility.

Opportunities to make meaningful choices were limited. Expanding choices may result in discovering new preferences.

10. None of the ISPs clearly addressed strengths, needs, and barriers related to informed decision-making. A basis to making informed decisions is offering individuals exposure to a variety of new experiences and opportunities to make choices throughout their day. These opportunities were not included in action plans in any substantial way. Self-advocacy activities are one of a number of ways of addressing this.

11. Three of the ISPs met criterion for this indicator to support the individual's overall independence.

- Individual #143 had action plans for dressing independently.
- Individual #59 had action plans for propelling his wheelchair independently.

- Individual #119 had action plans for operating her DVD and the vending machine independently.
- Individual #268 had action plans to make his own snack that were discontinued following g-tube placement and not replaced.
- Individual #490's greater independence goal to organize and decorate her room had but one action plan to purchase bins for organization.
- Individual #149 did not have goals or action plans to support greater independence.

12. None of the ISPs integrated strategies to minimize risks in ISP action plans. While risks were addressed through action plans included in the IHCP, supports were not routinely integrated into other action plans when relevant, and risks were not always identified by the IDT. Rarely were SAPs written to provide staff with strategies for implementing plans and, when SAPs were written, they did not include specific mobility, behavioral, and safe eating supports.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well integrated in ISPs. In most cases, supports were fragmented, with little evidence that IDT members were sharing data and collaborating on developing supports. For example,

- Individual #268's behavioral and medical supports were not integrated into his action plans.
- Individual #143 had complex needs that would require integrated supports related to his behavioral, medical, neurological, communication, and physical therapy needs. There was little evidence that the IDT had taken a collaborative effort to address his support needs. Recommendations from his orientation and mobility assessment, behavioral assessment, and communication assessment were not integrated into action plans.
- Individual #119's communication goals were not integrated into other action plans. At her annual ISP meeting, the IDT identified communication supports as a priority for her, however, they only discussed action plans related to stand alone therapy.
- Individual #490 had at least 50 falls in the six months leading to her annual ISP meeting. Mobility supports were not integrated into her ISP action plans. Her assessments indicated that she had a degenerative medical condition that will lead to a decline in her independent functioning. The IDT was not proactive in developing supports that might slow this decline or address her changing needs. For example, she had a goal to go to the community library to check out books and movies. It was discontinued due to her declining vision. The IDT did not consider replacing the goal or adapting it to meet her changing needs.
- Individual #149's communication strategies were not integrated into action plans. He has had several incidents of removing his g-tube, leading to significant medical issues. His behavioral support plan does not address removing his g-tube.
- For Individual #143 and Individual #119, there was little documented evidence of integration with the school system. The Center needs to strengthen its relationship with the public school. This should include regular observations/visits from Center staff to the school, sharing of information with school personnel to ensure consistency in PBSP implementation, and consideration of programming at the Center (e.g., SAPs, SOs) to support the individuals' IEP goals and objectives.

ISPs summarized assessment results, however, assessments offered few recommendations for supporting new skill development. When there were recommendations, they were rarely integrated into action plans for learning new skills. This was particularly true for communication skills.

14. Three of the ISPs included action plans to support meaningful integration into the community.

- Individual #143 and Individual #119 had action plans to attend school in the community, however, neither had action plans to support community integration outside of attending school.
- Individual #490 had an action plan to go to the library twice monthly. Going to the library would be a great opportunity for community integration, however, the action plan was never implemented and later discontinued.

Aside from the two school aged individuals, individuals made trips into the community, but were not given opportunities to utilize community resources that might support them to be more independent and integrated into the community. Individuals did not have goals for banking, volunteering, getting haircuts, joining a church, or joining a gym in the community. Outings were limited to specific events, such as eating out, going to the movies, or attending a sporting event. While these types of activities support community exposure, they are unlikely to lead to meaningful integration.

15. Two of the ISPs documented the IDT's consideration of opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. As noted, Individual #143 and Individual #119 were attending school in the community. This was positive. It was not evident, however, that the IDT had considered ways to increase participation and integration in school activities. Both spent their day in a non-integrated pubic school classroom.

For the other four individuals, action plans did not address preferences in regard to work/day programming. Action plans were not present that would support skill development which might lead to work/day programming in a less restricted setting. Vocational assessments were not adequate for identifying preferences outside of the limited vocational opportunities offered at the facility and assessing skills that might lead towards work in a more integrated setting.

16. ISPs did not support substantial opportunities for functional engagement described with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Overall, the ISPs provided limited opportunities for learning and functional skill development. During observations, activities were rarely functional and did not provide opportunities to experience new things and learn new skills. IDTs need to expand the preference assessment to offer more opportunities to try new things and identify new interests.

- Document review and observations did not support that Individual #268, Individual #59, Individual #490, and Individual #149 were engaged in meaningful day programming or had opportunities to learn new skills that might lead towards a more meaningful day.
- During numerous observations, it was noted that Individual #268, Individual #490, and Individual #149 spent a majority of their day in their bedrooms not engaged in activity. Individual #59 was observed at various times during the week sitting in the day room in his wheelchair not engaged in any activities.
- Outside of school, Individual #143 and Individual #119's ISP did not include action plans to support functional engagement for periods not in school (evenings, holidays, weekends).

17. ISPs did not adequately address barriers to achieving goals and learning new skills. Goals were not consistently implemented, and IDTs did not address barriers to implementation. A review of ISP preparation documents indicated that some goals that had not been implemented, or the individual failed to make progress, were continued from the previous ISP without addressing barriers. None of the ISPs addressed identified barriers to community transition in a meaningful way.

18. Action plans did not describe detail about data collection and review, in almost all cases. The one exception was Individual #59's action plans/skill acquisition plan related to his leisure recreation goal. Overall, ISPs did not usually include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action plans were broadly stated, not individualized, and, in most cases, skill acquisition plans were not developed when needed to ensure consistent training strategies were implemented.

Although IDTs had created some goals that were more individualized and based on known preferences, few had specific teaching strategies to ensure staff were implementing them and measuring success consistently. Additionally, few had been fully implemented. Thus, individuals did not have person-centered ISPs that were really leading them towards achieving their personal goals. The Center needs to focus on barriers that are preventing individuals from achieving their goals and develop plans to address those barriers.

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

Summary: Individuals' preferences were examined for all but one individual for this review and the past review, too. With sustained high performance, indicator 19 might be moved to the category of requiring less oversight after the next review. Some clinician input was not available for the living option discussion because assessments were not submitted. Ultimately though, the team as a whole made a decision. This has been the case for this and the previous three reviews, too (with one exception in each of the previous two reviews). Therefore, indicator 22 will be moved to the category of requiring less oversight. More creativity and individualization regarding addressing obstacles referral was needed. It was positive to observe good leadership by the ISP facilitator in encouraging an LAR to explore some living options. These indicators will remain in active monitoring (other than indicator 22).

#	Indicator	Overall Score	Individuals: 268	143	119	59	490	149			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	83% 5/6	1/1	1/1	1/1	0/1	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.	0% 0/1			0/1						
21	The ISP included the opinions and recommendation of the IDT's staff members.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	17% 1/6	0/1	0/1	0/1	0/1	1/1	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).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	100% 1/1			1/1						
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	100% 1/1			1/1						
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A									

Comments:

19. Five ISPs included a description of the individual's preference for where to live and how that preference was determined by the IDT. The other three did not:

- Individual #59's ISP noted that his awareness of living options was limited. He had lived in institutional settings since age six. It was noted that he had last been on a CLOIP tour almost three years ago. It was not evident that the IDT had individualized plans to increase his awareness of other living options.

20. Individual #119's annual ISP meeting was observed. The IDT recommended a tentative living option goal to move to the community, however, they did not specifically discuss her living option preferences or support needs.

21. For all individuals, behavioral health and psychiatry assessments were not submitted prior to the ISP, so recommendations were not available for IDT review.

22. All ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.

23. One of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths (Individual #490). The other five ISPs did not indicate that the IDT had considered other living options that specifically supported their preferences and support needs.

24. All ISPs identified a list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed.

26. None of the individuals had individualized, measurable action plans to address obstacles to referral, or were referred if obstacles were not identified.

25 and 27. Individual #119's annual ISP meeting was observed. Although the IDT agreed that community living should be considered, Individual #119's mother expressed her desire for Individual #119 to continue living at Brenham SSLC.

- The QIDP facilitator did a nice job of encouraging Individual #119's mother to at least consider other living options. In the end, she did agree that she would go with facility staff to look at other living options this summer.

28. Individuals did not have individualized and measurable action plans to educate the individual and/or LAR on living options that might be available to support their needs. ISPs included action plans for the individual to attend a provider fair and group home tours, however, these were not individualized based on the individual or LAR's current knowledge regarding living options or specific to living options that could provide identified supports needed in the community. As noted, Individual #119's mother did agree to visit some community placement options during the upcoming year. The IDT, however, did not discuss specific action plans to ensure that this happened.

29. Barriers were identified to referral for all individuals.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
Summary: ISPs were not fully implemented in a timely manner. Additional participation by various team members, at the annual ISP meeting, was needed for some of the individuals. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	268	143	119	59	490	149			
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).	33% 2/6	1/1	0/1	0/1	0/1	1/1	0/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in	33% 2/6	1/1	0/1	1/1	0/1	0/1	0/1			

	the planning process.										

Comments:

32. Documentation was not submitted that showed that action plans were implemented within a timely basis for any of the individuals.

33. Two individuals attended their ISP meetings (Individual #268, Individual #490).

34. Two of the individuals had an appropriately constituted IDT based on the individual's strengths, needs, and preferences, who participated in the planning process (Individual #268, Individual #119).

- Individual #143's psychiatrist did not attend his meeting, nor did he submit an assessment prior to the annual meeting.
- Individual #59's OT/PT did not attend his annual meeting. He has a goal to self-propel his wheelchair. Input from the OT/PT would have been beneficial in developing supports.
- Individual #490's PCP did not attend her meeting. She had a degenerative disease that was affecting all areas of her life. The IDT needs to consult with the PCP regarding how her progressing healthcare issues will affect her daily functioning and develop supports to address those areas.
- The following IDT members were absent from Individual #149's ISP meeting: his PCP, direct support staff, psychiatry, and his SLP. His ISP did not adequately address his support needs.

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

Summary: Most IDTs considered and listed the assessments that were needed for the upcoming ISPs. But then, none of the IDTs arranged for and obtained all of these assessments. The Center needs to continue to make obtaining assessments a priority. These two indicators will remain in active monitoring

Individuals:

#	Indicator	Overall Score	268	143	119	59	490	149			
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.	83% 5/6	1/1	1/1	1/1	0/1	1/1	1/1			
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. IDTs considered what 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 five individuals.

Individual #59's IDT has not explored employment and the IDT has not considered an updated vocational assessment. He spent a majority of the day just sitting idly in his wheelchair. Additionally, he had a goal to self-propel his wheelchair. The IDT did not request an assessment to determine his support needs and action plans did not guide staff implementing this goal. The PT should help the IDT

develop a SAP to teach this skill.

36. None of the IDTs arranged for and obtained all needed, relevant assessments prior to the IDT meeting. The timely submission of assessments had been identified as an issue that the facility needs to address in the QA/QI Council meeting minutes. Action plans were developed by the facility to address the timeliness of behavioral and psychiatric assessments.

- Individual #268's behavioral health assessment had not been updated and his psychiatric assessment was submitted late.
- Individual #143's behavioral health, psychiatric, and functional skills assessment were all submitted late.
- Individual #59's psychiatry assessment was not submitted 10 days prior to his ISP meeting and his behavioral assessment was not updated until after his ISP meeting.
- Individual #119's behavioral health assessment was not updated prior to her ISP meeting.
- Individual #490's functional skills assessment and psychiatric assessment were not submitted timely.
- Individual #149 did not have a behavioral health assessment update and his psychiatry assessment was submitted after his annual ISP meeting.

Without relevant assessments for the IDT to review, comprehensive supports and services were not developed, and all risks were not addressed. Having information from assessments would greatly assist the IDTs in developing meaningful goals with action plans to address needed supports. The facility needs to continue to make obtaining assessments a priority going forward.

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

Summary: The IDT reviewed supports, services, and serious incidents during ISPA meetings. This was good to see; however, IDTs did not routinely revise supports or goals or address barriers when progress was not evident. Consistent implementation and monitoring of ISP action steps remained areas of concern. ISP action plans were not regularly implemented for any of the individuals. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	268	143	119	59	490	149			
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:

37. The IDT reviewed supports, services, and serious incidents during ISPA meetings. This was good to see; however, IDTs did not routinely revise supports or goals or address barriers when progress was not evident.

As noted in other sections of this report, data were rarely available to assist the IDT in decisions regarding revising the ISP.

38. Consistent implementation and monitoring of ISP action steps remained areas of concern. ISP action plans were not regularly implemented for any of the individuals.

For the most part, monthly reviews were routinely submitted on time and included a cursory review of all services. The consistent completion of the QIDP monthly reviews was good to see, however, they included little meaningful information regarding progress towards goals and efficacy of supports. When additional assessments were recommended throughout the ISP year, it was often not apparent that the IDT obtained those assessments, reviewed any resulting recommendations, and/or implemented changes to supports when recommended.

Some QIDP monthly reviews included data for some action plans, but rarely included an analysis of those data to determine what specific progress had been made towards achievement of goals. Information regarding behavioral supports, habilitation therapy, and medical supports was inserted in the monthly reviews without a summary of status, statement on the efficacy of supports, or efforts made to follow-up on outstanding issues. There was little documentation of follow-up when plans were not implemented or not effective. This practice places individuals at significant risk for harm when the IDT cannot determine if supports to address risks are consistently implemented or effective.

Going forward, the QIDPs will need to be sure that they are gathering data for the month, summarizing progress, and revising the ISP as needed, particularly when goals are not consistently implemented.

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

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

#	Indicator	Overall Score	Individuals: 143	268	286	217	149	276	76	490	91
a.	The individual's risk rating is accurate.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
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.	50% 9/18	2/2	1/2	1/2	1/2	0/2	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 #143 – falls, and choking; Individual #268 – falls, and constipation/bowel obstruction; Individual #286 – falls, and constipation/bowel obstruction; Individual #217 – constipation/bowel obstruction, and aspiration; Individual #149 – skin integrity, and falls; Individual #276 – polypharmacy/side effects, and aspiration; Individual #76 – infections, and skin integrity; Individual #490 – falls, and constipation/bowel obstruction; and Individual #91 – osteoporosis, and skin integrity).

a. For the individuals reviewed, IDTs did not effectively identify or use supporting clinical data, and/or use the risk guidelines when determining a risk level.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #143 – falls, and choking; Individual #268 – constipation/bowel obstruction; Individual #286 – constipation/bowel obstruction; Individual #217 – aspiration; Individual #276 – aspiration; Individual #76 – infections; and Individual #91 – osteoporosis, and skin integrity.

Psychiatry

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

Summary: Brenham SSLC made some progress moving forward to have psychiatric indicators for reduction, relating them to the diagnoses, and describing them in observable terminology for some individuals, slightly more so than at the last review. This was not yet being done for psychiatric indicators for increase. Also, two individuals had psychiatric goals built upon from the psychiatric indicators. Goals were not yet appearing properly in ISPs/IHCPs and reliable data for psychiatric indicators were not yet collected. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	0% 0/9	1/2	1/2	0/2	0/2	1/2	0/2	1/2	1/2	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	1/2	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 has a denominator of 2, which is comprised of whether criteria were met for all sub-indicators for psychiatric indicators/goals for (1) reduction and for (2) increase. Note that there are various sub-indicators. All sub-indicators must meet criterion for the indicator to be scored positively.

4. Psychiatric indicators:

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

In behavioral health services positive behavior support plans (PBSPs), the focus is upon what are called target behaviors and replacement behaviors. 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 and normed for this population.

The Monitoring Team looks for:

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

Brenham SSLC showed some progress in this area as all individuals in the review group had one or more indicators related to the reduction of psychiatric symptoms (i.e., sub-indicator a). And for seven of the individuals, the indicators for reduction were related to their diagnosis or diagnoses (all but Individual #268 and Individual #143). And for five of the individuals, the indicators were described in observable terminology. For Individual #417, because the indicators were not described in observable (clear) terminology, it was not possible to determine how the indicators related to her psychiatric diagnosis. Individual #417 had a diagnosis of Schizoaffective Disorder. One of the identified indicators was auditory hallucinations. These were to be tracked via observational data. There was no description of the auditory hallucinations or how these were exhibited by this individual, thus, it would not be possible for staff to correctly identify them.

None of the individuals in the review group had psychiatric indicators for increase in positive/desirable actions identified. The Center psychiatrists will need identify psychiatric indicators for increase and document their rationale of how the positive/desirable actions relate to the diagnosis.

Thus, criteria were met for all three sub-indicators (a, b, c) for psychiatric indicators for reduction for five individuals in the review group (Individual #279, Individual #281, Individual #119, Individual #599, Individual #59), and for none of the individuals for psychiatric indicators for increase.

5. Psychiatric goals:
The Monitoring Team looks for:

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

At Brenham SSLC, there were acceptable goals written regarding psychiatric indicators for reduction for three of the individual. There were no indicators identified for increase, so there were no goals written regarding these psychiatric indicators.

There were notations indicating that in some instances, data would be collected via direct care staff or behavioral health services and while this seemed reasonable, the indicators will need to be clearly described in observable terminology in order for them to be accurately identified. Because the purpose of the psychiatric indicator is to determine an individual's symptom experience, a mixture of individually defined indicators and/or data from direct observations by staff of psychiatric indicators with goals and the collection of data utilizing rating scales normed for this population could be considered. Currently, the facility was utilizing the ADAMS (Anxiety, Depression, and Mood Scale) and the Abbreviated ADHD rating scale. The facility had data graphed and they trended the results of the rating scales over time, which was good to see. The scales, however, were completed by the behavioral health clinician at the beginning of each month. As such, if an individual's psychiatry clinic was held later in the month, the data would be stale.

Thus, both sub-indicators were met for three of the individuals for goals for reduction (Individual #599, Individual #59) and for none of the individuals for goals for increase.

6. Documentation:
The Monitoring Team looks for:

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

At Brenham SSLC, psychiatric indicators/goals for reduction were not regularly incorporated into the Center's overall documentation system, the IHCP. In one example, regarding Individual #599, the goals were included in the IHCP, but they were not all documented correctly. Specifically, there was no time metric associated with the goal for the result of the depressed mood and anxiety subscales of the ADAMS rating scale. It was, however, good to see progress regarding inclusion of the indicator goals. The IHCP was confusing because the document indicated that the psychiatric indicator goals were met, but this was not consistent with a review of this individual's data reports. It seemed odd that a goal entered into the new year's ISP/IHCP would say it was already done. If so, then one would expect a different goal. It may be that the psychiatrist wanted to keep the same goal from the previous year. That is, an individual might have met a goal for no occurrences of psychiatric indicators (for reduction). The psychiatrist might feel it appropriate

to keep the same goal and target for the upcoming year (not uncommon in psychiatry practice). If so, it might be better to indicate this logic rather than inserting statement that the goal was done.

Goals for increase were not yet authored and, therefore, not incorporated into the IHCP.

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, data were reported for behavioral challenges and identified target behaviors. In many examples, the data provided at psychiatry clinic were stale in that they were only reported through the previous month, or rating scales that were performed at the beginning of the month with a clinic date performed at the end of the month. Data graphs were not included in the psychiatric documents, but were available for psychiatry electronically. During the clinical encounters observed during the monitoring visit, the psychiatrists had requested sleep data and asked to review said data. In several observations, these data were not available for use in clinical decision-making.

The collection and presentation of reliable data is an area of focus for the psychiatry department. Likely, maintaining this will require ongoing collaborative work between psychiatry, behavioral health, residential services, day/vocational services, and the Center's ADOP. This will be the case as Brenham SSLC moves towards further individualizing psychiatric indicators for decrease and increase that may not be identical to what is already being measured by the PBSP as target behaviors/replacement behaviors.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.												
Summary: CPEs continued to be missing one or more items for all but one individual. Other documentation did not meet criteria. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
12	The individual has a CPE.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B										
14	CPE content is comprehensive.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	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	0% 0/1			0/1						

	completed within the first business day, and a CPE was completed within 30 days of admission.										
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	67% 6/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1

Comments:

14. The Monitoring Team looks for 14 components in the CPE. One CPE included all of the required components. The evaluations were missing one to five elements. One evaluation was missing one element, one evaluation was missing two elements, three evaluations were missing three elements, one evaluation was missing four elements, and one evaluation was missing five elements. The most common deficient element was the bio-psycho-social formulation. This was incomplete in six examples.

15. For Individual #162, who was admitted in the two years prior to the onsite review, there were delays in completion of the admission assessments. While the initial CPE was performed the day following admission and there was an IPN from nursing documented on the day of admission, there was no IPN or admission note from the primary care provider.

16. There were three individuals whose documentation revealed inconsistent diagnoses across disciplines, Individual #279, Individual #162, and Individual #143.

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

Summary: Annual evaluations were completed for most individuals and was submitted timely for about two-thirds of the individuals. The documentation was complete for about one-third of the individuals. Psychiatrists attended about annual meetings for about half of the individuals. Overall, performance about the same as at the last review. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 279	281	162	417	119	268	599	59	143
17	Status and treatment document was updated within past 12 months.	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	33% 3/9	0/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1	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	1/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	56% 5/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1	0/1
21	The final ISP document included the essential elements and showed	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	evidence of the psychiatrist's active participation in the meeting.	0/9									

Comments:

17. Nine individuals required annual evaluations. Seven were completed.

18. The Monitoring Team scores 16 aspects of the annual evaluation document. Three of the annual evaluations contained all of the required elements. The other annual evaluations were missing seven to 14 of the required elements. One evaluation was missing seven elements, one evaluation was missing eight elements, one evaluation was missing 13 elements, and one evaluation was missing 14 elements.

The three evaluations that met all the criteria were well done. The psychiatrist had created a Word document that included headings noting all of the information required by the monitoring tool and entered this into the IRIS electronic medical record.

The other evaluations were scant on detail and provided little information regarding the individual. One issue identified during the monitoring visit was that this facility continued to perform four quarterly evaluations and one annual evaluation. The substitution of the fourth quarterly evaluation for the annual evaluation was discussed with the clinicians. This would result in some time/effort savings and perhaps allow for timely completion of the evaluations.

19. Three individuals, Individual #281, Individual #162, and Individual #599, requiring an annual CPE had one completed prior to the annual ISP meeting.

In the case of Individual #162, the annual CPE was of poor quality and provided little useful information. In this case, there was a quarterly evaluation performed within 90 days of the meeting that provided more detail. The CPEs for three individuals, Individual #59, Individual #268, and Individual #279, were not completed within the required timeframe for submission for the meeting, however, these individuals had a quarterly psychiatric clinical encounter documented within 90 days of the meeting. Three individuals did not have an annual evaluation submitted within the required time frame and there was no documentation of a quarterly psychiatry clinical encounter within 90 days prior to the ISP meeting.

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

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

and realized side effects of the medication in addition to the benefits.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.											
Summary: PSPs showed continued improvement, both meeting criteria for this review. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	100% 2/2									
Comments: 22. The PSPs were reviewed for two individuals, Individual #579 and Individual #41. The PSP documents were brief but contained the essential information for direct care staff to identify the indicators, document the indicators, and respond to the individuals.											

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
Summary: Additional attention to two areas of content of consents for psychiatric medications would likely lead to both indicators scoring higher in the future. Both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.										
30	A risk versus benefit discussion is in the consent documentation.	11% 1/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	44% 4/9	0/1	1/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1
32	HRC review was obtained prior to implementation and annually.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments: 30. The risk versus benefit discussion was not included in the consent forms in eight examples. In a comment on the draft version of this report, the State pointed to documentation regarding risk-benefit discussion for two individuals. The Monitor's responses are below: • Individual #599: The State quoted from the document: "Based on fact she is tolerating Lorazepam without known untoward effects, and she has exhibited benefit, current benefit deemed greater than risk." The Monitor's response is that solely a											

statement that the risk is outweighed by the benefit does not meet criterion with this indicator. There is a need to weigh the specific risks associated with the medication and determine if the risk is worth the benefit. In the case of this individual, she had a high risk rating for osteoporosis, falls, and fracture. Further, per the most recent ISP, she had a history of two falls, and a partial compression fracture. This risk should be considered (described) when treating with a benzodiazepine that increases the fall risk.

- Individual #59: The State quoted from the document: "The main immediate concern is will be on potential 2 qtc prolonging agents. However, current qtc not elevated, so potential benefits deemed greater than this and other potential but unrealized side effects above. Although he has never been diagnosed with Bipolar Disorder, manic symptoms were considered in past, but ultimately the symptoms were deemed more secondary to ADHD type syndrome. Will need to say wary for manic symptoms also, but this does not outweigh potential benefits." The Monitor's response is that the risk/benefit discussion for the antidepressant medication, Lexapro, was a good discussion. For the second consent form, for the second generation anti-psychotic Zyprexa, the risk/benefit discussion stated that "based on no current side effects known to olanzapine, and evidence of response, the benefit is deemed significantly greater than the risk." This individual had issues with regard to spasticity and limb jerking. This was documented as not due to psychotropic medication, but rather due to the neurodegenerative process associated with the diagnosed chromosome deletion. He had documentation of an elevated MOSES score at 15 (per the documentation in the IRRF). A review of MOSES scores revealed that on 3/1/18 there was a dyskinesia score of 3, on 6/7/18 there was noted "moderate limb jerking, writhing," and on 9/27/18 scores for limb jerking and dyskinesia were negative. He was treated with Klonopin due to spasticity. Because antipsychotic medication can be associated with movement disorders and advance this individual's difficulties, the benefit that he is reportedly receiving was likely worth the risk, however, this needs to be addressed in the medication consent document.

31. The consent forms for four of the individuals in the review group included alternate, individualized, non-pharmacological interventions in four examples. In a comment on the draft version of this report, the State pointed to the PBSP for Individual #599. Although this is one alternate, individualized, non-pharmacological intervention, to meet criterion with this indicator, at least one other intervention must be in place and identified.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.	
Summary: Regarding indicator 1, two individuals were identified for whom further assessment should be conducted to determine if a PBSP is warranted. Goals were written in measurable terms. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. On the other hand, reliability of data was seriously problematic. Teams were not confident in the data being accurate, clinicians reported incorrect and uncollected data, and the Monitoring Team observed numerous occurrences of problem/target behaviors of which more than three-quarters were not documented or recorded.	Individuals:

Correcting this should be a high priority area for the Center. Indicators 3 and 5 will remain in active monitoring.

#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
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% 9/9	1/1	1/1	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% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

1. During the onsite visit. Individual #149 was reported to have been pulling on his mic key button/g tube, a potentially risky behavior. Data indicated that this had been ongoing since at least November 2018, with rates as high as 13 times in one month. While the team agreed to begin collecting measures on this behavior, there was no evidence that this had ever been addressed in his PBSP. Further, it was reported that he was refusing feedings and trying to bite nursing staff when they attempted to feed him. It would be advisable for behavioral health services staff to observe feeding times to try to identify variables that might contribute to this behavior and develop strategies to improve Individual #149's response.

In another home. Individual #523 was observed repeatedly slapping himself in the head and biting his hand, but when his I-Book was reviewed, there was no PBSP. Staff are advised to conduct observations and interview staff to determine whether a functional behavior assessment and PBSP are warranted.

2. Individual #279 did not have identified goals related to his counseling services.

3. The goals for all nine individuals were measurable and based upon their assessments.

5. A review of monthly PBSP progress notes and data reliability reports indicated that inter-observer agreement was not assessed regularly over a six-month period. Staff also reported concerns with data reliability. For instance, during the psychiatry clinic for

Individual #599, the BCBA reported that she did not believe the data were accurate. In the graphs included in Individual #162's PBSP progress notes, there was a phase change line to indicate a switch to paper data sheets. When an explanation was requested, staff reported that this had been introduced for all of Fanin A due to "a significant concern with the reliability with data that was being completed." However, due to the high numbers of pulled staff working on the home, data were still not being recorded. A decision was made to return to the electronic data system. As noted below, data were requested for several individuals. In none of the data sheets provided was there evidence that data had been entered into CareTracker every two hours, that is, regarding data timeliness.

During the onsite visit, the Monitoring Team observed individuals engaging in problematic behavior. A request was made for PBSP data for these individuals to determine whether documentation occurred. A summary is provided below.

On Monday 4/1/19:

- Individual #523 was observed repeatedly hitting himself. These behaviors were not documented. A check of his I-Book indicated that he did not have a PBSP.
- Individual #425 was observed engaging in self-injurious behavior. These behaviors were not documented.
- Individual #143 was observed hitting himself while getting dressed. These behaviors were not documented.
- Individual #436 pushed a member of the Monitoring Team. This behavior was documented.

On Wednesday 4/3/19:

- Individual #599 was observed engaging in repeated screaming and self-injurious behaviors while at her day program. There was no documentation of these behaviors during the first shift when these were observed. During this same observation, she also displayed aggression, but this was not documented.
- Individual #212 was observed engaging in SIB. This behavior was not documented.
- Individual #377 was observed hitting staff after dropping to the floor. This behavior was documented.
- Individual #259 was observed licking the floor. This behavior was not addressed in her PBSP, therefore, there was no documentation of this behavior. Staff, however, offered her a drink as she crouched on the floor. More appropriate would be if she were asked to sit at a table before receiving a drink.
- Individual #157 was observed attempting to hit/bite the torso of another person. While a new behavior of her growling was documented, her aggressive responses were not.

On Thursday 4/4/19:

- Individual #599 was observed engaging in screaming and self-injurious behavior. These behaviors were not documented.
- Individual #157 was observed making a suicide threat. This behavior was documented.

Thus, three of 11 problems behaviors (27%) observed by the Monitoring Team were documented.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.												
Summary: Performance remained about the same as at the last review. Few individuals had behavioral health assessments that met criteria. About two-thirds of individuals had functional assessments that were current and complete. Across the review group, criteria for all three indicators were met for some (Individual #599, 59), and for others, criteria were not met for any of the indicators (Individual #143). These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
10	The individual has a current, and complete annual behavioral health update.	33% 3/9	0/1	0/1	1/1	0/1	0/1	0/1	1/1	1/1	0/1
11	The functional assessment is current (within the past 12 months).	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1
12	The functional assessment is complete.	67% 6/9	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1

Comments:

10. Eight of the nine individuals had a current behavioral health assessment. The exception was Individual #143 whose assessment was completed in February 2017, one month after his admission to the Center.

Three of the assessments (Individual #162, Individual #599 Individual #59) were considered complete. All others either were missing a review of the individual's physical health over the previous year (Individual #279, Individual #281, Individual #119) or provided no information under the section addressing preferences, strengths, and goals (Individual #417, Individual #268).

11. The functional behavior assessment was current for seven of the individuals. The exceptions were Individual #162 and Individual #143, both of whom had direct and indirect assessments completed in 2017.

12. The functional behavior assessment for six individuals included all essential elements. The exceptions were Individual #279, Individual #417, and Individual #143. Individual #279's FBA did not include information for two of his targeted problem behaviors, self-injury and problematic departure, and there were no observations completed in 2018. Although Individual #417's FBA included a review of direct observation, no target behaviors were observed. No explanation was provided as to why additional observations were not necessary. Individual #143's FBA did not identify antecedents or consequences of the targeted problem behaviors, and it did not include a clear summary statement based on the hypothesized function(s) these behaviors served.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.	
Summary: Brenham SSLC did not maintain its practice of following protocols for approval and implementation of PBSPs. Similarly, there were more problems with PBSP content (i.e., with treatment strategies) than at the last review. This might be	Individuals:

addressed with additional clinical supervision, peer review, quality assurance procedures, and so forth. Both indicators will remain in active monitoring.											
#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	44% 4/9	1/1	0/1	1/1	0/1	0/1	0/1	1/1	1/1	0/1
14	The PBSP was current (within the past 12 months).	Due to the Center's sustained performance, this indicator moved to the category of requiring less oversight.									
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

13. For four individuals, Individual #279, Individual #162, Individual #599, and Individual #59, there was documentation that the PBSP had been implemented within 14 days of all consents. Of these, Individual #162's plan was approved by the guardian, facility director, and human rights committee more than four months before it was approved by the behavior therapy committee. For Individual #281, Individual #417, Individual #119, and Individual #268, the implementation date was before all consents had been obtained. For Individual #143, the facility reported that consent tracking was not completed or could not be located.

15. Although none of the PBSPs were considered complete, seven plans included the majority of the identified components. These included operational definitions of both targeted problem behaviors and replacement behaviors, antecedent and consequent strategies, the training of functionally equivalent replacement behaviors, and clear, precise interventions. Individual specific feedback is provided below.

- It was positive to review three plans (Individual #279, Individual #162, Individual #268) that included reinforcement for the absence of problem behavior. The token programs for Individual #279 and Individual #162 also reinforced identified appropriate behaviors, including participating in activities, attending programming, helping with chores, and appropriate social interactions.
- Individual #281's FBA noted that he would hit himself in the chest, but this was not addressed in the operational definition of self-injury.
- Staff are advised to consider documenting Individual #417's behavior of sticking her fingers down her throat separately from hallucinations.
- Staff are advised to discontinue the term "junk" behavior. Individual #119's behaviors likely serve an important function. This term is disrespectful and does not operationalize the behaviors "intended to annoy, irritate…"
- The definition of Individual #143's loud vocalizations required staff interpretation to determine that the noise was not meant for communication. It was unclear how staff could arrive at this conclusion.
- None of the PBSPs included sufficient, specific schedules for replacement behaviors to be trained or reinforced.
- For Individual #162 staff were directed to use first/then statements once he had refused to engage in hygiene, meals, medication administration, activities, etc. This may establish a chain of responding in which he learns to first refuse and then is told he will earn tokens if he complies.
- In Individual #268's plan, the instructions for threatening others was confusing because one section includes encouraging him

to use coping skills while also actively ignoring him.

- In Individual #143's plan, the consequences for self-injurious were unclear because staff were advised to not provide him a preferred activity, but then later were advised to provide him a sensory item when he displayed this behavior.
- Treatment objectives were not always clearly identified. Individual #279's plan noted that objectives for problematic departure and self-injurious behavior would be developed after baseline measures were collected. The Center reported that baseline data were collected by March 2019. However, the IDT did not meet until one month later to develop objectives. This occurred following a request by the Monitoring Team on the first day of the onsite visit.
- Although the state policy notes that PBSPs should be signed, none of these were.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
Summary: Plans and progress notes were either not provided/available or did not contain the minimum content. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	0% 0/2	0/1					0/1			

Comments:
25. A counseling plan and accompanying progress notes were provided for Individual #268. Although there were goal directed services with measurable objectives and a data-based criterion for triggering a review, other elements were missing. Evidence-based practices were not identified, data to determine progress was not consistently reviewed, and there were no identified procedures for generalizing the skills he learned in counseling. The counselor was not identified in the plan. Nothing was presented for Individual #279.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.										
Summary: Center staff should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines, and that PCPs complete them according to the agreed-upon schedule. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending	Due to the Center's sustained performance with these indicators, they moved to the category requiring less oversight.									

	on the individual's clinical needs.										
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.

Most of the individuals reviewed had no interval medical reviews. The only exception was Individual #268 for whom the PCP completed one, dated 2/22/19.

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Center staff should continue to improve the quality of the medical assessments. PCPs should complete timely and complete interval medical reviews. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91
a.	Individual receives quality AMA.	11% 1/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance 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 Individual #217's AMA included all of the necessary components, and addressed the selected chronic diagnoses or at-risk conditions with thorough plans of care. Problems varied across the remaining medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed family history, social/smoking histories, childhood illnesses, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, pertinent laboratory information, and updated active problem lists. Most, but not all included, as applicable, pre-natal histories, and past medical histories. Moving forward, the Medical Department should focus on ensuring medical assessments include thorough plans of care for each active medical problem, when appropriate.

c. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions [i.e.,

Individual #143 – seizures, and weight; Individual #268 – weight, and polypharmacy/side effects; Individual #286 – aspiration, and skin integrity; Individual #217 – osteoporosis, and other: osteoarthritis; Individual #149 – gastrointestinal (GI) problems, and polypharmacy/side effects; Individual #276 – falls, and urinary tract infections (UTIs); Individual #76 – weight, and skin integrity; Individual #490 – weight, and other: obstructive sleep apnea; and Individual #91 – respiratory compromise, and other: obstructive sleep apnea].

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. In addition, PCPs had not completed any interval medical reviews for eight of the nine individuals reviewed, which was of significant concern.

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

Summary: As indicated in the last several reports, overall, much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 143	268	286	217	149	276	76	490	91
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	6% 1/17	0/2	0/2	0/2	0/2	1/2	0/1	0/1	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	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, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions (i.e., Individual #143 – seizures, and weight; Individual #268 – weight, and polypharmacy/side effects; Individual #286 – aspiration, and skin integrity; Individual #217 – osteoporosis, and other: osteoarthritis; Individual #149 – GI problems, and polypharmacy/side effects; Individual #276 – falls, and UTIs; Individual #76 – weight, and skin integrity; Individual #490 – weight, and other: obstructive sleep apnea; and Individual #91 – respiratory compromise, and other: obstructive sleep apnea).

The following IHCPs included action steps to sufficiently address the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations: Individual #149 – polypharmacy/side effects, and Individual #76 – skin integrity. This was not applicable to Individual #276 for UTIs, because UTIs were not a concern at the time the PCP completed the AMA, and the IDT developed the ISP/IHCP.

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: Improvement was noted with regard to the completion of quality annual dental exams. More specifically, it was positive that for eight of the nine individuals reviewed, the dental exams included all of the required components. Indicator b will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91
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.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	Due to the Center's sustained performance with this indicator, it moved to the category requiring less oversight.									
Comments: b. It was positive that for eight of the nine individuals reviewed, the dental exams included all of the required components. Individual #76's dental exam included most of the required components, but it did not include periodontal charting, updated within the last year, or a justification for not completing it with a plan to complete it.											

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.											
Summary: For six out of nine individuals reviewed, nurses completed timely annual nursing reviews and physical assessments. For seven out of nine, nurses completed timely quarterly nursing record reviews and/or physical assessments. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91

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.	N/A									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	67% 6/9	1/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1	0/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1

Comments: a.i. and a.ii. A number of the individuals reviewed had timely annual comprehensive nursing reviews and physical assessments. Problems included:

- For Individual #276, the dates for the information included in the annual nursing review represented a quarter as opposed to a year (i.e., 6/23/18 to 9/17/18).
- Similarly, Individual #76's annual review only covered a quarter (i.e., 3/1/18 to 5/15/18), as did Individual #91's annual review (i.e., 11/19/18 to 1/25/19).

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

- For Individual #286, the dates on the quarterly nursing record reviews did not represent quarters (i.e., 8/31/18 to 8/31/18, and 9/1/18 to 10/15/18).
- For Individual #76, a quarterly record review included information from 5/11/18 to 10/17/18.

Outcome 4 – Individuals have quality nursing assessments to inform care planning.											
Summary: Work is needed to ensure that nurses complete thorough record reviews and physical assessments on an annual and quarterly basis, including analysis of data related to their at-risk conditions. In addition, when individuals experience changes of status, nurses need to complete assessments in accordance with current standards of practice. All of these indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91
a.	Individual receives a quality annual nursing record review.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual receives quality annual nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score;	33% 3/9	1/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1

	iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.										
c.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual receives a quality quarterly nursing record review.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality quarterly nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	44% 4/9	1/1	1/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1
f.	On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
g.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	20% 2/10	0/1	1/1	0/1	0/1	0/2	0/1	0/1	1/2	N/A

Comments: a. As discussed above, three individuals' annual nursing record reviews did not cover an annual period. As a result, they did not meet any of the sub-indicators for this measure. It was positive that the remaining six annual nursing record reviews included, as applicable, the following:

- Active problem and diagnoses list updated at the time of annual nursing assessment (ANA);
- Social/smoking/drug/alcohol history;
- List of medications with dosages at the time of the ANA;
- Immunizations;
- Consultation summary;
- Lab and diagnostic testing requiring review and/or intervention; and
- Tertiary care.

The components on which Center staff should focus include:

- Family history;
- Procedure history; and
- Allergies or severe side effects to medication.

b. Some of the items missing from a number of the annual physical assessments reviewed included weights, and fall risk scores.

c. and f. For nine individuals, the Monitoring Team reviewed a total of 18 specific risk areas (i.e., Individual #143 – falls, and choking; Individual #268 – falls, and constipation/bowel obstruction; Individual #286 – falls, and constipation/bowel obstruction; Individual #217 – constipation/bowel obstruction, and aspiration; Individual #149 – skin integrity, and falls; Individual #276 – polypharmacy/side effects, and aspiration; Individual #76 – infections, and skin integrity; Individual #490 – falls, and constipation/bowel obstruction; and Individual #91 – osteoporosis, and skin integrity).

Overall, none of the annual comprehensive nursing or quarterly assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Nurses often had not included status updates in annual and quarterly assessments, including relevant clinical data (i.e., the exceptions were in the quarterly assessment for Individual #76 in relation to infections and skin integrity, but unfortunately the nurse had not analyzed this data); 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.

d. It was positive that all of the quarterly nursing record reviews the Monitoring Team reviewed included the following, as applicable:
- Active problem and diagnoses list updated at the time of the quarterly assessment;
- Social/smoking/drug/alcohol history;
- List of medications with dosages at the time of the quarterly nursing assessment;
- Immunizations;
- Consultation summary;
- Lab and diagnostic testing requiring review and/or intervention; and
- Tertiary care.

The components on which Center staff should focus include:
- Family history;
- Procedure history; and
- Allergies or severe side effects to medication.

e. Some of the items missing from a number of the quarterly physical assessments reviewed included weights, and fall risk scores.

g. On a positive note, the assessment for the following change of status was consistent with applicable nursing guidelines:
- An IPN and IView entry, dated 2/10/19 at 8:23 p.m., indicated that Individual #268 fell in the dining room. The IView documentation showed that the nurse conducted a complete assessment.

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

- An IPN, dated 9/25/18, at 3:57 p.m., noted that Individual #143 returned from school and "assess injury report made started neuro, sent to dental and primary care physician also was started on fall." As written, the IPN did not make sense. In addition, a note, which it appeared school staff sent to the Center, said that the individual fell, and then hit his head five times with his helmet, but the nursing IPN did not include this information. Although a nurse documented an assessment in IView, his blood pressure was low at 101/51, and the nurse did not retake it to verify the results.

  In its comments on the draft report, the State sought to provide clarification, and stated: "This blood pressure is consistent with Individual #143's baseline." Based on the Monitoring Team member's review of IView entries submitted, Individual #143 had a number of blood pressures that the IRIS system flagged as "low" (e.g., on 9/25/18, it was 96/54), as well as a number that were flagged as "high" (e.g., on 9/26/18, it was 123/97). However, based on the documentation submitted, nurses had not retaken his blood pressure when they obtained these high or low readings. Moreover, based on the documentation submitted, he had not been classified as having "low" baseline blood pressure. Given the injury he sustained (i.e., hit his head five times) that warranted neurological checks, and the system's identification that the blood pressure reading was low, the nurse should have retaken his blood pressure.
- According to an ISPA, dated 10/1/18, in October 2017, Individual #286 needed to start using a wheelchair after a hip fracture, but when he transferred to another home, he started to ambulate again. Based on the documents submitted, nursing staff did not document this change in status, nor did they conduct and/or document regular assessments of his gait and ambulation.
- An IPN, dated 12/27/18, noted that a nurse administered a Bisacodyl suppository to Individual #217. However, based on a review of the IPNs and IView entries, the nurse did not conduct and/or document an assessment, nor did the nurse indicate when the individual's last bowel movement occurred.
- An IPN, dated 12/19/18, indicated that staff discovered a blister on Individual #149's scrotum. Based on a review of IPNs and IView entries, nursing staff did not conduct and/or document an assessment (i.e., the IPN referenced IView, but the nurse had not documented an assessment there).

  In its comments on the draft report, the State disputed this finding, said nursing staff completed an assessment, and stated: "The requested fomat [sic] of IView 'Results Review-> 'Ambulatory View' tab in list view' [sic] will not provide this type of assessment data on an IView flowsheet. An assessment was completed on 12/19/18 16:30 and was documented in IView under 'Incision/Wound/Skin (Scrotum Right Upper).' In order to view this assessment, one would need to view 'Assessments View' on the 'Clinical View' Flow sheet." The Monitoring Team has worked closely with State Office staff to revise its document requests to ensure that necessary information is requested/provided. In addition, the document request as written has been in place since the Round 12 reviews. Center staff as well as State Office staff have had opportunities to clarify the "views" that the Monitoring Team should request in order to ensure that necessary information is available for review. Based on the State's comments, the Monitoring Team was unable to confirm that nurses had completed an assessment consistent with applicable standards. Moreover, it was unclear to which paragraph the State was referring in its comments, because it quoted part of the above paragraph and part of the one directly below.
- An IPN, dated 12/4/18, at 7:20 p.m., indicated that Individual #149 "tripped on w/c [wheelchair], fell to his face on the left side." Based on review of the IPNs and IView entries, the nurse did not: 1) include the exact time of the fall; 2) conduct and/or

document an assessment of the individual's face for swelling or redness, or conduct assessments for visual issues, headache, or mental status; or 3) complete neurological checks.

- When an electrocardiogram (EKG) report noted that Individual #276 had a prolonged QT interval, nursing staff did not implement assessments for dizzy spells, or vital signs. Further, when propanol was initiated, nursing staff did not conduct and/or document assessments of her blood pressure (i.e., lying and standing), and pulse.
- An IPN dated, 11/7/18, at 10:29 p.m. indicated that Individual #76 had two red spots in the center of his back, and the note referenced IView for the assessment. Based on a review of the IPNs and IView entries, nursing staff did not conduct and/or document an assessment of this skin integrity issue. In its comments on the draft report, the State disputed this finding for the same reason as for Individual #149. For the same reasons, the Monitoring Team has not modified its finding.
- An IPN, dated 2/26/19, indicated that Individual #490 was getting into bed, lost her balance, and slid down to her knees. She complained of her left great toe hurting, but nursing staff did not assess her pain using a pain scale. Based on review of IView documentation, nursing staff did not ask the individual if she was dizzy. Her blood pressure was 92/57, which was significantly lower than readings in IView for other days. Nursing staff provided no description of her toe, if she was able to move it, the presence or absence of swelling, or pain, when bearing weight. The following day, at 5:38 a.m., according to the IPNs, nursing staff administered Tylenol. However, the nurse did not complete and/or document an assessment of the toe in the notes. On 2/27/19, a PCP documented seeing the individual for left great toe pain, "unknown specific etiology." Based on this note, it did not appear that nursing staff informed the PCP that the individual injured her toe during a fall on the previous day.

Outcome 5 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.

Summary: Given that over the last several 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: 143	268	286	217	149	276	76	490	91
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. through f. The IHCPs reviewed were missing key nursing supports. For example, RN Case Managers and IDTs generally had not individualized interventions in relevant nursing guidelines and included in the action steps of IHCPs specific assessment criteria for regular nursing assessments at the frequency necessary to address conditions that placed individuals at risk (e.g., if an individual was at risk for skin breakdown/issues, then an action step(s) in the IHCP that defines the frequency for nursing staff to assess the color, temperature, moisture, and odor of the skin, as well as the drainage, location, borders, depth, and size of any skin integrity issues). In addition, often, the IDTs had not included in the action steps nursing assessments/interventions to address the underlying cause or etiology of the at-risk or chronic condition (e.g., if an individual had poor oral hygiene, a nursing intervention to evaluate the quality of the individual's tooth brushing, and/or assess the individual's oral cavity after tooth brushing to check for visible food; if an individual's positioning contributed to her aspiration risk, a schedule for nursing staff to check staff's adherence to the positioning instructions/schedule; if an individual's weight loss was due to insufficient intake, mealtime monitoring to assess the effectiveness of adaptive equipment, staff adherence to the Dining Plan, environmental factors, and/or the individual's food preferences, etc.). Significant work is needed to include nursing interventions that meet individuals' needs into IHCPs.										

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. Given the Center's sustained performance in this area (Round 11 – 100%, Round 12 – N/A, Round 13 – 100%, and Round 14 - 100%), Indicator e, will move to the category of less oversight. Work is still needed with regard to the timely referral of individuals to the PNMT, as well as ensuring the PNMT completes reviews and assessments for individuals that meet criteria, and that the PNMT involves necessary team members in their reviews and assessments. The quality of the PNMT comprehensive assessments also needs improvement. At this time, all of the remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91
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	0/1	1/1	N/A	1/1	N/A	0/1	1/1	1/1

b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	57% 4/7	1/1	0/1	1/1		0/1		0/1	1/1	1/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/4	0/1	0/1	N/A		N/A		0/1	0/1	N/A
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	43% 3/7	0/1	1/1	1/1		0/1		0/1	0/1	1/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 5/5	1/1	1/1	1/1		1/1		N/A	N/A	1/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	29% 2/7	0/1	1/1	0/1		0/1		0/1	0/1	1/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/3	N/A	N/A	0/1		0/1		N/A	N/A	0/1
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4	0/1	0/1	N/A		N/A		0/1	0/1	N/A

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

- On 4/30/18, Individual #143's IDT referred him to the PNMT, and on 5/7/18, the PNMT completed a review. The PNMT did not complete a comprehensive assessment, but should have. The review stated that because the diagnosis of pneumonia was questionable, the PNMT would not assess or follow him. However, the "questionable" diagnosis was based on a second x-ray, completed on 5/2/18, which was nine days after the event, which occurred on 4/25/18. At the time of his admission to the hospital, on 4/25/18, an x-ray was positive for aspiration pneumonia. Based on the second x-ray, the PCP stated he was unsure if the individual had pneumonia, and if he did, it was resolved. Even if the hospital diagnosis was incorrect, what Center staff knew was that the individual had a history of aspiration with thin liquids, and according to the PNMT's review, the individual experienced seizure activity prior to the event, which they identified as a potential cause of the pneumonia. In addition, the pneumonia was in the right lower lobe, which is commonly associated with aspiration.

  In its comments on the draft report, the State disputed these findings and stated: "Per PNM Policy numbered 0124 section IV-B-2-a: 'The PNMT can complete a PNMT Review following a PNMT RN Post-Hospitalization Assessment/Review, or at any point in the PNMT process:'

a. For individuals who may not require comprehensive PNMT evaluation/services.

Based on diagnostic reports of perihilar pneumonia and a lack of medical history significant for dysphagia related [sic] aspiration pneumonia, the PNMT suspected aspiration of bacterial laden oral sections and/or stomach contents during seizure activity vs. prandial aspiration as the primary cause of #143's respiratory compromise. As such, a comprehensive PNMT evaluation was not indicated. Because the PCP did not consider this respiratory compromise to be a 'true pneumonia', the PNMT Review stated that the PNMT would 'not track this as a pneumonia in the PNMT tracking database.'"

The Monitoring Team reviewed the State's comments, and respectfully maintains its findings that given this individual's history (e.g., decreased oral motor function, silent aspiration), and the circumstances of this event (i.e., possible aspiration of bacteria-laden saliva), a comprehensive assessment was warranted.

The State also indicated: "Per PNM Policy numbered 0124 section IV-B-2-b: 'The PNMT Review should address as appropriate:

- Presenting problem;
- Pertinent diagnoses and medical history;
- Applicable risk ratings;
- Current health and physical status;
- Potential impact on and relevance to PNM needs;
- Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan

Because aspiration events can occur during seizure activities, the PNMT reviewed all PNM risks levels and their associated supports which included Aspiration/ Respiratory Compromise, Dental, Neurological, Seizures, and Medication Side Effects and provided additional recommendations to the IDT for IHCP action steps to further enhance supports in Aspiration/ Respiratory Compromise, Dental, and Neurological, Seizures. Because radiological evidence of infiltrates in the gravity dependent lung zones (right or left lower lobes) and #143's [sic] reported history of decreased airway protection when swallowing thin liquids, the PNMT provided recommendations for implementing the use of suction tooth during oral care to mitigate aspiration risks during oral hygiene tasks."

Again, the Monitoring Team considered the State's comments, but maintained its original finding. The PNMT review for Individual #143 lacked evidence of observation and assessment. It included a recommendation regarding suction tooth brushing, but it is unclear how the PNMT recommended an intervention without first assessing it, which there was no evidence of in the review. The review also did not include all the required components, so was not comprehensive. The PNMT's assumption appeared to be that the incident was a result of the seizure, but because this was not certain, PNMT members should have observed/assessed and discussed other potential contributing factors, such as positioning after eating, mealtime, etc.

- In February, May, July, and August 2018, Individual #268 met the criteria for referral to the PNMT for emesis (i.e., greater than three emesis in 30 days), but his IDT did not refer him to the PNMT until September 2018. Although the PNMT completed a review and assessment in October 2018, these should have occurred sooner. The PNMT indicated that these earlier events did not result in a review or assessment, because the emesis were of known cause. However, the PNMT/IDT misinterpreted the term "known cause." A known cause would be, for example, emesis due to an illness such as the flu. In this individual's case,

the "known cause" was described as a nurse seeing the individual when he coughed and had emesis. Since a nurse saw the emesis, then it was listed as a known cause and not counted toward the individual meeting the threshold.

- On 12/20/18, the same day that Individual #286 had TIVA for dental procedures, he was admitted to the hospital for aspiration pneumonia. On 12/25/18, he returned to the Center, but on 12/26/18, he was sent back to the ED. On 12/28/18, the IDT referred him to the PNMT, with a review completed on 1/8/19. Given that the aspiration pneumonia occurred after a dental procedure, the dentist and dental hygienist should have participated in the review, but based on the documentation submitted, they did not. The review lacked information about the actual procedure, as well as the process post-sedation. Other than stating that the PNMP was followed, the PNMT documented little discussion in the review.

- According to an ISPA, dated 2/1/19, Individual #149's IDT referred him to the PNMT for review/assessment due to multiple fractured ribs. However, in the documents submitted, no evidence was found that the PNMT conducted a review. Given that rib fractures could have a significant impact on respiration, and, therefore, the individual's ability to clear his lungs, as well as the possibility of the need for altered positioning due to pain, the PNMT should have at least conducted a review.

  In its comments on the draft report, the State disputed this finding, and stated: "Per PNM Policy numbered 0124 section IV-C-8, the PNMT criteria for fracture includes Fracture of a long bone, spine, or hip. The PNMT did not complete a review of rib fractures as these injuries were not criteria events nor did the PNMT receive a referral form from #149's IDT requesting assistance."

  The State is correct with regard to the ribs not being considered long bones. Therefore, they are not listed in the criteria for referral to the PNMT. However, according to the ISPA, dated 2/1/19, the IDT stated they did refer Individual #149 to the PNMT, but the PNMT did not provide a review or assessment. Again, as stated in the draft report, given the impact that multiple fractured ribs might have on an individual's overall respiratory functioning, pain etc., at least a review was warranted. In other words, the IDT's referral seemed reasonable, and it was concerning that the PNMT did not receive the referral (i.e., the Monitoring Team has no way to confirm the assertion that the referral did not make it to the PNMT), and/or conduct at least a review.
- On 11/6/18, Individual #76's IDT made a referral to the PNMT with regard to skin integrity issues (i.e., two Stage 2 pressure ulcers). The PNMT initiated and completed a review for this issue. However, based on the PNMT minutes, dated 9/25/18, in September 2018, Individual #76 showed a loss of 7.9 pounds, which represented a 7.8% weight loss. Rather than make a self-referral, the PNMT questioned the accuracy of the weight, and as opposed to asking that staff reweigh the individual immediately, they decided to wait until they received next month's weight. The following month's weight showed a 9.3-pound weight loss, at which point, they made a self-referral. At this point, they initiated an assessment, which combined both the skin integrity and weight issues. However, the assessment was not completed, because on 12/3/18, the individual died. Based on review of the PNMT notes (i.e., 11/6/18 to 11/27/18), significant concerns were noted. These included a rusty and dirty wheelchair that was a poor fit for the individual and had a strong odor. The PNMT also noted that the odor from the individual, who was not soiled, was concerning enough that they asked the direct support professional to bathe him. It was extremely concerning that staff and the IDT did not identify and/or address these issues until a significant event occurred. This reflected a highly reactive approach, and potentially a lack of systems in place to detect basic cleanliness and equipment issues.

- For Individual #490, in October 2018 as well as February 2019, the PNMT conducted reviews in a timely manner in response to falls. More specifically, on 2/5/19, the PNMT completed a review for a referral, dated 1/29/19, and on 10/30/18, the PNMT completed a review in response to a referral, dated 10/23/18. However, the PNMT did not provide a comprehensive assessment despite ongoing issues with falls. More specifically, per the PNMT review conducted on 10/30/18, the individual fell 178 times in the past approximately four years (i.e., 2015 – 28 falls, 2016 – 26 falls, 2017 – 78 falls, and through October 2018 – 46 falls). Despite falls continuing in between the October and February PNMT reviews and beyond (i.e., September 2018 – 7 falls, October 2018 – 4 falls, November 2018 – 11 falls, December 2018 - 3 falls, January 2019 – 7 falls, February 2019 – 5 falls, and March 2019 – 7 falls), the PNMT did not conduct a comprehensive assessment.

  In its comments on the draft report, the State disputed this finding, and stated: "Per PNM Policy numbered 0124 section IV-B-2-a: 'The PNMT can completed [sic] a PNMT Review following a PNMT RN Post-Hospitalization Assessment/Review, or at any point in the PNMT process:'
  - For individuals who may not require comprehensive PNMT evaluation/services

  1. #490 [sic] was reviewed by PNMT in April of 2017 and again in September 2017 due to >3 falls in 2 consecutive months. #490's [sic] IDT also completed a RCA ["root cause analysis"] in July 2017. Despite these actions from these assessments/meetings #490 [sic] continued to experience multiple falls.
  2. #490 [sic] was referred to PNMT on 1/4/18 due to multiple falls in November and December. PNMT completed a comprehensive assessment on 1/31/18 with 12 recommended interventions which the IDT agreed upon. #490 [sic] was on PNMT's active caseload for PNMT IHCP goal progress and action step implementation and effectiveness from 2/5/18 to 7/6/18. #490 [sic] was then discharged from PNMT active caseload as she had met her PNMT IHCP goal for falls and all action steps had been implemented by the IDT.
  3. #490 [sic] met fall criteria again in October of 2018 and was referred to PNMT. Based on Review findings, #490 [sic] had not experienced any change in condition (ex. change in baseline gate [sic]) which was not previously identified in the comprehensive assessment completed in January 2018 for which she was followed for by PNMT in the preceding 6 months. However, the review did identify areas where supports were not being implemented effectively and made recommendations for improved implementations [sic].
  4. In February of 2019, a review for #490 [sic] was completed at the request of IMRT to review current supports. Findings from this review indicated that #490's [sic] falls had decreased in the last 2 months (November = 11 falls, December = 2 falls) and that #490 [sic] had not experienced any change in condition (ex. change in baseline gate [sic]) which was not previously identified in the comprehensive assessment. However, PNMT did provide additional recommendation for improvements in current support implementation.

  In April of 2019 #490 [sic] again met criteria for referral for falls. PNMT completed a review and found that there was no change in the reasons for her falls. However, issues were identified with current supports and recommendations were made to the IDT to address those issues. #490 [sic] remains on active caseload for falls currently."

  As noted in the draft report, the PNMT reviews focused on a multitude of supports, including increased training, new gait belts, and a rolling walker, but did not include any evidence of actual assessment. PNMT members documented observations, but did not include evidence of assessing the individual's gait etc., outside of the OT/PT assessment that occurred in October for her

ISP meeting. Due to the excessive number of falls that placed her at extremely high risk of a serious injury, paired with the behavioral components to the falls, an assessment was warranted. Moreover, based on the documents submitted, Behavioral Health Services staff did not participate in the PNMT review.

The Monitor has not changed the original findings. The reviews and assessments completed had not effectively addressed the individual's falls. As noted in the draft report, the reviews completed did not include the necessary assessments. Moreover, given that the quality of the Center's reviews and assessments has not met criteria over multiple reviews, it will be essential that as Center staff make improvement to the PNMT processes and products that individuals assessed in the past are reassessed to ensure that their needs for quality assessments are met, including the identification of underlying cause(s) of PNM issues and the development of recommendations to address them.

- On 7/24/18, Individual #91's IDT timely referred him to the PNMT for pneumonia and sepsis diagnoses. On 7/30/18, the PNMT completed a timely review. The review lacked evidence of direct observations or any discussion regarding the underlying cause(s) of the PNM issue. This individual had a history of pneumonias, including two aspiration pneumonias within the past three years.

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, three individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #143, Individual #76, and Individual #490). The following summarizes some of the findings related to the one PNMT assessment the Monitoring Team reviewed:

- Positive aspects of Individual #268's PNMT assessment were that:
  - It clearly identified the problems as emesis, falls, and weight.
  - It was also good to see that the PNMT recommended: "Consider referral to OT/PT to address generalized deconditioning and decreased balance and stamina."
  - The PNMT included discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs.

- Some of the concerns with the assessment were that:
  - The PNMT assessment did not include a review of his fall risk.
  - Although the PNMT discussed his medications and the potential side effects, it appeared that they made some incorrect assumptions. For example, the PNMT assessment stated that the use of Risperidone and Clonazepam started in July 2018, which coincided with the increase in falls, emesis, and weight loss. However, falls were ongoing and peaked at 12 in February 2018, which was before the medication changes occurred. Similarly, emesis was ongoing, dating back to February 2018. Weight loss also had been occurring since February 2018. February 2018 appeared to be a significant month in terms of changes of status, but the PNMT did not pursue these relevant changes in the data. Moreover, the PNMT offered no recommendations to address the hypothesis that the medications had an impact on his PNM issues.

In its comments on the draft report, the State indicated: "The PNMT provided #268's [sic] IDT with the following recommendations to address medication side effects on PNM issues 'Discuss risks vs. risk in consideration of alternative mood stabilizer to decrease medication side effects related to nausea, vomiting, worsening dysphagia, and balance disturbance.'" In response, discussing risks versus risk is not the same as investigating the hypothesis of the potential impact(s) of medication on the individual's PNM issues. In other words, recommending a risk-versus-risk discussion assumes the issue is the medication, and the IDT's decision is whether the risk is worth the benefit of the medication, or if there are other alternative medications. This would be difficult to determine when there has not been sufficient observations or analysis of available data to support hypothesis.

- A therapist did not assess his head-of-bed elevation (HOBE) until after the PNMT assessment. It was unclear why it was not completed as part of the PNMT assessment.

  In its comments on the draft report, the Stated indicated: "A HOBE was not indicated for this assessment as #268 [sic] did not present with a history suspicious for respiratory compromise due to aspiration pneumonia. A HOBE was completed by 268's [sic] Hab [sic] team after the assessment was completed as 268's [sic] has a peg-tube placement which increased his risk of aspiration due to use of a peg-tube."

  Individual #268 had multiple occurrences of greater than three emesis episodes in 30 days. This occurred in February, May, July, and August of 2018. Due to the ongoing emesis, the PNMT should not have waited until he had a PEG-tube to conduct a HOBE evaluation. A HOBE should be conducted for anyone who is having ongoing issues with emesis.

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

Summary: Overall, as noted in the last several reports, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. On a positive note, good improvement was noted with regard to the quality of PNMPs in addressing individuals' specific needs. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 143	268	286	217	149	276	76	490	91
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% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/1	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.	67% 6/9	1/1	1/1	1/1	1/1	0/1	1/1	0/1	0/1	1/1

d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	17% 3/18	0/2	0/2	0/2	0/2	0/2	0/2	2/2	0/2	1/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	2/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: Individual #143 – choking, and aspiration; Individual #268 – GI problems, and falls; Individual #286 – falls, and aspiration; Individual #217 – aspiration, and choking; Individual #149 – GI problems, and fractures; Individual #276 – aspiration, and choking; Individual #76 – skin integrity, and weight; Individual #490 – choking, and falls; and Individual #91 – GI problems, and aspiration.

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. It was positive that six of the nine PNMPs/Dining Plans reviewed met the individuals' needs. Problems varied across the remaining PNMPs and/or Dining Plans reviewed.

- It was positive that all of the PNMPs, as applicable to the individuals' needs included:
  - Photographs;
  - Descriptions of assistive/adaptive equipment;
  - Positioning instructions;
  - Transfer instructions;
  - Mobility instructions;
  - Bathing instructions;
  - Toileting/personal care instructions;
  - Handling precautions or moving instructions;
  - Mealtime instructions;
  - Medication administration instructions; and
  - Oral hygiene instructions.
- As applicable to the individuals, most, but not all of the PNMPs reviewed:
  - Were reviewed and/or updated within the last 12 months (i.e., Individual #76's PNMP was not updated to reflect his weight loss and the increased risk of skin breakdown); and
  - Included a full list of risks and triggers.
- The component of the PNMPs on which the Center should focus on making improvements relates to the inclusion of:
  - Complete communication strategies.

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

e. The IHCPs reviewed that identified the necessary clinical indicators were those for: Individual #76 – skin integrity, and weight; and Individual #91 – aspiration.

f. The IHCPs that identified triggers and actions to take should they occur were those for: Individual #76 – skin integrity, and weight.

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

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: Indicator b will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	Due to the Center's sustained performance with this indicator, it moved to the category requiring less oversight.									
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/1		0/1			N/A				N/A
Comments: b. For Individual #268, the return to oral intake assessment lacked a clear oral motor and pharyngeal assessment and/or establishment of the individual's baseline. The IDT had not put strategies in place despite behavioral issues related to not eating.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.	
Summary: The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied. The quality of OT/PT assessments continued to be an area on which Center staff should devote considerable focus. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	Due to the Center's sustained performance with these indicators, they have moved to the category of requiring less oversight.									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.										
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	38% 3/8	1/1	0/1	1/1	N/R	1/1	0/1	0/1	0/1	0/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	38% 3/8	1/1	0/1	1/1	N/R	1/1	0/1	0/1	0/1	0/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/3	0/1	N/A	N/A	N/R	0/1	N/A	N/A	0/1	N/A
e.	Individual receives quality OT/PT Assessment of Current	0%	N/A	0/1	0/1	N/R	N/A	0/1	0/1	N/A	0/1

	Status/Evaluation Update.	0/5									

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

- Individual #268 experienced 12 falls in February 2018, and continued to have at least one fall in each of the subsequent months through August 2018. The PT did not complete an assessment update until August 2018.
- Individual #276 had no falls from 4/19/17, through 4/19/18. She then had three falls between 9/10/18, and 12/7/18. Having three falls in relatively quick succession, after having none for a year, warranted at least a PT consult to evaluate the possible cause(s), but this did not occur until after she experienced two subsequent falls that caused a serious injury. On 12/18/18, she required emergency department (ED) treatment for fall-related injuries, including a facial contusion, a facial abrasion, a nasal contusion, avulsion of multiple teeth due to trauma, contusion of her mouth, and laceration repair. There was no evidence of PT consults provided or requested by the IDT to address this emergent concern until 12/19/18, after the serious injuries and subsequent ED visit had occurred.
- On 11/6/18, the PNMT noted Individual #76's poor fitting wheelchair, and documented that it was also in poor repair and soiled. Because these deficiencies would have developed over time, this demonstrated failures in the Center's processes for identifying potential issues with adaptive equipment and reassessing the individual's needs.
- On 10/9/18, Habilitation Therapy staff conducted a rolling walker assessment for Individual #490, which concluded the equipment was not safe for her because of issues such as kicking the wheels and impulsivity when using walker. Instead, the IDT simply continued the existing supports. Despite continuing falls (e.g., 11 in November 2018, two in December 2018, and five in January 2019), the OT/PT did not complete any additional assessment to identify other falls-prevention supports or strategies.
- For Individual #91, both the 2018 and 2019 OT/PT assessments identified that his wheelchair was not optimal, further stating that appropriate seating was "vital" to reducing his risk of aspiration and pneumonia. From the time the 2018 assessment identified this need, Individual #91 had experienced two episodes of pneumonias and one Stage 2 pressure ulcer, but Habilitation Therapy staff did not produce a wheelchair assessment until 3/5/19. It provided no justification for the delay, since the need was identified in 2018, nor did it provide a rationale for the subsequent delay from the time the wheelchair assessment was performed on 2/1/19, until the written report was developed on 3/5/19. Given the documented critical need, the IDT and Habilitation Therapy staff should have acted with more urgency to address it.

d. None of three comprehensive assessments met all criteria for a quality assessment. It was positive, though, that all three comprehensive assessments reviewed met criteria, as applicable, with regard to:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths were used in the development of OT/PT supports and services; and,
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale).

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

- 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.

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

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- 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;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

In its comments on the draft report, the State listed a number of these sub-indicators and provided page references for where information about them could be found in Individual #143's assessment (e.g., "Comparative analysis found on **pgs.** 7, 8, 9, 10, 11, 15"). The concerns the Monitoring Team identified related to the quality of the information/assessment. Many assessments reviewed included information related to the sub-indicators, but if the information was incomplete, and/or the therapists had not completed necessary analyses, then the assessments did not meet criteria.

e. It was positive that all the updates reviewed met criteria, as applicable, with regard to:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services; 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.

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

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- 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; and,
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale).

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

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires

fewer or more services; 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.

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

Summary: It was positive that ISPs included thorough descriptions of individuals' OT/PT functioning, which represented considerable improvement from previous reviews. Although ISPs/ISPAs generally included interventions/programs recommended in assessments, as discussed above, assessments did not consistently address unmet OT/PT needs. As such, this high score was not an accurate reflection that ISPs included a full set of strategies and interventions to meet individuals' needs, but rather ISPs included only those interventions OTs/PTs identified in flawed assessments. OTs/PTs should work together to make sure IDTs discuss and include information related to individuals' OT/PT supports in ISPs and ISPAs. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 143	268	286	217	149	276	76	490	91
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	Due to the Center's sustained performance with this indicator, it remained in the category of 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.	70% 7/10	1/1	1/1	1/1	1/1	0/1	0/2	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.	50% 3/6	N/A	N/A	1/1	N/A	0/1	0/2	N/A	1/1	1/1

Comments: a. All nine of the ISPs reviewed included concise, but thorough descriptions of individuals' OT/PT functional statuses. This was good to see.

c. and d. It remained concerning that OT/PT assessments often did not include recommendations to address individuals' needs in this area, despite identified deficits. Within the context of that significant gap, though, it was positive that ISPs/ISPAs for most individuals

included the limited recommendations for strategies, and programs (e.g. skill acquisition programs). However, IDTs were not formally including direct therapy interventions (i.e., goals/objectives) in ISPs, or incorporating them through ISPAs.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: Work was needed to improve the timeliness and 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. This includes ensuring that individuals receive the appropriate level of assessment in accordance with their needs. These indicators will remain in active oversight.			Individuals:								
#	Indicator		143	268	286	217	149	276	76	490	91
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.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.										
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	71% 5/7	1/1	0/1	1/1	N/A	1/1	0/1	N/A	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	44% 4/9	1/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1	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;	0% 0/3	N/A	N/A	N/A	0/1	N/A	0/1	0/1	N/A	N/A

	• 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.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/5	0/1	0/1	N/A	N/A	0/1	N/A	N/A	0/1	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. through c. The following provides information about problems noted:

- A Center Speech Language Pathologist (SLP) last completed a communication assessment for Individual #268 in 2017. He had experienced a number of physical and cognitive changes since that time, but the SLP had not completed an updated screening or assessment.
- For Individual #286, the Center only provided a screening, dated 1/26/18. The screening stated a communication program was in place; therefore, an update was warranted.
- Several other individuals received screenings or assessments that did not meet their individualized needs related to communication. For example, for Individual #217 and Individual #76, the Center completed screenings that were vague and did not clearly identify the content of the screening. For example, the screenings did not address required criteria such as functional and receptive skills; functional aspects of vision, hearing, and other sensory input; and/or, AAC devices and supports. Instead, the screenings covered medical history, and then skipped directly to findings and recommendations without further content. In addition, the Center completed a screening for Individual #276 that was vague and did not clearly identify the methodology or content. It also did not provide recommendations other than stating there was no need for a focused assessment, but without a clear justification why such an assessment was not needed.

d. As noted above, the Center did not submit a comprehensive assessment for Individual #268, but should have. None of the five comprehensive assessments reviewed met all criteria, as applicable. Most, but not all met criteria, as applicable, with regard to:

- A comparative analysis of current communication function with previous assessments; and,
- Evidence of collaboration between Speech Therapy and Behavioral Health Services, as indicated.

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

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;

- The individual's preferences and strengths are used in the development of communication supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;
- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services; 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.

e. The Center should ensure individuals are provided with needed updated assessments. As noted above, the Center did not submit an update for Individual #286, but should have. This resulted in a finding that none of the following criteria were met.

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 the Center continued to perform at a high level with regard to describing in each ISP how individuals communicate and how staff should communicate with them. Based on this sustained performance (i.e., Round 12 - 100%, Round 13 - 100%, and Round 14 - 100%), Indicator a will move to the category of requiring less oversight. The IDTs also continued to make some progress in ensuring individuals' ISP/ISPA included recommended communication strategies, interventions and programs, but this was limited by the frequent lack of SLP assessment recommendations to address identified communication deficits. To move forward, QIDPs and SLPs should work together to make sure IDTs discuss and include information related to individuals' communication supports in ISPs. The remaining indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 143	268	286	217	149	276	76	490	91
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,	0%	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	and it comprehensively addresses the individual's non-verbal communication.	0/8									
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	80% 8/10	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/2
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: a. It was positive that ISPs for each individual provided complete functional descriptions of how they communicated and how staff should communicate with them.

b. Individual #268 communicated verbally and did not require a Communication Dictionary. For the remaining eight individuals, the ISPs did not include clear evidence of a meaningful IDT review and approval of their respective Communication Dictionaries. Instead, the ISPs stated the IDTs had reviewed and accepted them, but included no 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 remained concerning that SLPs often did not include recommendations in their assessments to expand individuals' communication skills, despite identified communication skill deficits. Within the context of that significant gap, though, it was positive that ISPs/ISPAs for most individuals included the limited recommendations for strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs). Most often, the IDTs incorporated these into individuals' Communication Dictionaries and/or PNMPs. The IDTs did not include the following recommended strategies:

- For Individual #76, the Center provided no evidence of implementation of a service objective (SO) for the use of a calendar box. Based on the ISP monthly reports, the SO to use the box was not developed as of October 2018, which was five months after the ISP meeting.
- Individual #91's 2018 assessment recommended a program to expand use of his AAC device into the classroom setting, but the skill acquisition plan (SAP) was never written or implemented. In November 2018, the IDT decided to defer further action on this goal until his 2019 ISP, but provided no justification for why it should be deferred.

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: Although in the category of less oversight and although it will remain in this category, indicator 1 showed poor performance. Across the nine individuals, there were a total of 13 SAPs, compared with 21 at the last review, and closer to 27 at many other Centers. Of the present SAPs, about half were based on assessment results and were practical, functional, and meaningful. About one-third had data	Individuals:

that were reliable. These three indicators will remain in active monitoring.											
#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
1	The individual has skill acquisition plans.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The SAPs are measurable.										
3	The individual's SAPs were based on assessment results.	69% 9/13	1/2	No SAPs	2/2	0/1	1/1	1/1	1/1	1/2	2/3
4	SAPs are practical, functional, and meaningful.	62% 8/13	1/2	No SAPs	2/2	0/1	0/1	1/1	1/1	1/2	2/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	38% 5/13	1/2	No SAPs	0/2	1/1	1/1	1/1	0/1	0/2	1/3

Comments:

1. Individual #281 had no SAPs identified in his ISP nor were there any plans developed for him.

There was a lack of SAP implementation for Individual #162. Although his ISP was held in August 2018, it was not until an ISPA meeting held in February 2019 that the team noted his SAPs had not been implemented. Two of three SAPs were discontinued at this same meeting.

A total of 13 SAPs were reviewed. The Monitoring Team's intent is to always review three SAPs per individual, for a typical total of 27 SAPs.

3. Nine of the 13 SAPs were based on assessment results. These were skills that the individual could not perform based on either the Functional Skills Assessment (FSA) or the baseline probe.

The exceptions were the following: Individual #279's FSA indicated that he could count to 10; Individual #417's FSA indicated she could operate a washing machine and dryer; Individual #59's SAP indicated he could propel his wheelchair for short distances with verbal prompts, the same level of prompting identified in the objective; and Individual #143's SAP indicated he could use a switch to turn on a light with a verbal prompt.

4. Eight of the 13 SAPs were considered practical, functional, and/or meaningful. The exceptions included the three SAPs noted above and the letter matching SAP for Individual #119. As the goal was to teach her to recognize her name. It would be more functional to teach her to discriminate her name from others.

5. Of the 13 SAPs reviewed, there was evidence that five had been monitored for data reliability. These were the following: Individual #279's write name SAP, Individual #417's laundry SAP, Individual #119's matching letters SAP, Individual #268's medication SAP, and Individual #143's putting on pants SAP.

Completed monitoring forms did not consistently indicate whether the assessment had been completed via observation or role play.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.											
Summary: Criteria for all three indicators were met for one individual, Individual #119. Overall, performance on these indicators remained the same as at the last review. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
10	The individual has a current FSA, PSI, and vocational assessment.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
12	These assessments included recommendations for skill acquisition.	22% 2/9	0/1	0/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1

Comments:

10. Six of the nine individuals had a current vocational assessment. The exceptions were Individual #599 and Individual #59, both of whom had a retirement assessment (and Individual #119, who was 13 at the time of her ISP meeting). Because both of these individuals were in their 50s, it is recommended that a vocational assessment be completed to determine whether additional meaningful activities can be identified. Currently, both spent a brief time in their day program, with the majority of their day spent on the home. Staff are also advised to ensure that the vocational assessment explores a range of work skills, in a variety of environments, and includes situational assessments. The current assessments were quite limited in scope with very little information regarding the individual's skills and preferences.

Although an orientation and mobility evaluation had been completed in March 2019 for Individual #143, it was limited in describing his ability to orient to materials. For example, while the evaluation noted that he could locate items, it was unclear as to what location was best when presenting materials (e.g., to his left, right, or center, etc.), the optimal distance for presenting materials, or specific characteristics of materials that he is most likely to see. For example, are there optimal color contrasts, would a lighted background help him locate items, and is sound a critical or helpful element when locating materials? Because Individual #143 was 15 years old with several years of school remaining, it will be essential for all staff to understand his visual abilities to maximize his educational gains. This will also be important information as he grows into adulthood and opportunities for employment, post-secondary learning, and expansion of his leisure and domestic skills are explored. The Center is encouraged to obtain a comprehensive functional vision assessment to ensure that recommendations for support and training are clearly outlined.

Similarly, Individual #281 had an orientation and mobility evaluation completed in December 2018. While this addressed his visual impairment, particularly regarding his mobility skills, it did not effectively address his combined hearing loss. The IDT had recommended a consultation from a professional who specialized in services for an individual who was diagnosed as deaf/blind, yet this did not occur. Staff are advised to re-visit this recommendation, so that Individual #281 can be effectively supported to develop and expand his skills across all domains.

During the ISP preparation meeting held in September 2018 for Individual #143, it was determined that the behavioral health assistant would assess his money skills and the home manager would assess his writing skills. At the time of the onsite visit, neither of these assessments had been completed.

11. For eight of the nine individuals, there was evidence that their assessments were available to the IDT 10 days prior to the ISP meeting. The exception was Individual #143. The date of completion of the FSA was not specified on the document and the QIDP tracking of assessments did not include a date for the FSA.

12. Recommendations for skill development were evident in the FSA for Individual #119 and the FSA and retirement assessment for Individual #599. For the remaining seven individuals, no recommendations for skill development were identified in their vocational assessment (Individual #279, Individual #281, Individual #417, Individual #268), in either their FSA or vocational assessment (Individual #162, Individual #143), or in their retirement assessment (Individual #59). As has been noted previously, the FSA assesses skills across 13 domains. Identifying needs across a range of skill areas would make this assessment more meaningful and useful to the individual's IDT.

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, 23 of these indicators had sustained high performance scores and moved to the category requiring less oversight, including one entire outcome in dental. Presently, one additional indicator in the area of psychiatry 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.

Goals/Objectives and Review of Progress

In psychiatry, as Brenham SSLC creates indicators and goals for reduction and for improvement of individuals' psychiatric disorders, data can be collected, and progress determined.

In behavioral health, without reliable data, the Monitoring Team could not make a valid determination of progress.

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

Given that State Office recently provided training and Center nursing staff are at the beginning stages of developing and implementing acute care plans that reflect the training, the Monitoring Team reviewed a small number of acute care plans. For the couple of acute events reviewed, prior to the individuals' transfers to the hospital for scheduled surgeries, nurses did not complete and/or document assessments. Nurses did complete assessments upon the individuals' returns to the Center, which were consistent with applicable standards of care. Improvements are needed with regard to the quality of acute care plans, as well as nurses' implementation or documentation of the completion of the interventions.

Of note, as part of the onsite review week, the Monitoring Team appreciated the Chief Nurse Executive and the Program Compliance Nurse's willingness to conduct an objective review of one acute care plan for one of the individuals reviewed, and discuss their findings openly with the members of the Monitoring Team and State Office staff. This effort showed Center staff's ability to identify the strengths, as well as some of the weaknesses in the acute care plans and the related nursing assessments. With some refinements to the process, and continued auditing with constructive feedback provided to the nurses responsible for

writing and implementing acute care plans, the Monitoring Team is hopeful that at the time of the next review improvements will have occurred.

With regard to acute issues treated at the Center, generally, the PCPs assessed and followed up on the acute issues the Monitoring Team reviewed according to accepted clinical practice. For acute issues for which individuals went to the ED or hospital, it was positive that PCPs or providers generally completed an IPN with a summary of the events leading up to the acute event and the disposition, and IDTs held post-hospitalization ISPA meetings. Improvements are needed with providers conducting quality assessments of individuals, whenever possible, prior to their transfer; with PCPs or nurses communicating necessary clinical information with hospital staff; and with regard to PCPs' post-hospitalization follow-up activities.

Regarding individuals who had frequent occurrences of crisis intervention restraint (more than three in a 30-day period), the Center was not meeting the requirements of review and planning.

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

Implementation of Plans

In psychiatry, as noted in the last report, the department planned to make improvements in the quarterly reviews, and progress was evident during this review. There was improvement in the percentage of reviews completed quarterly and in those that contained the required content. Moreover, the conduct of psychiatric clinic met all criteria for all individuals for three consecutive reviews.

For the most part, polypharmacy justification was not done as required. And, no individuals had a plan regarding tapering (or a rationale for why not needed). The Monitoring Team attended/observed polypharmacy committee. Various disciplines attended and there was lots of discussion about how the medications acted and functioned at the neurotransmitter level. This was good to see.

In behavioral health, even when the Center's own data showed there was no progress or worsening of target behaviors, actions were suggested for a small percentage of the individuals. Actions, however, were implemented when suggested.

Attention needs to be paid to the training of a higher percentage (e.g., all) staff on individuals' PBSPs.

In behavioral health, progress was not reviewed each month and/or the monthly reports did not consistently include comments on the individual's progress. A bright spot, however, was that the Center was, for the first time, holding internal and external peer review meetings at the required minimum frequency.

PBSP graphs often referenced episodes of problem behavior, yet the PBSP defined the targeted behaviors as individual events with frequency measures identified as the data system. This can result in under-reporting of the rates of problem behaviors.

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

Overall, the individuals reviewed generally received timely preventive care, which was good to see.

However, for most individuals' chronic or at-risk conditions reviewed, 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.

Moreover, IHCPs did not include action steps to address individuals' medical needs. In fact, only one of the IHCPs reviewed had any action steps assigned to the PCP, and that IHCP included only one such action step, which the PCP implemented. 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).

For the consultations reviewed, the PCPs generally indicated agreement or disagreement, and wrote IPNs that explained the consultation results. However, problems continued with regard to the timeliness of these reviews. It was good to see that PCPs generally wrote orders for agreed-upon recommendations.

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.

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.

Proper fit of adaptive equipment was sometimes still an issue.

Based on observations, there were still numerous instances (35% of 40 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should

determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
Summary: All but one of these indicators scored lower than at the last review. This reflects that the Center is not meeting the requirements of implementing the required protections (reviews and planning) for individuals who have frequent occurrences of crisis intervention restraint. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	162	417	268					
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.	0% 0/4	0/1	0/1	0/1	0/1					
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	50% 2/4	0/1	1/1	1/1	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	0% 0/4	0/1	0/1	0/1	0/1					

	them?										
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).	50% 2/4	0/1	1/1	0/1	1/1					
26	The PBSP was complete.	N/A									
27	The crisis intervention plan was complete.	0% 0/3	0/1	0/1		0/1					
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	25% 1/4	0/1	0/1	0/1	1/1					
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	50% 2/4	1/1	1/1	0/1	0/1					

Comments:

18-19. During a six-month period prior to the onsite visit, four of the individuals in the review group had experienced more than three restraints in a rolling 30-day period. These were Individual #279, Individual #162, Individual #417, and Individual #268. For all, but Individual #162, there was evidence that their IDTs met within 10 business days of the fourth restraint and there were sufficient meetings held to address this issue. In Individual #162's case, he had experienced more than three restraints in a rolling 30-day period twice in August 2018, but no ISPAs were provided for that month. There was evidence of a meeting held within 10 business days of the fourth restraint that occurred in September 2018.

There were problems regarding the accuracy of restraint reporting. The ISPA meeting held for Individual #279 indicated a total of three physical holds had been applied on the same day, but the master crisis restraint list indicated two physical holds. Similarly, data on the use of restraint varied from one document to another for Individual #162. His PBSP progress note from February 2019 indicated he had had no restraints since August 2018. However, in the October 2018 QIDP monthly progress note, four personal holds were reported in September 2018. These holds were not included in the master list of crisis restraints. Further, when reviewing the reported list of individuals for whom restraint was eliminated over the past nine months, it was determined that 14 of the 23 individuals listed, including Individual #279 and Individual #162, were included in the master list of crisis restraints that had occurred

over the previous six-month period.

20-23. In no case were all of the potential variables discussed and/or adequately addressed by the individual's IDT, as required by these four indicators. Specific comments are provided below.

- In the ISPA for Individual #279, there was some confusion as to the specific events that led to restraint. However, all three noted that a peer was riding a bike and Individual #279 then intervened to take the bike. There were no other reviews of his adaptive skills or his relationship with this particular peer. There were no suggestions to invest in additional bikes, so that he could go for a ride without waiting for a peer to relinquish a bike. There was discussion of revising his PBSP to address problematic departures and self-injurious behavior. It appears that it took two months to complete this revision.
- Individual #162's IDT reviewed restraints that occurred following his scratching his scrotum. While it was noted that this behavior occurred most often when he was waking up and found the itchiness unbearable. Although staff were to be retrained to employ his token economy to reinforce his wearing a brief when sleeping and to reinforce the absence of problem behaviors, there were no plans (e.g., immediately offering clean and dry clothing, applying a salve or some other comforting ointment, etc.) identified to address this discomfort when he first woke up. His adaptive behavior was not reviewed.
- The IDT reviewed Individual #417's psychiatric symptoms and agreed to continue to monitor her medications. They also agreed to remind Individual #417 that she could talk with staff when she was hearing voices. There was no review of her adaptive skills, and while psychosocial issues were noted (i.e., a new roommate had moved in the previous month), there were no plans to address her reported adjustment to this change. It was also noted that she had left her home when upset, but the immediate antecedents were not reviewed. Lastly, it was noted that she had made a suicide attempt when staff were using a sheet to protect her privacy after she had disrobed. There were no plans to train staff to ensure that Individual #417 could not wrap the sheet or her discarded clothing around her neck.
- According to the ISPA minutes for Individual #268, the first restraint occurred when a float staff person redirected Individual #268 after he asked for a cigarette. While redirection was not clearly defined, his PBSP noted that his smoking schedule must be followed, and if he must be told that it is not yet time for a cigarette, staff should be prepared for problem behavior. This did not provide a constructive strategy for addressing this situation. Further, it was noted that his irritability could be due to his depression, but other than addressing his medication, there was no indication that his counselor would be contacted to address this matter. No other variables were reviewed.

24-27. At the time of repeated restraints, all four individuals had a PBSP. Reviews of the individuals' PBSPs can be found in the Psychology/Behavioral Health section of this report. Crisis Intervention Plans were also provided for Individual #279, Individual #162, and Individual #268. None of these plans identified the author or the date of implementation. A review of the Human Rights Committee (HRC) consents, suggested that the CIPs for Individual #162 and Individual #268 were implemented in August 2018.

Because the plans referenced PMAB restraint techniques, staff are advised to update these since Safe Use of Restraint (SUR) had been introduced at the facility. Based on the HRC document, the CIP for Individual #279 was implemented in November 2018. None of the CIPs were considered complete. The plans for Individual #279 and Individual #268 did not specify the type of restraint that was approved for use, and the CIP for Individual #162 noted he should be released when calm, but this was not operationally defined. Individual #162 also had a modified restraint plan. Signatures indicated that this had been approved sometime between February 2017 and February 2018. There was no evidence that the state discipline coordinator for behavioral health services had approved this plan.

28. Data provided by the Center indicated that treatment integrity was not assessed each month per facility guidelines. Further, treatment integrity was not assessed for Individual #279, Individual #162, or Individual #417 during the month(s) of repeated restraint. There was evidence that treatment integrity was assessed for Individual #268 during the period of time when he was restrained more than three times.

A request was made for the data on the use of the Ukeru pads. For all nine individuals, the Center's response was "no data in CareTracker."

A final issue was raised when observing Individual #34. On every visit to his home, he was observed wearing gloves. When staff were interviewed, they reported that he chose to wear these. When a plan and data were requested, the Center reported that his Protective Mechanical Restraint for Self-Injurious Behavior (PMR-SIB) Plan had been discontinued in December 2017. No data were collected regarding his wearing gloves "… as this is not a restriction and considered a preference." It is suggested that staff should work with Individual #34 to fade these gloves so that he can use his hands more frequently and with greater ease to engage in meaningful activities.

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 for all but one individual. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	279	281	162	417	119	268	599	59	143

		Score									
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
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.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
8-9. Given the absence of reliable data for all psychiatric indicators, along with the absence of psychiatric indicators for increase, psychiatric goals, progress could not be determined for goals for reduction or for increase. Moreover, there were six individuals with no goals written or included in the IHCP, thus, goals could not be updated. Three individuals had goals (Individual #599, Individual #281), but the goals did not include metrics regarding time. In another example, regarding Individual #59, the indicators were identical to the behavioral health PBSP target behaviors.

10-11. It was apparent that, in general, when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (e.g., medication adjustments) were developed and implemented. For one individual, however (Individual #279), there was documentation on 10/4/18 by the treating psychiatrist of plans to discuss alterations to the medication regimen. Specifically, this was regarding adding another mood stabilizer and reducing other medications with a plan for Individual #279 to return to clinic in one week to review the plan. The return clinic did not occur. When he was seen at the next scheduled appointment, for a quarterly 12/12/18, this was not documented as further reviewed.

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

Summary: Both indicators scored higher than at the last review. One psychiatric provider coordinated and integrated treatment planning with behavioral health services. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 279	281	162	417	119	268	599	59	143
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
24	The psychiatrist participated in the development of the PBSP.	33% 3/9	0/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1

Comments:
23. The psychiatric documentation referenced the behavioral health target behaviors. Individual #143 did not have a current

behavioral health assessment or positive behavioral support plan.

24. The psychiatric progress notes for three individuals documented discussions with behavioral health staff regarding behavioral issues and the possible etiology of some behaviors as well as considerations for interventions. In addition, the psychiatrist treating these three individuals was noted to attend behavioral therapy committee and participate in the discussion. This psychiatrist was a part time employed psychiatrist whereas the other psychiatry providers were retained via a locum tenens contract. In order to allow for more consistent and integrated services, the Monitoring Team suggests that the facility reduce the reliance on contract providers who provide services for a limited period of time, transitioning to providers who are permanent members of an individual's treatment team.

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: No individuals in the review group were prescribed medications to treat both disorders. However, for one individual, Individual #143, three seizure medications were prescribed with little apparent collaboration with psychiatry. These indicators will remain in active monitoring for possible review at the next onsite visit.

#	Indicator	Overall Score	Individuals: 279	281	162	417	119	268	599	59	143
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	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									

Comments:
25 -27. These indicators did not apply to any of the individuals in the review group. Although Individual #143 and Individual #119 each had a diagnosis of seizure disorder, it was noted that the medications prescribed for seizures were not being utilized for a dual purpose.

Regarding Individual #143, this individual had a severe seizure disorder and was prescribed three medications to address seizure activity. Given the severity of his seizure disorder and the potential impact of this on his psychiatric diagnosis, collaboration and consultation should be considered. This individual had frequent consultation with a pediatric neurologist, but psychiatric documentation did not reveal information regarding the consultation. This was a missed clinical collaboration opportunity.

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

Summary: As noted in the last report, the psychiatry planned to make improvements in the quarterly reviews, and progress was evident during this review. There was improvement in the percentage of reviews completed quarterly and in those that contained the required content. Moreover, the conduct of psychiatric clinic met all criteria for all individuals for three consecutive reviews. Due to this sustained high performance, indicator 35 will be moved to the category of requiring less oversight. Indicators 33 and 34 will remain in active monitoring. Note that all indicators for this outcome were met for two of the individuals.

#	Indicator	Overall Score	Individuals: 279	281	162	417	119	268	599	59	143
33	Quarterly reviews were completed quarterly.	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1
34	Quarterly reviews contained required content.	33% 3/9	0/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 1/1							1/1		

Comments:

33. Quarterly reviews were completed in a timely manner for the seven individuals requiring them.

The records of Individual #143 and Individual #162 did not indicate consistent quarterly clinical reviews. For example, regarding Individual #162, there was a quarterly evaluation dated 3/14/18. The next evaluation was performed 7/25/18. There should have been a quarterly evaluation performed in June 2018. Regarding Individual #143, while he was seen frequently in clinic, often in monthly reviews, there were only two evaluations that were designated as quarterly, 8/23/18 and 2/28/19.

34. The Monitoring Team looks for nine components of the quarterly review. Three of the examples included all the necessary components, with the other examples missing two to six components.

35. During the monitoring visit, the psychiatric clinic was observed for one individual in the review group. In addition, psychiatry clinic was observed for three individuals not included in the review group. Overall, the psychiatry clinics were comprehensive. The psychiatrists indicated that they had reviewed available data prior to the clinic.

However, in the clinic regarding Individual #205, Individual #439, and Individual #327, the psychiatrist asked about sleep data, but these data were not available for the month prior.

Psychiatry had begun to identify psychiatric indicators for reduction and in the clinic examples, there were goals regarding these indicators. This was good to see. This will allow for the use of data to determine improvement, or lack thereof, with regard to

psychiatric symptomatology.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: There was no improvement in this indicator compared with the last review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	22% 2/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1

Comments:
36. There were problems with both the timely completion and prescriber review of MOSES and AIMS assessments.

For example, regarding Individual #279, the prescriber did not review the AIMS assessments dated 1/26/19, 8/7/18, and 5/17/18. There was an AIMS assessment in August 2018 with the next assessment dated January 2019, there should have been an assessment performed in November 2018. The MOSES dated 5/17/18 was not reviewed by the prescriber. There should have been a subsequent MOSES assessment performed in November 2018.

Regarding Individual #268, the AIMS dated 5/1/18 was not reviewed by the prescriber until 5/18/18. The prescriber did not review the MOSES and AIMS assessments dated 8/15/18 until 8/22/18. Moreover, the prescriber did not consider the possible effects of antipsychotic medication on Individual #268's dysphagia, and need for a g-tube.

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

Comments:

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: These indicators remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A									
Comments:											

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.											
Summary: For the most part, polypharmacy justification was not done as required. And, no individuals had a plan regarding tapering (or a rationale, indicator 45). For justifications, indicator 44 will remain in active monitoring. Indicator 45 will remain in the category of requiring less oversight, however, the psychiatry department should work on improving this.			Individuals:								
#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	20% 1/5	0/1		0/1		0/1	0/1	1/1		
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 one example (Individual #599). This facility added individuals with polypharmacy related to seizure medications to the polypharmacy list for tracking purposes. This was good to see.											

45. There was no documentation for individuals who met criteria for polypharmacy showing a plan to taper various psychotropic medications or documentation as to why this was not being considered.

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. Even when the Center's own data showed there was no progress or worsening of target behaviors, actions were suggested for a small percentage of the individuals. Actions, however, were implemented when suggested. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
6	The individual is making expected progress	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A									
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	25% 1/4				0/1		1/1	0/1	0/1	
9	Activity and/or revisions to treatment were implemented.	100% 1/1						1/1			

Comments:

6. The graphs provided by the Center suggested that Individual #279, Individual #281, Individual #162, Individual #119, Individual #59, and Individual #143 were making progress on their target problem behaviors and/or replacement behaviors. However, this indicator is rated zero for all nine individuals due to the identified problems with inter-rater agreement and data timeliness.

7. Established goals had not been met for any of the individuals.

8-9. The graphs indicated a lack of progress for Individual #417, Individual #268, Individual #599, and Individual #59 (replacement behavior only). For Individual #268, actions had been taken to address his worsening behavior.

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

Summary: To repeat from the last review: Attention needs to be paid to the training of a higher percentage (e.g., all) staff on individuals' PBSPs. Indicator 16 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
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% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
17	There was a PBSP summary for float staff.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
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.										

Comments:
16. For none of the individuals was there evidence that over 80% of their assigned staff had been trained on their PBSPs. Documentation of training on Individual #143's plan could not be located. For the other eight individuals. training rosters indicated that between 2% and 71% if assigned staff had received training.

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

Summary: Overall, Brenham SSLC showed poor performance on these standard aspects of behavioral treatment. A bright spot, however, was the Center was, for the first time, holding internal and external peer review meetings at the required minimum frequency. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
19	The individual's progress note comments on the progress of the individual.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
20	The graphs are useful for making data based treatment decisions.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	0% 0/2					0/1		0/1		
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	0% 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.	100%									

Comments:
19. There was evidence of consistent review of progress for Individual #119. Her monthly reports commented on her progress (which was good to see), but graphs were not included (which was not good to see).

For several individuals (Individual #279, Individual #162, Individual #417, Individual #268, Individual #143) it was evident that progress was not reviewed each month over the previous six months.

For others (Individual #281, Individual #599, Individual #59), the monthly reports did not consistently include comments on the individual's progress. The individual was identified in the header of the progress reports for Individual #417 and Individual #119.

20. Monthly data were presented in all of the graphs. However, due to problems with interpretation and the lack of phase change lines for significant changes or events, none of the graphs were useful for making data-based treatment decisions.

21. During the onsite visit, observations were conducted of the ISP meeting for Individual #119 and the psychiatric clinic for Individual #599. At Individual #119's meeting, staff discussed her SAP for matching the letters of her name, but they did not review data. At Individual #599's meeting, it was clear that the psychiatrist had reviewed data prior to the meeting, but the BCBA did not present the data or a graph for review by other members of the team.

22. There was evidence that Individual #268 had been reviewed by the internal peer review committee. There was no evidence of subsequent revisions to a token economy or that thickened drinks had been tried.

23. There was evidence that over a six-month period, internal peer review occurred at a minimum of three times each month and external peer review occurred once each month.

Outcome 8 – Data are collected correctly and reliably.

Summary: There was not continued progress in this outcome and its indicators. Data collection systems were adequate (indicator 28), however, attention to detail (e.g., episodes versus frequency) was needed. This set of indicators remain in active monitoring.

#	Indicator	Overall Score	Individuals: 279	281	162	417	119	268	599	59	143
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	11% 1/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	56% 5/9	1/1	0/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 9/9	1/1	1/1	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%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

		0/9									

Comments:
26. Although all of the PBSPs identified a frequency measure for collecting data on targeted problem behaviors, graphs for Individual #281, Individual #162, Individual #599, Individual #59, and Individual #143 depicted episodes. But episodes were not defined in any of the plans. Further, as an episode suggests duration with possible repeated occurrences of targeted behavior, and these were determined to be inadequate data collection systems.

For Individual #417 and Individual #119, their PBSPs noted that if multiple behaviors occurred within the same situation, staff were to explain it under one behavior in the comments section. This could result in underreporting of any of the targeted problem behaviors. Lastly, the vertical axis on Individual #268's graph depicting suicidal statements/gestures, aggression, and refusals was not labeled. This did not allow for a determination of the adequacy of the data collection system.

27. The data collection system identified for replacement behaviors was found to be adequate for five individuals. Similar to the problems noted above, four individuals (Individual #281, Individual #599, Individual #59, Individual #143) had a frequency measure identified in their PBSPs, however, episodes of replacement behavior(s) were noted in the graphs.

28. The Center presented a monitoring tool that was used to assess data timeliness, IOA, and treatment integrity. When used during an observation of staff interacting with an individual, this was determined to be an acceptable measure of IOA and treatment integrity. However, because this allowed for only one review of timeliness at the moment of observation, it was not an acceptable measure of staff documenting identified behaviors at a minimum of once every two hours. The director of behavioral health services concurred regarding this.

29. The Center reported that the expectation is that data timeliness, IOA, and treatment integrity will be assessed monthly. Expected levels for IOA and treatment integrity are 80%. Due to the current manner in which data timeliness was being assessed, measures can either be 0% or 100%, therefore, the latter score is expected.

30. Over the past six months, data collection timeliness, IOA, and treatment integrity were not assessed each month for any of the nine individuals. These measures were assessed five times for Individual #281, four times for Individual #268 and Individual #59, three times for Individual #417 and Individual #599, twice for Individual #119, and once for Individual #279, Individual #162, and Individual #143. Although all reported measures were 100%, direct observation of staff working with the individual did not occur during all assessments for Individual #281, Individual #162, Individual #268, Individual #599, Individual #59, and Individual #143.

There were at least three occurrences of targeted problem behavior during which staff clearly did not follow the individual's PBSP.

- On two occasions, Individual #599 was observed screaming and engaging in self-injurious behavior. Staff did not notify a nurse after five minutes as directed in her plan. They also provided a back rub as these behaviors continued. While she did calm, this response may reinforce her screaming and self-injurious behavior. Behavioral health service staff are advised to observe Individual #599 in her day program and meet with staff to ensure that her plan is implemented with integrity.
- On another occasion, staff were observed instructing Individual #546 to go to the gym. Rather than providing him two choices as indicated in his PBSP, staff began counting after the initial instruction. This counting suggested that if he did not comply, a

more intrusive prompt would follow. His plan clearly indicated that staff should not use assertive or demanding prompts.

In general, behavioral health services staff are advised to conduct observations of staff interacting with individuals in their home and day program sites at a minimum of once monthly to ensure that plans are implemented with integrity.

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.

#	Indicator	Overall Score	Individuals: 143	268	286	217	149	276	76	490	91
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	22% 4/18	2/2	1/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #143 – seizures, and weight; Individual #268 – weight, and polypharmacy/side effects; Individual #286 – aspiration, and skin integrity; Individual #217 – osteoporosis, and other: osteoarthritis; Individual #149 – GI problems, and polypharmacy/side effects; Individual #276 – falls, and UTIs; Individual #76 – weight, and skin integrity; Individual #490 – weight, and other: obstructive sleep apnea; and Individual #91 – respiratory compromise, and other: obstructive sleep apnea).

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 #143 – seizures, and weight; Individual #268 – weight; and Individual #490 – weight.

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, these indicators will continue in active oversight 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: 143	268	286	217	149	276	76	490	91
a.	Individual receives timely preventative care:										
	i. Immunizations	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
	ii. Colorectal cancer screening	100% 4/4	N/A	1/1	1/1	1/1	N/A	N/A	N/A	N/A	1/1
	iii. Breast cancer screening	100% 2/2	N/A	N/A	N/A	1/1	N/A	1/1	N/A	N/A	N/A
	iv. Vision screen	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	100% 7/7	N/A	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
	vii. Cervical cancer screening	100% 2/2	N/A	N/A	N/A	N/A	N/A	1/1	N/A	1/1	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	13% 1/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	1/1	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 #143, the record did not include his varicella antibody status, and it was unclear if he received Gardasil. During the Monitoring Team's onsite review, the PCP ordered them.
- For Individual #91, on 4/26/13, a varicella titer showed he was antibody equivocal. Based on documentation submitted, no follow-up occurred.

b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. In other words, the PCP should review the QDRR, provide an interpretation of the results, and discuss what changes can be made to medications based on this information, or state if the individual is clinically stable and changes are not indicated. Individual #490's PCP provided a thoughtful review of the medication potentially contributing to metabolic syndrome.

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

Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91
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	N/A	N/A	N/A	N/A	N/A	N/A	0/1

Comments: a. According to Individual #91's AMA, he had an out-of-hospital (OOH) DNR Order. It had been in place since 2009. However, based on documentation submitted, he did not have a qualifying condition. He had chronic progressive cerebral palsy. His medical conditions appeared stable.

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

Summary: With regard to acute issues treated at the Center, generally, the PCPs assessed and followed up on the acute issues the Monitoring Team reviewed according to accepted clinical practice. For acute issues for which individuals went to the ED or hospital, it was positive that PCPs or providers generally completed an IPN with a summary of the events leading up to the acute event and the disposition, and IDTs held post-hospitalization ISPA meetings. Improvements are needed with providers conducting quality assessments of individuals, whenever possible, prior to their transfer; PCPs or nurses communicating necessary clinical information with hospital staff; and with regard to PCPs' post-hospitalization follow-up activities. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91

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% 15/16	1/1	2/2	1/2	2/2	2/2	2/2	2/2	2/2	1/1
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	86% 6/7	N/A	1/2	1/1	2/2	N/A	1/1	1/1	N/A	N/A
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	91% 10/11	N/A	2/2	1/2	1/1	2/2	2/2	1/1	N/A	1/1
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	50% 1/2		1/1	N/A	N/A	0/1	N/A	N/A		N/A
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring 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.	64% 7/11		2/2	0/2	0/1	2/2	1/2	1/1		1/1
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	100% 3/3		N/A	1/1	N/A	1/1	N/A	N/A		1/1
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	60% 3/5		N/A	0/1	N/A	0/1	2/2	N/A		1/1
Comments: a. and b. For the nine individuals reviewed, the Monitoring Team reviewed 16 acute illnesses addressed at the Center, including: Individual #143 (seizures and Diastat use on 1/10/19), Individual #268 (sinusitis on 11/5/18, and diarrhea on 11/1/18), Individual #286 (hip wound on 9/28/18, and breakthrough seizure on 9/4/18), Individual #217 (arthritis pain on 9/20/18, and drowsiness on 10/30/18), Individual #149 (scrotal boil on 12/20/18, and left ear redness/dryness on 11/26/18), Individual #276 (left elbow bruise on 12/13/18, and fall on 1/2/19), Individual #76 (left shoulder and left hip pressure wounds on 11/2/18, and abrasion to back on 11/9/18), Individual #490 (right great toe pain on 2/27/19, and vaginal discharge and perineal rash on 2/13/19), and Individual #91 (left buttock wound on 9/27/18).										

Generally, for the acute issues treated at the Center that the Monitoring Team reviewed, the PCPs assessed and followed up on them according to accepted clinical practice. The following provide descriptions of concerns noted:

- On 11/1/18, Individual #268's PCP ordered a KUB due to the individual's history of constipation, and also ordered a decrease in Miralax, and a urine culture. On 11/8/19, at 9:29 a.m., the PCP noted that the urine culture showed no growth. However, based on the documentations submitted, the PCP did not follow-up on the completion of the KUB and/or provide an interpretation of the results.
- For Individual #286's hip wound on 9/28/18, the PCP did not document the source of the information.

c. For seven of the nine individuals reviewed, the Monitoring Team reviewed 11 acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #268 (ED visit for emesis on 1/3/19, and ED visit for hypotension on 10/24/18), Individual #286 (hospitalization for aspiration pneumonia on 12/20/18, and ED visit for vomiting with blood on 12/26/18), Individual #217 (ED visit for vomiting), Individual #149 (hospitalization for pneumonia, sepsis, and lethargy on 12/27/18, and hospitalization for respiratory distress on 12/31/18), Individual #276 (ED visit for fall with laceration on 12/19/18, and ED visit for fall with facial injuries on 12/18/18), Individual #76 (ED visit for full code on 12/3/18), and Individual #91 (hospitalization for fever on 2/16/19).

c. and d., and f. through 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: Individual #268 (ED visit for emesis on 1/3/19, and ED visit for hypotension on 10/24/18), Individual #149 (hospitalization for pneumonia, sepsis, and lethargy on 12/27/18), Individual #276 (ED visit for fall with laceration on 12/19/18), Individual #76 (ED visit for full code on 12/3/18), and Individual #91 (hospitalization for fever on 2/16/19).
- On 12/20/18, the same day that Individual #286 had TIVA for dental procedures, he was admitted to the hospital for aspiration pneumonia. On 12/25/18, he returned to the Center, but on 12/26/18, he was sent back to the ED. Although 12/26/18 was a state holiday, the PCP did not write a note until 12/28/18, and based on the documentation, the PCP did not conduct further follow-up on this hospitalization.
- With regard to Individual #149's hospitalization for respiratory distress, the transfer occurred on 12/31/18 at 8:59 a.m., but the PCP or another provider did not complete an assessment. On 1/7/19, upon the individual's return to the Center, the PCP wrote an IPN at 5:11 p.m. The plan was to refer the individual to the PT to evaluate and treat him for deconditioning, oral thrush treatment, and treatment of the perineal intertrigo with topical and oral antifungal medications. The PCP updated the drug allergy list to include Vancomycin and Aztreonam, and noted the individual's hypoxia and apnea were due to an adverse drug effect of clomipramine, which caused the hospitalizations from 12/27/18 to 12/30/18, and 12/31/18 to 1/7/19. The PCP entered a several-page IPN reviewing details from the back-to-back hospitalizations. However, the PCP did not enter any additional IPNs for a week, until 1/14/19, and this IPN was not a post-hospital review note, but addressed the status of the fungal skin infection and thrush. The PCP followed the individual's thrush infection to resolution on 2/11/19.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: For the consultations reviewed, the PCPs generally indicated agreement or disagreement, and wrote IPNs that explained the consultation results. However, problems continued with regard to the timeliness of these reviews. It was good to see that PCPs generally wrote orders for agreed-upon recommendations. If the Center sustains its performance with regard to Indicators a, c, and d, after the next review, they might move to the category of less oversight.			Individuals:								
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	93% 14/15	2/2	2/2	1/2	2/2	1/1	2/2	N/A	2/2	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	67% 10/15	2/2	2/2	1/2	0/2	1/1	1/2		1/2	2/2
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.	93% 14/15	2/2	2/2	1/2	2/2	1/1	2/2		2/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	86% 14/15	2/2	2/2	1/2	1/2	1/1	2/2		1/1	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A		N/A	N/A

Comments: For eight of the nine individuals reviewed, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed included those for Individual #143 for Ear, Nose, and Throat (ENT) on 2/15/19, and neurology on 12/11/18; Individual #268 for pulmonology on 11/12/18, and endocrinology on 10/19/18; Individual #286 for neurology on 8/18/18, and neuromuscular clinic on 10/25/18; Individual #217 for orthopedics on 12/11/18, and gastroenterology on 1/22/19; Individual #149 for orthoptist on 1/25/19; Individual #276 for cardiology on 11/29/18, and neurology on 2/13/19; Individual #490 for podiatry on 11/29/18, and neurology on 1/16/19; and Individual #91 for ophthalmology on 9/11/18, and podiatry on 1/31/19.

a. For all but one of the consultation reports reviewed, PCPs indicated agreement or disagreement with the recommendations, and provided rationales for disagreements. The exception was for Individual #286 for the neuromuscular clinic on 10/25/18. The PCP did not write an IPN, or write orders for follow-up. It appeared that the PCP had not seen the consultation report.

b. The reviews that did not occur timely were for Individual #286 for the neuromuscular clinic on 10/25/18; Individual #217 for orthopedics on 12/11/18, and gastroenterology on 1/22/19; Individual #276 for cardiology on 11/29/18; and Individual #490 for podiatry on 11/29/18.

c. For the most part, PCP IPNs related to the consultations reviewed included all of the components State Office policy requires. The exception was for Individual #286 for the neuromuscular clinic on 10/25/18, as discussed above.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, with the exceptions of the following: Individual #286 for the neuromuscular clinic on 10/25/18, and Individual #217 for orthopedics on 12/11/18.

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

Summary: For most of the individuals' chronic or at-risk conditions reviewed, medical assessment, tests, and evaluations consistent with current standards of care were not completed, and/or the PCP had not identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.

#	Indicator	Overall Score	Individuals: 143	268	286	217	149	276	76	490	91
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	33% 6/18	1/2	2/2	0/2	2/2	0/2	0/2	0/2	0/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #143 – seizures, and weight; Individual #268 – weight, and polypharmacy/side effects; Individual #286 – aspiration, and skin integrity; Individual #217 – osteoporosis, and other: osteoarthritis; Individual #149 – GI problems, and polypharmacy/side effects; Individual #276 – falls, and UTIs; Individual #76 – weight, and skin integrity; Individual #490 – weight, and other: obstructive sleep apnea; and Individual #91 – respiratory compromise, and other: obstructive sleep apnea).

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 PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #143 – seizures; Individual #268 – weight, and polypharmacy/side effects; Individual #217 – osteoporosis, and other: osteoarthritis; and Individual #91 – respiratory compromise. The following provide examples of concerns noted:

- During the past year, Individual #143 was underweight. In August 2018, he weighed 63.9 pounds, and in December 2018, he weighed 79.4 pounds. He remained below the 5th percentile on the Centers for Disease Control (CDC) growth chart, with a body mass index (BMI) of 15.5. On 10/8/18, a high-calorie snack pack was offered every hour to help reduce his challenging behaviors and to promote weight gain, but reportedly, it did not improve his behaviors at school, but he continued to have challenging behaviors at meal times while seated at the table. Staff continued to offer the snack pack informally as needed in the home. The formal trial was discontinued. On 11/30/18, the PCP prescribed/restarted Remeron, which is associated with increasing appetite. On 10/2/17, it had been stopped while the individual was hospitalized due to a concern that it might have contributed to leukopenia. The PCP also prescribed Divalproex, which also is associated with weight increase. He was prescribed Topamax, but this was discontinued and changed to an alternative antiepileptic medication, because it is associated with weight loss. On 10/3/18, and 6/29/18, his total protein and albumin levels were adequate. Despite the low BMI and

underweight status, the AMA, dated 12/13/18, did not include this concern in a plan of care to ensure all relevant medical issues were addressed. The nutritional assessment did review many important areas, including the impact of medication. Another concern was that his antiepileptic medication and small frame/underweight status placed him at risk for osteoporosis. Vitamin D levels had been adequate. He had several challenges to any muscle strengthening program due to his spastic hemiplegia, optic atrophy, and cortical blindness. To reduce his risk of osteopenia/osteoporosis, Habilitation Therapy involvement would be critical in creating a weight-bearing exercise program to strengthen his musculoskeletal system.

- As a baseline, Individual #286 had unsafe eating habits, as he had a tendency to place large food items in his mouth. Chewing skills were considered adequate. After chewing food, staff had observed him place more food in his mouth before swallowing the prior bite of food. He required verbal and physical prompts to slow down. An ISPA, dated 1/30/19, showed the IDT reviewed the PNMP instructions and confirmed that he did not have a requirement to remain upright after intake. A review of his past medical history showed that on 10/18/17, this individual developed a post-operative aspiration pneumonia, but otherwise had no significant respiratory infections requiring hospitalization until 12/20/18. He had a dental procedure under TIVA and later that day became febrile. This led to a five-day hospitalization for sepsis and aspiration pneumonia. On 12/25/18, he was discharged on Augmentin. On 12/26/18, he vomited and was sent back to the ED, with concern for gastroccult positive vomitus, but the ED testing did not confirm this, and he was returned to the Center.

  On 12/28/18, the PCP reviewed the hospitalization and ED visit records, and a 1/9/19 ISPA showed the IDT reviewed his hospitalization and provided recommendations. The IDT noted that he was not provided twice daily tooth brushing most days. A two-minute sand timer was requested to assist direct support professionals in completing tooth brushing for the recommended two minutes. Direct support professionals also were to be retrained on documentation of tooth brushing. Additionally, the IDT recommended a three-month recall to the dental office due to his ongoing poor oral hygiene, and that the IDT planned to ask dental staff to brush his teeth once weekly in the home. A Habilitation Therapy note, dated 1/3/19, indicated that on 1/3/19, the PNMT speech language pathologist (SLP) completed a meal observation, and no dysphagia intervention or diagnostics were indicated. On 1/11/19, the therapist recommended that staff use verbal prompting followed by physical prompting, if necessary to slow down his eating.

  Subsequently, in the Monitoring Team's interview with the dentist, it was determined that the IDT had not conducted a "root cause analysis" to address the complication of aspiration pneumonia and sepsis following the dental procedure under TIVA. Such an analysis was needed to ensure all steps in the process, from the state of his health the morning of the procedure (i.e., stability of vital signs, or fever, etc.), through the procedural steps (e.g., suctioning at time of throat pack removal, environment of the procedure, review of prior pneumonia post-operatively), through post-operative care (e.g., positioning, evidence of reflux with aspiration, post-operative monitoring). Evaluation and treatment were inadequate in ensuring prevention of another aspiration pneumonia/complication following a dental procedure under TIVA/GA.

- On 9/27/18, Individual #286 developed a Stage 2 pressure wound on his right hip. The next day, the PCP saw him, and noted the individual did not display pain during examination of the wound. The skin integrity nurse was consulted. On 10/3/18, the PCP indicated the hip wound had decreased in size. However, on 10/15/18, the PCP noted there was no further improvement, and, in fact, the pressure wound was worse with an increase in the size of the wound. Yellow slough was noted at the wound

base. The skin integrity nurse was again consulted. On 10/16/18, the individual moved to another home. Nursing documentation indicated the wound had progressed to a Stage 3 wound. Modifications in topical treatment then occurred. The PCP documented the wound had resolved by 11/28/18.

As part of the evaluation as to cause, the individual was referred to neurology for his apparent diffuse muscle wasting, which was noted in October 2017, following a right hip fracture. Consultation through neurology to the neuromuscular disease clinic was originally denied in June 2018, but a repeat request was successful in obtaining consultation on 10/25/18. The final diagnosis was deconditioning with muscle wasting with the recommendations to continue PT/OT.

IPNs indicated that Habilitation Therapy staff completed serial evaluations, but it was unclear if they provided direct therapy to recondition him in all extremities, or if the habilitation therapy plan was monitored for effectiveness. A subsequent PCP IPN, dated 11/28/18, indicated that the individual was much more active in the new home, and was ambulatory, in contrast to when he was usually seen in a wheelchair in the prior home. A post-hospitalization habilitation therapy note, dated 12/27/18, indicated he was back to baseline, including ambulation, and that habilitation therapy services would be available for consultation as needed. A nursing IPN summary, dated 1/7/19, documented that an ill-fitting wheelchair was determined to be the underlying cause of the original wound. Once staff identified the wound, the skin integrity treatment was appropriate until healed. However, it was problematic that an ill-fitting wheelchair was the cause of the pressure wound. It also was concerning that despite on-site availability of direct habilitation therapy services, he remained deconditioned in his original home, but then improved in the new home. It was not clear from submitted documentation whether Habilitation Therapy staff had provided instructions to staff in the original home on how to augment the habilitation therapy treatments throughout the day and include these exercises in his active treatment.

- On 12/4/12, Individual #149 underwent gastrostomy tube (G-tube) placement and Nissen fundoplication. On 5/20/14, the G-tube was replaced with a Mickey tube. A Modified Barium Swallow Study (MBSS), dated 7/19/16, indicated the continued need for nothing-by-mouth (NPO) status. On 12/2/17, he was sent to the ED for elevated gastric residuals, but there were no findings on computed tomography (CT) scan. At that time, bolus feedings were stopped and a gravity bag was used to provide a slower rate of 23 minutes per feeding. The submitted IPNs began in September 2018 (i.e., even though the Monitoring Team requested them back to 8/1/18). From that time through February 2019, he refused numerous feedings. For much of this time, he would knock over the feeding bag pole to interrupt feeding. This was further complicated by him pulling out his Mickey button (this latter behavior appeared to have resolved by March 2019). However, his feeding refusal continued, and at one point, he refused up to seven consecutive feedings. From an IPN, dated 11/5/18, he refused the feeding, but became upset when the nurse walked away. The ISPA, dated 11/6/18, indicated the behaviors might be a side effect from his Luvox. At that time, the IDT noted that he had not lost weight, despite the feeding refusals. A PCP IPN, dated 12/12/18, discussed the request that the QIDP call an IDT meeting, including psychiatry, to discuss the refusals. In the ISPA, dated 12/14/18, the IDT indicated it believed a component of his behavior was due to obsessive compulsive disorder (OCD), and psychiatry recommended Clomipramine. On 12/27/18, a CT of the abdomen and pelvis was completed, and showed some mild stomach distention with fluid and minimal wall thickening of the gastric antrum. The PCP mentioned that staff attempted to engage him in activities, because the IDT was concerned he might be bored. Although there appeared to be an increasing trend toward refusing the 11:00 a.m. feeding most frequently, based on the submitted documents, the IDT did not conduct a review of his refusals to try

to identify any pattern. Although his refusals had been frequent since at least September 2018 (i.e., as far back as the records submitted went), it was not until 11/6/18, that the IDT held the first ISPA meeting to address this issue. At times, it appeared the individual was attempting to communicate something (e.g., pain, boredom, discomfort, etc.), but the IDT did not hold a meeting to discuss these puzzling behaviors and attempt to interpret them. In December 2018, psychiatry did make changes in medication. The role of Behavioral Health Services staff was not well documented, but should have been a constant major presence to address this individual's needs.

- Due to Individual #149's noncompliance with feeding and his recurrent dislodging of his Mickey tube, the psychiatrist placed him on clomipramine as a temporary emergency. On 12/27/18, it was noted he was weak, and drowsy with an unsteady gait. He was transferred to the ED and admitted for sepsis. On 12/30/18, he returned to the Center, but continued to have unstable vital signs, and on 12/31/18, he returned for further hospitalization where he developed respiratory distress with hypoxia and apnea, which recurred when clomipramine was restarted. Based on review of the IPNs, it was not clear whether the PCPs were aware of the new psychiatric medication, nor was it clear that Center staff passed along this information to the hospitalist, as it was during the second hospital admission that the discovery was made of respiratory decline following the re-initiation of clomipramine. However, at the morning medical meetings with pharmacy and psychiatry in attendance, this concern should have been identified, and discussed with further communication made to the hospital after the discussion. Instead it appeared from the PCP IPN, dated 1/7/19, at 5:11 p.m., that during a discussion between the PCP and the hospital attending physician "it was discovered that he was being weaned off fluvoxamine and had recently been started on clomipramine." This suggested the need for improved communication among departments, as well as improvements in the content of information transferred to the ED. Clomipramine was subsequently listed an allergy in the electronic record.

  In is comments on the draft report, the State disputed these findings, and stated: "PCPs [sic] extensive detailed IPN on 01/07/2019 indicated that PCP had known about the new medication and had discussion with the treating medical provider at the Hospital… The attached complete IPN note has evidence of passing of information to the treating medical provider at the hospital… From Hospital notes:
  - Principal problem noted as acute respiratory failure with hypoxia and hypercapnia; medication vs infection???; hold sedating agents
  - 1/01/2019 continue to hold sedating medications
  - 1/04/2019 Zyprexa and Clomipramine restarted, and he became obtunded responding only to noxious stimuli. Periods of apnea noted. Transferred to ICU and placed on BiPap.
  - …, Hospitalist NP, spoke to [Center PCP] "regarding medications, & she reported that Anafranil is a new medication, just started end of December. Plan was to wean off Luvox & transition to Anafranil. Suspect that new medication is too sedating & causing respiratory depression. Will DC med."
  - 1/05/2019 Per …, Hospitalist NP, progress note, 'Experienced respiratory depression yesterday with periods of apnea after antipsychotics resumed. Spoke with PCP, clomipramine a recent addition. Psychiatry was weaning of fluvoxamine, started clomipramine. Likely too oversedating'

  Conversation between PCP and treating medical Provider in the hospital occurred Jan 4th as noted above and Psychiatrist discontinued his clomipramine on Jan 4th @ 1402 even prior to his return to the facility on Jan 7th"

The PCP IPN, dated 1/7/19, included many details. On page 124 of the pdf, it stated: "On the morning of the 4th, home antipsychotics were resumed. He became very obtunded, with decreased respirations and periods of apnea… case was discussed with his PCP, and **it was discovered** that he was being weaned off fluvoxamine and had recently been started on clomipramine. It was determined that clomipramine was the most likely culprit" (emphasis added). Whether the discussion occurred on 1/4/19 or 1/7/19, Individual #149 experienced two hospitalizations before the hospital team became aware that clomipramine was a new medication. The Monitoring Team's finding stands that there was insufficient communication of critical information to the hospital team. Based on the documentation submitted, until the hospitalist contacted the PCP, the IDT had not considered the possibility that the new medication was a potentially significant etiologic factor in the individual's repeated episodes of respiratory failure/lethargy.

- On 9/19/18, Individual #276 had a catheterized urine specimen, which on urinalysis showed many bacteria and many white blood cells (WBCs). She was empirically started on Macro twice a day (BID). On 10/4/18, nursing staff provided direct support professional staff with instructions for care of this individual with a UTI (i.e., peri-care every two hours, encourage fluids with each meal, snack, and medication pass). On 10/16/18, she then underwent a test of cure. The UTI had resolved. She had remained on Macrobid since the urine culture had shown resistance to ampicillin, cefazolin, and fluoroquinolones. She underwent a test of cure, although current national guidelines for antibiotic stewardship tests of culture are not indicated, and are associated with increasing resistance. Increased resistance already existed in this individual and continued urine culture testing and treating would likely risk worsening resistance. The infection control program needs an antibiotic stewardship program. For individuals who do not communicate verbally, identification of a set of signs and symptoms that might suggest a UTI in the individual would add needed information as to whether there was ongoing infection or not to consider a repeat culture. Consultation with an infectious disease specialist would allow the development and implementation of policies and procedures consistent with national antibiotic stewardship recommendations adapted to the intellectual and developmental disabilities (IDD) population.

- Individual #76 had an estimated desired weight range (EDWR) of 100 to 125 pounds. In May 2017, his weight was 103.2 pounds, and in May 2018, it was 97.4 pounds. A nutrition assessment, dated 5/14/18, indicated he was provided 8700 calories per day. The assessment noted that staff discussed with him the food he received for the meal and assisted with feeding him the various food items. Given that he had profound hearing loss and complete blindness, the effectiveness of this plan was unclear. The IDT reportedly was to make referrals to the PNMT if he had an unplanned or verified weight loss of greater than five pounds in a month. In May 2018, the AMA indicated that he was of small stature and build, and that his pre-albumin and nutritional status were adequate at that time. On 6/29/18, an ISPA recorded the recommendations from an MBSS, with downgrading from nectar to honey-thick liquids.

  A PCP IPN, dated 11/7/18, indicated he had lost 9.33 pounds in the prior month, although the PCP did not record the previous weight in the IPN. His diet at that time was 9164 calories per day. The PCP requested staff reweigh him, and then document twice weekly weights for four weeks. Staff reported that he was eating well (97-100% intake), but on review of a detailed report, the PCP found staff had not documented many breakfast and lunch meals. The PCP requested that the Home Manager and staff be re-in-serviced on documentation in Care Tracker, and that the IDT and Registered Nurse Case Manager (RNCM) follow up on this concern. Nursing staff were to offer one carton of Boost pudding with each medication pass BID. On

11/12/18, he weighed 91.4 pounds. A subsequent nursing IPN, dated 11/20/18 indicated he had gained some weight, and he was close to his EDWR. However, there was no completed PNMT consult submitted based on the greater than five-pound weight loss in one month. Additionally, the documentation submitted in response to request #31, indicated he had not had unplanned weight loss or gain in the most recent three months requiring a plan of care. There was need for improvement in communication and monitoring at many levels, including, for example, accurate documentation of meal and fluid intake by direct support professionals, PNMT review of findings for which their review was indicated, increased monitoring by dietary and residential supervisory personnel to ensure the accuracy and completeness of intake records, review of the role of direct support professional staff communication with the individual during meals if he had profound deafness and complete blindness, and the need for the development of a plan of care in a timely manner for such significant weight loss. Although the PCP had a role to initiate actions to correct this situation, other members of the IDT needed to play their parts in ensuring that similar intake documentation inaccuracies and weight loss were prevented for other individuals in the home.

- During overnight polysomnography testing on 12/28/17, Individual #490 was noted to have obstructive sleep apnea (OSA). Symptoms at that time included excessive daytime sleepiness, snoring, and gasping for air during sleep. On 3/8/18, respiratory therapy delivered continuous positive airway pressure (CPAP) apparatus and provided an in-service to the direct support professionals and nursing staff in the home. However, a pulmonology follow-up on 4/11/18, indicated she had "complete" noncompliance with the CPAP machine, in part because she liked to roll over in bed and was unable to do so with the apparatus attached. At that time, recommendations included avoiding the supine position with the use of pillows, and to encourage weight loss. She was to return to the pulmonologist as needed. At baseline, she required HOBE at 10 degrees with a mediwedge (used to treat GERD). In August 2018, habilitation therapy staff assessed the optimal HOBE, and determined she was unable to tolerate greater than a 10-degree elevation. Habilitation Therapy staff educated staff concerning the long-term risks of untreated OSA. On 8/1/18, the IDT agreed to attempt CPAP use during her daytime naps. Also, the IDT agreed that Behavioral Health Services staff and the direct support professionals would work together to motivate improved compliance with her CPAP use. From September 2018 through much of February 2019, IPNs indicated she refused CPAP use. It was not clear if the IPNs captured all refusals of CPAP use. The submitted documents did not indicate that the IDT held ongoing ISPA meetings to address her noncompliance with the CPAP system, attempts at addressing any discomfort in application of the device, less invasive/alternative CPAP apparatus, reinforcement for use based on length of time CPAP was applied correctly, the outcome of collaboration between Behavioral Health Services staff and the direct support professionals, etc. From 4/22/18, when the pulmonologist documented noncompliance through to the time of document production, the IDT only held one ISPA meeting that addressed the individual's noncompliance, and they had held none since the most current ISP meeting, which occurred on 11/5/18. IDT response, with the leadership of the PCP, was inadequate and lacked timeliness. The training Habilitation Therapy staff provided occurred four months after the pulmonology visit, which appeared to be a delayed response to a significant health problem. As their training indicated, the risks of OSA include hypertension, cardiovascular morbidity, metabolic syndrome, atrial arrhythmias, and increased risk of mortality.

- Since at least 2016, Individual #91 had obstructive sleep apnea. On 4/19/18, a sleep study indicated the continued benefit of CPAP with heated humidifier. However, numerous IPNs indicated that the individual was not compliant with use of the CPAP mask. At times, he pulled the CPAP hose off the bedside table, and removed the CPAP mask from his face. IPNs documented these behaviors in December 2018 (six times), January 2019 (10 times), and February 2019 (eight times). When an IPN was

	not written, it was not clear whether or not he refused the use of the CPAP mask. There were times when he repeatedly pulled the mask off. Despite the many nights without CPAP compliance, the AMA, dated 2/1/19, indicated that he was "generally compliant" with his CPAP use. Based on the documents submitted, the IDT had not held an ISPA meeting to address this concern. The IDT had not engaged in an analysis to determine the reason he refused to use the CPAP equipment (e.g., a behavior to seek attention, an ill-fitting or uncomfortable mask, discomfort with the settings used, positioning considerations, boredom, etc.), or to develop and implement steps to potentially resolve this problem.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
Summary: Overall, IHCPs did not include action steps to address individuals' medical needs. In fact, only one of the IHCPs reviewed had any action steps assigned to the PCP, and that IHCP included only one such action step, which the PCP implemented. 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	143	268	286	217	149	276	76	490	91
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: a. As noted above, individuals' IHCPs generally did not include action steps to address individuals' medical needs. However, the PCP completed the one action steps assigned in the IHCP for Individual #268 - weight [i.e., to review the esophagogastroduodenoscopy (EGD) results].											

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: The Center had made some progress since the previous review toward the development of clinically relevant outcomes (i.e., Round 13 - 11%, and Round 14 - 56%), but this continued to be an area that needed focus. None of the goals were measurable, because they did not include expected timeframes for completion, and they did not include criteria for achievement. Even when clinically relevant goals were present, IDTs did not have information available in monthly progress reports upon which to assess progress. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91

a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	56% 5/9	0/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Monthly 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 dental goal(s)/objective(s); and	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, 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 Monitoring Team reviewed seven individuals for whom their IDTs had identified medium or high dental risk ratings. It was good to see that five of these seven had clinically relevant, and achievable goals/objectives related to dental. However, none of these goals/objectives were measurable, because they did not include expected timeframes for completion (e.g., within the next six months), and/or criteria for achievement (e.g., 30 out of 60 trials for two consecutive months). Of note, all of these goals related to the length of time that individuals brushed their teeth (i.e., increasing it to two minutes). The Dental Department needs to work with IDTs to ensure that goals are tailored to meet individuals' needs (e.g., some individuals might need to improve the quality of their tooth brushing, others might need to floss, etc.). In addition, the IHCPs generally did not include action steps that would assist the individuals to increase the amount of time that they brushed their teeth. Without such action steps, it is highly unlikely that individuals' tooth brushing will improve.

Goals that were not clinically relevant or measurable were for Individual #143 and Individual #490, both of which stated only that the individual would maintain good oral health over the next year.

The IDTs had rated the other two individuals (i.e., Individual #149 and Individual #91) as having low dental risk, but per their Integrated Risk Rating Forms (IRRFs), both required suction tooth brushing due to the potential for aspiration. The respective IDTs should have taken into consideration that this need also put the individuals at high risk for safe oral hygiene practices. Although their IRRFs indicated both individuals required suction tooth brushing twice a day, their ISPs did not include relevant measurable goals or action plans.

c. through e. While the Center had improved its performance somewhat in the development of clinically relevant, and achievable goals since the previous review, integrated progress reports on these goals, with specific 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 Monitoring Team conducted full reviews of the processes related to the provision of dental supports and services for all nine individuals.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91
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 (NR)									
Comments: a. 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 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	143	268	286	217	149	276	76	490	91
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: N/A			Individuals:								
#	Indicator	Overall	143	268	286	217	149	276	76	490	91

		Score									
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	Due to the Center's sustained performance with these indicators, they moved to the category requiring less oversight.									
b.	If the dental emergency requires dental treatment, the treatment is provided.										
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.										
Comments: a. through c. None.											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: 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. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	33% 1/3	N/A	N/A	N/A	N/A	0/1	N/A	1/1	N/A	0/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/3	N/A	N/A	N/A	N/A	0/1	N/A	0/1	N/A	0/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/3	N/A	N/A	N/A	N/A	0/1	N/A	0/1	N/A	0/1
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/3	N/A	N/A	N/A	N/A	0/1	N/A	0/1	N/A	0/1

Comments: a. IDTs included suction tooth brushing strategies/plans in ISPs/IHCPs for only one of three applicable individuals. Per their IRRFs, both Individual #149 and Individual #91 received suction tooth brushing twice daily, but their respective ISPs/IHCPs did not include specific goals or action plans. Their IDTs placed the frequency in the IRRFs, but did not transfer them to the ISP or IHCP (i.e., the vehicles IDTs use to make sure that needed supports are delivered).

b. Based on documentation submitted, for each of the three individuals, lapses occurred in the provision of suction tooth brushing in terms of frequency and/or duration. The available data did not indicate reasons suction tooth brushing was not completed for the days/times that staff did not implement the required tooth brushing support.

c. Although available data indicated 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.

d. QIDP monthly integrated progress reports did not include information regarding suction tooth brushing for any of the three individuals. Moving forward, specific suction tooth brushing data is needed to summarize the frequency of sessions completed in comparison with the number anticipated (e.g., 60 out of 62 sessions). Additionally, a second data subset is needed on the number of such events during which the individual completed the expected duration of suction tooth brushing (e.g., of the 60 completed sessions, in 12 sessions the individual completed two minutes of suction tooth brushing).

Outcome 9 – Individuals who need them have dentures.											
Summary: If the Center sustains it performance with regard to the dentist making clinically justified recommendations related to dentures for individuals with missing teeth, after the next review, Indicator a might move to the category of less oversight.			Individuals:								
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	100% 6/6	N/A	1/1	1/1	1/1	1/1	1/1	N/A	1/1	N/A
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 clinical justification for not recommending dentures.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: For the couple of acute events reviewed, prior to the individuals' transfers to the hospital for the scheduled surgeries, nurses did not complete and/or document assessments. Nurses did complete assessments upon the individuals' returns to the Center, which were consistent with applicable standards of care. Improvements are needed with regard to the quality of acute care plans, as well as nurses' implementation or documentation of the completion of the interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall	143	268	286	217	149	276	76	490	91

		Score									
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	N/A	N/A	N/A							
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.	N/A	N/A	N/A							
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	N/A	N/A	N/A							
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0% 0/2	0/1	0/1							
e.	The individual has an acute care plan that meets his/her needs.	0% 0/2	0/1	0/1							
f.	The individual's acute care plan is implemented.	0% 0/2	0/1	0/1							

Comments: Given that State Office recently provided training and Center staff are at the beginning stages of developing and implementing acute care plans that reflect the training, the Monitoring Team reviewed a small number of acute care plans. Specifically, the Monitoring Team reviewed two acute illnesses and/or acute occurrences for two individuals, including those for Individual #143 – on 2/7/19, a planned surgery to replace the vagus nerve stimulator (VNS) battery; and Individual #268 – on 12/21/18, a planned surgery to replace the gastrostomy tube (G-tube).

a. through c. For the acute occurrences reviewed, because they were planned surgeries, these indicators were not applicable.

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

The following provide some examples of findings related to this outcome:

- For Individual #143, prior to his transfer to the hospital for the scheduled surgery, nurses did not complete and/or document an assessment. An assessment was needed to document his overall physical status, skin integrity, and mental status, which would provide a baseline with which to compare his status upon his return. A nurse did complete an assessment upon his return to the Center, which was consistent with applicable standards of care. The acute care plan did not address post-surgery related issues, such as assessing for constipation, infection, pain, respiratory status, sleep, the site of the surgical procedure, the individual's need for assistance, ability to void, the effects of the sedation, and the risk for falls. Given that the surgery was

scheduled, nurses had ample time to develop a clinically relevant acute care plan.

- Similarly, for Individual #268, prior to his transfer to the hospital for the scheduled surgery, nurses did not complete and/or document an assessment, which was necessary for the reasons cited above. In fact, for this individual, no IPN was submitted showing that he left the Center for his G-tube replacement surgery. A nurse did complete an assessment upon his return to the Center, which was consistent with applicable standards of care. The acute care plan did not define nursing assessments and the frequency of such assessments for the G-tube site, signs of infections, respiratory issues, sleep, and/or constipation issues. It did not address the need for oral care, since the individual was in a nothing-by-mouth (NPO) status. It also did not include patient education regarding the tube for this individual who was highly capable of understanding issues related to G-tube care.

Of note, as part of the onsite review week, the Monitoring Team appreciated the Chief Nurse Executive and the Program Compliance Nurse's willingness to conduct an objective review of one acute care plan for one of the individuals reviewed, and discuss their findings openly with the members of the Monitoring Team and State Office staff. This effort showed Center staff's ability to identify the strengths, as well as some of the weaknesses in the acute care plans and the related nursing assessments. With some refinements to the process, and continued auditing with constructive feedback to the nurses responsible for writing and implementing acute care plans, the Monitoring Team is hopeful that at the time of the next review improvements will have occurred.

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: 143	268	286	217	149	276	76	490	91
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	11% 2/18	0/2	0/2	0/2	1/2	0/2	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: For nine individuals, the Monitoring Team reviewed a total of 18 specific risk areas (i.e., Individual #143 – falls, and choking; Individual #268 – falls, and constipation/bowel obstruction; Individual #286 – falls, and constipation/bowel obstruction; Individual #217 – constipation/bowel obstruction, and aspiration; Individual #149 – skin integrity, and falls; Individual #276 – polypharmacy/side effects, and aspiration; Individual #76 – infections, and skin integrity; Individual #490 – falls, and

constipation/bowel obstruction; and Individual #91 – osteoporosis, and skin integrity).

Although the following goals/objectives were measurable, because they not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #217 – constipation/bowel obstruction, and Individual #91 – skin integrity.

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

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

Summary: Nurses often did not include interventions in IHCPs to 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	143	268	286	217	149	276	76	490	91
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% 0/12	0/1	0/1	0/2	0/1	0/2	0/1	0/1	0/1	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

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

- Based on a review of the ISPAs provided, Individual #143's IDT had not discussed or analyzed data related to his falls. It appeared that because he had not sustained serious injuries from his falls, his IDT did not see it as a priority to take additional steps to prevent them. Given that the individual's next fall could result in a serious injury, the IDT had not acted in a proactive manner to reduce his risk to the extent possible.
- The documentation in the nursing annual record review indicated that Individual #268 had at least 40 falls during the past year, and the Center's response to document request #TX-BR-1904-II.P.1-20 recorded that he fell on 12/15/18, 12/24/18, 1/15/19, 2/10/19, and 3/11/19. Based on a review of the ISPAs submitted, his IDT had not discussed or analyzed data related to his falls.
- The ISPAs provided indicated that the IDT regularly discussed Individual #286 transitioning from using a wheelchair to ambulating with a gait belt. However, according to the AMA, dated 2/2/18, he had a significant history of fractures from falls, and it was not clear that the current IDT took this history fully into consideration. After a hip fracture in October 2017, he used a wheelchair for all his mobility needs. The ISPA, dated 10/1/18, indicated he was receiving physical therapy "at the time of his ISP" (no date provided) to regain independent mobility. The ISPA, dated 10/19/18, indicated that he was getting up quickly and running across the room. The ISPA indicated that the PT was to conduct an assessment of his gait. The ISPA, dated 10/23/18, indicated that he was continuing to "impulsively get out of his chair and run/walk across the room." The documentation indicated that the PT assessment "was not available at the time of the meeting." At this time, the IDT initiated one-to-one level of supervision (LOS). The ISPA, dated 11/15/18, indicated that from 10/23/18 to 11/14/18, he had initiated standing 56 times, and the IDT continued the one-to-one LOS. The ISPAs, dated 11/27/18, and 12/11/18, indicated he continued to impulsively stand up. However, no data were provided to determine if this was happening more or less than previously. The ISPA, dated 1/9/19, indicated that the one-to-one LOS was discontinued. However, the IHCP did not include regular nursing assessments related to his gait and time ambulating. This was particularly important due to his history of fractures and serious injuries prior to his use of the wheelchair for all mobility. The Center's response to document request #TX-BR-1904-II.P.1-20 indicated that on 3/21/19 and 3/29/19, he fell. The IDT should have taken assertive action to prevent him from further falls and harm due to injuries and fractures to the extent possible.
- The ISPA, dated 10/1/18, noted that Individual #286 was at risk for constipation "due to the continued use of the wheelchair and his inability to independently walk." The IRRF noted that he had developed a post-operative "ileus vs bowel obstruction during admission 10/17/17" for a hip fracture. It also noted that the direct support professionals were to offer him fluids at least every two hours throughout the day. However, none of the documentation submitted reflected that staff were offering him extra fluids or that staff were tracking his fluid intake. The IRRF noted that since 9/4/18, nursing staff administered a glycerin suppository every Tuesday and Saturday. However, from review of the ISPAs provided, his IDT had not conducted an analysis of his constipation to ensure that he consumed an appropriate amount of fluids and to validate the need for regular suppository use.
- The ISPA, dated 9/27/18, noted that Individual #217's goal at that time was "will not have constipation with current medication in place." However, the ISPA noted that on 6/30/18, she required a medication for constipation. The ISPA indicated that: "the team discussed this goal and agreed to the new goal of will have no more than 4 episodes of constipation

requiring suppositories for the year." Based on the ISPA, the IDT did not discuss why she had episodes of constipation. The change to the goal without any type of analysis of her constipation appeared to be the team's attempt to set a goal that they could conclude the individual had "met," which was not a clinically sound approach. Based on review of the nursing annual and quarterly record reviews, as well as the ISPAs, the IDT had not analyzed relevant data (e.g., constipation episodes, fluid intake, fiber intake, exercise, medications prescribed, etc.) to determine the underlying cause or etiology of her constipation, and from that analysis develop interventions aimed at preventing it.

- Review of the ISPAs for Individual #149 revealed the following concerns:
  - The ISPA, dated 11/2/18, indicated he pulled out his G-tube 10 times in two days. Based on review of the IPNs and IView entries, nursing staff had not completed a comprehensive assessment addressing pain, discomfort, vital signs, or skin issues. This ISPA also recorded the IDT's decision to place him on one-to-one LOS, and apply mittens.
  - The IPNs noted this individual had been refusing his enteral feedings, at times, but the IDT did not hold an ISPA meeting to address this issue. In the nursing annual and quarterly record reviews, the RN Case Manager did not include data to show tracking, monitoring, and review of how much of each feeding he tolerated, or daily totals. His nutritional status potentially had a significant impact on his skin issues.
  - In the documents submitted, the Monitoring Team found no indication that prior to 11/2/18, the IDT made Behavioral Health Services staff aware or asked for a consultation regarding his meal refusals or tube pulling behaviors.
  - The ISPA, dated 12/14/18, indicated that the individual's meal refusals were increasing to a total of seven refusals in "the past few days." No nursing assessments were found addressing this issue.
  - The IDT discovered that nursing staff had been administering Individual #149's feedings while he was in bed, but the IDT was "unaware" as to how long this had been happening. The IDT concluded that trying to provide feedings anywhere else might be contributing to his aggression and refusals due to his diagnosis of obsessive compulsive disorder (OCD). This issue was of significant concern, and indicated that nurses were not following his PNMP.
  - The ISPA, dated 12/14/18, noted that the Dietician was "concerned of continuous meal refusals and recent weight loss," and noted: "It is very important the [Individual #149] receives nutrition as soon as possible." The documentation provided did not show that the IDT increased the frequency of obtaining his weights, and no specific weight data were included in the ISPA.
  - In the ISPA, dated 12/21/18, the IDT discussed an abuse allegation. The allegation was that on 12/20/18, while on one-to-one supervision, he pulled out his G-tube, again.
  - Based on documentation submitted, aside from one-to-one staffing and mittens, it did not appear the IDT was implementing other assessments or interventions to identify the cause of him pulling out the button and refusing enteral meals. For example, the IDT did not review related data, such as residuals, vital signs, pain assessments, or the activities in which he was engaged during the day. The ISPA, dated 12/14/18, noted that the psychiatrist was initiating clomipramine to address his OCD, and Ativan to address anxiety and feeding refusals. The ISPA did not include the justification for either of these medications, and as mentioned above, the IDT had not conducted and/or documented a thorough analysis of his behaviors to attempt to identify the cause(s) of the issues.
  - The ISPA, dated 1/8/19, indicated that Individual #149 was hospitalized twice (i.e., 12/27/18, and 12/31/18) due to respiratory suppression from the initiation of the psychiatric medications noted above. He also developed a skin allergic reaction to two of the antibiotics he was prescribed for respiratory issues, which at the time, were not attributed to the sedating effects of the medications that were initiated.

    - Unfortunately, this episode ended with a computed tomography (CT) scan, from 12/27/18, noting that he had "healing posterior right 8th, 9th, and 11th rib fractures," and "healing anterior left 5th and 6th rib fractures" from an unknown cause.
- Based on review of Individual #149's IRRF, he had a history of falls, fractures, and injuries due to his falls. As noted above, a CT scan, dated 12/27/18, noted multiple rib fractures of unknown cause. The IRRF noted he used bilateral shoe inserts to provide musculoskeletal support for both feet. While observing medication administration, a member of the Monitoring Team noted that the individual was wearing shoes that were at least two sizes too big. The direct support professional staff, the medication nurse, as well as the Chief Nurse Executive, and Program Compliance Nurse did not notice and/or address his ill-fitting footwear despite of his high risk for falls and fractures.
- Although the ISPA, dated 12/11/18, indicated that Individual #276's IDT raised her risk level from medium to high regarding medication side effects, the IDT's justification for making the change was not clear. The ISPA indicated that the psychiatrist discontinued her Trazadone, and was decreasing her Latuda. However, the IDT did not clearly articulate the issue regarding her prolonged QT interval in the ISPA, nor did the IDT define what symptoms she could experience from this issue. In addition, the ISPA noted that the cardiologist started Propanol 20 mg twice a day, which also can significantly lower her heart rate and blood pressure. However, even after the two significant falls she had on 12/18/18, and 12/19/18, the IDT did not add nursing assessments to the IHCP to address her lying and standing blood pressure, pulse, or dizziness related to the medication, and/or the EKG finding of a prolonged QT interval.
- From review of the ISPAs for Individual #76, the following issues were noted:
    - The ISPA, dated 11/13/18, indicated that in the past month, he lost 9.3 pounds, and he had been below his estimated desired weight range (EDWR) for most of the year. However, no ISPAs were found to show that the IDT analyzed related data or took steps to address this issue.
    - This ISPA indicated that the PCP ordered that staff to offer him eight to 16 ounces of water/fluids at meals and at all snack times, with at least 48 ounces of total fluid intake per day. The ISPA indicated that: "there was noted lack of documentation in care tracker for meal and snacks." In addition, based on the documentation submitted, staff were not tracking his fluid intake.
    - Although Individual #76 had skin breakdown (i.e., on 11/2/18, two Stage 2 pressure ulcers on the left greater trochanter and left humoral head), the IDT noted in this ISPA that he was currently rated as a medium risk for skin integrity and "no risk rating will be changed at this time."
    - On 12/3/18, Individual #76 died at the age of 36. However, the nursing mortality review did not address these issues, or issues related to the quality of the annual and quarterly nursing reviews, or problems with the IHCP.
- Although the ISPAs provided indicated that Individual #490's IDT met and discussed her continuous falls (i.e., 50 falls in approximately six months, according to the Center's response to document request #TX-BR-1904-II.P.1-20), the ISPAs did not show that the IDT reviewed data related to planned interventions, such as monitoring if she wore her glasses, or followed up on, for example, the OT assessment for a walker, actions the IDT was taking to address her refusals to use her gait belt, or the use of her CPAP machine for her severe obstructive sleep apnea, which also could have an impact on her focus, attention, and steadiness. Her IHCP did not include any proactive interventions to prevent falls, and the IDT did not include in her IHCP any nursing assessments to measure signs and symptoms of her Chronic Cerebellar Ataxia, except for the increasing number of falls she experiences.

During the Monitoring Team member's medication observation, this individual was wearing socks and slid in them as she walked. Also, she told the medication nurse that she was slipping on the wooden chair, when the medication nurse asked her to sit up straight for her medications. Given her ongoing falls and her diagnosis of Chronic Cerebellar Ataxia, these issues required attention. When the Monitoring Team member pointed out these issues, which increased her risk of falls, to staff, they reported she had a diagnosis that put her at risk for falls, but still did not recognize that they should take action to potentially prevent falls.

- Based on review of the ISPAs for Individual #91, the IDT did not meet to address his Stage 2 skin breakdown (i.e., on 9/24/18), nor had the IDT included any interventions in the IHCP for any discipline to conduct regular skin assessments.

Outcome 7 – Individuals receive medications prescribed in a safe manner.

Summary: For at least the two previous reviews, as well as this review, the Center did well with the indicators related to: 1) nurses administering medications according to the nine rights; 2) nurses implementing individuals' PNMPs during medication pass; and 3) nurses adhering to infection control procedures while administering medications. However, given the importance of these indicators to individuals' health and safety, these indicators will continue in active oversight 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: 143	268	286	217	149	276	76	490	91
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R							N/A		
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	88% 7/8	1/1	0/1	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	0% 0/6	0/1	N/A	0/1	N/A	0/1	0/1	0/1	N/A	0/1

	includes lung sounds in IView or the IPNs.										
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/2
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.	86% 6/7	1/1	1/1	1/1	1/1	1/1	N/A		1/1	0/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1		0/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of eight individuals, including Individual #143, Individual #268, Individual #286, Individual #217, Individual #149, Individual #276, Individual #490, and Individual #91.

c. It was positive that for the individuals the Monitoring Team member observed during medication passes, nursing staff generally

followed the nine rights of medication administration.

However, of concern, during the medication pass, Individual #268 stated at least twice that he did not feel well. The medication nurse did not conduct an assessment, nor did the medication nurse, Chief Nurse Executive (CNE), or Program Compliance nurse ask him what was wrong. Inquiring why he did not feel well and conducting an assessment was necessary to determine if there was any reason he should not have received his medications at that time.

d. The following concerns were noted:

- After receiving his medication, Individual #143 coughed. However, the medication nurse did not conduct a respiratory assessment. Neither the medication nurse nor the Program Compliance nurse recognized his cough as a possible symptom that warranted an assessment due to his high risk for aspiration.
- On 12/20/18, Individual #286 was diagnosed with aspiration pneumonia, but his IDT had not included respiratory assessments in his IHCP.
- Individual #149 was at high risk for aspiration pneumonia, and on 12/31/18, he was hospitalized for acute respiratory failure. However, his IHCP did not include respiratory assessments.
- Individual #276 and Individual #76 were at high risk for respiratory compromise/aspiration pneumonia. However, their IHCPs did not include respiratory assessments.
- Individual #91 was at high risk for aspiration pneumonia, but his IHCP did not include regular respiratory assessments, and the medication nurse did not conduct them during the medication pass.

f. For six of seven individuals with PNMP instructions related to medication administration, medication nurses implemented the individuals' PNMPs and checked the position of the individuals prior to medication administration. The exception was:

- For Individual #91, it was only when the Monitoring Team member asked about the PNMP that the medication nurse reviewed the PNMP in relation to positioning for medication pass. Staff needed to pull the individual up in his wheelchair. The Center's nurse observer did not identify and address this issue.

g. For the individuals observed, nursing staff generally followed infection control practices, which was good to see. The exception was the nurse touched the bottle of medication for Individual #490's feet on her feet cross-contaminating the medication. The Center's nurse observer did not identify this infection control issue.

In its comments on the draft report, the State disputed this finding, and stated: "Per the Program Compliance Nurses [sic] daily minutes (see below), as well as direct observation by the CNE [Chief Nurse Executive] and the nurse being observed; the IC [infection control] issue WAS identified and corrected by the PCN immediately. This information was also communicated to the State Office Discipline Coordinator April 1st at the end of the day.

Med pass observation (BD-CHA) with Nurse PC.

- *Comments from Johanna Schroeder, PCN*
- *Powder for tinea pedis touched actual skin on both feet; now contaminated.*
- *Comments from Dr. Lund*

** Good med pass*"

A discrepancy exists between the recollection and notes of the Center staff and the Monitoring Team member. According to the Monitoring Team member, the Center nurse observer acknowledged the breach in response to the Monitoring Team member raising it. In addition, the Monitoring Team member does not recall the Center's nurse observer taking corrective action with regard to the now potentially contaminated bottle of medication. In its comments, the State did not state what "immediate" action was taken, and the notes that the State provided did not address this issue.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: At times, for individuals that met criteria for referral to the PNMT, their IDTs did not make referrals, and the PNMT did not initiate self-referrals. Overall, 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	143	268	286	217	149	276	76	490	91
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% 0/9	0/1	N/A	0/1	0/2	0/1	0/2	N/A	0/1	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/9	0/1		0/1	0/2	0/1	0/2		0/1	0/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/9	0/1		0/1	0/2	0/1	0/2		0/1	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/9	0/1		0/1	0/2	0/1	0/2		0/1	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/9	0/1		0/1	0/2	0/1	0/2		0/1	0/1
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	78% 7/9	1/1	1/2	1/1	N/A	1/1	N/A	1/2	1/1	1/1

	ii.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9	0/1	0/2	0/1		0/1		0/2	0/1	0/1
	iii.	Individual has a measurable goal/objective, including timeframes for completion;	11% 1/9	0/1	0/2	1/1		0/1		0/2	0/1	0/1
	iv.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	11% 1/9	0/1	0/2	1/1		0/1		0/2	0/1	0/1
	v.	Individual has made progress on his/her goal/objective; and	0% 0/9	0/1	0/2	0/1		0/1		0/2	0/1	0/1
	vi.	When there is a lack of progress, the IDT takes necessary action.	0% 0/9	0/1	0/2	0/1		0/1		0/2	0/1	0/1

Comments: The Monitoring Team reviewed nine goals/objectives related to PNM issues that seven individuals' IDTs were responsible for developing. These included goals/objectives related to: Individual #143 – choking; Individual #286 – falls; Individual #217 – aspiration, and choking; Individual #149 – GI problems; Individual #276 – aspiration, and choking; Individual #490 – choking; and Individual #91 – GI problems.

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

b.i. The Monitoring Team reviewed nine areas of need for seven 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 for: Individual #143 – aspiration; Individual #268 – GI problems, and falls; Individual #286 – aspiration; Individual #149 – fractures; Individual #76 – skin integrity, and weight; Individual #490 – falls; and Individual #91 - aspiration.

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

- In February, May, July, and August 2018, Individual #268 met the criteria for referral to the PNMT for emesis (i.e., greater than three emesis in 30 days), but his IDT did not refer him to the PNMT until September 2018.
- Based on the PNMT minutes, dated 9/25/18, in September 2018, Individual #76 showed a loss of 7.9 pounds, which represented a 7.8% weight loss. Rather than make a self-referral, the PNMT questioned the accuracy of the weight, and as opposed to asking that staff reweigh the individual immediately, they decided to wait until they received next month's weight. The following month's weight showed a 9.3-pound weight loss, at which point, they made a self-referral.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT did not develop clinically relevant, achievable, and measurable goals/objectives for these individuals. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #286 – aspiration.

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of clinically relevant and 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: None of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Monthly integrated reviews often provided no specific information or data about the status of the implementation of the action steps. Substantially more work is needed to document that individuals receive the PNM supports they require. In addition, in numerous instances, IDTs did not take immediate action, when individuals' PNM risk increased or they experienced changes of status. On a positive note, for the two individuals discharged from the PNMT, the individuals' ISP/ISPA reflected comprehensive discharge/information sharing between the PNMT and IDT. At this time, these indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 143	268	286	217	149	276	76	490	91
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	11% 1/9	0/1	0/2	1/1	N/A	0/1	0/2	0/2	0/1	0/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	100% 3/3	N/A	2/2	N/A	N/A	N/A	N/A	N/A	1/1	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Monthly integrated reviews often provided no specific information or data about the status of the implementation of the action steps.

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

- Individual #143's IDT met with the PNMT to discuss the results of a review conducted with regard to aspiration pneumonia. The IDT rejected the PNMT's recommendation to initiate suction tooth brushing. The IDT indicated that the individual would not tolerate it, but did not provide any evidence of a trial or exposure to suction tooth brushing.
- Between February and August 2018, Individual #268 experienced increased emesis, but the IDT did not conduct a head-of-bed elevation (HOBE) evaluation, or require increased monitoring.
- Similarly, beginning in February 2018, Individual #268 experienced increased falls, but the IDT did not request and the OT/PT did not complete consultations.

- On 1/31/19, Individual #149 was diagnosed with multiple fractured ribs. However, the IDT did not request and the OT/PT did not complete a consultation to determine the impact of the broken ribs on his functioning.
- Based on review of the PNMT notes (i.e., 11/6/18 to 11/27/18) for Individual #76, significant concerns were noted. These included a rusty and dirty wheelchair that was a poor fit for the individual and had a strong odor. The PNMT also noted that the odor from the individual, who was not soiled, was concerning enough that they asked the direct support professional to bathe him. It was extremely concerning that staff and the IDT did not identify and/or address these issues until a significant event occurred. This reflected a highly reactive approach, and potentially a lack of systems in place to detect basic cleanliness and equipment issues. During the month of September 2018, Individual #76 also experienced significant weight loss (i.e., 7.8% loss), but the IDT did not hold an ISPA meeting to discuss potential causes.
- According to the PNMT review conducted on 10/30/18, the individual fell 178 times in the past approximately four years (i.e., 2015 – 28 falls, 2016 – 26 falls, 2017 – 78 falls, and through October 2018 – 46 falls), and based on documentation submitted, she continued to fall (i.e., September 2018 – 7 falls, October 2018 – 4 falls, November 2018 – 11 falls, December 2018 - 3 falls, January 2019 – 7 falls, February 2019 – 5 falls, and March 2019 – 7 falls). On 10/9/18, the PT conducted a rolling walker assessment that stated that the individual had some issues with the walker, such as kicking the wheels, etc. The therapist concluded that it was not safe due to this issue, as well as the individual's impulsivity when using the walker. As the individual's falls continued, the PT conducted no further assessment, despite the fact that it appeared her current supports were ineffective at preventing falls. The PT provided no rationale as to why a trial of therapy would not have been appropriate due to her ability to follow directions etc.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: Based on observations, staff completed transfers correctly. However, efforts are needed to continue to improve Dining Plan implementation, and positioning. Often, the errors that occurred (e.g., taking large bites, and/or eating at an unsafe rate) placed individuals at significant risk of harm. Implementation of PNMPs is non-negotiable. The Center, including Habilitation Therapies, as well as Residential and Day Program/Vocational staff, and Skill Acquisition/Behavioral Health staff should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them. These indicators will continue in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	65% 26/40	
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	67% 2/3	

Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 15 out of 24 observations (63%). Staff followed individuals' dining plans during 10 out of 15 mealtime observations (67%). Staff completed transfers correctly during one out of one observations (100%).

The following provides more specifics about the problems noted:

- With regard to Dining Plan implementation, the great majority of the errors related to staff not using correct techniques (e.g., cues for slowing, presentation of food and drink, prompting, etc.). Individuals were at increased risk due to staff's failure, for example, to intervene when they took large unsafe bites, ate at too fast a rate, or staff did not provide liquids in between bites. It was good to see that texture/consistency was correct, adaptive equipment was correct, and staff and the individuals observed were positioned correctly at mealtime.
- With regard to positioning, problems varied, but the most common problem was that individuals were not positioned correctly. In addition, in about 10% of the observations, necessary adaptive equipment/supports were not present, and in about 15% of the observations, staff had not used equipment correctly.
- For the one transfer observed, staff followed the PNMP instructions.

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	143	268	286	217	149	276	76	490	91
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. As discussed above, for Individual #268, the return to oral intake assessment lacked a clear oral motor and pharyngeal assessment and/or establishment of the individual's baseline. The IDT had not put strategies in place despite behavioral issues related to not eating.											

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: Most individuals reviewed did not have clinically relevant, and 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	Individuals:

active oversight.											
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/7	0/1	0/1	0/1	N/A	0/1	0/2	N/A	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/7	0/1	0/1	0/1		0/1	0/2		0/1	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/7	0/1	0/1	0/1		0/1	0/2		0/1	
d.	Individual has made progress on his/her OT/PT goal.	0% 0/7	0/1	0/1	0/1		0/1	0/2		0/1	
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/7	0/1	0/1	0/1		0/1	0/2		0/1	

Comments: a. and b. Individuals who needed formal OT/PT goals (e.g., to improve their activities of daily living) sometimes did not have them. This was particularly true for individuals who had some good basic skills, but needed to improve some of their higher-level skills. Although the following goals/objectives were clinically relevant and achievable, the IDTs had not incorporated them into the individuals' ISPs/ISPAs: Individual #149 (i.e., ambulate 300 feet without sitting down with supervision), and Individual #276 (i.e., dynamic standing). Criteria for achievement also were missing (e.g., for three consecutive therapy sessions). Individual #217, Individual #76, and Individual #91 did not have a need for formal OT/PT services and supports.

c. through e. The ISP monthly progress report for Individuals #149 did not include any review of his ambulation goal. For Individual #276, the ISP monthly progress report referenced the dynamic standing goal, but did not provide any data to demonstrate progress or lack thereof. The OTs/PTs typically documented the data from direct therapy sessions in their notes, which was good to see, but therapists need to work with QIDPs to make improvements in the incorporation of these data and their analysis in the QIDP integrated reviews.

Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. The Monitoring Team conducted full reviews for eight individuals, with the exception of Individual #217, for whom no goal was clearly indicated or warranted, and who was part of the outcome group. Individual #76 and Individual #91 were part of the core group, so the Monitoring Team conducted full reviews for them.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.	
Summary: For the individuals reviewed, evidence was not found in ISP integrated reviews to show that OT/PT supports were implemented. OTs/PTs need to work with QIDPs to ensure that integrated reviews include data from OT/PT direct	Individuals:

therapy programs, and the data is analyzed for IDT review. These indicators will continue in active oversight.											
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/3	N/A	N/A	N/A	N/A	0/1	0/2	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.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	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 OT/PT needs were implemented for individuals who had measurable ISP/ISPA strategies and action plans. It was good that for the three measurable strategies that were applicable, the IDTs provided some evidence of implementation through the OT/PT notes. Still, it remained concerning that the ISP monthly integrated progress reports did not provide the needed data or analysis upon which to determine whether progress was being made. b. The IDTs for one of two individuals held an ISPA meeting as needed to discuss and approve termination of OT/PT services and supports. For Individual #149, the Center did not provide evidence that an ISPA was held to discuss completion of PT direct therapy.										

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, Indicator c will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	233	591	330	21	91	470	163	102	398
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they remained in 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.	79% 26/33	1/1	0/1	1/1	2/2	0/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		599	475	86	217	323	335	18	254	59
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	0/1	1/1	1/1	2/2	1/1	1/1	0/1
		Individuals:									
#	Indicator		34	249	148	287	94	95	474	96	413
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		2/2	0/1	1/1	1/1	1/1	1/1	1/1	1/2	1/1
		Individuals:									
#	Indicator		257	44							
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	0/1							
Comments: c. Based on observation of Individual #91, Individual #59, Individual #249, and Individual #44 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors. Individual #86's seatbelt for her wheelchair was loose, and staff indicated it tended to come loose when she moved around in the chair. Two individuals did not have their equipment present and available for use (i.e., the weighted blanket for Individual #591 and the hand carrots for Individual #96).											

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, one of these indicators had sustained high performance scores sufficient to move to the less oversight category. Presently, no additional indicators will move to the category of less oversight.

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

Brenham SSLC now had some goals that were individualized, but not being measurable and without data, progress cannot be determined.

For the most part, direct support professional staff interviewed and observed throughout the week were knowledgeable about individual's preferences and support needs. The exception was staff working with Individual #143.

Regarding SAPs, although none 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 incorrect performance.

During SAP implementation observations, staff appeared to be familiar with the plans and exhibited positive interactions with the individuals

Most SAPs were not properly reviewed each month and about two-thirds had graphs.

It was positive to observe an individual who was completing his job. He was moving from one building to another, independently taking care of recycled materials and replacing trash bags. On the other hand, activities observed in both New Horizons and Education and Training were very limited. On multiple occasions, staff were observed undoing a completed task in full view of the individual (e.g., towel folding). Teaching techniques were not clearly outlined resulting in poor presentation and instruction.

Engagement was not being regularly measured by the Center and when it was, likely the numbers were overstated.

Regarding public school collaboration, the Center needs to strengthen its relationship with the public school, especially the high school. This should include regular observations/visits from Center staff to the school, sharing of information with school personnel to ensure consistency in PBSP implementation, and consideration of programming at the Center (e.g., SAPs, SOs) to

support the individuals' IEP goals and objectives. If the local public school cannot provide the protections and supports needed, the SSLC staff should discuss next steps with State Office. Please see detailed comments under indicator 25 below.

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. As has been stated in several reports, Center staff 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), but not being measurable (indicator 2) and without data (indicator 3), progress cannot be determined. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	268	143	119	59	490	149			
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: 4-7. A personal goal that meets criteria for indicators 1 through 3 is a pre-requisite for evaluating whether progress has been made. For this review period, no goals met these prerequisite criteria. See Outcome 7, Indicator 37, for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans.											

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: It was good to see that many staff were knowledgeable about individuals' preferences and support needs. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	268	143	119	59	490	149			

39	Staff exhibited a level of competence to ensure implementation of the ISP.	83% 5/6	1/1	0/1	1/1	1/1	1/1	1/1			
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. For the most part, direct support professional staff interviewed and observed throughout the week were knowledgeable about individual's preferences and support needs.

The exception was staff working with Individual #143. Individual #143 was observed on two separate occasions engaging in SIB. Staff in the home did not intervene when he was hitting his head on the wall or floor. His PBSP included specific interventions for SIB. On one occasion, he hit his head extremely hard on the floor. The Monitoring Team had to prompt staff to assess him for injury.

40. Action steps were not regularly and correctly implemented for all goals and/or action plans, as noted throughout this report. ISPs rarely included detailed instructions to guide staff when implementing the ISP. As noted throughout this section of the report, ISPs often included service objectives that did not have specific implementation methodologies and this contributed to the lack of implementation.

Going forward, IDTs need ensure all staff have instructions for carrying out action plans and then monitor the implementation of all action plans and address barriers to implementation.

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 these three indicators, in part due to problems in the overall design of SAPs (indicators 3-5 and 13), and in part due to absence of review and modification to plans. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
6	The individual is progressing on his/her SAPs.	15% 2/13	0/2	No SAPs	0/2	0/1	0/1	1/1	0/1	1/2	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A									
8	If the individual was not making progress, actions were taken.	0% 0/11	0/2		0/2	0/1	0/1		0/1	0/1	0/3
9	(No longer scored)										

Comments:

6. Based upon a review of the data presented in the Client SAP Training Progress Note, it was determined that progress was being made on two of the 13 SAPs. These were Individual #268's medication SAP and Individual #59's propel wheelchair SAP.

Three SAPs (Individual #279 - count to 10; Individual #162 - check blood sugar and verify change) had not yet been introduced. Individual #143's learning to put on his pants had been discontinued due to the home manager's report that he could pull up his pants. The SAP addressed the entire chain of putting on his pants and the data indicated that he was not making progress on this skill. Rather than discontinuing the plan, staff should have observed a teaching session and made adjustments accordingly.

7. No one had mastered the skill identified in their individual SAPs.

8. Although it was noted that the BCBA had recommended that the assistant observe a training session for Individual #279's name writing SAP, it was not clear that this had been conducted. In no other cases, were actions identified or taken to address the individual's lack of progress.

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

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

#	Indicator	Overall Score	Individuals: 279	281	162	417	119	268	599	59	143
13	The individual's SAPs are complete.	0% 0/13	0/2 11/20	No SAPs	0/2 14/20	0/1 7/10	0/1 6/10	0/1 5/10	0/1 8/10	0/2 14/20	0/3 15/30

Comments:
13. In order to be scored as complete, a skill acquisition plan (SAP) must contain 10 components necessary for optimal learning. Because all 10 components are required for the SAP to be judged to be complete, the Monitor has provided a second calculation in the individual boxes above that shows the total number of components that were present for all of the SAPs chosen/available for review.

Although none of the SAPs were considered complete, better than 90% included a task analysis, where appropriate, a behavioral objective, operational definitions of the skill, and a relevant discriminative stimulus. The majority of the SAPs also included a schedule of implementation, consequences for correct responding, and plans for maintenance and generalization. Specific feedback is provided below.

- Ensure that all instructions are specific to the task. These should be written clearly enough so that all staff can provide consistent implementation. Include presentation of materials, location of the instructor and learner, and the order of task completion. When the individual has a sensory deficit, ensure that the instructions include specific strategies to employ inconsideration of the individual's vision and/or hearing loss.
- For skills that can be taught multiple times in one session, e.g., writing one's name, matching letters, counting, and determining correct change, it would be helpful to indicate the number of expected trials within the training schedule.

- Most of the SAPs included very generic guidelines for staff to implement following an individual's incorrect response. Staff are advised to write these to ensure that staff use task-specific prompts following incorrect responding.
- Ensure that the current step is listed in the documentation section of the SAP.

Outcome 5- SAPs are implemented with integrity.

Summary: Performance remained about the same as the last review. SAPs were implemented, but not as written. SAPs for some individuals were attempted, but not observed by the Monitoring Team. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 279	281	162	417	119	268	599	59	143
14	SAPs are implemented as written.	20% 1/5	0/1	No SAPs	Attempted	0/1	1/1	Attempted	0/1	Attempted	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.	38% 5/13	1/2	No SAPs	0/2	1/1	1/1	1/1	0/1	0/2	1/3

Comments:

14. Although observations were scheduled for the eight individuals who had SAPs, five training sessions were observed. The exceptions were Individual #162 whose staff member reported that the SAP upset him, Individual #268 whose SAP could not be rescheduled to accommodate the Monitoring Team, and Individual #59 who was in bed at the scheduled time. A review of the conducted observations is provided below.

- Individual #119 was observed learning to match the letters of her name to a sample. The staff member implemented the SAP as it was written. A discussion ensued regarding teaching Individual #119 to discriminate her name from others.
- The SAP provided to the Monitoring Team indicated that Individual #279 was working on step 3, which was to copy all the letters of his last name. Staff presented a sheet of paper with his first and last names printed with dashed lines under each name on which he could copy the letters. The staff member directed Individual #279 to copy his first name only. This was the first step in the teaching plan. Praise and high fives were exchanged as noted in the SAP.
- While working with Individual #417, the staff member delivered the discriminative stimulus, provided praise and positive feedback, and scored the SAP as indicated. However, she explained that the washing machine had been replaced a few months earlier, resulting in a change in SAP implementation. The new machine no longer had dials for setting the load size or temperature. Rather, this machine required Individual #417 to press two buttons, one on the left and one on the right. The only step she needed assistance with was pressing the second dial. The staff member explained that the SAP would be revised at the upcoming ISP meeting. It is suggested that the SAP should have been revised when the machine was replaced. It is also suggested that the team re-assess the need to continue this SAP because Individual #417 appeared to have acquired the skill with only small accommodations needed (e.g., numbering the buttons).
- Individual #599 was observed making her tea while at her day program in New Horizons. Rather than placing the materials on a table in front of Individual #599, staff presented a cup and tea mix to her as she sat in her chair. The discriminative stimulus

was delivered as written and a more intrusive verbal prompt was used when she did not respond initially. Eventually, hand over hand assistance was provided. Staff reported that a physical prompt would be documented.

- Individual #143 was observed putting on his shirt. The staff member told him to put on his shirt, then told him to grab the shirt. Individual #143 required a physical prompt to put this on over his head. He had been prompted to put his arms in the sleeves prior to this step. The task analysis was written so that he will put his arms in the sleeves after the shirt is over his head. It may be advisable to employ a backward chain when teaching this task. Staff could prompt the first three steps in the chain and then Individual #143 could begin by learning to pull the shirt down over his torso.

15. Per state policy, SAP integrity should be assessed at a minimum of twice annually. Goal levels were established at 80% or better. Based upon the documentation provided, it was determined that five of the 13 SAPs had been monitored at least once over the previous six-month period. As noted previously, it was unclear whether all of these monitoring sessions had been conducted via observation or role play.

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

Summary: Performance for these two indicators also remained about the same as last time. That is, most SAPs were not properly reviewed each month and about two-thirds had graphs. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 279	281	162	417	119	268	599	59	143
16	There is evidence that SAPs are reviewed monthly.	38% 5/13	0/2	No SAPs	0/2	1/1	0/1	0/1	1/1	2/2	1/3
17	SAP outcomes are graphed.	62% 8/13	0/2	No SAPs	0/2	1/1	1/1	1/1	1/1	2/2	2/3

Comments:

16. There was evidence of a monthly data-based review of five of the 13 SAPs. These were Individual #417's laundry SAP, Individual #599's make tea SAP, Individual #59's propel wheelchair and feed fish SAPs, and Individual #143's constellation light SAP.

In all other cases, either the SAP was not reviewed in the QIDP monthly report or data were not provided. For three individuals (Individual #279, Individual #162, Individual #143), months passed from the date of the individual's ISP without SAP implementation. In two cases (Individual #279's write name SAP, Individual #143's put on shirt SAP), although this was noted in the QIDP monthly report, there were graphs that reflected program implementation.

17. Graphs were provided for eight of the 13 SAPs. The exceptions included two graphs that did not indicate the current step (Individual #279's writing name SAP, Individual #143's putting on his pants SAP).

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
Summary: Individuals were not engaged in activities and were not offered many opportunities. As a result, many instead engaged in stereotypic or problematic behaviors. Engagement was not being regularly measured by the Center and when it was, likely the numbers were overstated. In addition, goals were not provided. For indicator 20 to remain in the category of requiring less oversight, documentation showing engagement goals needs to be presented at the next review. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
18	The individual is meaningfully engaged in residential and treatment sites.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	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 work sites, day programs, and/or home environments. Individual #281, Individual #162, and Individual #417 were observed in their homes only because they worked off campus. Individual #119 was observed to be meaningfully engaged. Individual specific comments are provided below.

Although Individual #279 was actively engaged while completing his janitorial job, he was otherwise unengaged when observed on his home. Meaningful engagement on the home was also lacking for Individual #281, Individual #162, Individual #417, and Individual #268.

When Individual #599 was observed repeatedly on her home, she was usually non-engaged in her bedroom. When observed in her day program, Individual #599 was seated in a recliner, fanning the pages of a magazine while music played in the background. About one minute after the observation began, Individual #599 began screaming. She then began hitting the side of her head. Eventually a staff member approached with a Ukeru pad. She spoke with Individual #599 and then began rubbing Individual #599's back. Individual #599 calmed. It may be appropriate for the team to explore a massager chair or pad that Individual #599 could learn to operate independently. It would also be appropriate to further assess her areas of interest, including situational work assessments, to determine whether more varied activities can be provided.

When Individual #59 was observed on his home, he was usually non-engaged while seated in his wheelchair with his hands inside his pants. In his day program, Individual #59 was observed placing cylinders in a board with eight openings. He did this quite well,

however, there was no systematic method (e.g., starting with the top row and moving from left to right) for completing this task. When he finished this task one time, the cylinders were removed from his view and he was prompted to repeat the task. His abilities suggested that he could learn to perform some work for which he would be paid. Therefore, it is recommended that a thorough vocational evaluation be completed with possible situational work exploration included.

Individual #143 was observed in both his home and at school. In neither setting was he actively engaged. On the home, two toys were available to him. These were a large ball and a toy truck. When observed, he was seated on the floor as he repeatedly bounced or hit the ball, or hit it against his head. On occasion, he would toss the ball. He also moved a truck, usually in a circle around himself. Staff generally did not interact with him as he engaged in these behaviors.

- At school, Individual #143 was non-engaged with the teacher reporting that she had been sitting on the mat with her arms wrapped around Individual #143 for approximately two hours.

Caleb's Corner: While onsite, the Monitoring Team entered a room identified as Caleb's Corner. This room, with the door window blocked out, contained a thick mat, a chair, and a cabinet. There were paint chips on the floor. When staff were asked about this room, they said that this was an active treatment area and was currently in use. Later, the active treatment manager reported that this was a sensory room that was currently being renovated. The room was to be locked until completion of renovation, however, the Monitoring Team was able to access the room. During renovation, all materials should be removed and the room should be cleaned each day as changes are made. Before the onsite visit concluded, a sign was placed on the door indicating the room was undergoing renovations.

Repetitive tasks: On at least two occasions during the onsite visit, staff were observed undoing a task that the individual had just completed. This was a level of disregard for the individual's accomplishments. Staff are also advised to present tasks in a consistent manner, so that the individual may learn to perform the skill independently.

19. The director of active treatment reported that the expectation was monthly assessment of engagement across all environments. This did not occur in any of the identified sites over the six-month period of September 2018 through February 2019. Although this information was included in the document request, the initial response was the following: "Document was not able to be produced at this time." Although this information was again requested the first day the Monitoring Team was onsite, it took several days to obtain this information.

20. Although requested, the facility did not provide expected engagement levels.

21. As noted above, the evidence provided indicated that monthly assessment of engagement over a six-month period did not occur in any of the eight identified homes or in any of the four identified day/work programs. Engagement scores that were reported were often above 70%. Observations conducted by the Monitoring Team during the onsite visit suggested much lower engagement across all sites.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: There was a decline in performance on these indicators, all of which will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	281	162	417	119	268	599	59	143
22	For the individual, goal frequencies of community recreational activities are established and achieved.	22% 2/9	1/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

22. Following the document request, the Monitoring Team was advised to review the QIDP monthly reports to find the frequency of community recreational activities for each individual over the past six months. When a request was submitted onsite for a simple listing of the number of outings experienced each month, the QIDP monthly reports were again provided with outing descriptions highlighted. Outings, however, were often repeated in the report, making it difficult to ensure that the numbers determined by the Monitoring Team were accurate. In the future, it would be preferable for staff to simply note the number of community outings each month for each individual.

Based upon this review, it was determined that Individual #279 and Individual #281 achieved the frequency of community outings identified in their ISPs. Although Individual #119's QIDP monthly report noted frequent outings, there was no goal identified in her ISP.

23. None of the nine individuals had identified goal frequencies for SAP training in the community.

24. There was no evidence that IDTs met to determine barriers to achieving community based recreational or training opportunities for each of the nine individuals.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
Summary: Brenham SSLC was not monitoring educational services sufficiently. After this review, the Monitoring Team had numerous comments regarding supervision, academic/educational programming, behavioral treatment, school attendance, and collaboration. Details are provided in the comments below. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	119	143							
25	The student receives educational services that are integrated with	50%	1/1	0/1							

	the ISP.	1/2										

Comments:
25. Two individuals in the review group attended school. These were Individual #119 and Individual #143. For both individuals, there was public school information in their ISPs, action plans to support the IEP, and evidence that their school progress was reviewed. Their IEPs also included consideration for inclusion and an extended school year. It was determined that both students would be educated in a substantially separate classroom and that neither required an extended school year. The ARD/IEP meeting was attended by Individual #119's QIDP, but not Individual #143's.

When meeting with the director of active treatment, she reported that unless the student had one to one staffing, staff were no longer accompanying individuals to school. She estimated this stopped in October 2018 when staff were reassigned. As such, events that occur at school may not be reported accurately to Center staff. It is strongly recommended that behavioral health services staff and other appropriate professional staff make regular visits (e.g., at a minimum of monthly) to the school. Staff should be observing both instructional activities and difficulties as they arise. Problems related to the lack of support from the Center were also reported by one special educator at the high school who indicated that several students required one to one support that could not be provided by the teacher and her assistant because they were trying to teach five students.

While onsite, the matter of school suspension was raised. When plans for addressing school suspensions were requested, the Center reported that the individual's IDT would determine whether the child attend Education and Training or develop an alternative daily schedule. During one discussion, Center staff reported that a possible plan for school suspensions was to send the student to Brenham Production Services. No specific plans for school children were provided.

Individual #177, an 11-year-old, was attending school on a part-time basis at the time of the onsite visit. When a request was made regarding the plan for increasing her time, the IEP was provided. The first step was to eliminate her one to one staffing. If she then could display good behavior for a week, her participation in school would be increased by half an hour. Her participation would continue to be increased by half hour increments if she displayed two weeks of good behavior. Staff are advised to ensure that objective data are reviewed and that Center BCBA staff remain actively involved to help ensure Individual #177's success.

The Monitoring Team visited the middle and high schools on the last day of the onsite visit.

- At the middle school, Individual #177 was observed completing a task that required her to fill in the missing word after reading sentences displayed with words and icons. This was an activity that could likely be reproduced and generalized to her home environment. It would be beneficial for facility staff to visit regularly, so that academic work could be expanded to her home environment.
- A visit was also made to a classroom at the high school in which five students from the Center received special education services. Upon arrival, the teacher was seated on a mat holding Individual #143 in her arms. Individual #143 was clearly distressed and, on at least three occasions, banged his head on the mat. He eventually calmed and allowed the teacher to him put on his shoes and socks. The teacher decided to then go for a walk. Before leaving the classroom, Individual #143 scooted off the mat and hit his head quite hard on the classroom floor (he was wearing his helmet.) The teacher reported that if Individual #143 continued to scream and engage in self-injurious behavior, he may be sent home. Because this was reported to be a frequent occurrence, facility staff are advised to maintain ongoing contact with school staff to ensure Individual #143's

success.

During the onsite visit, staff mentioned that an individual who had recently been admitted was being considered for home schooling. This was apparently due to his not leaving his home for two years while at a state hospital and the difficulty in managing him when he became upset. When a plan was requested for Individual #319, an ISPA from March 2019 was provided. This indicated that, if approved, a Homebound program would consist of a teacher from the local public school providing educational services on campus for two hours daily twice a week. As this was a 16-year-old individual, the Center is urged to address his special education needs as soon as possible. If home schooling is determined to be the most appropriate option, it will be important for the Center to arrange additional services outside of the scheduled four hours per week offered by the local public school.

Staff are advised to review the Texas Education Association regulations to ensure that specific protocols have been adhered to when implementing a shortened school day for students receiving special education services.

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A									
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									
Comments: a. through d. 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 refused dental care.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: As with previous reviews, overall, IDTs did not have a way to measure clinically relevant communication outcomes for individuals reviewed. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	10% 1/10	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/2
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	10% 1/10	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/10	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/2
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/10	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/2
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/10	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/2
Comments: a. and b. Most individuals reviewed did not have communication goals that were both clinically relevant and measurable, but should have. The exception was for Individual #91, whose goal for turning on the television using his augmentative and alternative communication (AAC) device was clinically relevant and measurable. c. through e. QIDP monthly reviews referenced Individual #91's goal (i.e., turn on the television using AAC), but only reported the number of times the device was provided and did not provide data or analysis on progress toward the goal. The Monitoring Team completed full reviews for all individuals 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: To move forward, QIDPs and SLPs should work together to make sure QIDP monthly reviews include data and analysis of data related to the implementation of communication strategies and SAPs. SLP assessments also often lacked clear review of the effectiveness of supports and services provided, and/or data/monitoring results to substantiate conclusions that supports were effective. These indicators will remain in active oversight.	Individuals:

#	Indicator	Overall Score	143	268	286	217	149	276	76	490	91
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/2
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.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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 for individuals who had measurable ISP/ISPA strategies and action plans. In these reviews, documentation was not present to show that staff implemented the measurable strategies for Individual #91.

The ISP integrated reviews for Individual #91 did not evidence implementation of either of two goals. For his goal to turn on the television using his AAC device, the ISP monthly review only noted the number of times the device was provided, but did not report on the progress of goal. The IDT had not developed or implemented the recommended SAP for expanding the use of the AAC device into the classroom.

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: Center staff should continue to focus on ensuring individuals have their AAC devices with them. Most importantly, SLPs should work with direct support professional (DSP) staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner. It was also concerning that, per observation, DSP staff did not use, and could not describe, strategies identified in Communication Dictionaries and PNMP when communicating with individuals. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	21	91	413	332	94	97	546		
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	29% 2/7	0/1	1/1	0/1	1/1	0/1	0/1	0/1		
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	14% 1/7	0/1	1/1	0/1	0/1	0/1	0/1	0/1		
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	0/3 0%									

Comments: a. and b. A small percentage of the individuals supported at Brenham SSLC had AAC communication devices (i.e., 32 out of

250 individuals, or 13%) and/or programs (i.e., 36 out of 250 individuals, or 14%). The Monitoring Team noted some increases in the use of high-tech AAC devices during this onsite visit, which was positive. However, it was concerning that often those 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.

c. Per observation, DSP staff did not use the individualized communication strategies identified in Communication Dictionaries and PNMPs when communicating with individuals. Per interviews regarding communication strategies, the DSPs did not refer to the Communication Dictionary and could not describe the content.

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. All remained in active oversight.

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

Pre-move training supports remained a significant area of concern. It is essential for Center staff to be able to objectively verify provider staff competence to implement all important health and safety supports prior to individuals' moves to the community. Pre-move training supports should address the content of training provider staff would need, as well as describe the staff to be trained, the training methodologies to be used, and the competency criteria. The Center must also describe how it will verify provider staff have the knowledge and competence to provide each individual's unique set of needed supports prior to relinquishing day-to-day responsibility for his or her health and safety. The Center should focus on defining specific competency criteria, and then on ensuring the tools for measuring those competencies are thorough and appropriate to the need.

Center staff are encouraged to continue making improvements in the development of a comprehensive set of supports, with particular emphasis on identifying supports to address all important requirements with regard to pre-move training for provider staff, and for behavioral, safety, healthcare, therapeutic, and supervision needs.

It was good to see that the Post-Move Monitor conducted timely monitoring. However, the quality of post-move monitoring required improvements. Some of the areas in which continued efforts were needed related to the PMM consistently gathering reliable and valid data upon which to make accurate judgements about the presence of needed supports, and the PMM correctly scoring the presence or absence supports based on the evidence. The PMM also needed to be more diligent in identifying issues and concerns that required follow-up and/or consultation with the IDT, and in implementing those follow-up activities to resolution.

While the IDT met as needed to discuss the potentially disrupted community transition (PDCT) event experienced by the individual in this review (i.e., an emergency department visit), improvements are needed to ensure this process includes a thorough critical analysis that supports the identification of process improvements that might help to avoid any similar issues for individuals moving to the community in the future.

Transition staff had identified the need to improve the quality and content of transition assessments, including the completion of all needed assessments and the inclusion of comprehensive and community-appropriate recommendations.

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: Pre-move training supports remained a significant area of concern. It is essential for Center staff to be able to objectively verify provider staff competence to implement all important health and safety supports prior to individuals' moves to the community. Pre-move training supports should address the content of training provider staff would need, as well as describe the staff to be trained, the training methodologies to be used, and the competency criteria. The Center must also describe how it will verify provider staff have the knowledge and competence to provide each individual's unique set of needed supports prior to relinquishing day-to-day responsibility for his or her health and safety. The Center should focus on defining specific competency criteria, and then on ensuring the tools for measuring those competencies are thorough and appropriate to the need.

Center staff are encouraged to continue making improvements in the development of a comprehensive set of supports, with particular emphasis on identifying supports to address all important requirements with regard to pre-move training for provider staff, and for behavioral, safety, healthcare, therapeutic, and supervision needs.

Individuals:

#	Indicator	Overall Score	179								
1	The individual's CLDP contains supports that are measurable.	0% 0/1	0/1								
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/1	0/1								

Comments: The Monitoring Team reviewed the transition for the one individual (i.e. Individual #179) who since the last review, had moved from Brenham SSLC to a community group home operated under the State's Home and Community-based (HCS) program. The Monitoring Team reviewed this transition and discussed it in detail with the Brenham SSLC Admissions and Placement staff.

1. IDTs need to 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. To move toward compliance, the IDTs should continue to focus on identifying the measurable criteria upon which the Post-Move Monitor (PMM) can accurately judge implementation of each support. Pre-move training supports remained a significant

area of concern. The IDT did not clearly identify what provider staff needed to know to ensure they could meet the individual's needs, nor did they require provider staff to demonstrate knowledge or competency. The Monitoring Team has discussed this concern with the Center on previous occasions. At one time, transition staff had prepared a draft policy with regard to expectations for provider training, but per interview, it had been reviewed, but not approved. The Center needed to consider how it would ensure provider competency prior to transition. Examples of supports that both met and did not meet criterion are described below:

- Pre-move supports: The IDTs developed nine pre-move supports for Individual #179.
    - Three pre-move supports addressed the availability of equipment (i.e., a weight scale) and environmental preparations (i.e., provider capacity to keep medications, chemicals, and items that could be used for self-injurious behavior locked in a secure location), and the completion of several medical appointments prior to transition. The support for environmental preparations was not measurable, because it did not provide clear criteria about the types of items he might use for self-injurious behavior that the provider was to lock up.
    - A fourth pre-move support addressed the need for 24-hour awake staff and level of supervision, including specific criteria for completing body and room checks. While it was positive this support spelled out clear requirements for the latter checks, it only called for evidence of the schedule for the home, but should have included a staff training and competency requirement.
    - The remaining five pre-move supports addressed pre-move training needs in the areas of his mealtime and medication administration strategies; positive behavior support plan (PBSP); preferences and dislikes; medications and diagnoses; and, communication strategies. Only the communication strategies support provided specific competency requirements and met criterion for measurability. It is essential for Center staff to be able to objectively verify provider staff competence to implement all important health and safety supports prior to individuals' moves to the community. To achieve compliance, pre-move training supports should address the content of training that provider staff would need, as well as describe the staff to be trained, the training methodologies to be used, and the competency criteria. Center staff should also describe how they will verify provider staff have the knowledge and competence to provide each individual's unique set of needed supports prior to relinquishing day-to-day responsibility for his or her health and safety. 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. Additional findings in this area included:
        - With the exception of the support for communication strategies, pre-move training supports provided a list of topics as the content to be covered under each broad area of training, but did not indicate the specific knowledge that provider staff would be required to know by the time of the transition.
        - Center staff provided no concrete evidence that provider staff had acquired the necessary knowledge or skills as result of the training. Staff had not administered any competency testing; instead, the only evidence provided for pre-move training was signed training rosters. These indicated that provider staff attended a training session and could ask questions, and they signed as attestation that they understood the supports and would implement them to best of their abilities.
- Post-Move: The IDT developed post-move supports for Individual #179. Many post-move supports were measurable, including those that described most medical and health care appointments. Examples of post-move supports that did not meet criterion included:
    - The CLDP included five post-move supports that addressed training for new provider staff that were otherwise

identical to the five pre-move provider training supports. Only the one for communication strategies included measurable competency criteria and required provider staff interview; as such, this was the only one that met criterion for measurability.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for the CLDP to meet this criterion. The Center staff identified many supports for Individual #179, and it was positive they made a diligent effort to address his needs. Still, the CLDP did not fully and comprehensively address the individual's support needs and it did not meet criterion, as described below.

- Past history, and recent and current behavioral and psychiatric problems: Overall, the CLDP included many specific and measurable supports that addressed Individual #179's past history, and recent and current behavioral and psychiatric problems. This was positive, but the CLDP did not include clear supports related to his history of elopement or the need to increase preventative monitoring for suicide attempts during periods of increased agitation or depression.
- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The IDT developed supports in some areas related to safety, medical, healthcare, therapeutic and risk needs, such as for scheduling of health care appointments. It was also positive the IDT developed a detailed support for level of supervision. Overall, though, IDTs still needed to develop clear and comprehensive supports in this area. For example, the CLDP included a support for provider staff to take monthly vital signs to monitor for sinus tachycardia. This support described his usual values, but did not provide staff with parameters that should prompt any additional action, such as notifying the nurse or primary care practitioner (PCP). The CLDP did not provide any post-move supports to ensure provider staff had knowledge of any other signs and symptoms related to his cardiac risk (e.g., shortness of breath, heart palpitations, chest pain, and/or fainting) that staff needed to monitor and/or report.
- 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. The CLDP identified important outcomes based on his ISP goals to compete in a fishing tournament; be a member of a Special Olympics team; obtain a driver's license, and live in a group home near his family. While the transition did address his goal to live in the community, the IDT did not address the remaining goals in an assertive manner, if at all. For example, the CLDP did not include any supports related to obtaining his driver's license or participating in a fishing tournament. Other concerns in this area included:
    - The CLDP discussion noted that he was enthusiastic about travel and that he and his father had a long-term goal to travel to the Philippines. The discussion further stated that his home of choice should provide opportunities to expose him to books and other information about places he was interested in visiting and that he could learn to read a map and get a passport as preparatory activities. The IDT did not develop any related supports.
    - The ISP goal for employment only indicated that it was not applicable because he already had a job in the community. Since the IDT knew employment was one of his most important personal goals, they should have revised that outcome to reflect that he would need other employment opportunities when he moved to the new location. As described below, the CLDP did not assertively address this desired outcome.
- Need/desire for employment, and/or other meaningful day activities: The CLDP did not meet criterion.
    - The IDT documented an extensive discussion about employment opportunities in the CLDP narrative, including some specific strategies and potential employers, but did not develop these into assertive supports that had an outcome expectation for work. In the one related support, the IDT required only that the provider assist Individual #179 with

obtaining employment by providing transportation for interviews and assisting with completing applications and other employment-related documents.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success: Given that employment was one of the most motivating parts of his life, and the IDT did not address it assertively, this indicator did not meet criterion.
- Teaching, maintenance, participation, and acquisition of specific skills:
  - The CLDP included only one support in this area, to continue a budgeting skill acquisition plan. It did not address his desire to learn to drive or any other community living skills. The Monitoring Team could not otherwise fully assess this requirement, because the Center did not provide a Functional Skills Assessment (FSA) describing his strengths and needs.
- 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. For this review, the IDT did not yet address all recommendations with supports or otherwise provide a justification, as described throughout the discussion about this indicator.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.											
Summary: Post-move monitoring required improvements. Some of the areas in which continued efforts were needed related to the PMM consistently gathering reliable and valid data upon which to make accurate judgements about the presence of needed supports, the PMM correctly scoring the presence or absence supports based on the evidence, and completing needed follow-up to resolve issues and concerns. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	179								
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	100% 1/1	1/1								
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/1	0/1								
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/1	0/1								
6	The PMM's scoring is correct based on the evidence.	0% 0/1	0/1								
7	If the individual is not receiving the supports listed/described in the CLDP, the IDT/Facility implemented corrective actions in a timely	0% 0/1	0/1								

	manner.										
8	Every problem was followed through to resolution.	0% 0/1	0/1								
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A	N/A								
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A	N/A								

Comments: 3. Post-move monitoring was completed at required intervals for Individual #179. Each of these post-move monitoring visits were within the required timeframes, were done in the proper format, and occurred at all locations where the individual lived or worked.

4. The PMM Checklists did not yet consistently provide valid and reliable data. To continue to move toward compliance, the Center should continue to focus on improving the overall clarity and measurability of supports to provide guidance to the PMM as to what criteria would constitute the presence of various supports, as well as ensuring that PMM documentation addresses all requirements of supports with corresponding evidence. The evidence provided was often not complete, valid, and/or reliable. For example:

- The CLDP included six post-move supports for training of new provider staff, most with deficits concerning competency criteria as described with regard to Indicator 1. At the time of the seven and 45-day PMM visits, the PMM provided no evidence that the provider had tested or otherwise confirmed new staff competence. The PMM did not document interviewing any of the new staff, instead relying on the provider supervisors' confirmation that they had provided the training and reviewing a completed training roster. It was positive that by the time of the 90-day PMM visit, the PMM had begun to document interviewing new staff in some instances. It was concerning, though, that the PMM never documented interviewing new staff and confirming their knowledge of Individual #179's behavioral supports, especially in light of documentation that indicated even existing staff were not able to articulate how to implement those supports. In each instance, the PMM marked the new staff training supports as in place, but the evidence provided did not substantiate this finding.
- The PMM did not always interview the direct support staff that would have the primary responsibility for the implementation of supports. For example, at the time of seven-day PMM visit, the PMM only documented interviewing the supervisor with regard to Individual #179's needs for supervision. Even this testing of knowledge was not thorough. Per the documentation, the PMM questioned the supervisory staff about the procedure for body checks, but not about the provision requiring the individual to inform staff if he wished to leave the property.
- The PMM sometimes marked supports as in place based only on the provider's statements that they were in place, or that there was a plan to achieve completion. For example, another post-move support called for training on budgeting skills, due by 11/19/18. At the time of the 45-day PMM visit, on 12/20/18, the provider had not put this support in place. Follow-up notes for the 45-day PMM visit indicated the provider case manager had confirmed to the PMM that the training had started as of 1/15/19, at the day program, and that documentation would be provided. As a result, the PMM marked the support as in place. At the 90-day PMM on 1/29/19, the PMM documented that the day program staff were unaware of the program, and that Individual #179 reported he had not been doing it. The PMM informed the provider case manager, who responded that she would retrain and send documentation. Based on this assertion, the PMM again marked the support as in place, but the provider had still provided no evidence this had occurred.

5. Based on information the Post Move Monitor collected, Individual #179 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 the individual had received supports due to the lack clarity and measurability of the supports as written, and/or a lack of reliable and valid evidence that demonstrated a support was in place as required. Other examples of supports not in place as required included the following:

- Per his CLDP, a psychiatrist should have seen Individual #179 within four weeks of his transition, and then quarterly thereafter. At the time of the seven-day PMM visit, the PMM documented that his appointment was scheduled for 11/21/18. At the time of the 45-day PMM visit, the PMM documented the appointment had been rescheduled to 12/18/18, because provider staff who accompanied him could not adequately answer questions. The PMM marked this as in place, but did not provide any description of evidence the PMM reviewed to ensure that the appointment had occurred. It was not until the time of the 90-day PMM visit that the PMM provided any such evidence, indicating the appointment had not occurred until 1/14/19.
- The CLDP included two post-move supports that required the provider to keep certain items Individual #179 might use to harm himself locked in secure locations. At the day program, the PMM documented that there were paper clips in the common area, no lock available for the closet in which chemicals were stored, and medications were sitting on the desk in an unlocked office at day program. The PMM spoke with the program director and provider nurse who said they would follow up. The PMM then marked these supports as in place, and documented no further follow-up to ensure resolution.

6. Based on the supports defined in the CLDP, the Post-Move Monitor's scoring was not consistently correct. In many instances, the PMM still marked supports as in place without having documented obtaining the required evidence that would confirm these findings. At times, the supports were marked as in place in spite of comments that indicated they were not. Examples included, but were not limited to the following:

- At the time of the 45-day PMM visit, the PMM documented Individual #179's cell phone support was not in place (i.e., it was broken), and the provider reported they were working with his father to replace or repair it. The PMM marked the support as in place, but should not have until resolution had been achieved.
- Individual #179 often declined to participate in activities. At the time of the 45-day PMM visit, the PMM documented that provider staff indicated they offered activities, but that he refused. In interview, the individual told the PMM he did not want to attend a day program, but wanted to work. The PMM marked related supports as in place, which was not accurate.
- The CLDP included a support for Individual #179 to have an EKG by 12/20/18. At the time of both the 45- and 90-day PMM visits, the PMM documented that the community PCP had decided not to order it, because she did not feel there was a need that warranted it. The PMM marked the support as in place, apparently based on the PCP's rationale, and documented no follow-up with the IDT to obtain their input and recommendation.

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. As described with regard to the previous indicators, the PMM did not always document the evidence needed to confirm presence or absence of a support, and sometimes marked supports in place despite evidence to the contrary. Other findings included:

- At the time of the 90-day PMM visit, Individual #179 indicated he was having a hard time with staff understanding him. It was

positive the PMM discussed this with the provider case manager who indicated she would look into a speech referral. The PMM documented that she would follow up, but the Center did not provide any documentation this follow-up had occurred.

- A post-move support required provider staff to be able to explain when the individual used his back brace, and to make sure it was available. At the time of the seven-day PMM visit, provider staff at the home could not locate the back brace, but the support was marked as in place. The PMM did not clearly document staff knowledge of this support at any of the three PMM visits. At the 45-day PMM visit, the provider indicated they would put a check sheet in place, but had not done so by the time of the 90-day visit. The PMM indicated she would follow up, but provided no evidence she had done so.

- For two supports related to health care needs, the community PCP declined to provide the necessary orders to implement them. In addition to the refusal to order the EKG, as described above, the community PCP would not order three-month fasting finger sticks, as two post-move supports required, because Individual #179 did not have "any diabetes issues." The provider nurse also had not measured his waist circumference, because the PCP had not ordered it, based on the same reasoning. The PMM appropriately marked this as not in place, but provided no evidence of follow-up with the IDT to address these unmet needs.

- At the time of the 45-day PMM visit, the PMM documented no medication changes had taken place; however, per documentation provided, some psychotropic dosage changes had occurred at his initial visit with the community PCP. For example, the PCP increased the Latuda dosage from 20 milligrams (mg) once a day to a total of 120 mg taken over two doses, and increased the Effexor dosage from 175 mg to 300 mg. The PMM should have brought this to the attention of the IDT for follow-up. The community PCP also prescribed medication for urinary pain; this also merited some additional follow-up, given his history of insertion of items into his penis.

9. through 10. Post-move monitoring did not take place during the onsite monitoring visit, so these indicators were not rated.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of preventable negative events following transition into the community.											
Summary: While the IDT met as needed to discuss the PDCT event experienced by the individual reviewed, improvements are needed to ensure this process includes a thorough critical analysis that supports the identification of process improvements that might help to avoid any similar issues for individuals moving to the community in the future.			Individuals:								
#	Indicator	Overall Score	179								
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	0% 0/1	0/1								

Comments: 11. Individual #179 experienced a PDCT event, specifically, an emergency department (ED) visit within 90 days of transition. He experienced a pseudo seizure while on an outing to a baseball game. Per the documentation, he told staff he wanted to leave because he was hungry and declined staff's offer to obtain food from the concession stand. He then began to have seizure-like activity. Provider staff were aware of his history of pseudo seizures, but called 911, reportedly because the seizure seemed very real. He was taken to the ED and later released after having blood work, with orders to follow up with the community PCP in seven days.

The IDT met to review this event and determined that staff had been trained on the issue of pseudo seizures. This training included describing what his pseudo seizures looked like and how staff should respond by communicating with him to get him to stop. Further, the PDCT ISPA narrative indicated the training informed provider staff that he did not have a current diagnosis of a seizure disorder and never had. Based on this, the IDT determined that provider staff should be re-trained; however, the assertion that he did not have a seizure diagnosis was not factual, which the IDT should have known. Based on other assessment documentation, he had both petit mal and grand mal seizures as a child, as well as a current (and recent) diagnosis of partial complex seizure disorder. In addition, the training materials the provider nurse used to review Individual #179's health care needs informed provider staff of his diagnosis of partial complex epilepsy and to call 911 if an episode lasted longer than five minutes. The same materials also included information about pseudo seizures and informed provider staff to treat any such activity as a real seizure. Overall, it appeared the provider staff acted appropriately based on the information they had been provided. Re-training, based upon an erroneous interpretation of his history of seizures, could potentially lead to a failure of provider staff to protect him in the event of an actual seizure.

The IDT should have re-examined its pre-move training in this area to ensure it provided an accurate expectation of provider staff knowledge of both his medical history and current status, and was also specific about the level of discretion provider staff should have when determining what steps to take when seizure-like activity occurred. The IDT also should have acknowledged that having an expectation that provider staff were competent in this regard would have required them to have tested that competence, but neither the IDT nor the provider had done so.

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: Transition staff had identified the need to improve the quality and content of transition assessments, including the completion of all needed assessments and the inclusion of comprehensive and community-appropriate recommendations. Although Center staff provided training to community provider staff, the CLDPs did not define the training thoroughly, and Center staff still were not able to confirm that community provider staff were competent to meet individuals' needs at the time of transition. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	179								
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a	0% 0/1	0/1								

	community setting.										
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	100% 1/1	1/1								
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/1	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% 0/1	0/1								
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 1/1	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.	100% 1/1	1/1								
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.	Due to the Center's sustained performance with this indicator, it moved to the category requiring less oversight.									
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/1	0/1								

Comments: 12. Assessments did not consistently meet criterion for this indicator. It was positive transition staff were planning training for discipline leads on the expectations for transition assessments. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated with 45 Days of transition: Most assessments provided for review met criterion for timeliness. Examples of assessment that did not meet criterion included:
  - The IDT did not provide a current FSA or nursing assessment within 45 days.
  - It was positive, though, that the IDT provided a QDRR, as well as a detailed review of the IRRF in the CLDP narrative.
- Assessments provided a summary of relevant facts of the individual's stay at the Center: Some disciplines provided a summary of relevant facts in the available assessments, but this was not consistent. For example, the Center provided a vocational assessment that was very poor, given this was a critical goal and that IDT said they would begin working on it well before transition. It provided no information about the work that had been done.

- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments did not yet thoroughly provide recommendations to support transition nor did they specifically address/focus on the new community home and day/work settings. Examples included, but were not limited to, the following:
    - Individual #179's vocational assessment only broadly recommended he obtain employment in the community to earn money to purchase items he likes.
    - The OT/PT assessment also made broad recommendations that were not individualized. For example, the recommendations included that staff would need to: 1) be available 24 hours a day in order to assure his highest level of safety and functional independence; 2) ensure his self-care tasks were consistently carried out efficiently; 3) ensure he attended scheduled appointments and activities in a timely manner; 4) ensure they provided him opportunities to participate in the variety of daily activities for health and safety; and 4) provide dietary, OT, PT, and SLP services on an "as needed" consultative basis.

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; and 3) the CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting: Individual #179's CLDP met criterion for this indicator. The Center maintained a detailed Transition Log, which was helpful in understanding how the Center's 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.

14. Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required: Training provided to community provider staff did not yet meet criterion for Individual #179's CLDP, as described below and with regard to Indicator 1 above. Pre-move training supports remained a significant area of concern. The IDT did not clearly identify what provider staff needed to know to ensure they could meet the individual's needs, nor did they require provider staff to demonstrate knowledge or competency. The Monitoring Team has discussed this concern with the Center on previous occasions. At one time, transition staff had prepared a draft policy, but per interview, it had been reviewed, but not approved. The Center needed to consider how it would ensure provider competency prior to transition.

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, and summarize findings and outcomes. The CLDP included a statement, indicating that no collaboration meeting with the counselor was needed, because it would be the same person Individual #179 was already seeing. The CLDP did not include evidence the IDT considered clinician-to clinician collaboration between PCPs, psychiatrists, or behavioral staff, but should have based on his significant history.

16. SSLC clinicians (e.g., OT/PT) complete assessments 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. Individual #179's IDT determined he did not need any settings assessments, but he did have specific environmental concerns related to his behavioral history that should have prompted the IDT to discuss whether behavioral staff should have evaluated the adequacy of the providers' preparations at both the home and day program. In hindsight, the PMM evidence indicated the preparations were inadequate

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 potentially should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results. Examples include provider direct support staff spending time at the Center, Center direct support staff spending time with the individual in the community, and/or Center and provider direct support staff meeting to discuss the individual's needs. The CLDP did not provide a clear statement describing the IDT's consideration in this regard, but it was positive the IDT arranged for a direct support professional to participate in the pre-move provider visit. Going forward, IDTs will need to document these considerations in the CLDP, with the details as described above.

19. The pre-move site review (PMSR) was completed prior to the transition date as required. 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 this PMSR did not accomplish this, as described above with regard to Indicator 1 and Indicator 14.

Outcome 5 – Individuals have timely transition planning and implementation.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	179								
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	100% 1/1	1/1								
Comments: 20. The CLDP met criterion for this indicator. On 3/12/18, Individual #179 was referred, and on 11/15/18, he transitioned. This slightly exceeded 180 days, but the transition log demonstrated sustained activity to locate community living options appropriate to his needs and preferences.											

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