United States v. State of Texas

Monitoring Team Report

Brenham State Supported Living Center

Dates of Remote Review: October 4th through 7th, 2021

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## Background

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

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

In addition, the parties set forth 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.

For this review, this report summarizes the findings of the two Independent Monitors, each of whom have 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 Center'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 review, the Monitoring Teams requested various types of information about the individuals who lived at the Center and those who had transitioned to the community. From this information, the Monitoring 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 Center's compliance with all provisions of the Settlement Agreement.

b. **Onsite review** – Due to the COVID-19 pandemic and resultant safety precautions and restrictions, the Monitoring Teams did not visit the campus in person. Instead, the Monitoring Teams collaborated with the Parties to create a remote virtual review protocol that allowed for the monitoring of all of the outcomes and indicators.
    1. 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 Center-wide documents. During the week of the remote review, the Monitoring Team requested and reviewed additional documents.
    2. Attending meetings – The Monitoring Team attended various regularly occurring meetings at the Center by calling in to a teleconference, or utilizing a video meeting platform (Microsoft Teams). Examples included daily morning medical meeting, daily incident management review team, physical nutritional management team, ISPs annual and preparation meetings, and QAQI Council.
    3. Interviews – The Monitoring Team conducted interviews of staff, managers, clinicians, individuals, and others by calling in to a teleconference, or utilizing a video meeting platform (Microsoft Teams).
    4. Observations – The Monitoring Team conducted observations of individuals and staff engaged in various activities with the usage of a video platform (Microsoft Teams). The Center assigned a staff member to host each observation. That staff member used a portable mobile device (e.g., iPhone) to show the individual and staff. Activities included administration of medication, implementation of skill acquisition plans, and engagement in activities at home.
c. **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 move to the category of requiring less oversight. At the next review, indicators that move to this category will not be rated, but may return to active oversight at future reviews if the Monitor has concerns about the Center's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the Center's plans for continued quality assurance and improvement. In this report, any indicators that were moved to the category of less oversight during previous reviews are shown as shaded and no scores are provided. The Monitor may, however, include comments regarding these indicators.

**Organization of Report**

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the 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 Center'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. 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.
g. **Quality improvement/quality assurance:** The Monitors' report regarding the monitoring of the Center's quality improvement and quality assurance program is provided in a separate document.

**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 Center showed sustained substantial compliance with many of the requirements of Section C of the Settlement Agreement. The exceptions are Section C.5 related to licensed health care staff's (nurses' and/or physicians') roles in

the monitoring of all types of restraints, and physicians' roles in defining monitoring schedules, as needed; and Section C.6 related to assessments for restraint-related injuries, as well as monitoring of individuals subjected to medical restraint. The Monitoring Teams will continue to monitor these remaining areas for which Center staff have not obtained substantial compliance using the outcomes and indicators related to these subjects. With the understanding that these topics are covered elsewhere in the Settlement Agreement, the SSLC exited from the other requirements of Section C of the Settlement Agreement. The report below contains the current review period's performance scores and commentary.

The Monitors and Monitoring Team members recognize that the COVID-19 global pandemic has required Center staff to make some significant changes to their practices, and that the steps necessary to protect individuals and staff require substantial effort. The time since the pandemic began has undoubtedly been a challenging one at the Centers, as it has been across the country.

State Office shared a chart in which Center staff outlined activities that were put on hold, and provided information about how staff believe such changes potentially impacted the delivery of supports and services that the Settlement Agreement requires. In conducting the review and making findings, the Monitors have taken into consideration the impact COVID-19 might have had on the scores for the various indicators. In some instances, the Monitors have indicated that they were unable to rate an indicator(s) due to this impact.

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at Brenham SSLC for their assistance with the review. The Monitoring Team appreciates the assistance of the Center Director, Settlement Agreement Coordinator, and the many other staff who assisted in completing the remote review activities.

**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 five outcomes and 21 underlying indicators in the areas of restraint management, pretreatment sedation/chemical restraint, and mortality review. At the time of the last review, one of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, no additional indicators will move to the category requiring less oversight.

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

Restraint

The Center showed sustained substantial compliance with many of the requirements of Section C of the Settlement Agreement. The exceptions are Section C.5 related to licensed health care staff's (nurses' and/or physicians') roles in the monitoring of all types of restraints, and physicians' roles in defining monitoring schedules, as needed; and Section C.6 related to assessments for restraint-related injuries, as well as monitoring of individuals subjected to medical restraint. The Monitoring Teams will continue to monitor these remaining areas for which Center staff have not obtained substantial compliance using the outcomes and indicators related to these subjects. With the understanding that these topics are covered elsewhere in the Settlement Agreement, the SSLC exited from the other requirements of Section C of the Settlement Agreement.

For one of the five physical restraints reviewed, nurses performed physical assessments, and documented whether individuals sustained any restraint-related injuries or other negative health effects. It was positive that for the one individual with protective mechanical restraint for self-injurious behavior (PMR-SIB), nurses consistently checked the condition of the device. Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: documenting actions taken/treatment provided for injuries and other negative health effects, and following the procedures and assessments for individuals with PMR-SIB.

Abuse, Neglect, and Incident Management

At a previous review, the Monitor found Brenham SSLC to have met substantial compliance criteria with Section D of the Settlement Agreement regarding abuse, neglect, and incident management. Therefore, this section and its outcomes and indicators were not monitored as part of this review.

Other

IDTs discussed use of pretreatment sedation.

**Restraint**

At a previous review, the Monitor found that that the Center achieved substantial compliance with many of the requirements of Section C of the Settlement Agreement.

The exceptions are Section C.5 related to licensed health care staff's (nurses' and/or physicians') roles in the monitoring of all types of restraints, and physicians' roles in defining monitoring schedules, as needed; and Section C.6 related to assessments for restraint-related injuries, as well as monitoring of individuals subjected to medical restraint. The Monitoring Teams will continue to monitor these remaining areas for which Center staff have not obtained substantial compliance using the outcomes and indicators related to these subjects (immediately below).

With the understanding that these topics are covered elsewhere in the Settlement Agreement, the SSLC exited from the other requirements of Section C of the Settlement Agreement.

| Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: For one of the five physical restraints reviewed, nurses performed physical assessments, and documented whether individuals sustained any restraint-related injuries or other negative health effects. It was positive that for the one individual with PMR-SIB, nurses consistently checked the condition of the device. Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: documenting actions taken/treatment provided for injuries and other negative health effects, and following the procedures and assessments for individuals with PMR-SIB. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 441 | 149 | 310 | 336 | 204 | | | | |
| a. | If the individual is restrained using physical or chemical restraint, nursing assessments (physical assessments) are performed in alignment with applicable nursing guidelines and in accordance with the individual's needs. | 20%<br>1/5 | 0/1 | N/A | 0/1 | 0/1 | 1/2 | | | | |
| b. | If the individual is restrained using PMR-SIB: | | | | | | | | | | |
| | i. A PCP Order, updated within the last 30 days, requires the use of PMR due to imminent danger related to the individual's SIB. | 0%<br>0/1 | N/A | 0/1 | N/A | N/A | N/A | | | | |

| | | | | | | | | | | | |
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| | ii. An IHCP addressing the PMR-SIB identifies specific nursing interventions in alignment with the applicable nursing guideline, and the individual's needs. | 0%<br>0/1 | | 0/1 | | | | | | | |
| | iii. Once per shift, a nursing staff completes a check of the device, and documents the information in IRIS, including:<br>a. Condition of device; and<br>b. Proper use of the device. | 100%<br>1/1 | | 1/1 | | | | | | | |
| | iv. Once per shift, a nursing staff documents the individual's medical status in alignment with applicable nursing guidelines and the individual's needs, and documents the information in IRIS, including:<br>a. A full set of vital signs, including SPO2;<br>b. Assessment of pain;<br>c. Assessment of behavior/mental status;<br>d. Assessment for injury;<br>e. Assessment of circulation; and<br>f. Assessment of skin condition. | 0%<br>0/1 | | 0/1 | | | | | | | |
| c. | The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects. | 67%<br>4/6 | 1/1 | 1/1 | 0/1 | 1/1 | 1/2 | | | | |
| d. | Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual. | 0%<br>0/3 | N/A | N/A | 0/1 | 0/1 | 0/1 | | | | |

Comments: The restraints reviewed included those for: Individual #441 on 7/18/21 at 1:25 a.m.; Individual #149 from 3/1/21 to 3/8/21 (PMR-SIB); Individual #310 on 3/12/21 at 9:12 p.m.; Individual #336 on 8/2/21 at 12:13 p.m.; and Individual #204 on 5/19/21 at 5:30 p.m., and 8/18/21 at 11:45 a.m.

a. and c. For Individual #204's restraint on 5/19/21 at 5:30 p.m., the nurse performed physical assessments, and documented whether there were any restraint-related injuries or other negative health effects.

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

- For Individual's #441's restraint on 7/18/21 at 1:25 a.m., the nurse did not arrive until 2:40 a.m. Although the nurse assessed the individual's pulse, heart rate, and blood pressure, the entries did not include respirations.
- For Individual #149's PMR-SIB:
  - Based on documentation submitted, no order existed for the timeframe reviewed. Center staff submitted an order for the period between 3/16/21 and 4/15/21, but not for timeframe from 3/1/21 to 3/8/21 (i.e., the timeframe selected for review).
  - Based on documentation submitted, the individual's IHCP did not define nursing interventions to address the use of PMR-SIB.

- It was positive that once per shift during the timeframe reviewed, nursing staff conducted and documented checks of the condition and proper use of the device.
- While nurses conducted some of the components of the required physical assessments each shift, nurses did not consistently document assessments of pain, gait/balance/coordination, circulation, or skin condition (i.e., "normal for ethnicity" did not show evidence of a skin assessment consistent with current standards).

- On 3/12/21, at 9:18 p.m., following the restraint, , and again, at 9:25 p.m., Individual #310's heart rate was elevated (i.e., 101). Based on documentation submitted, nursing staff did not check his pulse again until 3/13/21, at 6:59 a.m. Nursing staff should have monitored the individual every four hours until his heart rate stabilized.

  In addition, on 3/16/21, a nurse entered a late note for 3/12/21, and 3/13/21. The nurse noted that the individual had bloody lips, but did not document whether or not he had any other injuries. The nurse indicated that they conducted the assessment on 3/13/21 at 1:38 a.m. The nurse indicated that the bloody lips appeared to be dry and cracked, and likely were not a result of the restraint. There was not follow-up notes to determine whether or not further care was needed.
- On 8/2/21, for Individual #336, the nurse did not assess and/or document his mental status. He sustained two injuries, including a scrape on his right elbow, and a scrape on his right knee. No follow-up was included in the documentation submitted, despite noting to check every other day (QOD). In addition, the nurse did not enter assessment results in IView, and the IPNs did not show evidence of a full assessment in accordance with the nursing guidelines. The IView entries, dated 8/3/21, did not refence an assessment for the injuries.
- On 5/19/21, Individual #204 sustained a laceration to her left knee, as well as abrasions to her right finger and left abdomen. The follow-up assessments included in IView and the IPNs sometimes included conflicting information, and they did not show that nurses conducted assessments of each of the injuries each time. At times, measurements were missing, so it was difficult to tell whether the injuries were healing. On 5/25/21, a nurse noted that the scrapes on her left knee were still the same size with dark brown scabbing, but there were no notes following this entry to show that the injuries healed.
- For Individual #204's restraint on 8/18/21, the nurse did not include the individual's pulse with the vital signs, and the only description of her mental status was "alert."

## Abuse, Neglect, and Incident Management

At a previous review, the Monitor found Brenham SSLC to have met substantial compliance criteria with Settlement Agreement provision D regarding abuse, neglect, and incident management. Therefore, this provision and its outcomes and indicators were not monitored as part of this review.

Aspects of incident management, occurrences of abuse/neglect, and investigations will remain and/or become part of the Center's quality improvement system and will be reviewed by the Monitoring Team as part of its monitoring of Quality Assurance/Improvement (i.e., section E of the Settlement Agreement).

**Pre-Treatment Sedation**

| Outcome 6 – Individuals receive dental pre-treatment sedation safely. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: These indicators will continue in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
| a. | If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed. | N/A | | | | | | | | | |
| b. | If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed. | N/A | | | | | | | | | |
| Comments: a. and b. Based on the documentation provided, during the six months prior to the review, none of the nine individuals in physical health review group received TIVA/general anesthesia or 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 | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
| a. | If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed. | 0% 0/1 | N/A | N/A | N/A | N/A | N/A | 0/1 | N/A | N/A | N/A |
| Comments: a. Informed consent was not provided for the pre-treatment medical sedation Individual #159 received on 6/4/21, for a DEXA scan. It was positive that on 6/1/21, the IDT met and provided input on the medication and dosage, and that nursing staff completed pre- and post- procedure vital sign assessments. | | | | | | | | | | | |

| Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS. | | | | | | | | | | | |
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| Summary: IDTs discussed use of PTS. In both cases, it was for non-reoccurring medical procedures. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
| 1 | IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics. | 100% 2/2 | | | 1/1 | | 1/1 | | | | |

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| 2 | If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | | |
| 3 | If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying 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. | N/A | | | | | | | | | | |
| 4 | Action plans were implemented. | N/A | | | | | | | | | | |
| 5 | If implemented, progress was monitored. | N/A | | | | | | | | | | |
| 6 | If implemented, the individual made progress or, if not, changes were made if no progress occurred. | N/A | | | | | | | | | | |
| Comments:<br>1-6. The facility reported that two of the nine individuals reviewed by the behavioral health monitoring team had received pretreatment sedation in the 12 month period prior to the review. In both cases, these were procedures completed off campus. Individual #119 was in need of a battery placement for her VNS. The team met, reviewed risks versus benefits, and approved the procedure. The minutes reflected witnessed verbal consent obtained from the guardian. It was also noted that the hospital obtained consent. Individual #33 was in need of an EGD and colonoscopy. Minutes from his ISPA meeting held prior to the procedures indicated the team had considered the need for these exams and noted that his mother had given her consent. It was also noted that consent was obtained at the hospital. | | | | | | | | | | | |

**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 | 81 | 593 | 220 | 508 | | | | | |
| 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. | 75%<br>3/4 | 0/1 | 1/1 | 1/1 | 1/1 | | | | | |
| b. | Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement. | 0%<br>0/4 | 0/1 | 0/1 | 0/1 | 0/1 | | | | | |

| | | | | | | | | | | | |
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| c. | Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement. | 0%<br>0/4 | 0/1 | 0/1 | 0/1 | 0/1 | | | | | |
| d. | Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement. | 0%<br>0/4 | 0/1 | 0/1 | 0/1 | 0/1 | | | | | |
| e. | Recommendations are followed through to closure. | 0%<br>0/3 | 0/1 | 0/1 | 0/1 | N/A | | | | | |

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

- On 1/11/21, Individual #81 died at the age of 78 with cause of death listed as COVID-19 pneumonia. On 2/1/21, the Clinical Death Review Committee completed its review, but it was not until 3/16/21, that the Administrative Death Review Committee met.
- On 1/14/21, Individual #54 died at the age of 58 with cause of death listed as COVID-19 pneumonia.
- On 3/20/21, Individual #593 died at the age of 67 with cause of death listed as aspiration pneumonia.
- On 5/29/21, Individual #220 died at the age of 61 with cause of death listed as brain herniation from an intracranial hemorrhage.
- On 7/11/21, Individual #267 died at the age of 19 with cause of death listed as cardiac arrest secondary to pulmonary embolism.
- On 7/30/21, Individual #191 died at the age of 52 with cause of death listed as sepsis.
- On 8/17/21, Individual #508 died at the age of 42 with cause of death listed as aspiration pneumonia.

b. through d. The Center completed death reviews for each of the four individuals. These reviews identified concerns, and resulted in some important recommendations. However, evidence was not submitted to show the Center staff conducted thorough reviews of the care and treatment provided to individuals, or an analysis of the mortality reviews to determine additional steps that should be incorporated into 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.

- Overall, disciplines' death reviews did not provide an objective review of the assessment, planning, treatment, care, and supports that Center staff provided to the individuals who died. Center staff should use mortality reviews as an opportunity to identify potential areas in need of improvement, including issues that might have impacted the individuals' deaths, but also issues that impacted the overall quality of care the individual received during at least the last several months of their lives. The reviews conducted did not achieve this objective.
    - For example, reviews did not consistently assess the quality of care versus the presence of documents. As one example, the nursing review for Individual #81 noted that he had multiple acute care plans in the six months prior to his death. The nurse reviewer conducted/documented no review of the quality of those acute care plans, and/or nurses' implementation of the plans. Similarly, there was no review of the quality of his Integrated Health Care Plans (IHCPs) in terms of their ability to meet his needs, as well as their adherence to generally accepted standards of care.

- Given that aspiration pneumonia was listed as a cause of death for two of the individuals (i.e., Individual #593, and Individual #508), further inquiry into the assessment of, and supports, care, and treatment provided to these individuals was warranted. In neither case did the committees take the opportunity to review the causes, evaluation, and treatment of these individuals at risk for aspiration pneumonia. Further, for Individual #508:
    - A modified barium swallow study (MBSS) indicated no changes in his diet were needed, yet he experienced repeated aspiration pneumonia. The Clinical Death Review Committee should have conducted further review.
    - As noted above, nursing reviews did not assess the quality of IHCPs or acute care plans. For this individual, the nurse reviewer listed the topics of his IHCPs, and stated: "I reviewed [Individual #508's] problem list along with comparing to his most recent AMA and agree that these IHCP's [sic] were appropriate." The Monitoring Team's findings for this individual (see below Outcomes #4, #6, and #7 for nursing) showed that his IHCP for aspiration/respiratory compromise did not meet his needs for ongoing, proactive nursing assessments, particularly given the IDT's decision for him to continue to eat orally. The IDT did not make changes to his IHCP despite his repeated diagnoses of aspiration pneumonia (i.e., in September 2020, and June and August 2021). The mortality review team did not analyze the events surrounding these diagnoses.
- For Individual #220:
    - He had documented mental status decline, but there was no mention of a diagnosis of dementia or dementia evaluation that had been completed. However, his death reviews did not result in a recommendation to provide an in-service training on the signs and symptoms of dementia, along with dementia care and treatment.
    - Another topic that the clinical review team should have considered for in-service training was heart block.
    - The nursing reviewer did not fully assess his history of falls. He fell in February 2021, and April 2021 without review of why. He also had a shoulder skin tear and redness in March 2021 that was not reviewed, but could have been related to a fall. He had falls more frequently along with mental status changes and weight loss. Given that he had third-degree heart block, he could have been having syncopal episodes, and the moaning he exhibited could have been related to chest pain. This was not reviewed. The Clinical Death Review Committee should have addressed it.
- At times the discipline-specific clinical death reviews identified concerns, but the death review committees did not adopt recommendations to address them. For example:
    - For Individual #593, the nursing reviewer identified that nursing staff had not completed appropriate assessments following the individual's hospitalization. This should have been included within the recommendations for training.
    - The medical reviewer for Individual #508 identified the need for: "retraining or re-emphasizing the importance of proper position… to staff." This was not addressed in the final recommendations.
    - The nursing reviewer for Individual #508 identified the need to: "Speak with the hospital pharmacy or administrator about better communication of individual's medication needs." This did not become a final recommendation.

e. For some recommendations, Center staff did not submit documentation to show completion. For example:
- The Administrative Death Review Committee for Individual #81 adopted a recommendation for the Assistant Director of Programs (ADOP) and Chief Nurse Executive (CNE) to review the systems in place to determine if insufficient meal/fluid intake is reported to Unit Incident Management Team (IMT). If not, they were to develop a process/procedure to do so. Based on documentation submitted as well as interview with the CNE during the remote review, this recommendation had not been completed.

Some improvement was noted with regard to the mortality review committees writing recommendations in a way that ensured that Center practice improved. For example, a recommendation was made for the Habilitation Therapy Department to: "Coordinate with the DRS [Director of Residential Services] & Home Manager supervisors to ensure that all staff working with high risk individuals are trained on the PNMP before they are assigned to that individual (at home or in the hospital)." The evidence listed was a policy and training rosters. The Administrative Death Review Committee also appropriately required that Campus Coordinators perform spot checks for direct support professionals assigned to the hospital. While this was a step in the right direction, it was not clear how often the spot checks would occur, or if any spot checks would occur for other individuals at high risk (i.e., not in the hospital).

However, other recommendations did not follow this format. For example, for the recommendation mentioned above related to the system for tracking meal/fluid intake, the evidence listed was "process/procedure," and the committee listed the monitoring plan and "N/A." This did not ensure that concerning practices changed. The recommendation should have been written in a manner that required monitoring to determine whether or not the process was in place and implemented.

At times, Center staff provided raw data as evidence of implementation. For example, staff training rosters were included, but Center staff did not include information about how many staff required training. As a result, this documentation could not be used to determine whether or not staff fully implemented the recommendation. Staff should summarize data, including, for example, the number of staff trained (n), and the number of staff who required training (N).

**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.

In a letter, dated 8/23/21, the Monitor notified the parties that the Center achieved substantial compliance with most of the requirements of Section Q of the Settlement Agreement. The exceptions are: 1) implementation of a policy/clinical guideline that is consistent with current generally accepted standards of care on perioperative assessment and management of individuals needing TIVA/general anesthesia for dental work, which the Monitoring Team will continue to assess and apply the findings to paragraph H.7 of the Settlement Agreement; and 2) personal goals/objectives for individuals who are at risk for dental problems, as well as the development and implementation of plans for individuals who require suction tooth brushing, which the Monitoring Team will assess as part of Section F. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Brenham SSLC exited from the other requirements of Section Q of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the related outcomes and indicators. As a result, this Domain contains one less outcome, and five fewer indicators.

Currently, this Domain contains 31 outcomes and 141 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, 26 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, six additional indicators will move to the category of less oversight in the areas of ISPs, nursing, PNM, and OT/PT. One indicator related to medical 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.

Assessments

In the ISPs, for all individuals in the review group, the IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP. But for none of the individuals did the IDT arrange for and obtain all of the assessments.

In behavioral health, the annual Behavioral Health Assessment (BHA) was current and complete for all but one individual, and in that case, the component that was missing was the assessment of cognitive abilities. There was also improvement in the content of the functional assessments, though some further improvements remained needed in order to meet criteria.

In skill acquisition, all three relevant assessments were completed for one-third of the individuals in the review group. Very few had specific recommendations for skill acquisition.

In order to assign accurate risk ratings, IDTs need to continue 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 and update the Integrated Risk Rating Forms (IRRFs) within no more than five days.

In the last report, the Monitor stated: "Based on the review of AMAs [annual medical assessments] for other indicators in the audit tool, for three of the nine individuals reviewed, PCPs did not complete AMAs within 365 days of the previous one. As a result, Indicator b is at risk of returning to active oversight." Unfortunately, for this review, primary care providers (PCPs) did not complete four of the nine AMAs reviewed within 365 days of the previous ones, and three of the four were between one month and two and a half months overdue. The related indicator will return to active oversight.

In addition, PCPs completed timely interval medical reviews (IMRs) for none of the nine individuals. For six of the nine individuals, Center staff submitted no IMRs.

For individuals in the review group, most of the AMAs met most of the criteria for quality. With concentrated efforts on the remaining areas of focus (i.e., as applicable, family history, and thorough plans of care for each active medical problem, when appropriate), by the time of the next review, PCPs could make good progress on continued improvements to the quality of AMAs.

For the six individuals in the review group, nurses completed timely annual nursing reviews and physical assessments. Five of the six individuals also had timely quarterly nursing record reviews and/or physical assessments. Due to the Center's sustained performance, the two related indicators will move to the category requiring less oversight.

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

Since the last review, the Center maintained its progress with regard to the timely referral of individuals to the Physical and Nutritional Management Team (PNMT). For individuals in the review group, the PNMT completed timely PNMT reviews and assessments. Overall, the quality of the PNMT comprehensive assessments continued to improve. Improvements in the quality of reviews and assessments should continue to be a focus.

For the individuals reviewed, the Center continued to evidence good progress towards providing Occupational and Physical Therapy (OT/PT) assessments that were timely and the types of assessment that were in accordance with individuals' needs. While more work was needed, the quality of the OT/PT assessments also continued to improve.

Significant work continued to be needed to improve the quality of communication assessments 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.

Individual Support Plans (ISPs)

For the ISPs, across the six individuals, personal goals met criteria in from three to five areas for a total of 23 goals that met criteria. Overall, this was an improvement from the last review. More work is needed regarding health and wellness goals regarding actions the individual might take to improve his or her own health and wellness and address any at-risk conditions.

Many of the goals had been in place for two or more years with no documented progress towards the goal.

About one-quarter of the goals (that met criteria with indicator 1) had a good set of action plans to support achievement of the goal.

About half of the goals had documentation or data to determine progress. Of the nine goals that had data to determine progress, two were met or progressing.

For all individuals, action plans had not been implemented and individuals had not made progress towards most goals. For the 53 action plans that could be implemented, 30 (57%) had been consistently implemented.

It was good to see that QIDPs were consistently reviewing goals and action plans and commenting on progress, however, plans were not revised, and barriers had not been addressed when services and supports were either not implemented or not effective.

For all individuals in the ISP review group, staff were knowledgeable of the individual's support needs, risk areas, ISP goals, and action plans. Staff were attentive and respectful to individuals during observations.

The psychiatry department was identifying psychiatric indicators for reduction and in some cases for increase. The psychiatry clinicians need to ensure that the relationship of the indicator to the individual's diagnosis is clearly designated and that indicators are consistently identified.

Psychiatric ISP annual updates were done for all individuals and the psychiatrist or member of the psychiatric team attended the individual's ISP meeting. Psychiatry ISP documentation, however, was not complete in terms of content.

In behavioral health, the Center had not (until just two or so months prior to this review) corrected various problems with their protocol for assessing inter-observer agreement (IOA) that were occurring during the last review period. Moreover, the Monitoring Team observed two occurrences of target behaviors, but neither was recorded in the data system.

In skill acquisition, about two-thirds of the SAPs were based on assessments and were meaningful. About one-third of SAPs had reliable data.

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

Six out of nine Physical and Nutritional Management Plans (PNMPs) reviewed met the requirements for quality. Given that during the previous two reviews, the Center's scores were 100%, and 89%, and problems noted during those reviews as well as this review were minimal, the related indicator will move to the category requiring less oversight.

**ISPs**

| Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable. | |
|---|---|
| Summary: None of the individuals had goals that met criteria for indicator 1 in all six ISP areas, however, half of the individual's goals met criteria for all five personal goal areas. Moreover, across the six individuals, personal goals met criteria in from three to five areas for a total of 23 goals that met criteria. Overall, this was an improvement from the last review. More work is needed regarding health and wellness goals regarding actions the individual might take to improve his or her own health and wellness and address any IRRF/risks.<br><br>The Monitor has provided additional calculations to assist the Center in identifying progress as well as areas in need of improvement. For indicator 1, the data boxes below separate performance for the five personal goal areas from the health and wellness goals. The Monitoring Team looks at two health and wellness areas that rated as being at medium or high risk (in the IRRF) plus a dental goal if that area is | Individuals: |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| rated as being at medium or high risk, plus suction toothbrushing if the individual receives suction toothbrushing.<br><br>Indicator 2 shows performance regarding the writing of goals in measurable terminology. About two-thirds of the goals that met criteria with indicator 1 were written in measurable terminology. Similarly, overall, about two-thirds of goals were written in measurable terminology. Indicator 3 shows that about one-quarter of the goals that met criteria with indicator 1 had a good set of action plans to support achievement of the goal. These three indicators will remain in active monitoring. | | | | | | | | | | | | |
| # | Indicator | | Overall Score | 119 | 33 | 448 | 199 | 159 | 143 | | | |
| 1 | The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her. | Personal goals | 50%<br>3/6<br>77%<br>23/30 | 4/5 | 3/5 | 5/5 | 5/5 | 1/5 | 5/5 | | | |
| | | Health goals | 0%<br>0/6<br>0%<br>0/13 | 0/2 | 0/2 | 0/2 | 0/2 | 0/3 | 0/2 | | | |
| 2 | The personal goals are measurable. | Personal goals | 17%<br>1/6<br>65%<br>15/23<br>68%<br>17/25 | 2/4<br>2/4 | 2/3<br>2/3 | 4/5<br>4/5 | 3/5<br>3/5 | 1/1<br>3/3 | 3/5<br>3/5 | | | |
| | | Health goals | 0%<br>0/6<br>--%<br>-/-<br>0%<br>0/13 | -/-<br>0/2 | -/-<br>0/2 | -/-<br>0/2 | -/-<br>0/2 | -/-<br>0/3 | -/-<br>0/2 | | | |
| 3 | ISP action plans support achieving the individual's personal goals. | | 0%<br>0/6<br>22%<br>5/23 | 1/4 | 2/3 | 0/5 | 1/5 | 0/1 | 1/5 | | | |

Comments: The Monitoring Team reviewed the ISP process for six individuals at the Brenham State Supported Living Center: Individual #448, Individual #33, Individual #119, Individual #199, Individual #159, and Individual #143. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed staff, including DSPs and QIDPs, and directly remotely observed individuals at the Brenham SSLC facility.

1. None of the individuals had a comprehensive score that met criterion for the indicator. During the last monitoring visit, the Monitoring Team found 19 goals that met criterion for being individualized, reflective of the individuals' preferences and strengths, and based on input from individuals on what was important to them. For this review, 23 goals met this criterion. The personal goals that met criterion were:

- the leisure goal for Individual #448, Individual #33, Individual #119, Individual #199, and Individual #143.
- the relationship goal for Individual #448, Individual #199, and Individual #143.
- the work/day/school goal for Individual #448, Individual #119, Individual #199, and Individual #143.
- the independence goal for all six.
- the living options goal for Individual #448, Individual #33, Individual #119, Individual #199, and Individual #143.

For the other goal areas:

- Individual #33, Individual #119, and Individual #159 did not have a relationship goal. Per their ISPs, they had limited relationships and limited relationship building skills. The IDT should consider teaching skills that might expand their ability to build relationships with others.
- Individual #33 and Individual #159 did not have day programming goals. During observations, they were not meaningfully engaged throughout the day. Individual #159's IDT was focused on trying to get him to attend the New Horizons Day Program for short periods during the day. They had not identified training that he could participate in based on his preferences while at the day program.
- Individual #159's recreation goal to spend time outside of his bedroom for a total of eight hours per day, did not identify his preferences or offer opportunities to learn new skills. His goal to live at Brenham SSLC was not aspirational.
- None of the individuals had goals to support their participation in improving or maintaining their own health and wellness. There were goals related to clinical outcomes (e.g., medical, nursing, dental; see bulleted list below), but none related to actions in which the individual might engage.
    - Individual #448: aspiration and choking
    - Individual #33: weight and osteoporosis/falls/fractures
    - Individual #119: choking and weight
    - Individual #199: gastrointestinal issues and skin integrity
    - Individual #159: dental, gastrointestinal, and cardiac disease
    - Individual #143: gastrointestinal issues and skin integrity

In some cases, it was difficult to determine if goals were individualized and/or aspirational because assessments were not completed prior to goal implementation to determine if the individual was interested in the activity or needed training in that area. Consequently, some goals were discontinued due to lack of interest or implementation during the ISP year.

The QIDP department was focused on revising the PSI process to improve identification of individual's preferences. This should lead to the development of better goals.

2. Of the 23 personal goals that met criterion for indicator 1, 15 also met criterion for measurability. Two others that did not meet criteria for indicator 1 were measurable. Those that were measurable:

- Recreation/Leisure: Individual #448 and Individual #159
- Relationship: Individual #448 and Individual #143
- Job/School/Day: Individual #448, Individual #119, Individual #199, and Individual #143
- Greater Independence: Individual #33, Individual #199, and Individual #159
- Living Option: all six

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

- Recreation/leisure: Individual #33, Individual #119, Individual #199, and Individual #143
- Relationship: Individual #33, Individual #119, Individual #199, and Individual #159
- Job/School/Day: Individual #33 and Individual #159
- Greater Independence: Individual #448, Individual #119, and Individual #143

3. For the 23 goals that met criterion for being personal and individualized, five had corresponding action plans that were supportive of goal-achievement. Action plans to support goals should include all necessary steps; be individualized; integrate strategies to reduce risk, incorporate needs included in ancillary plans; offer opportunities to make choices and decisions, where relevant; and support opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals. Goals that had action plans that were likely to lead to achievement of the goals were:

- Individual #33's recreation/leisure, and greater independence goals.
- Individual #119's recreation/leisure goal.
- Individual #199's recreation/leisure goal.
- Individual #143's recreation/leisure goal.

Examples of goals that did not meet criteria:

- Individual #448's work/day goal to obtain a competitive part-time job in the community was aspirational. The IDT had not addressed individualized job training specific to jobs that he might be interested in seeking. Action plans included:
    - SAP to pay for purchases.
    - QIDP to follow up with vocational program regarding his work schedule.
    - QIDP to follow up with the Business Development Coordinator regarding finding employment in the community and keeping park crew job.
    - QIDP will monitor Individual #448's wages monthly.
    - QIDP will assist Individual #448 with completing his WIOA paperwork annually

- Individual #33's living option goal was to live in Houston near family in a group home that can accommodate his visual impairments. Action plans were broad statements, not individualized, that did not include enough teaching strategies and supports needed for consistent implementation and documentation. Action plans did not include identifying specific living options near Houston that might support his needs or scheduling visits. For example:
    - Provide Individual #33 with information about his living options on an annual basis and as requested.
    - Provide Individual #33 with the Opportunity to attend Providers' Fairs.
    - Provide (LAR) with information about living options on an annual basis and as requested.
    - QIDP will provide (LAR) with an update of the significant topics/outcomes of the meeting.
    - Out to eat/shopping - Individual #33 will go out to eat/get to go food or will go shopping, at least once monthly.
    - will go to the movies in the community or on campus, quarterly.

- Individual #119's greater independence goal was to independently choose her own snacks at snack time. Action plans were not individualized. They did not include enough detail regarding supports needed. Action plans included:
    - Continue direct speech therapy
    - Use dining choice board
    - Monitor weekly vending ($1.75)

- Action plans to support Individual #199's work goal to obtain a part-time job working at a video game store in the community. Did not include training or supports needed specific to the job. The IDT did not assign responsibility for supporting Individual #199 to find and obtain a job. Action steps included:
    - WIOA Paperwork - QIDP will obtain the needed signed WIOA paperwork, annually.
    - Career Counseling - Individual #199 will receive career counseling, annually.
    - SAP: Fill out Job Application
    - Staff will remind Individual #199 to wear his glasses and will assist him with the care and maintenance of them.
    - Counseling Attendance - QIDP will continue to track and monitor his counseling services and follow up as needed.

- Individual #143's living option goal was to live at home with his dad. This goal was aspirational and based on his preferences. Action plans were not individualized and were unlikely to lead towards achievement of her goal.
    - Provide Individual #143 with information about his living options on an annual basis and as requested.
    - Provide Individual #143 with the Opportunity to attend Educational Tours.
    - Provide (father) with information about Individual #143's living options on an annual basis and as requested.

| Outcome 2: The individual's ISP set forth a plan to achieve goals. | |
|---|---|
| Summary: For the most part, action plans that met criteria with indicators 1 and 3 also met criteria with indicator 4 (but only a small number of personal goals met criteria with indicators 1 and 3). The others were simple statements, lacking | Individuals: |

| specific implementation strategies, supports needed, and criteria for documenting and assessing progress. For indicator 5, for those goals that met criteria with indicators 1 and 2, more than half had documentation. These indicators will remain in active monitoring. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 119 | 33 | 448 | 199 | 159 | 143 | | | |
| 4 | Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur. | 75%<br>3/4<br>80%<br>4/5 | 1/1 | 1/2 | -/- | 1/1 | -/- | 1/1 | | | |
| 5 | There is documentation (e.g., data, reports, notes) that is valid and reliable to determine if the individual met, or is making progress towards achieving, each of the personal goals. | 17%<br>1/6<br>60%<br>9/15 | 0/2 | 1/2 | 4/4 | 2/3 | 0/1 | 2/3 | | | |

Comments:

4. Four of the action plans provided sufficient detailed information for implementation, data collection, and review to occur. When looking across all action plans, that is, including those that were not included in the scoring for this indicator, for the most part, action plans were simple statements, lacking specific implementation strategies, supports needed, and criteria for documenting and assessing progress. The four goals that included action plans that met criteria were:

- Individual #33's greater independence goal.
- Individual #119's recreation/leisure goal.
- Individual #199's recreation/leisure goal.
- Individual #143's recreation/leisure goal.

5. Of the 15 goals that met criteria with indicators 1 and 2, nine had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals. QIDPs were doing a better job of summarizing progress/lack of progress towards goals. This included:

- Individual #448: recreation/leisure, relationship, day/work, and living option goals.
- Individual #33: greater independence goal
- Individual #199: work/day and greater independence goals
- Individual #143: relationship and work/day goals

| Outcome 3: All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance. | |
|---|---|
| Summary: Of the nine goals that had data to determine progress, two were met or progressing. IDTs did not take action on those that were not progressing. These indicators will remain in active monitoring. | Individuals: |

| # | Indicator | Overall Score | 119 | 33 | 448 | 199 | 159 | 143 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 6 | The individual met, or is making progress towards achieving, his/her overall personal goals. | 0%<br>0/4<br>22%<br>2/9 | -/- | 0/1 | 0/4 | 1/2 | -/- | 1/2 | | | |
| 7 | If personal goals were met, the IDT updated or made new personal goals. | 0%<br>0/1 | | | | | | 0/1 | | | |
| 8 | If the individual was not making progress, activity and/or revisions were made. | 0%<br>0/4<br>0%<br>0/7 | -/- | 0/1 | 0/4 | 0/1 | -/- | 0/1 | | | |

Comments:
6-8. Individual #143 met his day goal to graduate from high school.

Individual #199 made some progress towards his greater independence goal.

For the remaining goals, the QIDP monthly review documented that action plans had not been implemented, thus, the individual had not made progress towards their goals.

For all individuals, few of the action plans in the ISP were consistently implemented.

QIDPs were reviewing action plans monthly, which was good to see, however, action was not routinely taken to revise action plans when progress was not made. IDTs were waiting until the next annual ISP meeting to revise plans.

| Outcome 4: ISPs, assessments, and IDT participation support the development of a comprehensive and individualized annual ISP. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: In general, ISPs were not implemented timely, and relevant IDT members attended one-third of the annual meeting. On the other hand, there was sustained high performance, indicator 11a, which will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 119 | 33 | 448 | 199 | 159 | 143 | | | |
| 9 | a. The ISP was revised at least annually (or was developed within 30 days of admission if the individual was admitted in the past year). | Due to the Center's sustained performance, this sub-indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| | b. The ISP was implemented within 30 days of the meeting or sooner if indicated. | 0%<br>0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 10 | The individual and all relevant IDT members participated in the planning process and attended the annual meeting. | 33%<br>2/6 | 0/1 | 0/1 | 1/1 | 1/1 | 0/1 | 0/1 | | | |
| 11 | a. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.<br>b. The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.<br>c. Assessments were updated as needed in response to significant changes. | 100%<br>6/6 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | | | |
| | | 0%<br>0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |
| | | 100%<br>2/2 | | 1/1 | | | 1/1 | | | | |

Comments:

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

- Individual #448's skill acquisition plans (SAPs) for casting a fishing pole and making pudding had never been developed.
- Action steps to supports Individual #199's goal to host a video game night were not implemented within 30 days.
- Individual #119's action plans to play her favorite music on the home and use her dining choice board were not implemented within 30 days.
- Individual #143's assessment to develop training on handwashing was not completed within 30 days. His sign language SAP was not implemented within 30 days.

10. Two of the six individuals (Individual #448, Individual #199) had appropriately constituted IDTs, based on their strengths, needs and preferences, who participated in the planning process. Findings included:

- Individual #33's SLP, PT, and PCP did not attend his annual meeting. He had complex medical, and therapy needs and supports.
- Individual #119's DSP/home staff did not attend her annual meeting.
- Individual #159's SLP did not attend his meeting. He had significant communication needs that were not integrated into his ISP.
- Individual #143 and his LAR did not attend his annual meeting.

The annual ISP meeting was observed for Individual #199. It was positive to see that Individual #199 actively participated in his ISP meeting; however, many of his concerns and opinions were brushed aside during the meeting. He was not onboard with some of his proposed action plans, but the IDT did not agree to revisions that he suggested.

11a. For all individuals, the IDT considered what assessments the individual needed and would be relevant to the developments of the ISP prior to the annual meeting.

11b. None of the IDTs arranged for and obtained the needed, relevant assessments prior to the IDT meeting. IDTs were waiting on assessments to determine preferences and/or needs prior to moving forward with developing action plans related to achievement of

goals. Vocational/day assessments often did not include a clear assessment of the individual's interests, needs, and strengths or recommendations for skill development. Examples of missing or late assessments included:

- For Individual #448, his IDT identified the need for an assessment to determine if he could make a milkshake, so relevant training could be developed. The assessment had not been completed and he had not made progress towards his goal.
- For Individual #33, his functional skills, annual medical, and behavioral health assessment were not submitted at least 10 days prior to his ISP meeting.
- Individual #119's annual medical assessment was late.
- Individual #199's behavioral health assessment was late
- Individual #159's behavioral health assessment was late
- Individual #143's functional skills and behavioral health assessments were not submitted prior to his ISP meeting.

11c. For two individuals assessments were updated as needed in response to significant changes. Individual #33 and Individual #159 had multiple changes in their health status over the past year due to illness and injury. Assessments were updated to assess changes in support needs.

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

Summary: Some indicators were met for some individuals. These indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 119 | 33 | 448 | 199 | 159 | 143 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 12 | There was a thorough examination of living options. | 83% 5/6 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | | | |
| 13 | a. ISP action plans integrated encouragement of community participation and integration. | 67% 4/6 | 1/1 | 0/1 | 1/1 | 1/1 | 0/1 | 1/1 | | | |
| | b. The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. | 50% 3/6 | 1/1 | 0/1 | 1/1 | 1/1 | 0/1 | 0/1 | | | |
| 14 | ISP action plans included individualized, measurable plans to educate the individual/ LAR about community living options. | 0% 0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |
| 15 | IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition. | 0% 0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |

Comments:

12. For five individuals, there was a thorough examination of living options.
    - Individual #159's ISP did not document discussion regarding other living options that might support his needs. Individual #159 had experienced a significant functional decline over the past year due to six fractures over a six-month period. The IDT

needed to discuss factors that might have contributed to his injuries and consider whether safer supports could be better provided in another environment to reduce his risks.

13a. Four ISPs integrated encouragement of community participation and integration. The exception were Individual #33 and Individual #159. Neither had action plans that were likely to lead towards community integration in a meaningful way. Individual #33 had broadly stated action plans for community outings, but those action plans did not describe supports needed to fully participate in the community. Individual #159 did not have action plans to be implemented in the community.

13b. Three ISPs considered opportunities for day programming in the most integrated setting consistent with preferences and support needs. Day and work opportunities were limited for most individuals. Vocational training was not focused on building skills that might lead towards employment in a more integrated setting. Individual #448 and Individual #199 had goals to work in the community, however, their assessments did not identify individual job interests or skills needed to obtain jobs in the community.

- Individual #448 had a goal to work in a competitive job in the community.
- Individual #119 attended high school in an integrated setting.
- Individual #199's goal was to obtain a part-time job in the community.

ISPs that did not meet criteria included:

- Individual #33's IDT did not consider an integrated setting for day programming that might support his preferences and needs. His day assessment did not offer recommendations or guidance for day programming. His ISP noted that he was not interested in work at the center, however, did not document consideration of alternate day programming. His day programming on the home offered minimal opportunities to try new activities and develop new skills.
- Individual #159 had a goal to spend time outside of his bedroom, however, the IDT did not discuss spending time in a less restrictive setting or identify opportunities to expand his interests and develop new skills. He did not have a day/work goal.
- Individual #143's ISP included little discussion of work/day programming following his graduation from high school. His vocational assessment did not identify his preferences and strengths other than to note that he did not appear to be interested in working. He had few opportunities during the day to explore new interests or develop new skills.

14. None of the ISP action plans included individualized measurable plans to educate the individual/ LAR about community living options. Individuals had broadly stated action plans to provide information to the individual and LAR annually, attend provider fairs, and/or attend a community tour. Action plans were implemented year after year with little revision and little impact on the individual's understanding of living options. For example,

- Individual #448's action plans to support his goal to live in a community group home were:
    - Will be invited to attend provider fairs hosted at BSSLC
    - LAR will be invited to attend provider fairs hosted at BSSLC
    - LAR will be provided with his living options at least annually or as requested
- Individual #33's action plans to support his goal to live in a group home in Houston near his family were:
    - Provide information about his living options on an annual basis and as requested
    - Provide the opportunity to attend providers' fairs
    - Provide information about living options on an annual basis and as requested

- Will go out to eat/get to go food or will go shopping, at least once monthly
- Will go to the movies in the community or on campus, quarterly

- Individual #199's action plans to support his goal to live near his grandmother in a group home were:
  - Provide information about his living options on an annual basis and as requested
  - Provide the opportunity to attend Educational Tours
  - Provide the opportunity to attend Providers' Fairs
  - Provide LAR with information about living options on an annual basis and as requested

15. IDTs had not created individualized, measurable action plans to address identified obstacles to referral. Action plans were broadly stated and carried over year after year. Few addressed actual barriers to living in a less restrictive setting.

Outcome 6: Individuals' ISPs are implemented, progress is reviewed, and supports and services are revised as needed.

Summary: For all individuals, staff were knowledgeable of the individual's support needs, risk areas, ISP goals, and action plans. Staff were attentive and respectful to individuals during observations. Given sustained high performance, indicator 16 will be moved to the category of requiring less oversight. For all individuals, action plans had not been implemented and individuals had not made progress towards most goals. It was good to see that QIDPs were consistently reviewing goals and action plans and commenting on progress, however, plans were not revised, and barriers had not been addressed when services and supports were either not implemented or not effective. These indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 119 | 33 | 448 | 199 | 159 | 143 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 16 | Staff were knowledgeable of the individual's support needs, risk areas, ISP goals, and action plans. | 100% 6/6 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | | | |
| 17 | Action plans in the ISP were consistently implemented. | 0% 0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |
| 18 | The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports. | 0% 0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |

Comments:

16. For all individuals, staff were knowledgeable of the individual's support needs, risk areas, ISP goals, and action plans. Staff were attentive and respectful to individuals during observations.

17. For all individuals, action plans had not been implemented and individuals had not made progress towards most goals. There was a total of 105 action steps evaluated. Fifty-two (50%) were on hold either due to COVID-19 community gathering restrictions or injuries/health concerns that impacted individual's ability to participate in implementation. There was no evidence that IDTs

considered alternate training opportunities while action plans were on hold. For the 53 action plans that could be implemented, 30 (57%) had been consistently implemented.

| Individual | # of Action Steps in ISP | Action Steps Implemented | Action Steps On Hold | Action Steps Not Fully Implemented |
|---|---|---|---|---|
| Individual #448 | 23 | 5 | 12 | 6 |
| Individual #33 | 12 | 3 | 7 | 2 |
| Individual #199 | 27 | 10 | 6 | 11 |
| Individual #159 | 12 | 1 | 11 | 0 |
| Individual #119 | 9 | 4 | 3 | 2 |
| Individual #143 | 22 | 7 | 13 | 2 |

18. QIDPs did not ensure the individual received required monitoring/review and revision of treatments, services, and supports. It was good to see that QIDPs were consistently reviewing goals and action plans and commenting on progress, however, plans were not revised, and barriers had not been addressed when services and supports were either not implemented or not effective. For example,

- Eleven of Individual #159's 12 action plans were on hold due to multiple fractures that inhibited his ability to participate in activities in his ISP. The IDT did not revise his action plans to consider new support needs or new training needs.
- Individual #143 had met his goal to graduate from high school. The IDT did not revise his day/work goal to address his continued needs or set new goals.
- Individual #199 had decided that he was no longer interested in purchasing a pet turtle. His goal to independently care for his own pet turtle was not revised. Action steps were on hold due to his lack of interest.
- Individual #33 had a goal to independently request a preferred activity using a communication device. The SLP assessed Individual #33 and determined that a communication choice board was not appropriate for Individual #33 and no further trials were needed. The IDT had not revised his greater independence goal or action plans.

| 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 and update the IRRFs within no more than five days. These indicators will remain in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
| a. | The individual's risk rating is accurate. | 50% 6/12 | 1/2 | 1/2 | 2/2 | 0/2 | N/R | 1/2 | 1/2 | N/R | N/R |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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% 6/12 | 2/2 | 2/2 | 1/2 | 0/2 | | 1/2 | 0/2 | | |

Comments: For six individuals, the Monitoring Team reviewed a total of 12 IRRFs addressing specific risk areas (i.e., Individual #33 – aspiration, and infections; Individual #448 – falls, and seizures; Individual #567 – aspiration, and seizures; Individual #566 – falls, and skin integrity; Individual #159 – fractures, and seizures; and Individual #508 – aspiration, and skin integrity).

a. The IDTs that effectively used supporting clinical data, used the risk guidelines when determining a risk level, and as appropriate, provided clinical justification for exceptions to the guidelines were those for Individual #33 – aspiration; Individual #448 – falls; Individual #567 – aspiration, and seizures; Individual #159 – fractures; and Individual #508 – aspiration.

b. For the individuals in the review group, it was positive that the IDTs updated their IRRFs at least annually. It also was positive that the following IDTs reviewed and/or modified individuals' risk ratings based on changes of status: Individual #448 – falls, and seizures; and Individual #567 – seizures.

However, at times, when changes of status occurred that necessitated at least review of the risk ratings, IDTs 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 #33 – aspiration, and infections; and Individual #159 – seizures.

**Psychiatry**

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

Summary: At Brenham SSLC, there was progress in the sub-indicators of some of the indicators in this outcome. The psychiatry department was identifying indicators for reduction and in some cases for increase. The psychiatry clinicians need to ensure that the relationship of the indicator to the individual's diagnosis is clearly designated and that indicators are consistently identified. The psychiatric clinicians were not regularly defining the indicators, but they were writing goals associated with the indicators. The indicators and goals were not regularly included in the CPE or quarterly psychiatric documentation, but rather included in the psychotropic medication treatment plan. The goals were not entered into the facility's overall treatment program, the IHCP. These indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 4 | Psychiatric indicators are identified and are related to the individual's diagnosis and assessment. | 0% 0/7 | 0/2 | 0/2 | 0/2 | | 0/2 | 0/2 | 0/2 | | 0/2 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 5 | The individual has goals related to psychiatric status. | 14%<br>1/7 | 0/2 | 1/2 | 0/2 | | 0/2 | 2/2 | 0/2 | | 0/2 |
| 6 | Psychiatry goals are documented correctly. | 0%<br>0/7 | 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%<br>0/7 | 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.

In psychiatry, the focus is upon what have come to be called psychiatric indicators. Psychiatric indicators can be measured via recordings of occurrences of indicators directly observed by SC 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 progress in this area as all individuals in the review group had at least one psychiatric indicator related to the reduction of psychiatric symptoms and two individuals had an indicator for increase identified. The indicators were documented in the psychotropic medication treatment plan and located in the goals grid included in the annual CPE. The indicators were not regularly included in or updated in the quarterly psychiatric documentation goals grid. The grids were incomplete as they did not include information regarding how the indicator related to the individual's psychiatric diagnosis.

Once an indicator is identified and related to a specific diagnosis, the next step is to define the indicator such that staff recording the presence of a specific indicator will be able to correctly identify the indicator. When indicators are the same as a behavioral health

target behavior, behavioral health generally defines the indicator. When indicators are different from behavioral health target behaviors, psychiatry needs to specifically define the indicator.

Thus, criteria were not met for all three sub-indicators (a, b, c) for psychiatric indicators for reduction or psychiatric indicators for increase for any of the individuals in the review group.

5. Psychiatric goals:
The Monitoring Team looks for:

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

The psychiatric goals regarding the indicators for increase and decrease were not regularly included in the psychiatric documentation (e.g., the CPE and quarterly psychiatric). Two individuals, Individual #219 and Individual #493, had goals regarding indicators included in the psychiatric goals grid in their annual CPE. Individual #219 had a goal regarding an indicator for reduction and Individual #493 had a goal for an indicator for reduction and a goal for an indicator for increase. The goals in these two examples met monitoring criteria in that they included a measurement, the modality or scale that would be used to obtain the measurement, and a time metric. Further, the grid indicated that the data collected to review the indicator would consist of either observational data per direct care staff documented in CareTracker or the ADAMS scale administered by BHS and included in the behavioral health monthly note.

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

Thus, both sub-indicators were met for two of the individuals for goals for reduction and for one individual 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, goals for reduction and increase were written for the identified indicators and documented in the psychiatry goals grid as noted above. The goals were not incorporated into the Center's overall documentation system, the IHCP. For instance, for Individual #33, the goals were included in the ISP document, but not in the IHCP. At Brenham SSLC, the goals were not regularly included in the psychiatric quarterly or annual, but included in the psychotropic medication treatment plan.

7. Data:
Reliable and valid data need to be available so that the psychiatrist can use the data to make treatment decisions. Data are typically presented in graphic or tabular format for the psychiatrist. Data need to be shown to be reliable.

At Brenham SSLC, data regarding indicators for decrease, when included in the psychiatric documentation, were presented as a series of numbers with additional behavioral health documentation attached to the clinical encounter including graphs. In addition, there were also tabulated data regarding the results of specific rating scales, the subscales of which were utilized to address specific indicators. In all examples, the data were a combination of behavioral health target data, data regarding other psychiatric symptom indicators, and rating scale data. Reportedly, the behavioral health target data and data regarding other psychiatric symptom indicators were not reliable. The data gathered via specific rating scales would have intrinsic reliability and validity based on the scale itself. As all individuals in the review group had a mix of data sources, none had completely reliable data.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: Performance was about the same as at the last review. All three indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | 1/1 | 0/1 | 0/1 |
| 15 | If admitted within two years prior to the onsite review, and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission. | 50% 1/2 | 1/1 | 0/1 | | | | | | | |
| 16 | All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation. | 57% 4/7 | 0/1 | 0/1 | 1/1 | | 1/1 | 1/1 | 1/1 | | 0/1 |

Comments:

14. The Monitoring Team looks for 14 components in the CPE. One of the CPEs, regarding Individual #135, included all of the required components. The remaining CPEs were missing from one to eight elements. The most common missing element was an adequate bio-psycho-social formulation, missing in the eight remaining CPEs. Overall, two evaluations were missing one element, one evaluation was missing two elements, one evaluation was missing four elements, one evaluation was missing five elements, two evaluations were missing six elements, and one evaluation was missing eight elements.

- The CPE regarding Individual #336 was missing the history of present illness, medical history, social history, physical examination, labs, diagnostic assessment, an adequate bio-psycho-social formulation, and treatment recommendations.
- The CPE regarding Individual #219 was missing the physical examination, labs, an adequate bio-psycho-social formulation, and treatment recommendations.

- The CPE regarding Individual #119 was missing an adequate bio-psycho-social formulation.
- The CPE regarding Individual #436 was missing the history of present illness, past psychiatric history, family history, physical examination, an adequate bio-psycho-social formulation, and treatment recommendations.
- The CPE regarding Individual #33 was missing an adequate bio-psycho-social formulation.
- The CPE regarding Individual #493 was missing labs and an adequate bio-psycho-social formulation.
- The CPE regarding Individual #448 was missing the history of present illness, social history, diagnostic assessment, an adequate bio-psycho-social formulation, and treatment recommendations.
- The CPE regarding Individual #199 was missing the history of present illness, family history, substance use history, physical examination, diagnostic assessment and an adequate bio-psycho-social formulation.

15. There were two individuals admitted in the two years prior to the review, Individual #336 and Individual #219.
    - For Individual #336, the CPE was completed on the day of admission 11/19/19 with an IPN from nursing on the day of admission and an IPN from primary care the next business day.
    - For Individual #219, the CPE was completed on the day of admission. There was a IPN from nursing dated the day of admission, but there was no IPN from primary care.

16. There were three records regarding Individual #336, Individual #219, and Individual #199, that revealed inconsistent diagnoses.
    - Regarding Individual #336, the BHA documented that diagnoses were ADHD and Autism. Psychiatry indicated that diagnoses were Autism, ADHD, Anxiety Disorder, and an Unspecified Mood Disorder. In this case, the psychiatric diagnoses were inconsistently documented in the psychiatric annual/quarterly and in a supplemental document that the facility utilizes, the psychotropic medication treatment plan. While the information included in the treatment plan was useful with regard to medication and side effects, this information should be included in the regular psychiatric documentation to reduce confusion and the potential for error between documents.
    - Regarding Individual #219, the BHA included diagnoses of Psychotic Disorder and Depressive Disorder while psychiatry noted diagnoses of Schizoaffective Disorder and Autism.
    - Regarding Individual #199, the AMA included a diagnosis of Depression.

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

Summary: Indicators 17-20 scored higher than in previous reviews, demonstrating progress. These indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 17 | Status and treatment document was updated within past 12 months. | 100% 6/6 | 1/1 | | 1/1 | | 1/1 | 1/1 | 1/1 | | 1/1 |
| 18 | Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP). | 17% 1/6 | 0/1 | 0/1 | 0/1 | | 0/1 | 0/1 | 0/1 | | 1/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 19 | Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months. | 71% 5/7 | 1/1 | 0/1 | 1/1 | | 1/1 | 1/1 | 0/1 | | 1/1 |
| 20 | The psychiatrist or member of the psychiatric team attended the individual's ISP meeting. | 86% 6/7 | 0/1 | 1/1 | 1/1 | | 1/1 | 1/1 | 1/1 | | 1/1 |
| 21 | The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting. | 0% 0/7 | 0/1 | 0/1 | 0/1 | | 0/1 | 0/1 | 0/1 | | 0/1 |

Comments:

17. Six individuals required annual evaluations. All were completed.

18. The Monitoring Team scores 16 aspects of the annual evaluation document. One of the annual evaluations, regarding Individual #199, contained all of the required elements. One evaluation was missing one element, and four evaluations were missing three elements. The most common missing element was the risk versus benefit discussion, missing in five evaluations. Overall, these evaluations were difficult to follow. They included a great deal of cut and paste information from prior evaluations making the current evaluators documentation difficult to discern.

- The annual CPE regarding Individual #336 was missing the risk of medication, an adequate risk versus benefit discussion, and past pharmacotherapy.
- The annual CPE regarding Individual #119 was missing the risk of medication, risk of illness, and an adequate risk versus benefit discussion.
- The annual CPE regarding Individual #33 was missing an adequate risk versus benefit discussion and past pharmacotherapy.
- The annual CPE regarding Individual #493 was missing and adequate risk versus benefit discussion.
- The annual CPE regarding Individual #135 was missing the risk of medication, risk of illness and an adequate risk versus benefit discussion.

19. Five of seven individuals requiring an initial or annual CPE had one completed prior to the initial or annual ISP meeting.

- For Individual #219, the CPE was dated 1/20/21 with an ISP date of 2/19/21. Per the QIDP data, the assessments were due 2/4/21 and the CPE was submitted 2/5/21, so it was a late submission. Even though it was within five days of the ISP, the requirement is that it is available 10 days prior.
- For Individual #135, the annual CPE was dated 4/15/21 with an ISP date of 4/14/21. Per the QIDP data, the information was submitted late.

20. The psychiatrist attended the ISP meeting for six of the seven individuals in the review group receiving psychiatric services. 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: | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | | |
| 22 | If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | | |
| Comments: | | | | | | | | | | | | |

| Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Performance was slightly higher than at the last review on these three indicators. They will remain in active monitoring. | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
| 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, this indicator was 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. | 43% 3/7 | 1/1 | 0/1 | 1/1 | | 0/1 | 1/1 | 0/1 | | 0/1 |
| 30 | A risk versus benefit discussion is in the consent documentation. | 57% 4/7 | 0/1 | 0/1 | 1/1 | | 1/1 | 1/1 | 1/1 | | 0/1 |
| 31 | Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered. | 57% 4/7 | 1/1 | 0/1 | 0/1 | | 1/1 | 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:
29. The consent forms included adequate medication side effect information in three examples. While the facility included some medication side effect information on the consent forms, they had also begun to include medication side effect information sheets with consent forms. This was good to see.

30. A sufficient risk versus benefit discussion was included in the consent forms in four examples. Given the complexity of the regimens, a statement that benefit is greater than risk is not sufficient. There should be a documentation of the prescriber's rationale and consideration of the risks/benefits of the regimen.

31. The consent forms for four individuals included alternate, non-pharmacological interventions in addition to the PBSP or PSP. The facility transitioned to the updated consent form that included a listing of alternatives that prescribers can choose from as well as the ability to write in other alternatives not included on the prepopulated list. In three examples, the prescriber chose only the PBSP as an alternative intervention.

**Psychology/behavioral health**

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

Summary: The Center had not (until just two or so months prior to this review) corrected various problems with their protocol for assessing IOA that were occurring during the last review period. That is, that IOA was not being assessed by a DSP and a BHS staff. Moreover, as noted in the comments below, the Monitoring Team observed two occurrences of target behaviors, but neither was recorded in the data system. This indicator will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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. | | | | | | | | | | |
| 4 | The goals/objectives were based upon the individual's assessments. | | | | | | | | | | |
| 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:

5. The facility reported adequate inter-observer agreement for at least five of six months for seven individuals, including Individual #119, Individual #436, Individual #33, Individual #493, Individual #135, Individual #448, and Individual #199. Individual #336 had adequate IOA reported for four of six months, with no monitoring occurring in July and August 2021. There were no measures of IOA reported for Individual #219 for the six-month period that she had an interim PBSP. Even though the facility reported that they were

conducting IOA assessments, they continued to conduct them incorrectly, that is, by having two BHS staff record some aspects of DSP implementation of the PBSP, but not data on occurrence/nonoccurrence of target behaviors. This was the same problem noted in the last review. It had been corrected, but only a couple of months before this review and only for some of the individuals. Thus, due to the problem with the method used to assess data reliability, this indicator is rated zero for all nine individuals.

Data collection timeliness met monitoring criteria for seven of the individuals (not Individual #336 for July or August 2021, or for Individual #219 because her PBSP was interim).

During the remote review week, PBSP data were requested following observations of problem behavior. The findings are summarized below.

- On Tuesday at approximately 9:30 am, Individual #493 was observed hitting herself in the face. This self-injurious behavior was not documented.
- On Wednesday at approximately 5:30 pm, Individual #143 was observed to hit both the nurse and a direct support professional. He was also observed to hit his head repeatedly on the table. Neither aggression nor self-injurious behavior were documented.

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

Summary: The BHA was current and complete for all but one individual, and in that case, the component that was missing was the assessment of cognitive abilities. With sustained high performance, indicator 10 might be moved to the category of requiring less oversight after the next review. There was also improvement in the content of the functional assessments, though some further improvements remained needed in order to meet criteria. These indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 10 | The individual has a current, and complete annual behavioral health update. | 89% 8/9 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 11 | The functional assessment is current (within the past 12 months). | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| 12 | The functional assessment is complete. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

Comments:
10. Based upon the facility's response to the initial document request, it was initially determined that seven of the nine individuals had a current and complete Behavioral Health Assessment (BHA). Although Individual #119's BHA was current, there was no assessment of her cognitive abilities. While she continues to attend school, facility staff should work with the school system to complete this assessment. Although Individual #33's BHA was complete, the document provided prior to the review was not current because the data

that were presented were through March of 2020. During the review week, an updated BHA was provided that was dated August of 2021, with a revision completed in October of 2021 and this was determined to meet criteria.

12. While none of the functional behavior assessments were considered complete, most included acceptable direct and indirect assessments, and the identification of potential antecedent conditions.

It was positive to find that for two individuals, Individual #336 and Individual #448, when observations revealed no targeted problem behavior, videotaped events were reviewed. This would have been useful for Individual #33 and Individual #199 because no problem behaviors were observed.

Staff should identify the consequences that are hypothesized to maintain the identified problem behaviors, rather than those indicated in the individual's PBSP. Also, BHS staff should not determine that behavioral function is nonsocial solely based upon the individual's diagnosis. For example, Individual #135's report noted a primarily nonsocial function for her target behaviors, but this was not what was suggested based upon both direct and indirect assessments. The assessments for other individuals, including Individual #336 and Individual #119, also placed particular emphasis on their diagnoses, resulting in suggested nonsocial function of targeted problem behaviors. Instead, the hypothesized function should be based upon completed assessments, particularly direct observations.

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

Summary: Same as at the last review, most but not all PBSPs were implemented as per the requirement for obtaining consent. There was continued improvement in the PBSPs. Both indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 13 | There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval | 78% 7/9 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 |
| 14 | The PBSP was current (within the past 12 months). | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| 15 | The PBSP was complete, meeting all requirements for content and quality. | 11% 1/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 |

Comments:

13. For seven of the nine individuals, there was documentation that the PBSP had been implemented within 14 days of all consents. The exceptions were Individual #336 whose plan was implemented 18 days following all consents, and Individual #448 whose plan was implemented before the consent of his LAR.

15. The PBSP for Individual #199 was considered complete. For the other eight individuals, all or most included the following elements:

- operational definitions of both target and replacement behaviors,
- antecedent and consequent strategies,

- guidelines for training identified replacement/alternative behaviors, and
- sufficient opportunities for the same.

Individual specific feedback is provided below.

- Individual #336's PBSP suggested that his targeted problem behaviors served primarily a nonsocial function. This did not correspond to the findings of his functional assessment.
- The consequence for several of Individual #219's target behaviors were somewhat confusing. She was to be directed back to an activity after one minute without displaying the identified behavior, but it was not clear whether this could include preferred activities.
- Individual #119's plan included the use of a mobile choice board. The use of an augmentative communication system was commendable, however, the plan directed staff to teach/reinforce this replacement behavior between 6:00 pm and 8:00 pm. If this is a useful tool for her to use and learn functional communication, it must be available to her at all times. When she was observed, the board was not present.
- Individual #436's plan included grabbing in both the aggression definition and the description of his communication skills. Ensure that staff understand the difference between an appropriate and inappropriate use of this gesture. His plan also noted that he had a history of hitting himself. If this behavior continues to occur, it should be considered to be included in the full PBSP. Lastly, staff should operationally define his calm behavior following aggression.
- Individual #33's revised PBSP was provided during the review week. It was positive to find that rumination had been added as a monitored behavior. The function of refusals was identified as escape, but the PBSP suggested it was access to tangibles. The plan should operationally define a firm tone to ensure that staff are not interacting in a manner that would be considered harsh or demanding.
- Individual #493's plan addressed her self-injurious behavior. The operational definition was complete, however, scratching her face, chest, or any other part of her body was not considered self-injurious behavior. Further, her replacement behavior was actually staff asking one of eight questions of her when she became loud. This was not teaching Individual #493 an alternative means to communicate her needs. It was not clear what initial action staff should take when she started to engage in self-injurious behavior, although the plan indicated what staff should do if she continued. There was an objective for social avoidance, but this behavior was not defined nor addressed in the plan.
- There was some overlap between precursor and target behaviors in Individual #135's PBSP. The definition of her aggressive behavior included yelling/screaming at others and cursing. Similarly, her bullying behavior included yelling at her peers. However, precursor behaviors included yelling and verbal aggression. Clarification is needed. It will also be necessary to operationally define her calm behavior following target behaviors and clarify whether direction to an ongoing activity includes identified preferred activities.
- As has been noted for other individuals, the plan needs to operationally define Individual #448's calm behavior following aggression. In addition, his PBSP did not describe antecedent strategies and it did not have an objective for the replacement behavior.

As discussed with the director of behavioral health services, the author of the PBSP should be identified in the plan.

| Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Counseling services for three individuals were not occurring due to changes in availability of counselors. This indicator will remain in active monitoring. | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
| 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. | N/A | | | | | | | | | |
| Comments:<br>24-25. Three individuals reviewed by the behavioral health monitoring team had been referred for counseling. Although Individual #219, Individual #135, and Individual #199 had all been receiving this support earlier in the year, at the time of the remote review, none were participating in counseling. The individuals' teams were exploring other counseling services at the time of review. It was also reported that Individual #199 would begin counseling in the near future. | | | | | | | | | | | | |

**Medical**

| Outcome 2 – Individuals receive timely routine medical assessments and care. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: In the last report, the Monitor stated: "Based on the review of AMAs for other indicators in the audit tool, for three of the nine individuals reviewed, PCPs did not complete AMAs within 365 days of the previous one. As a result, Indicator b is at risk of returning to active oversight." Unfortunately, for this review, PCPs did not complete four of the nine AMAs reviewed within 365 days of the previous ones, and three of the four were between one month and two and a half months overdue. As a result, Indicator b will return to active oversight.<br><br>In addition, PCPs completed timely IMRs for none of the nine individuals. For six of the nine individuals, Center staff submitted no IMRs. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
| a. | For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary, depending on the individual's clinical needs. | Due to the Center's sustained performance, these indicators moved to the category requiring less oversight. | | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| b. | Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days. | However, due to several problems noted with the timeliness of AMAs during this review, Indicator b will return to active oversight. | | | | | | | | | |
| c. | Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months | 0%<br>0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

Comments: b. Indicator b has been in less oversight since the Round 12 review. In the last report, the Monitor stated: "Based on the review of AMAs for other indicators in the audit tool, for three of the nine individuals reviewed, PCPs did not complete AMAs within 365 days of the previous one. As a result, Indicator b is at risk of returning to active oversight." Unfortunately, for this review, PCPs did not complete four of the nine AMAs reviewed within 365 days of the previous ones. As a result, Indicator b will return to active oversight. At times, the delays were for a month or more. More specifically:

- On 9/7/21, Individual #33's PCP completed his most recent AMA. The previous one was completed on 7/7/20 (i.e., a two-month delay).
- On 12/23/20, Individual #448's PCP completed his most recent AMA. The previous one was completed on 12/20/19 (i.e., a three-day delay).
- On 9/8/21, Individual #242's PCP completed her most recent AMA. The previous one was completed on 8/6/20 (i.e., a one-month delay).
- On 5/24/21, Individual #159's PCP completed his most recent AMA. The previous one was completed on 3/9/20 (i.e., a two-and-a-half month delay).

c. Per the instruction of State Office, and as memorialized in the State Office Medical Care policy #009.3, with an effective date of 2/29/20, PCPs are expected to complete IMRs quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable"). PCPs at Brenham SSLC were not following this guidance. None of the nine individuals had the required IMRs. For six of the nine individuals, Center staff submitted no IMRs.

| Outcome 3 – Individuals receive quality routine medical assessments and care. | |
|---|---|
| Summary: Most of the annual medical assessments met most of the criteria for quality. With concentrated efforts on the remaining areas of focus (i.e., as applicable, family history, and thorough plans of care for each active medical problem, when appropriate), by the time of the next review, PCPs could make good progress on this indicator.<br><br>As noted above, PCPs did not complete timely IMRs for individuals in the review group. As a result, timely updates on individuals' chronic and at-risk conditions were not available.<br><br>Indicators a and c will remain in active oversight. | Individuals: |

| # | Indicator | Overall Score | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Individual receives quality AMA. | 11% 1/9 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| b. | Individual's diagnoses are justified by appropriate criteria. | Due to the Center's sustained performance, this indicator 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 #242'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 AMAs the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all AMAs addressed pre-natal histories, social/smoking histories, childhood illnesses, past medical histories, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, pertinent laboratory information, and updated active problem lists. Most, but not all included complete physical exams with vital signs. Moving forward, the Medical Department should focus on ensuring medical assessments include as applicable, family history, and thorough plans of care for each active medical problem, when appropriate.

Most of the annual medical assessments met most of the criteria for quality. With concentrated efforts on the remaining areas of focus, PCPs could make good progress on this indicator.

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 #33 – urinary tract infections (UTIs), and gastrointestinal (GI) problems; Individual #448 – GI problems, and seizures; Individual #567 – cardiac disease, and seizures; Individual #566 – fractures, and skin integrity; Individual #242 – other: pain management, and UTIs; Individual #159 – seizures, and osteoporosis; Individual #508 – skin integrity, and GI problems; Individual #143 – aspiration, and seizures; and Individual #134 – osteoporosis, and UTIs].

As noted above, for six of the nine individuals, Center staff submitted no IMRs. For other individuals, Center staff submitted only one IMR (i.e., every six months), when they should have had quarterly reviews.

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.

Individuals:

| # | Indicator | Overall Score | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | current standards of practice consistent with risk-benefit considerations. | | | | | | | | | | |
| b. | The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. | N/R | | | | | | | | | |

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 #33 – UTIs, and GI problems; Individual #448 – GI problems, and seizures; Individual #567 – cardiac disease, and seizures; Individual #566 – fractures, and skin integrity; Individual #242 – other: pain management, and UTIs; Individual #159 – seizures, and osteoporosis; Individual #508 – skin integrity, and GI problems; Individual #143 – aspiration, and seizures; and Individual #134 – osteoporosis, and UTIs).

None of the 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.

b. As noted above, per the instruction of State Office, and as memorialized in the State Office Medical Care policy #009.3, with an effective date of 2/29/20, PCPs are expected to complete IMRs quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable"). As a result, IHCPs no longer need to define the parameters for interval reviews, so the Monitoring Team did not rate this indicator.

**Dental**

In a letter, dated 8/23/21, the Monitor notified the parties that the Center achieved substantial compliance with most of the requirements of Section Q of the Settlement Agreement. The exceptions are: 1) implementation of a policy/clinical guideline that is consistent with current generally accepted standards of care on perioperative assessment and management of individuals needing TIVA/general anesthesia for dental work, which the Monitoring Team will continue to assess and apply the findings to paragraphs H.7 of the Settlement Agreement; and 2) personal goals/objectives for individuals who are at risk for dental problems, as well as the development and implementation of plans for individuals who require suction tooth brushing, which the Monitoring Team will assess as part of Section F. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Brenham SSLC exited from the other requirements of Section Q of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the related outcomes and indicators.

**Nursing**

| Outcome 3 – Individuals have timely nursing assessments to inform care planning. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: For the six individuals in the review group, nurses completed timely annual nursing reviews and physical assessments. Five of the six individuals also had timely quarterly nursing record reviews and/or physical assessments. As a result of the Center's sustained performance, Indicator a.ii (i.e., Round 15 – N/R, Round 16 – 83%, and Round 17 – 100%), and Indicator a.iii (i.e., Round 15 – N/R , Round 16 – 83%, and Round 17 – 83%) will move to the category requiring less oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
| 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 | N/A | N/A | N/A | N/A | N/R | N/A | N/A | N/R | N/R |
| | 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. | 100% 6/6 | 1/1 | 1/1 | 1/1 | 1/1 | | 1/1 | 1/1 | | |
| | iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due. | 83% 5/6 | 1/1 | 1/1 | 1/1 | 1/1 | | 0/1 | 1/1 | | |
| Comments: a.ii. All six individuals in the review group had timely annual comprehensive nursing reviews and physical assessments.<br><br>a.iii. For Individual #159, the RNCM completed a quarterly physical assessment on 5/20/21, and relied on it for the record review that was completed 11 days later, on 5/31/21. To ensure that record reviews include pertinent data, physical assessments should not be completed any more than a week prior to the record review. | | | | | | | | | | | |

| Outcome 4 – Individuals have quality nursing assessments to inform care planning. | |
|---|---|
| Summary: Work is needed to improve the content and thoroughness of annual and quarterly physical assessments, and to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to individuals' at-risk conditions. When individuals experience exacerbations of their chronic conditions, 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 | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Individual receives a quality annual nursing record review. | 0%<br>0/6 | 0/1 | 0/1 | 0/1 | 0/1 | N/R | 0/1 | 0/1 | N/R | N/R |
| b. | Individual receives quality annual nursing physical assessment, including, as applicable to the individual:<br>i. Review of each body system;<br>ii. Braden scale score;<br>iii. Weight;<br>iv. Fall risk score;<br>v. Vital signs;<br>vi. Pain; and<br>vii. Follow-up for abnormal physical findings. | 17%<br>1/6 | 1/1 | 0/1 | 0/1 | 0/1 | | 0/1 | 0/1 | | |
| c. | For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk. | 0%<br>0/12 | 0/2 | 0/2 | 0/2 | 0/2 | | 0/2 | 0/2 | | |
| d. | Individual receives a quality quarterly nursing record review. | 0%<br>0/6 | 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:<br>i. Review of each body system;<br>ii. Braden scale score;<br>iii. Weight;<br>iv. Fall risk score;<br>v. Vital signs;<br>vi. Pain; and<br>vii. Follow-up for abnormal physical findings. | 0%<br>0/6 | 0/1 | 0/1 | 0/1 | 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%<br>0/11 | 0/2 | 0/2 | 0/2 | 0/1 | | 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. | 30%<br>3/10 | 0/2 | 0/1 | 2/2 | 1/2 | | 0/1 | 0/2 | | |
| Comments: a. It was positive that all of the annual or new-admission nursing record reviews for individuals in the review group included, as applicable, the following:<br>• Allergies or severe side effects to medication. | | | | | | | | | | | |

Most, but not all included, as applicable:

- Active problem and diagnoses list updated at the time of annual nursing assessment (ANA);
- Family history;
- List of medications with dosages at the time of the ANA;
- Consultation summary; and
- Tertiary care.

The components on which Center staff should focus include:

- Procedure history;
- Social/smoking/drug/alcohol history;
- Immunizations; and
- Lab and diagnostic testing requiring review and/or intervention.

b. It was positive that for one individual in the review group, a nurse completed an annual physical assessment that addressed the necessary components. Problems with the remaining assessments included incomplete or inaccurate (i.e., based on other documentation) systems assessments, a lack of follow-up for abnormal findings, no description of the pain scale used, and/or a lack of abdominal circumference and/or weight.

c. and f. For six individuals, the Monitoring Team reviewed a total of 12 IHCPs addressing specific risk areas (i.e., Individual #33 – aspiration, and infections; Individual #448 – falls, and seizures; Individual #567 – aspiration, and seizures; Individual #566 – falls, and skin integrity; Individual #159 – fractures, and seizures; and Individual #508 – aspiration, 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. For example, nurses did not include complete status updates in annual or quarterly assessments, including relevant clinical data. Nurses also did not analyze this information, including comparisons with the previous quarter or year, and/or make necessary 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 conditions to the extent possible.

In addition, it is essential in annual and quarterly assessments that nurses provide specific dates. At times, individuals' clinical stories were unclear, because dates of various events or summary data were missing.

d. It was positive that all of the most recent quarterly nursing record reviews for individuals in the review group included the following, as applicable:

- Allergies or severe side effects to medication.

Most, but not all of the most recent quarterly nursing record reviews for individuals in the review group included, as applicable:

- Active problem and diagnoses list updated at the time of the quarterly assessment;
- Family history;
- List of medications with dosages at the time of the quarterly nursing assessment;
- Consultation summary; and

- Tertiary care.

The components on which Center staff should focus include:

- Procedure history;
- Social/smoking/drug/alcohol history;
- Immunizations; and
- Lab and diagnostic testing requiring review and/or intervention.

e. Problems with the most recent quarterly physical assessments included incomplete or inaccurate (i.e., based on other documentation) systems assessments, a lack of follow-up for abnormal findings, no description of the pain scale used, and/or a lack of abdominal circumference and/or weight.

g. The following are examples of when assessing exacerbations in individuals' chronic conditions (i.e., changes of status), nurses adhered to nursing assessment guidelines in alignment with individuals' signs and symptoms:

- On 7/4/21, Individual #567 experienced emesis. Nursing staff followed the nursing guidelines in assessing the individual, and then monitored her each shift for 24 hours.
- On 4/19/21, at 11:52 a.m., Individual #567 had a seizure. Nursing staff followed the seizure guidelines in assessing her.
- On 7/29/21, staff identified a pressure injury on Individual #566's right ischial tuberosity. Nursing staff conducted an immediate assessment of the size, and made a referral to the skin team, who completed a full assessment, including measurements, diet, mobility, and the Pressure Ulcer Scale for Healing (PUSH).

The following provide a few examples of concerns related to nursing assessments in accordance with nursing guidelines or current standards of practice in relation to exacerbations in individuals' chronic conditions (i.e., changes of status):

- On 6/5/21, at 2:15 p.m., Individual #33 had an episode of emesis. The nurse completed an assessment, but it did not coincide with the nursing guidelines for vomiting. The nurse noted the individual's vital signs and lung sounds, but did not assess the individual for pain, hydration, or level of consciousness, and did not conduct and/or document an abdominal assessment, including bowel sounds, or provide a description of the emesis.
- On 7/28/21, Individual #33 sustained a laceration above his left eye. Staff reported that he bumped into staff's desk hitting his left eyebrow. The injury report, dated 7/28/21, at 2:35 p.m., did not describe the injury or wound. While it indicated that nursing staff initiated mild neurological checks, no documentation of such checks was found in the IView or IPN entries submitted. Nursing staff did monitor the wound for redness and swelling, but did not conduct and/or document an assessment, including measurements according to the skin impairment nursing guidelines.
- On 6/25/21, at 2:58 a.m., Individual #448 had a seizure. Although a nurse conducted an assessment that included vital signs, bowel sounds, respirations, and characteristics of the seizure, the nurse did not assess/record the individual's last bowel movement, which is part of the seizure nursing guidelines.
- On 6/6/21, at 3:43 p.m., Individual #566 ran into a staff member, fell, hit his head on a chair, and sustained a 0.5-centimeter (cm)-by-1-cm scratch with redness, a hematoma, and significant bruising. Nursing staff initiated and completed mild neurological checks, and notified the on-call provider. Although the nurse followed the nursing guidelines for a head injury, they did not document all of the elements related to the nursing guidelines for a fall. For example, it was not until the next day

that a nurse documented the individual's pain level, and it was not until 24 hours later that nursing staff addressed gait changes.

- On 4/5/21, at 3:15 a.m., Individual #159 fell out of bed onto his right hip. Direct support professional staff were at his bedside, and heard a pop when he fell. At 12:42 a.m., nursing staff had administered pain medication. After the fall, the nurse conducted an assessment of the individual's pain, and vital signs, but did not assess the individual's skin, range-of-motion (ROM), or assess him for deformity.
- According to nursing documentation, on 8/2/21, at 12:05 p.m., Individual #508's head was leaning to the left side of his head rest. He had an audible rattling in his chest, with an increased respiration rate, and oxygen (O2) saturation at 75%. At 12:06 p.m., his respiration rate was 20, and O2 saturation was 76% on room air. At 12:07 p.m., his respiration rate was 18 with an O2 saturation of 82% with 4 liters (L) of oxygen via mask. Nursing staff documented PCP orders to transfer the individual to the hospital. At 12:13 p.m., his respiration rate was 20, and O2 saturation was 86% with 6L of O2 via a mask. At 12:20 p.m., his O2 saturation increased to 89% with 8L of O2 via a mask. According to an IPN, timed at 1:55 p.m., a nurse noted that the individual was in an upright position in his wheelchair, and was unresponsive to verbal stimuli. His skin was warm, dry, and a pale color. He had bilateral rhonchi, and the nurse noted anterior and posterior bilateral rattles in the upper and lower lobes. The nurse documented notification of the Nurse Practitioner, but did not document what information they relayed. Based on the documentation submitted, the nurse did not assess the individual's abdomen as per the nursing guidelines for respiratory distress. In addition, the nurse entered the note 45 minutes after the individual left for hospital. While it was understandable that the nurse entered documentation after attending to the individual's immediate needs, the nurse did not document the actual time of the assessment.
- On 4/27/21, at 8:30 a.m., staff discovered that Individual #508 had a wound. In IView entries at 10:14 a.m., and an IPN, at 11:21 a.m., nursing staff documented incomplete measurements of the wound (i.e., only noted 0.8-cm open area). This was inconsistent with the nursing guidelines for skin integrity or a suspected pressure injury. The nurse did note the characteristics of the wound. It was not until 4/28/21, at 6:19 a.m., that a nurse documented the first full set of measurements. At that time, the wound measured 0.9 cm by 0.7 by 0.1 cm.

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: 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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% 0/12 | 0/2 | 0/2 | 0/2 | 0/2 | N/R | 0/2 | 0/2 | N/R | N/R |
| b. | The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition. | 8% 1/12 | 0/2 | 0/2 | 0/2 | 1/2 | | 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%<br>0/12 | 0/2 | 0/2 | 0/2 | 0/2 | | 0/2 | 0/2 | | |
| d. | The IHCP action steps support the goal/objective. | 0%<br>0/12 | 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). | 17%<br>2/12 | 0/2 | 0/2 | 1/2 | 1/2 | | 0/2 | 0/2 | | |
| f. | The individual's ISP/IHCP identifies the frequency of monitoring/review of progress. | 8%<br>1/12 | 0/2 | 0/2 | 0/2 | 0/2 | | 0/2 | 1/2 | | |

Comments: a. through f. The IHCPs reviewed all included nursing interventions, but all 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(s) or etiology(ies) 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's 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.

b. IHCPs generally did not include preventative interventions. In other words, they did not include interventions for staff and individuals to proactively address the chronic/at-risk condition. Examples might include drinking a specific amount of fluid per day to prevent constipation, washing hands before and/or after completing certain tasks to prevent infection, etc. The IHCP that included preventative interventions was for: Individual #566 – falls.

e. The IHCPs that included specific clinical indicators for measurement were for: Individual #567 – seizures; and Individual #566 – falls.

f. The IHCP that identified the frequency of monitoring/review of progress was for: Individual #508 – aspiration.

**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: Since the last review, the Center maintained its progress with regard to the timely referral of individuals to the PNMT. If this continues, after the next review, Indicator a might move to the category requiring less oversight. For individuals in the review group, the PNMT completed timely PNMT reviews and assessments. Overall, the quality of the PNMT comprehensive assessments continued to improve. Improvements in the quality of reviews and assessments should continue to be a focus. The remaining indicators will continue in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
| a. | Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT. | 100%<br>7/7 | 1/1 | 1/1 | N/A | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A |
| b. | The PNMT review is completed within five days of the referral, but sooner if clinically indicated. | 100%<br>2/2 | N/A | 1/1 | | N/A | N/A | 1/1 | N/A | N/A | |
| c. | For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely. | 100%<br>4/4 | 1/1 | N/A | | 1/1 | 1/1 | N/A | 1/1 | | |
| d. | Based on the identified issue, the type/level of review/assessment meets the needs of the individual. | 100%<br>6/6 | 1/1 | 1/1 | | 1/1 | 1/1 | 1/1 | 1/1 | | |
| e. | As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results. | Due to the Center's sustained performance, this indicator moved to the category requiring less oversight. | | | | | | | | | |
| f. | Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue. | 67%<br>4/6 | 0/1 | 1/1 | | 1/1 | 1/1 | 0/1 | 1/1 | | |
| g. | If only a PNMT review is required, the individual's PNMT review at a minimum discusses:<br>• Presenting problem;<br>• Pertinent diagnoses and medical history;<br>• Applicable risk ratings;<br>• Current health and physical status;<br>• Potential impact on and relevance to PNM needs; and | 0%<br>0/2 | N/A | 0/1 | | N/A | N/A | 0/1 | N/A | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan. | | | | | | | | | | |
| h. | Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary. | 0%<br>0/4 | 0/1 | N/A | | 0/1 | 0/1 | N/A | 0/1 | | |

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

- For Individual #33, on 4/20/21, the PNMT made a self-referral after the individual did not gain weight despite IDT interventions for 90 days. On 5/20/21, the PNMT completed an assessment. The quality of the assessment is discussed below.
- According to the RN post-hospitalization review, Individual #448 returned from the hospital on 6/30/21. Due to the diagnosis of aspiration pneumonia on 6/25/21, following an episode of status epilepticus, a PNMT review was triggered. On 7/6/21, he was referred to the PNMT. On 7/13/21, the PNMT completed a review, which was within the five days, as reflected by the positive score for Indicator b.

  On 7/6/21, the PNMT nurse completed a review. The reasoning provided for the delay was that the PNMT nurse was out, and the covering nurse had new employee orientation (NEO) responsibilities.

  The review submitted only included the RN's name, making it unclear who participated it in its development. In its comment on the draft report, Center staff pointed the Monitoring Team to the additional document that included time-stamped electronic signatures for the other disciplines that participated in the review.

  According to the review, the PNMT RN and SLP observed the individual on 7/7/21, but the observation was limited. The SLP conducted a dysphagia assessment, and noted the individual's swallow status was unchanged. There was no clear review of the individual's positioning and its impact on his ability to better tolerate emesis after seizures since this was noted in the review to be the primary cause of the aspiration pneumonia. The PNMT's recommendations included increasing the individual's risk rating from medium to high, but they offered no additional supports to address his increased risk. They stated that the IDT should update the IHCP goal, given the new diagnosis of aspiration pneumonia, but offered no recommendation as to what the new goal might be.
- On 8/9/21, Individual #566's IDT referred him to the PNMT due to the discovery of a Stage 3 pressure injury. On 9/1/21, the PNMT completed an assessment. The quality of the assessment is discussed below.
- On 2/15/21, Individual #242 fractured her left tibia and fibula, and on 2/22/21, the PNMT RN completed a post-hospitalization review. On 2/23/21, the PNMT initiated an assessment, which they completed on 3/24/21. The quality of the assessment is discussed below.
- On 11/23/20, Individual #159 was referred to the PNMT due to fractures of his right medial malleolus and distal anterior tibial. On 12/2/20, the PNMT completed a review. The only signature was from the SLP, which did not reflect an interdisciplinary approach. The Monitoring Team's document request asked for signature pages, but none were provided.

  With regard to the quality of the PNMT review, it was positive that it clearly identified the presenting problem of the leg fracture, as well as the cause of the fracture (i.e., stepping on a speaker). On 11/7/20, the initial visit to the ED resulted in a

diagnosis of a sprain to his right ankle, but follow-up indicated a fracture. The PNMT reviewed the individual's history of fractures due to poor safety awareness, behaviors, and osteoporosis. They provided a clear breakdown of supports to aid in the healing process. They reviewed the monitoring that Habilitation Therapy staff completed (i.e., two in the past 12 months) with no issues noted. However, despite stating multiple times in the review that the individual's fractures were impacted by poor safety awareness, the PNMT offered no plan or recommendations to mitigate the issue and potentially improve his status. The individual had the ability to understand visual cues and single-step requests. On 3/17/21, he fractured his right femur; on 4/5/21, he was diagnosed with a displaced oblique fracture of the shaft of the right femur; and on 5/17/21, a subacute fracture of the distal ulnar shaft of his left arm was identified, and determined to be an old fracture.

- On 6/7/21, Individual #508 was diagnosed with aspiration pneumonia. On 6/13/21, he returned from the hospital with a PNMT RN assessment completed on 6/14/21, resulting in a referral to the PNMT. On 6/15/21, the PNMT initiated an assessment, and on 7/15/21, they completed it. The quality of the assessment is discussed below.
- Individual #143 also was referred to the PNMT due to more than 10 falls in 90 days. However, the referral was rescinded, because three of the 10 falls occurred while playing ball on the playground, which were considered typical under the circumstances.

h. For the four PNMT assessments completed for individuals in the review group:

- It was positive that all four thoroughly addressed the following:
  - Presenting problem;
  - Review of the applicable risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification;
  - Discussion of medications that might be pertinent to the problem, and discussion of relevance to PNM supports and services;
  - Evidence of observation of the individual's supports at his/her program areas;
  - Identification of the potential causes of the individual's physical and nutritional management problems; and
  - Recommendations, including rationale, for physical and nutritional interventions.
- For Individual #33, the following summarizes some of the concerns with the assessment:
  - The PNMT identified rumination syndrome as a primary issue, and included psychiatric notes in the assessment regarding continuation of medication. However, the assessment lacked an active observation or participation by Behavioral Health Services staff in the process. The assessment stated that his weight loss was due to rumination, but then stated that weight loss was not due to challenging behaviors. Although there might be other causes of rumination, it was not clear from the assessment that challenging behavior was ruled out as a potential contributing factor.

    In its comments on the draft report, the State indicated: "Individual #33's" PNMT Assessment noted that his target behaviors (i.e., challenging behaviors) are defined by BHS as "SIB, and disruptive behaviors" (**TX-BR-2110-II-DL.10 pg. 5 of 70)**. Based on reports from BHS data collection, Individual #33 did not demonstrate an increase in any of these behaviors in the last 12 months **(TX-BR-2110-II-DL.10 pg. 16 of 70)**. Given this data, Individual #33's challenging behaviors (i.e., SIB and disruptive behaviors) were not associated with his weight loss trend." The PNMT

did not provide a thorough breakdown of the rumination, and whether it had a behavioral component to it that would require ongoing behavioral health support.
    - It was positive that the PNMT assessed the individual's oral motor structure and functioning. The PNMT did not discuss the potential connection of positioning, and its relation to the occurrence or prevention of emesis/rumination other than stating his current position.

      In its comments on the draft report, the State stated: "Based on findings from the prior PNMT assessment **(TX-BR-2110-II-DL.10 pg.42 – 44 of 70)**, it was hypothesized that Individual #33's rumination activity was being documented as emesis episodes. As Individual #33 was not experiencing actual 'emesis' episode but rather was demonstrating symptoms of his rumination syndrome, which is a psychiatric condition as described by his psychiatrist **(TX-BR-2110-II-DL.10 pg. 31 of 70),** body positioning was not considered to be a factor in causing or preventing rumination activity and therefor was not explored during this assessment." The PNMT assessment lacked a clear breakdown and assessment of positioning as it related to rumination patterns.
    - The PNMT did not discuss the impact of weight loss on his risk for skin breakdown, given that he was already at high risk.
    - The PNMT did not develop clear indicators or goals to show how success in relation to his weight would be measured.
- The PNMT assessment for Individual #566 met most of the criteria for quality. The following problems were noted:
    - With regard to the discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs, the PNMT discussed the individual's "moderate" intellectual disability, cerebral palsy, and Spina Bifida. However, they did not mention the finger fracture, which was identified as the primary precursor to the injury due to increased sitting.
    - The recommendations included a short-term monitoring schedule, and continued use of a cushion beyond wound healing. Missing was a breakdown of how staff should intervene if his transfers should again be impacted or sitting increase. Due to the significant impact, the PNMT also should have included a clear trigger that would warrant re-referral, if not to the PNMT, then to the IDT.
- The PNMT assessment for Individual #242 overall met most of the criteria for quality. However, the assessment did not include investigation into the impact of the fracture on the person's ability to maintain healthy skin due to mobility and positional issues.
- The PNMT assessment for Individual #508 also met most of the criteria for quality. However, the PNMT only stated to defer to the IDT's goal. Based upon their findings in the assessment, if the goal the PNMT would recommend was the same as the IDT's goal, the PNMT should state this within this section along with providing a copy/quote of the written goal. As stated, the PNMT's specific recommendation for a goal was unclear.

| Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions. | |
|---|---|
| Summary: Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. The plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause(s) or etiology(ies) of the PNM issues in the action steps. In addition, many action steps were not measurable. | Individuals: |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Six out of nine PNMPs reviewed met the requirements for quality. Given that during the previous two reviews, the Center's scores were 100%, and 89%, respectively, and problems noted during those reviews as well as this review were minimal, Indicator c will move to the category requiring less oversight. | | | | | | | | | | | |
| # | Indicator | Overall Score | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
| a. | The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP). | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| b. | The individual's plan includes preventative interventions to minimize the condition of risk. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| c. | If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs. | 67% 6/9 | 0/1 | 0/1 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 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. | 11% 2/18 | 0/2 | 0/2 | 1/2 | 0/2 | 0/2 | 0/2 | 0/2 | 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 | 1/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 1/2 |
| g. | The individual ISP/IHCP identifies the frequency of monitoring/review of progress. | 6% 1/18 | 0/2 | 0/2 | 1/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: Individual #33 – weight loss, and aspiration; Individual #448 – aspiration, and falls; Individual #567 – aspiration, and skin integrity; Individual #566 – skin integrity, and choking; Individual #242 - fractures, and choking; Individual #159 – fractures, and choking; Individual #508 – aspiration, and choking; Individual #143 – falls, and choking; and Individual #134 – falls, and choking.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP.

b. Overall, ISPs/IHCPs reviewed did not include preventative physical and nutritional management interventions to minimize the individuals' risks.

c. All individuals reviewed had PNMPs and/or Dining Plans. Six of the PNMPs reviewed fully met the individuals' needs. The problems with the remaining three included:

- Weight was not listed as a PNM risk on Individual #33's Dining Plan.
- For Individual #448, falls were not listed as a PNM risk area. In addition, his soft shell helmet was not listed under assistive/adaptive equipment.
- Individual #566's PNMP was last updated in October 2020. It did not appear that Habilitation Therapy staff updated it to reflect the interim use of cushions or his increased risk for skin breakdown. No pictures were provided of the cushions, and they were not listed under assistive/adaptive equipment.

Given that during the previous two reviews, the Center's scores were 100%, and 89%, and problems noted during those reviews as well as this review were minimal, Indicator c will move to the category requiring less oversight.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for: Individual #567 – skin integrity, and Individual #134 – choking.

f. The IHCPs that identified triggers and actions to take should they occur were those for: Individual #567 – skin integrity, and Individual #134 – choking.

g. Often, the IHCPs reviewed did not include the frequency of PNMP monitoring/review of progress. The one that did was for: Individual #567 – skin integrity.

**Individuals that Are Enterally Nourished**

| Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs. | | | | | | | | | | | |
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| Summary: Indicator b will remain in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
| 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, this indicator 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. | N/A | | | N/A | | | | | | |
| Comments: b. None. | | | | | | | | | | | |

**Occupational and Physical Therapy (OT/PT)**

| Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments. | | | | | | | | | | | |
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| Summary: For the individuals reviewed, the Center continued to evidence good progress toward providing assessments that were timely and in accordance with individuals' needs. Due to sustained progress (Round 15 – 89%, Round 16 - 100%, and Round 17 - 89%), Indicator a.iii will move to the category of requiring less oversight. The Center needed to continue to focus on the quality of OT/PT assessments. These remaining indicators will continue in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
| a. | Individual receives timely screening and/or assessment: | | | | | | | | | | |
| | i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment. | Due to the Center's sustained performance, these indicators 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 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. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| b. | Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs. | 78% 7/9 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 |
| c. | Individual receives quality screening, including the following:<br>• Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills;<br>• Functional aspects of:<br>▪ Vision, hearing, and other sensory input;<br>▪ Posture;<br>▪ Strength;<br>▪ Range of movement; | N/A | | | | | | | | | |

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| | ▪ Assistive/adaptive equipment and supports;<br>• Medication history, risks, and medications known to have an impact on motor skills, balance, and gait;<br>• Participation in ADLs, if known; and<br>• Recommendations, including need for formal comprehensive assessment. | | | | | | | | | | |
| d. | Individual receives quality Comprehensive Assessment. | 56%<br>5/9 | 0/1 | 1/1 | 0/1 | 1/1 | 1/1 | 0/1 | 0/1 | 1/1 | 1/1 |
| e. | Individual receives quality OT/PT Assessment of Current Status/Evaluation Update. | N/A | | | | | | | | | |

Comments: a. and b. Most individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status, as well as assessments that were in accordance with the type they needed. The following describes the exceptions noted:

- For Individual #33, Center staff did not ensure the completion of an orientation and mobility (O&M) assessment as recommended in his comprehensive assessment or an assessment to address his sensitivity to touch. Based on his comprehensive assessment, he did not need direct therapy services, but due to his visual impairment and moderate-to-severe hearing loss, touch was needed to provide instruction for therapy-related activities. However, he did not tolerate physical touch, including interaction with therapists.
- For Individual #143, the Center did not complete an O&M assessment to address his visual impairment and its impact on overall ambulation and safety. Between 3/10/21 and 5/15/21, three of his 10 falls reportedly occurred when he was playing, but the IDT should have reviewed and addressed the remaining seven falls. On 5/3/21, the IDT held an ISPA meeting, but did not devise a plan to address the individual's poor vision.

d. It was positive to see that the comprehensive assessments for five individuals (i.e., Individual #448, Individual #556, Individual #242, Individual #143, and Individual #134) met all criteria for a quality assessment. It was also positive that all of the remaining four 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;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale.
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments; and,
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services.

All but one of the assessments addressed a discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings. The exception was for Individual #159, for

whom the assessment included information on completed monitoring, but did not include the results of consults completed during the past 12 months.

All but one of the assessments also addressed, 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. The exception was for Individual #33, for whom the assessment noted that touch was needed to provide instruction for therapy-related activities, but that he did not tolerate physical touch. The assessment did not provide any recommendation to address touch sensitivity. In addition, the assessment did not include any recommendations for an O&M assessment, but should have.

The Center should focus most on ensuring that assessments include a discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services.

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

Summary: To move forward, QIDPs and OTs/PTs should work together to make sure IDTs discuss and consistently include information related to individuals' OT/PT supports in ISPs and ISPAs. These indicators will continue in active oversight.

| # | Indicator | Overall Score | Individuals: 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | The individual's ISP includes a description of how the individual functions from an OT/PT perspective. | Due to the Center's sustained performance, this indicator moved to the category requiring less oversight | | | | | | | | | |
| 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. | 78% 7/9 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 |
| c. | Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment. | 17% 1/6 | N/A | N/A | N/A | 0/1 | 0/2 | 0/2 | N/A | N/A | 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. | 17% 1/6 | N/A | N/A | N/A | 0/1 | 0/2 | 0/2 | N/A | N/A | 1/1 |

Comments: a. and b. Seven of nine IDTs reviewed and updated the PNMP/Positioning Schedule at least annually, or as the individual's needs dictated. The following describes the exceptions noted:

- For Individual #566, Center staff did not provide an updated PNMP for the IDT to review.
- For Individual #143, the ISP only stated the IDT reviewed and approved the PNMP, but did not provide any detail with regard to what the IDT reviewed and/or approved.

c. As applicable, most individual's ISPs/ISPAs did not include the strategies, interventions and programs as recommended in their assessments.

d. For most applicable individuals, IDTs met to discuss the provision of direct therapy, but did not discuss and approve the specific goals/objectives initiated outside of the annual ISP meeting. It was positive that on 3/31/21, IDT for Individual #134 held an ISPA meeting to discuss and approve his specific goal/objective. However, the IDTs for three other individuals met to discuss therapy, but did not approve implementation of the specific goals/objectives as needed.

**Communication**

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

Summary: Overall, while many individuals reviewed received timely assessments that were of the correct type in accordance with their needs, Center staff needed to continue to focus on the quality of those assessments. If the Center sustains its progress with regard to the timeliness of communication assessments, after the next review, Indicator a.iii might move to the category requiring less oversight. The applicable indicators will remain in active oversight.

| # | Indicator | Overall Score | Individuals: 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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, these indicators 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. | 100% 8/8 | 1/1 | N/A | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| b. | Individual receives assessment in accordance with their individualized needs related to communication. | 78% 7/9 | 0/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| c. | Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following:<br>• Pertinent diagnoses, if known at admission for newly-admitted individuals;<br>• Functional expressive (i.e., verbal and nonverbal) and receptive skills;<br>• Functional aspects of:<br>▪ Vision, hearing, and other sensory input;<br>▪ Assistive/augmentative devices and supports;<br>• Discussion of medications being taken with a known impact on communication;<br>• Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and<br>• Recommendations, including need for assessment. | 0%<br>0/1 | N/A | 0/1 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| d. | Individual receives quality Comprehensive Assessment. | 0%<br>0/8 | 0/1 | N/A | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| e. | Individual receives quality Communication Assessment of Current Status/Evaluation Update. | N/A | | | | | | | | | |

Comments: a. through c. Overall, for many individuals reviewed, SLPs conducted assessments that were timely and of the correct type of assessment (i.e., screening, or comprehensive) in accordance with individuals' needs. The following describes the exceptions noted:

- For Individual #33, on 7/19/21, the SLP initiated a trial of a choice board. The SLP completed three related IPNs. On 7/29/21, the IPN documented good participation, while the IPN, dated 8/6/21, indicated the individual refused, and the IPN, dated 8/16/21, documented the SLP was unable to see him due to quarantine. However, an ISPA, dated 8/26/21, stated that all sessions ended in refusal and a choice board was not appropriate. Not only did this not appear to accurately reflect the documentation in the IPNs, two sessions would not have been sufficient to make a determination.
- For Individual #448, his screening identified a number of skills that reflected a need for the completion of a more comprehensive assessment. For example, the screening identified skills that included the ability to follow one- to two-step requests, answer yes/no questions, and initiate conversation with familiar listeners. What was lacking was a focus on the potential for increasing the individual's ability to understand two- to three-step requests or initiate conversations with unfamiliar listeners.

d. None of eight comprehensive assessments included all the required elements. It was positive, though, that all of the assessments reflected that the individual's preferences and strengths were used in the development of communication supports and services.

Most of the applicable assessments included the following components:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- The effectiveness of current supports, including monitoring findings;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated; and,
- A comparative analysis of current communication function with previous assessments.

The Center should focus on all of the following sub-indicators:

- 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;
- 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.

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: Improvement is needed with regard to most of these indicators. 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: 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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. | Due to the Center's sustained performance with this indicator, it moved to the category requiring less oversight. | | | | | | | | | |
| b. | The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication. | 29% 2/7 | 0/1 | N/A | 0/1 | N/A | 1/1 | 0/1 | 0/1 | 1/1 | 0/1 |
| c. | Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment. | 75% 3/4 | 0/1 | N/A | N/A | N/A | N/A | N/A | 2/2 | 1/1 | N/A |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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: b. For five of the seven applicable individuals reviewed, the ISPs only indicated a one-word response of "yes" with regard to the approval of the Communication Dictionary. The ISPs did not otherwise document any discussion or note any specific changes to the document. Moving forward, ISPs will need to provide evidence with regard to what the IDT reviewed, revised, and/or approved, and/or whether the current Communication Dictionary was effective at bridging the communication gap.

c. As described with regard to Outcome 1 above, for two of three individuals, their respective IDTs integrated the communication goals/objectives recommended in their assessments into their ISPs/ISPAs. The exceptions was for Individual #33. However, five individuals had unmet communication needs for which their assessments did not make recommendations. This resulted in a false positive score.

**Skill Acquisition and Engagement**

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

Summary: There was some regression in indicator 2, that is, about one-quarter of the SAPs did not indicate the prompting/independence criterion for the individual. This should be corrected. Performance on the other three indicators remained about the same as at the last review. They will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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. | 65% 11/17 | 3/3 | 1/2 | 2/2 | 1/1 | 1/1 | 0/1 | 3/3 | 0/1 | 0/3 |
| 4 | SAPs are practical, functional, and meaningful. | 53% 9/17 | 2/3 | 1/2 | 1/2 | 1/1 | 1/1 | 1/1 | 2/3 | 0/1 | 0/3 |
| 5 | Reliable and valid data are available that report/summarize the individual's status and progress. | 31% 4/13 | 0/2 | 0/2 | 2/2 | | | 0/1 | 1/2 | 0/1 | 1/3 |

Comments:
1. All nine individuals had at least one Skill Acquisition Plan (SAP). Four of the individuals (Individual #436, Individual #33, Individual #493, Individual #448) had only one SAP.

2. Thirteen of the 17 SAPs were measurable. The exceptions were SAPs that did not indicate whether the skill was to be performed independently or with prompting. These were: Individual #119 - operate television; Individual #33 - operate joy player; Individual #448 - greet others; and Individual #199 - identify address.

3. Eleven of the 17 SAPs were based on assessment results. The exceptions were: a) Individual #219's FSA indicated she knew how to pay for goods purchased, b) Individual #448's baseline assessment and FSA both noted he could independently greet others, and c) the baseline assessment for four SAPs should have been updated because they were last completed in May 2019 (Individual #493 - operate joy player) or October 2019 (Individual #199 - identify medication, complete a job application, and identify his address).

4. Nine of the 17 SAPs were considered practical, functional, and meaningful. The exceptions included the pay cashier SAP for Individual #219 and the greeting SAP for Individual #448 for reasons noted above. Six additional SAPs did not meet this indicator.

- Individual #336 was learning to address an envelope, but he was expected to do so by writing a relative's address. His FSA noted that he did not have writing skills, and when this was observed, he did not copy the name legibly or in the correct location on the envelope. It would be more functional if he were taught to affix preprinted labels in the appropriate location on the envelope.
- Individual #119 was supposed to be learning to recognize her name, but in fact she was simply learning to insert pieces into a puzzle. It would be more functional for her to learn to identify her name from an array or to learn to match her printed name to a sample.
- Individual #135 was learning to wash her clothing. While a functional skill, this was not related to her goal of winning a gold medal in the Special Olympics.
- Individual #199 was learning to identify his medication, but this was not related to his learning to order a pizza.
- Similarly, he was learning to repeat his address after staff stated it. This also was not going to increase his independence in learning to order a pizza. It would be more functional if Individual #199 was able to reference an identification card to recite his address.
- Lastly, Individual #199 was learning to complete a job application. As he stated at his ISP meeting, this was not developing his work skills. He was unlikely to be obtaining a job in the community in the near future and he was more interested in developing and enhancing his skill set.

5. SAP monitoring, including an assessment of data reliability, had occurred for four of 14 SAPs. In each case, inter-observer agreement was 100%. These were the following SAPs: Individual #119 - operate television and complete name puzzle; Individual #135 - wash clothes; and Individual #199 - identify address. Although Individual #448's greeting SAP had been monitored, there was no indication whether this was based upon role play or a direct observation. For this reason, this was scored zero. Four SAPs that had just recently been introduced were excluded from this analysis as monitoring had not yet been required. These were: Individual #336 - address envelope; Individual #436 - clean glasses; Individual #33 - operate joy player; and Individual #135 - identify buildings.

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: Overall, performance was about the same as at the last review, though with sustained high performance, indicator 11 might be moved to the category of requiring less oversight after the next review. In general, this set of assessments were not available/found and/or did not provide much useful information to IDTs. These indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 10 | The individual has a current FSA, PSI, and vocational assessment. | 33% 3/9 | 1/1 | 1/1 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 | | 0/1 |
| 11 | The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP. | 89% 8/9 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 12 | These assessments included recommendations for skill acquisition. | 11% 1/9 | 0/1 | 0/1 | 1/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

Comments:

10. Nine individuals had a current Preferences and Strengths Inventory (PSI). Three of the nine also had both a Functional Skills Assessment (FSA) and vocational assessment. These were Individual #336, Individual #219, and Individual #135.

For four individuals (Individual #119, Individual #436, Individual #448, Individual #199), the facility reported that their FSAs could not be found. While summaries were provided, these often did not present a complete assessment of the individual's strengths and needs.

For five individuals, a vocational assessment was not completed. At the time of the document request, Individual #119 and Individual #199 were both attending school and were within the age of transition as identified by the Individuals with Disabilities Education Act. A vocational assessment is essential to determine their work interests, strengths, and needs to ensure appropriate training and support as they begin their transitions to adult life. For three individuals (Individual #436, Individual #33, Individual #493), a day program assessment was provided, but it offered no clear assessment of the individual's interests, strengths, or needs.

Although most vocational and day program assessments offered very limited information about the individual, it was positive to find in depth reviews of situational work assessments that had been completed with Individual #336 and Individual #219. This was commendable.

11. Based upon the QIDP tracking data, the assessments that were completed were available to the IDT for eight individuals 10 days prior to the scheduled ISP meeting. The exception was Individual #219 whose vocational assessment was completed after the meeting.

12. Recommendations for skill acquisition were provided in the FSA summary for all nine individuals. However, for five individuals, only one SAP was recommended. As has been noted in the past, the FSA is a comprehensive assessment that should be used to determine a wide array of needs that could be addressed by the IDT. Vocational assessments that were completed did not include any

recommendations for SAP development. Day assessments also did not include any recommendations for skill development. Individual #119 was scored positively for this indicator because her assessment included a recommendation for skill acquisition.

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

In a letter, dated 8/23/21, the Monitor notified the parties that the Center achieved substantial compliance with most of the requirements of Section Q of the Settlement Agreement. The exceptions are: 1) implementation of a policy/clinical guideline that is consistent with current generally accepted standards of care on perioperative assessment and management of individuals needing TIVA/general anesthesia for dental work, which the Monitoring Team will continue to assess and apply the findings to paragraph H.7 of the Settlement Agreement; and 2) personal goals/objectives for individuals who are at risk for dental problems, as well as the development and implementation of plans for individuals who require suction tooth brushing, which the Monitoring Team will assess as part of Section F. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Brenham SSLC exited from the other requirements of Section Q of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the related outcomes and indicators. As a result, this Domain contains six less outcomes, and 21 fewer indicators.

Currently, this Domain contains 29 outcomes and 107 underlying indicators related to the provision of clinical services. At the time of the last review, 22 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, six additional indicators in the area of psychology, medical, PNM, and OT/PT will move to the category requiring less oversight.

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

Goals/Objectives and Review of Progress

The Monitoring Team attended psychiatry clinics with both providers. Data were reviewed during clinic and other input was obtained from other team members. Data were graphed through the month prior, with data for the month of the clinic provided verbally.

Acute Illnesses/Occurrences

Nursing assessments at the onset of signs and symptoms of acute illnesses/occurrences that are in alignment with applicable guidelines is an area on which the Center needs to focus. It was positive that in most instances reviewed, nursing staff timely notified the practitioner/physician of individuals' signs and symptoms. Often, though, they did not document the specific information they shared with the providers in IPNs, as required by the relevant nursing guidelines.

For the six acute illnesses/occurrences reviewed, nursing staff developed acute care plans. Three of them met the criteria for quality, but one of these three was initiated late, which did not meet the individual's needs. The remaining three included some of the necessary interventions, but they were missing key interventions. Nurses thoroughly implemented only one of the six acute care plans.

For most of the acute issues addressed at the Center that the Monitoring Team reviewed, PCPs conducted the necessary assessments, and follow-up. With regard to acute issues requiring ED visits or hospitalizations, as appropriate, prior to the hospitalization, ED visit, PCPs need to complete quality assessments.

Based on review of one of the individuals in the review group who had two aspiration pneumonia events, and two deaths related to aspiration pneumonia, PCPs need to provide more aggressive surveillance and documentation of acute aspiration pneumonia and aspiration-related illnesses. The Medical Director should provide oversight to ensure thorough evaluation, treatment, and documentation.

For psychiatry and neurology, attention needs to be paid to dual purpose medications for some individuals and one individual needed a neurology consultation.

Psychiatry prescriber review of MOSES and AIMS assessments was either late or not done.

Implementation of Plans
For most individuals, the psychiatrist participated in the development of the PBSP.

Psychiatry quarterly reviews were occurring. More work remained to ensure all content was in the documentation of each quarterly reviews.

Polypharmacy committee was occurring on a regular basis, but not all individuals were reviewed as required, even if there were adjustments to the medication regimen. The Center staff were (incorrectly) excluding any medications prescribed for side effect management. On the positive, the committee retained new admissions for approximately six months.

It was positive to observe a meeting of the Internal Peer Review Committee. There was good participation with numerous recommendations made for the team to consider.

In behavioral health, the Center reported that all individuals in the review group were making progress. This was good to hear about, however, the delayed correction to the way the Center collected IOA data resulted in indicator 5 being scored 0 and, therefore, without data shown to be reliable, indicator 6 is scored 0.

The Center met criteria for staff training for more than half of the individuals. For the others, it ranged from 50% of the staff up to close to the required 80%.

In the individuals' clinical meetings, there was evidence that data were presented and reviewed to make treatment decisions. And, there was evidence of documentation of follow-up and/or implementation of recommendations made in peer review.

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

Although additional work was necessary, it was positive that for a number of individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate.

Since the last review, it was good to see improvement with regard to the timeliness of PCPs' reviews of non-facility consultations, the completion of related Integrated Progress Notes (IPNs), and PCPs writing orders for agreed-upon recommendations. The Center needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

Improvements are needed with regard to medication nurses following the nine rights, as well as infection control procedures. In addition, in IHCPs, IDTs need to include interventions for respiratory assessments for individuals with high risk for respiratory compromise that are consistent with the individuals' level of need, and the implementation of such nursing supports.

Thirty-five out of 39 individuals observed had assistive/adaptive equipment that appeared to be the proper fit.

Based on observations, there were still numerous instances (33% of 40 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. Often, the errors that occurred (e.g., staff not intervening when individuals took large bites, or ate at an unsafe rate, or staff not providing liquids in between bites) placed individuals at significant risk of harm. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Center staff should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

**Restraints**

As noted in Domain #1 of this report, the Monitor found that that the Center achieved substantial compliance with many of the requirements of Section C of the Settlement Agreement, including the Center's response to frequent usage of crisis intervention restraint (i.e., more than three times in any rolling 30-day period.

**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 is obtaining data for some psychiatric indicators, indicators 8 and 9 can be assessed by the Monitoring Team. The Monitoring Team acknowledges the efforts of the psychiatry staff in taking action for individuals who are not meeting treatment goals. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
| 8 | The individual is making progress and/or maintaining stability. | 0% 0/7 | 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. | N/A | | | | | | | | | |
| 10 | If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made. | 100% 7/7 | 1/1 | 1/1 | 1/1 | | 1/1 | 1/1 | 1/1 | | 1/1 |
| 11 | Activity and/or revisions to treatment were implemented. | 86% 6/7 | 1/1 | 1/1 | 1/1 | | 1/1 | 1/1 | 1/1 | | 0/1 |
| Comments:<br>8-9. Per a review of the individual's goals and indicators as well as available data, there were two individuals who were making progress toward their treatment goals. Specifically, Individual #493 was progressing with regard to the indicators/goals for reduction and increase. Individual #33 was making progress with regard to weight gain, the indicator/goal for increase. The issue was that for Individual #493, the indicators were not described as related to her specific diagnoses, and the data were reportedly not reliable | | | | | | | | | | | | |

(indicators 4 and 7). For Individual #33, although it was reported that he had gained weight, the goals grid designated that weight measurements would be gathered via observational data. The grid did not state that if the measurements would be obtained via nursing or direct care staff, nor the required frequency of the weight measurements.

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, environmental changes) were developed and implemented. There were individuals in the review group who were noted per their treating psychiatrist to be psychiatrically stable, however, some individuals with this designation were noted to have adjustments to their medication regimen or behavior management program. For one individual, Individual #199, despite psychiatry indicating that he was not considered psychiatrically stable, there had been no adjustments to his medication regimen in the past year. He was referred for individual counseling, but this was not occurring. Individual #135 was also considered as not psychiatrically stable, but she had medication regimen adjustments implemented. She was also referred for individual counseling, but this was not occurring. Because the medication adjustments were implemented, she was scored affirmatively for this indicator.

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

Summary: Both indicators were met for five of the individuals. These indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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. | 71% 5/7 | 0/1 | 0/1 | 1/1 | | 1/1 | 1/1 | 1/1 | | 1/1 |
| 24 | The psychiatrist participated in the development of the PBSP. | 71% 5/7 | 0/1 | 0/1 | 1/1 | | 1/1 | 1/1 | 1/1 | | 1/1 |

Comments:

23. The psychiatric documentation referenced the behavioral health target behaviors and the functional behavior assessment discussed the role of the psychiatric disorder upon the presentation of the target behaviors for five of the individuals in the review group receiving psychiatric services. For Individual #336 and Individual #219, the diagnoses included in the BHA were not consistent with those documented by psychiatry.

24. The seven individuals in the review group receiving psychiatric services had a PBSP. Although there was documentation of psychiatry attending Behavior Therapy Committee on a regular basis and participating in the development of Behavior Support Plans, this was not evident in the examples regarding Individual #336 and Individual #219 because their plans were based on diagnoses that were inconsistent with psychiatry.

| 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: Attention needs to be paid to when it is possible that medications are being used for psychiatric and seizure disorders. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
| 25 | There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use. | 0% 0/1 | | | | | | | 0/1 | | |
| 26 | Frequency was at least annual. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| 27 | There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken. | 0% 0/1 | | | | | | | 0/1 | | |
| Comments:<br>25 and 27. These indicators applied to one individual in the review group, Individual #135.<br>• Individual #135 was prescribed the antiepileptic medications Depakote and Zonegran. Per the pharmacy indication and psychiatry documentation, Depakote is a dual-purpose medication. A review of the neurology records did not reveal documentation regarding Depakote because neurology focused only on Zonegran. | | | | | | | | | | | |

| Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Quarterly reviews were occurring and with sustained high performance, indicator 33 might be moved to the category of requiring less oversight after the next review. More work remained to ensure all content was in the documentation of each quarterly reviews. Both indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
| 33 | Quarterly reviews were completed quarterly. | 100% 7/7 | 1/1 | 1/1 | 1/1 | | 1/1 | 1/1 | 1/1 | | 1/1 |
| 34 | Quarterly reviews contained required content. | 29% 2/7 | 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. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| Comments:<br>33. Quarterly reviews were completed in a timely manner for all individuals requiring them. | | | | | | | | | | | |

34. The Monitoring Team looks for nine components of the quarterly review. Two of the examples, regarding Individual #493 and Individual #135 included all the necessary components. The remaining evaluation examples were missing from one to five elements. One evaluation was missing one element, one evaluation was missing two elements, one evaluation was missing three elements, and two evaluations were missing five elements. The most common missing element was whether the non-pharmacological interventions recommended by the psychiatrist and approved by the IDT were being implemented. Overall, the quarterly evaluations were difficult to follow as they included a great deal of information from prior clinical encounters making the current information difficult to distinguish.

- The evaluation regarding Individual #336 was missing the basic information, pertinent laboratory examinations, results of the most recent MOSES and AIMS, the psychiatric diagnosis with a description of symptoms that support the diagnosis, and non-pharmacological interventions.
- The evaluation regarding Individual #219 was missing the non-pharmacological interventions.
- The evaluation regarding Individual #119 was missing the basic information, pertinent laboratory examinations, the results of the most recent MOSES and AIMS, the psychiatric diagnosis with a description of symptoms that support the diagnosis, and non-pharmacological interventions.
- The evaluation regarding Individual #33 was missing the psychiatric diagnosis with a description of symptoms that support the diagnosis, and non-pharmacological interventions.
- The evaluation regarding Individual #199 was missing the basic information, the psychiatric diagnosis with a description of symptoms that support the diagnosis, and non-pharmacological interventions.

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

Summary: Side effect assessments were not always completed and, when completed, were not always reviewed by the prescriber. This indicator will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 36 | A MOSES & DISCUS/AIMS was completed as required based upon the medication received. | 0% 0/7 | 0/1 | 0/1 | 0/1 | | 0/1 | 0/1 | 0/1 | | 0/1 |

Comments:

36. There were delays in the completion of MOSES and AIMS assessments and in the prescriber review.

- Regarding Individual #336, a MOSES assessment was completed 11/5/20 and then 6/8/21. There should have been a MOSES assessment completed in May 2021. Neither of the completed MOSES assessments were reviewed by the prescriber. The AIMS dated 8/3/21 was not reviewed by the prescriber and the AIMS dated 2/1/21 was not reviewed until 3/5/21.
- Regarding Individual #219, the AIMS and MOSES assessments dated 8/4/21 were not reviewed by the prescriber.
- Regarding Individual #119, a MOSES assessment was completed 9/3/20 with the next assessment dated 4/20/21. An assessment should have been performed in March 2021. Neither MOSES assessment was reviewed by the prescriber. The AIMS assessments dated 10/5/20 and 4/27/21 were not reviewed by the prescriber.
- Regarding Individual #33, an AIMS assessment was completed 11/4/20 with the next assessment dated 4/30/21. An assessment should have been performed in February 2021. The AIMS dated 4/30/21 was not reviewed by the prescriber. The MOSES dated 3/23/21 was not reviewed until 4/26/21.

- Regarding Individual #493, the AIMS assessment dated 7/20/21 was not reviewed by the prescriber until 9/1/21 and the MOSES assessment dated 7/20/21 was not reviewed by the prescriber.
- Regarding Individual #135, there was a MOSES assessment performed 12/31/20 with the next assessment dated 7/19/21. There should have been an assessment in June 2021. The AIMS and MOSES dated 12/31/20 were not reviewed by the prescriber until 1/28/21. The AIMS dated 3/22/21 and 6/24/21 were not reviewed by the prescriber. The MOSES dated 7/19/21 was not reviewed by the prescriber.
- Regarding Individual #199, an AIMS assessment was performed 2/9/21 with the next assessment dated 6/23/21. There should have been an assessment in May 2021. The MOSES assessments dated 11/12/20 and 5/31/21 were not reviewed by the prescriber.

| 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: | | | Individuals: | | | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | | | |
| 40 | Daily medications indicate dosages not so excessive as to suggest goal of sedation. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | | | |
| 41 | There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment. | | | | | | | | | | | | |
| 42 | There is a treatment program in the record of individual who receives psychiatric medication. | | | | | | | | | | | | |
| 43 | If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy. | | | | | | | | | | | | |
| 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: Improvements are needed in order for indicators 45 and 46 to remain in the category of requiring less oversight after the next review. Indicator 44 will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
| 44 | There is empirical justification of clinical utility of polypharmacy medication regimen. | 33% 2/6 | 1/1 | 1/1 | 0/1 | | 0/1 | 0/1 | | | 0/1 |
| 45 | There is a tapering plan, or rationale for why not. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | |
| 46 | The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified. | | | | | | | | | | |

Comments:

44. Of the 138 individuals participating in psychiatry clinic at the facility, 72 individuals or 52% were prescribed medication regimens that met the definition of polypharmacy. These indicators applied to six individuals, Individual #336, Individual #219, Individual #119, Individual #33, Individual #493, and Individual #199. The justification for polypharmacy was not appropriately documented for Individual #119, Individual #33, Individual #493, and Individual #199.

45. There was a documentation for four of the six individuals who met criteria for polypharmacy showing a plan to taper a psychotropic medication or a rationale as to why this was not considered.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of regular meetings from January 2021 through October 2021. The facility revived their polypharmacy committee during the prior monitoring visit and had a reconfiguration meeting in February 2021 with consistent meetings since that time.

The facility did a good job of including newly admitted individuals with medication regimens meeting criteria for polypharmacy in the meeting minutes and maintaining these individuals on the agenda for approximately six months after admission.

Although there was documentation of annual reviews of regimens meeting criteria for polypharmacy in some cases, there was no documentation of quarterly reviews when regimens were changed.

- There was no evidence of a review regarding Individual #336.
- Individual #119 was included in the minutes dated 4/28/21, but this was not a documented as a review of the polypharmacy regimen. Further, given the adjustments to her medication regimen, the review should have been done quarterly.

- For Individual #33, there was documentation of a medication dosage change in January 2021 and a polypharmacy review in March 2021. Given the adjustments to his medication regimen, he should be reviewed quarterly.

The polypharmacy committee meeting was observed during the remote monitoring visit. The committee discussed adjustments to the criteria for reviews discussing that per a new policy, they do not need to include side effect medications or antiepileptic medications in their review. This was not the procedure followed by other facility committees, and these medications would need to be considered when reviewing a regimen in a comprehensive manner.

During the meeting, the committee reviewed individuals who were newly admitted with polypharmacy regimens and three individuals who were classified as having justified polypharmacy regimens. For the latter group, this was their annual review as their polypharmacy regimens were stable. These reviews were essentially a review of the individual's indicators and data with little discussion regarding the actual medication regimen. Then, the committee presented four individuals who had recent medication changes focusing on behavioral health data in these cases.

Overall, the meeting did not focus on a presentation of the regimen and discussion of the prescriber's rationale for the specific regimen. Generally, this meeting should be a brisk discussion of the regimens with the psychiatrist presenting the justification of polypharmacy for critique. Individuals should be scheduled for review annually, or quarterly if medication adjustments are made, or if there is an active medication taper in progress.

**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: The Center reported that all individuals were making progress. This was good to hear about, however, the delayed correction to the way the Center collected IOA data resulted in indicator 5 being scored 0 and, therefore, without data shown to be reliable, indicator 6 is scored 0. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
| 6 | The individual is making expected progress | 0%<br>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. | 0%<br>0/2 | | | | 0/1 | 0/1 | | | | |
| 8 | If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested. | N/A | | | | | | | | | |
| 9 | Activity and/or revisions to treatment were implemented. | N/A | | | | | | | | | |

Comments:
6. PBSP progress reports were reviewed for the months of March through August 2021 for all nine individuals. Based upon the most recent graphs provided, it appeared that everyone who was reviewed was making progress on all or most of their targeted problem behavior(s) and replacement behavior(s). This was good to see, however, due to problems with the reported method of assessing inter-observer agreement, this indicator was rated zero for all nine individuals.

7. Data presented graphically suggested that Individual #436 had met his objective for aggression, while Individual #33 had met his objectives for self-injurious behavior and refusals. For neither individual was there evidence that his objective had been updated.

8-9. As indicated, graphs suggested progress for most or all behaviors addressed in the individuals' PBSPs. Individual #199's inappropriate sexual behavior had worsened over the last two months of data reporting. If this trend continued for a third month, his team should meet to discuss possible revisions to his plan.

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

Summary: The Center met criteria for staff training for more than half of the individuals. For the others, it ranged from 50% of the staff up to close to the required 80%. This indicator will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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. | 56% 5/9 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 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. A review was completed of staff rosters and training records for each of the nine individuals who had a PBSP. For five of these individuals, evidence indicated that 80% or more of the assigned staff had received training. These were Individual #219, Individual #119, Individual #436, Individual #33, and Individual #493. For the remaining four individuals, documentation indicated that between 50% and 79% of their assigned staff had been trained on the PBSP.

18. Based upon the documentation provided, it was determined that the functional behavior assessment and the PBSP had been written by a BCBA or a behavior health specialist who had completed or was enrolled in coursework in Applied Behavior Analysis. These individuals were Individual #219, Individual #119, Individual #493, Individual #135, and Individual #199. Although the assessment and plan had been reviewed by a BCBA, for the remaining four individuals there was no indication that the identified author was enrolled in appropriate coursework. At the time of this review, there were several vacancies for certified staff.

| Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Monthly BHS progress notes did not meet criteria for two-thirds of the individuals. Indicators 21 and 23 showed sustained high performance and will be moved to the category of requiring less oversight. The other three indicators will remain in active monitoring. | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
| 19 | The individual's progress note comments on the progress of the individual. | 33% 3/9 | 0/1 | 1/1 | 1/1 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 | 0/1 |
| 20 | The graphs are useful for making data based treatment decisions. | 22% 2/9 | 1/1 | 1/1 | 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. | 100% 2/2 | | | 1/1 | | | 1/1 | | | |
| 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. | 100% 1/1 | | | | | | | 1/1 | | |
| 23 | This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months. | 100% 1/1 | | | | | | | | | |

Comments:

19. Documentation suggested that monthly review of progress occurred for Individual #219, Individual #119, and Individual #448. For the other six individuals, problems included the following:

- progress reports were completed for only four of six months (Individual #199);
- the narrative report did not always correspond to the data presented graphically (Individual #336, Individual #493);
- comments were inconsistently included regarding progress or the lack thereof (Individual #436, Individual #33); or
- no comments were provided (Individual #135).

PBSP goals should be in the progress notes. This was evident for Individual #219 and Individual #199.

20. Although monthly graphs were presented for all individuals who had PBSPs, only those for Individual #336 and Individual #219 were considered useful for making data based treatment decisions. Some progress notes included phase change lines for important events, but the events were not always defined. Phase change lines should be included for new or revised PBSPs, including, but not limited to changes in reinforcement plans such as token economies, work incentives, etc. It was positive to find graphs appropriately labeled when episodes of the behavior were documented.

21. During the review week, a psychiatry clinic was held for Individual #119 and Individual #493. At both meetings, behavioral health services staff presented data from past months and through the beginning of October 2021 `.

22. Individual #119 and Individual #135 had been reviewed by the Internal Peer Review Committee in the six-month period prior to the monitoring review. There were no recommendations identified in the minutes for Individual #119. In Individual #135's case, the facility provided documentation that many of the original recommendations had been addressed by her team.

23. The facility reported that between March and August of 2021, a total of 20 meetings of the Internal Peer Review Committee were held. For five of these six months, three to four meetings were held each month. There was one month in which two meetings were held. As a result, this indicator was met or exceeded in five of the six months.

During the week of the monitoring review, an observation was completed of a meeting of this committee. There was good discussion among the participants, with several recommendations identified. The responsible person for each recommendation was identified with follow-up planned in one month's time.

Outcome 8 – Data are collected correctly and reliably.

Summary: With sustained correction of IOA protocols (to include a DSP), these indicators are likely to score higher at the next review. Indicator 29 will be moved to the category of requiring less oversight due to sustained high performance. They will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 26 | If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites. | 11% 1/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 | 0/1 |
| 27 | If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites. | 78% 7/9 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 |
| 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% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

Comments:
26. Following a review of individual PBSPs, it was determined that the data collection system adequately measured Individual #448's targeted problem behaviors. For all others, the PBSP indicated that episodes of targeted behaviors would be measured. In most cases, episodes were separated by five minutes without the occurrence of the target, but some episodes were as long as 10 minutes. There can be a great deal of variability in the length of episodes and by simply reporting on the number of episodes, one runs the risk of underreporting the significance of the behavior, particularly for those behaviors that can cause harm. BHS should consider measuring the duration of episodes, particularly as this information is usually included in the documentation guidelines.

27. The data collection system identified for replacement behaviors was found to be adequate for seven of nine individuals. The exceptions were Individual #336 and Individual #448 whose PBSPs did not include guidelines for documenting these appropriate behaviors.

28. The same monitoring tool that had been in place during the previous review continued to be used to assess data collection timeliness, inter-observer agreement, and treatment integrity.

As noted in the last report, the methodology for data collection timeliness and treatment integrity were acceptable.

As described in indicator 5, the BHS director had recognized this problem and had introduced a new form that assessed the degree to which two or more independent observers (i.e., a direct support professional and a behavioral health care staff member) reported the same measure of a behavior(s) after observing the same events. This was a very positive step, however, it had only been used with three individuals for the most recent one to two months (Individual #119, Individual #135, Individual #448).

29. The facility reported that the expectation was that data timeliness, IOA, and treatment integrity would be assessed monthly. Expected levels were 80%.

30. Between March 2021 and August 2021, measures of data collection timeliness, IOA, and treatment integrity were reported for at least five of six months for everyone, but Individual #336 and Individual #219.

No data were available for Individual #336 in July and August 2021.

Monitoring did not begin for Individual #219 until her full PBSP was implemented in late July 2021. As has been noted previously, interim PBSPs should also be assessed to ensure that data are accurate and that staff are not applying strategies that may be counterproductive to overall improvement.

Even though the scores for this indicator are low (due to the above reasons), facility staff are commended for taking steps to improve their IOA monitoring.

## 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. |
|---|
| The Monitoring Team no longer rates this outcome. The Center's responsibilities for these goals/objectives are now assessed as part of the Section F – ISP audit tool. |

Outcome 4 – Individuals receive preventative care.

Summary: It was positive that five of the nine individuals reviewed received the preventative care they needed. The remaining four individuals received most of the required preventative care. The area that requires the most focus is the provision of immunizations.

For six of the seven applicable individuals in the review group, medical practitioners 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. This showed improvement in comparison with the previous review.

| # | Indicator | Overall Score | Individuals: 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Individual receives timely preventative care: | | | | | | | | | | |
| | i. Immunizations | 56% 5/9 | 0/1 | 1/1 | 0/1 | 0/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| | ii. Colorectal cancer screening | 100% 3/3 | N/A | N/A | 1/1 | N/A | 1/1 | N/A | N/A | N/A | 1/1 |
| | iii. Breast cancer screening | 100% 2/2 | N/A | N/A | 1/1 | N/A | 1/1 | N/A | N/A | N/A | N/A |
| | iv. Vision screen | 100% 8/8 | N/A | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| | v. Hearing screen | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| | vi. Osteoporosis | 88% 7/8 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A | 1/1 |
| | vii. Cervical cancer screening | 100% 1/1 | N/A | N/A | N/A | N/A | 1/1 | N/A | N/A | N/A | N/A |
| b. | The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. | 86% 6/7 | 1/1 | N/A | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | N/A |

Comments: a. It was positive that five of the nine individuals reviewed received all of the preventive care they needed. The area that requires the most focus is the provision of immunizations. The following provide more specifics about the findings:

- For Individual #33:

- On 2/23/09, his last tetanus, diphtheria, and acellular pertussis (Tdap) vaccine was administered. In the AMA, the PCP acknowledged that it was 2.5 years overdue, and indicated that Center staff were seeking consent to administer a Td/Tdap booster.
- According to his last DEXA scan on 8/30/16, he had a T-score of -4.7. On 10/4/19, he was uncooperative with an attempt to complete a DEXA scan. On 7/14/21, the PCP reordered one.

- Individual #567 was 69 years old. On 1/15/13, she received her last Pneumovax 23 vaccination. After she turned 65, it should have been offered five years after her last dose, but this was not done.
- Similarly, Individual #566 was 66 years old. On 11/1/94, he received his last Pneumovax 23 vaccination. After he turned 65, it should have been offered again, but this was not done.
- On 8/6/20, Individual #242 had Hepatitis B antibody titer testing, which showed a non-reactive status. Based on interview with the PCP, a repeat series had not yet been scheduled.

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. It was positive that for most of the applicable individuals, PCPs did this, which showed good improvement in comparison with the previous review.

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 | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
| 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. | 50% 1/2 | N/A | N/A | 0/1 | N/A | N/A | N/A | 1/1 | N/A | N/A |

Comments: a. The reason listed for Individual #567's out-of-hospital (OOH) DNR was progressive cerebral palsy with spastic quadriplegia, oropharyngeal dysphagia, seizures, osteoporosis, hypertension (HTN), and diastolic dysfunction. It was initiated on 9/20/19. The indication for the DNR was not consistent with State Office guidelines.

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

| Summary: For most of the acute issues addressed at the Center that the Monitoring Team reviewed, PCPs conducted the necessary assessments, and follow-up. With regard to acute issues requiring ED visits or hospitalizations, as appropriate, prior to the hospitalization, ED visit, PCPs need to complete quality assessments. Given that over the last two review periods and during this review, when individuals were | Individuals: |
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| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| transferred to the hospital, the PCP or nurse often communicated necessary clinical information with hospital staff (Round 15 – 90%, Round 16 – 100%, and Round 17 - 92%), Indicator f will move to the category requiring less oversight.<br><br>Based on review of one of the individuals in the review group who had two aspiration pneumonia events, and two deaths related to aspiration pneumonia, PCPs need to provide more aggressive surveillance and documentation of acute aspiration pneumonia and aspiration-related illnesses. The Medical Director should provide oversight to ensure thorough evaluation, treatment, and documentation. | | | | | | | | | | | |
| # | Indicator | Overall Score | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
| 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. | 100% 14/14 | 2/2 | 1/1 | N/A | 2/2 | 2/2 | 2/2 | 2/2 | 1/1 | 2/2 |
| b. | If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes. | 80% 8/10 | 1/1 | 1/1 | | 1/1 | 0/2 | 2/2 | 1/1 | 1/1 | 1/1 |
| c. | If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition. | 83% 10/12 | 1/1 | 1/1 | 2/2 | 1/1 | 1/1 | 0/2 | 2/2 | N/A | 2/2 |
| d. | As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN. | 43% 3/7 | 1/1 | N/A | 0/1 | 1/1 | N/A | 0/1 | 1/2 | | 0/1 |
| e. | Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care. | Due to the Center's sustained performance, this indicator 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. | 92% 11/12 | 1/1 | 1/1 | 2/2 | 0/1 | 1/1 | 2/2 | 2/2 | | 2/2 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| g. | Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate. | 100% 8/8 | N/A | 1/1 | 2/2 | N/A | N/A | 2/2 | 1/1 | | 2/2 |
| h. | Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness. | 82% 9/11 | 1/1 | 1/1 | 2/2 | 1/1 | 1/1 | 2/2 | 0/1 | | 1/2 |

Comments: a. For eight of the nine individuals in the review group, the Monitoring Team reviewed 14 acute illnesses/occurrences addressed at the Center, including: Individual #33 (agitation on 7/30/21, and not swallowing on 7/27/21), Individual #448 (abdominal distension on 6/9/21), Individual #566 (cough on 6/24/21, and sore buttocks on 7/29/21), Individual #242 (cerumen impaction on 4/14/21, and left lower extremity swelling on 6/24/21), Individual #159 (rash on arms and legs on 4/20/21, and wound to right hip on 4/30/21), Individual #508 (wound on right hip on 5/12/21, and congestion on 5/7/21), Individual #143 (skin rash on 7/19/21), and Individual #134 (ecchymosis on 3/31/21, and hematuria on 5/21/21).

It was positive that the PCPs assessed all of these acute issues according to accepted clinical practice.

b. In most cases reviewed, the PCPs conducted follow-up assessments and documentation at a frequency consistent with the individuals' status and the presenting problem until the acute problem resolved or stabilized. The following provide specifics about concerns noted:

- According to an IPN, dated 4/14/21, the PCP found that Individual #242's bilateral tympanic membranes were occluded with cerumen. The plan was to start Debrox, and refer the individual to audiology for possible lavage. Based on interview with the medical compliance nurse, the audiology consult was not completed, because the audiologist was not notified. Reportedly, when a PCP writes an order in IRIS for an audiology consult, it is not transmitted to the audiologist.
- In an IPN, dated 6/24/21, the PCP ordered an x-ray of Individual #242's left tibia/fibula due to swelling. The plan also included for the individual to avoid weight bearing until further notice, and take Tylenol twice a day. Based on the documentation submitted, the PCP did not conduct follow-up. There was no evidence that the PCP reviewed the x-ray results, nor was it clear what the next steps were with regard to weight bearing activities.

c. For eight of the nine individuals reviewed, the Monitoring Team reviewed 12 acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #33 (ED visit for lethargy, low blood sugar, and a UTI on 4/5/21), Individual 448 (hospitalization for status epilepticus on 6/25/21), Individual #567 (hospitalization for seizures, pneumonia, and COVID-19 on 4/19/21; and hospitalization for seizures, COVID-19, and hypoxia on 4/24/21), Individual #566 (ED visit for fracture of proximal phalanx on 6/10/21), Individual #242 (ED visit for emesis, GERD, and UTI on 5/1/21), Individual #159 (hospitalization for fracture of right femur on 3/9/21, and hospitalization for fracture of right femur on 4/5/21), Individual #508 (hospitalization for sepsis and aspiration pneumonia on 6/7/21, and hospitalization for aspiration pneumonia on 8/2/21), and Individual #134 [hospitalization for septic shock due to UTI on 5/22/21, and hospitalization for septic shock, neutropenia, fever, and respiratory syncytial virus (RSV) positive on 8/16/21].

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, and follow-up care: Individual #33 (ED visit for lethargy, low blood sugar, and a UTI, on 4/5/21), Individual 448 (hospitalization for status epilepticus on 6/25/21), Individual #567 (hospitalization for seizures, COVID-19, and hypoxia on 4/24/21), and Individual #566 (ED visit for fracture of proximal phalanx on 6/10/21).
- On 4/19/21, during regular business hours, Individual #567 experienced a seizure that did not respond to Ativan 1 milligram (mg). After 20 minutes, staff contacted Emergency Medical Services (EMS) for transport to the ED. During this time, no evidence was found that a provider attempted to complete an exam. This individual's last seizure occurred on 5/26/16. During the event on 4/19/21, the individual's oxygen (O2) saturation dropped to 88 to 92%, and improved to 96%, when nursing staff administered oxygen at 2 liters per minute (LPM). While on route to the hospital, EMS staff administered another dose of Ativan as well as Versed, and the seizures abated while the individual was in the ED. She was hypotensive. A computed tomography scan of the brain showed no acute changes. The plan was to send her for a continuous electroencephalograph (EEG), but the hospital could not find a bed. She remained in the ED for three days, and required pressors briefly.
- For Individual #566's ED visit, no evidence was found that Center staff contacted hospital staff to provide a report.
- For Individual #159:
    - According to IPNs, dated 3/19/21, at 11:29 a.m., and 3:26 p.m., the PCP provided telephone triage prior to the individual being sent to the hospital, where he was diagnosed with a fractured right femur. It was not clear why a PCP/provider did not assess him in the hours between the telephone conversations with nursing staff. In the second IPN, the PCP reported receiving a report from radiology, and discussed sending the individual to the ED, but did not discuss what the report stated that would require an ED visit.
    - On 5/27/21, at 10:23 a.m., the PCP wrote an IPN for the individual's transfer to the ED on 4/5/21 at 3:20 a.m. A nurse had called to report that the individual fell out of bed, and staff heard a pop. The individual was complaining of pain and his right leg had started to swell. The PCP gave an order for the individual to go to ED via EMS.
- For Individual #508:
    - On 6/7/21, he was hospitalized with severe sepsis and aspiration pneumonia. Upon his return from the hospital, on 6/13/21, no PCP post-hospital IPNs to document follow-up were found in the submitted documents.
    - On 8/2/21, at 12:07 p.m., the PCP received a call from a nurse stating that the individual had just finished eating, and had received his medication. He was in distress, making gurgling sounds while breathing. His O2 saturation was 70%. At 12:10 p.m., the PCP wrote an order to place him on an oxygen face mask, and to send him to the ED. It was not until 12:33 p.m. that EMS transported him to the ED. Given that these events occurred during business hours, it was unclear why a provider did not attempt to go to the home during the 23-minute window of time to assess and treat the individual until EMS arrived. He was admitted to the hospital and diagnosed with aspiration pneumonia. On 8/17/21, he died with cause of death listed as aspiration pneumonia.
- For Individual #134:
    - From 5/22/21 to 5/25/21, the individual was hospitalized for septic shock due to a UTI. The PCP did not see him on the first day of his return, but rather only reviewed the discharge report from the hospital in an IPN. On 5/26/21, the PCP wrote no note.
    - When the individual was sent to the hospital on 8/16/21, the PCP was off-site, but spoke to nursing staff who reported that the individual was on the commode, was difficult to arouse, and was shivering with a temperature of 96.2. He had

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| a cough and congestion. The PCP ordered his transfer to the ED. It was not clear why during business hours, another provider was not available on campus to assess and/or treat the individual. |

| Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Since the last review, it was good to see improvement with regard to the timeliness of PCPs' reviews of non-facility consultations, the completion of related IPNs, and PCPs writing orders for agreed-upon recommendations (i.e., after the last review, Indicator d was at risk of returning to active oversight). The Center needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
| a. | If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement. | Due to the Center's sustained performance, this indicator moved to the category requiring less oversight. | | | | | | | | | |
| b. | PCP completes review within five business days, or sooner if clinically indicated. | 83% 15/18 | 0/2 | 2/2 | 2/2 | 1/2 | 2/2 | 2/2 | 2/2 | 2/2 | 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. | 100% 18/18 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 |
| d. | If PCP agrees with consultation recommendation(s), there is evidence it was ordered. | Due to the Center's sustained performance, this indicator moved to the category requiring less oversight. | | | | | | | | | |
| e. | As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans. | 50% 3/6 | 0/2 | N/A | 0/1 | N/A | 2/2 | 1/1 | N/A | N/A | N/A |

Comments: For the nine individuals in the review group, the Monitoring Team reviewed a total of 18 consultations. The consultations reviewed included those for Individual #33 for dermatology on 4/27/21, and endocrinology on 7/13/21; Individual #448 for neurology on 6/9/21, and neurology on 8/11/21; Individual #567 for podiatry on 7/8/21, and optometry on 7/27/21; Individual #566 for endocrinology on 6/12/21, and neurology on 4/14/21; Individual #242 for orthopedics on 4/16/21, and orthopedics on 5/28/21; Individual #159 for endocrinology on 6/10/21, and neurology on 7/9/21; Individual #508 for allergist on 7/19/21, and neurology on 7/14/21; Individual #143 for ear, nose, and throat (ENT) on 5/10/21, and neurology on 4/20/21; and Individual #134 for hematology on 6/18/21, and urology on 7/22/21.

b. The following did not occur timely:

- Individual #33's consultations for dermatology on 4/27/21 (on 5/25/21, medical records received the consult report, but the PCP entered the IPN on 5/21/21), and endocrinology on 7/13/21 (on 7/19/21, medical records received the consult report, but the PCP entered the IPN on 7/15/21). For these two consults, the Monitoring Team could not determine when the consult was available based on discussion with the PCP or evidence submitted; and
- Individual #566's consultation for endocrinology on 6/12/21 (i.e., IPN on 6/22/21).

c. and d. It was positive that all of the PCP IPNs related to the consultations reviewed included all of the components State Office policy requires. In addition, when PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments.

e. The PCP indicated the need for IDT referral for: Individual #33 for dermatology on 4/27/21, and endocrinology on 7/13/21. However, based on the ISPAs submitted, the IDT did not meet to discuss them.

For Individual #567's optometry consultation on 7/27/21, the PCP made a referral to the IDT "as per routine." During interview, the PCP was not able to explain what this meant. Based on the ISPAs submitted, the IDT did not meet to discuss this consultation.

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

Summary: Although additional work was necessary, it was positive that for a number of individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.

| # | Indicator | Overall Score | Individuals: 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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. | 67% 12/18 | 1/2 | 0/2 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 1/2 | 0/2 |

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #33 – UTIs, and GI problems; Individual #448 – GI problems, and seizures; Individual #567 – cardiac disease, and seizures; Individual #566 – fractures, and skin integrity; Individual #242 – other: pain management, and UTIs; Individual #159 – seizures, and osteoporosis; Individual #508 – skin integrity, and GI problems; Individual #143 – aspiration, and seizures; and Individual #134 – osteoporosis, and UTIs).

a. For the following individuals' chronic or at-risk conditions, PCPs conducted medical assessments, tests, and evaluations consistent with current standards of care, and the PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #33 – GI problems; Individual #567 – cardiac disease, and seizures; Individual #566 – fractures, and skin integrity; Individual #242 – other: pain management, and UTIs; Individual #159 – seizures, and osteoporosis; Individual #508 – skin integrity, and GI problems; and Individual #143 – seizures.

The following provide examples of concerns noted:

- On 7/19/16, Individual #33 completed a urology consult for recurrent UTIs and urosepsis. He had a history of urological repair resulting in multiple fine web urethral strictures that required manual dilation. At that time, there was no evidence of urinary retention. The recommendation was that nursing staff should not undertake urethral catheterization at the home, and that urology would be in charge of obtaining urine samples, if needed, via catheterization due to the risk of injury from the presence of the stricture(s). An aggressive laxative regimen and serial kidney, ureter, and bladder x-rays (KUBs) were also recommended to monitor constipation, because his large stool burden at the time was considered a significant risk contributing to UTIs. On 1/18/17, at a follow -up visit for recurrent UTIs, the urologist was unable to complete urethral dilation due to the individual's uncooperativeness, and the consultant cancelled all follow-up appointments. On 2/9/18, 7/6/18, and 1/31/19, the individual subsequently received treatment for UTIs. During a hospitalization in 2019 for a small bowel obstruction, he had an acute kidney injury. On 9/11/19, a new urologist saw him, and follow-up was to be scheduled as needed. In December 2020, he was hospitalized with respiratory failure due to COVID-19 positivity, multifocal pneumonia, and a UTI. In January 2021, he was hospitalized for alteration in mental status and a UTI, associated with vomiting.

  At the time of the Monitoring Team's review, he continued to have unresolved issues. The 2019 urology consult did not provide follow-up resolution as to whether staff could catheterize him. There was no follow-up regarding whether or not serial urethral dilatation every six months was indicated. The submitted physician orders for this review did not include a statement that staff at the SSLC were not to catheterize him. These issues needed further clarification. He has continued to have UTIs, but it was not clear if he had ongoing asymptomatic bacteriuria for which treatment would only lead to increasing resistance. Further urology review was indicated.

- Individual #448 had a seizure disorder. In March 2015, he developed status epilepticus, and was started on Keppra. On 10/26/16, he again had status epilepticus and was diagnosed with pneumonia, which was treated. On 3/16/18, he was sent to the ED for a seizure, and was given Ativan to stop the seizure. On 10/5/19, he had a postictal hemiplegia. On 12/29/19, he was hospitalized for seizures. On 4/27/20, he was hospitalized for seizures with postictal hemiparesis, as well as pneumonia. On 9/24/20, he was hospitalized for postictal Todd's paralysis and anisocoria. On 12/8/20, he was sent to the ED due to having a seizure associated with a fall and a head injury. At that time, he sustained a nondisplaced left temporal bone fracture of his skull. No treatment was indicated. He also had a rupture of his tympanic membrane. A neurology consult recommended an increase in the Keppra dosage. The anisocoria resolved. Due to the severity of the fall-related injury, a soft shell helmet was recommended. Staff verbally reported that he did not tolerate the helmet, but there was no written documentation of attempts or reactions from the individual. On 3/10/21, a neurologist consultation report included recommendations to continue Keppra and start Vimpat. On 6/9/21, neurology follow-up indicated no further change in medication. On 6/25/21, he had a prolonged seizure requiring rectal diazepam gel, and he was hospitalized for hypoxia, vomiting, and a seizure cluster. Aspiration pneumonia was suspected, because he vomited. On 7/7/21, at the time of his return to the SSLC, testing showed that Keppra and Lacosamide levels were initially low. The following day, these tests were repeated, as he was no longer having seizures. The repeat testing indicated therapeutic levels for both medications. On 8/11/21, neurology recommendations were to continue the medications. The prevention of future head injury was not further reviewed. As stated above, the lack of helmet use remained a concern, especially given the lack of documentation of attempts, or involvement of other disciplines, such as

behavioral health. Evaluation and treatment remained incomplete in preventing further injury during seizures to the extent possible.

- On 5/30/19, Individual #448 was hospitalized for a large emesis with coffee ground color. His hemoglobin (Hgb) was 7.8. An esophagogastroduodenoscopy (EGD) revealed an antral ulcer with cauterization of a vessel. He underwent a transfusion with two units of packed red blood cells. A nine-centimeter (cm) foreign body was found in his stomach. Removal was not successful. There was concern about esophageal perforation or aspiration during attempts. It appeared to have been present for some time. He was started on Protonix, a proton pump inhibitor. He was found to be H pylori positive, and this was treated. On 7/31/20, he underwent partial removal of the foreign body/bezoar, with initiation of a pica protocol at that time. On 8/28/20, he underwent a laparoscopic gastrostomy foreign body/bezoar removal. He was continued on a proton pump inhibitor.

  The plan of care section of the AMA did not address pica prevention, such as his level of supervision, frequency of pica sweeps, identification of specific items that he was at risk for ingesting, etc. Referral was made to behavioral health services and psychiatry. There was subsequent verbal discussion from other departments that pica restriction and environmental sweeps were being reduced and/or removed. The reason for these reductions were not clear. The submitted ISPAs, and PCP IPN documentation, as well as the PNMP, did not discuss pica and steps taken to prevent pica.

- Individual #143 has a history of dysphagia. On 4/10/17, an MBSS indicated moderate oropharyngeal dysphagia with recommendations for a diet of chopped solids and honey-thickened liquids. Based on an MBSS report, dated 10/11/19, he was changed to a ground diet with nectar-thickened liquids. In addition, an OT IPN, dated 3/19/21, documented that he had a high risk of choking due to several challenges, including decreased swallowing/chewing skills, as well as lethargy, limited attention to task, and a prior history of choking incidents. An OT IPN, dated 6/8/21, documented an MBSS update, in which he chewed continuously, but had difficulty forming a bolus, and moving it to the back of his mouth in order to initiate a swallow. At that time, the same diet was recommended (i.e., ground diet with nectar-thickened liquids). He had silent aspiration with thin liquids. However, although the dietary section of the AMA, dated 11/4/20, recorded a ground diet and nectar-thickened liquids, the plan of care section in the AMA indicated he "receives chopped diet and nectar thickened liquids currently." This was incorrect. If someone were to focus on the plan of care section of the AMA and implement this diet, it would put the individual at increased risk. Inconsistencies in documentation need to be minimized to ensure documents reflect the needs of the individual, and treatment is based on relevant evaluations.

- Individual #134 had a history of recurrent UTIs as well as renal pathology. An 11/23/19 CT of the abdomen and pelvis reported a concentric urinary bladder with wall thickening, likely due to cystitis. There also were indeterminate bilateral renal lesions found. As a follow-up, on 1/10/20, a CT of the abdomen was completed, and the report indicated Bosniak 2F left midportion and inferior renal cysts. More recently, on 5/21/21, he reportedly had gross hematuria. He subsequently was hospitalized for urosepsis. A blood culture was negative and a urine culture was not completed in the hospital, but empiric therapy resolved his illness. On 5/25/21, he returned to the SSLC. Discharge recommendations included that he follow up with urology for benign prostatic hyperplasia (BPH) and possible urinary retention. On 6/10/21, a follow-up straight catheterization was completed, and it grew out a resistant strain of E coli sensitive to nitrofurantoin, which was prescribed. He

remained asymptomatic during this time. On 7/5/21, a repeat culture grew another multiple drug resistant organism (MDRO), and he was prescribed Fosfomycin. He remained asymptomatic. On 7/21/21, a follow-up urine specimen was collected by catheterization, which again showed bacteriuria. He was not treated, but on 7/22/21, he had an appointment with a urologist. The urologist recommended monitoring the urine culture, and indicated they could not determine post-void residual. It was recommended that cystoscopy under anesthesia might be needed in the future to provide more information. On 8/16/21, the individual was sent to the hospital for a change in mental status, and during the hospitalization was treated with intravenous (IV) antibiotics. During this hospitalization, infectious disease consultation was provided, and a full course of IV antibiotics was recommended. On 9/2/21, after receiving IV therapy at an Acute Care Long-term Care (LTC) facility, he returned to the SSLC. The PCP note, dated 9/3/21, indicated no further antibiotic treatment was to be given.

For this individual, it would be important that a urologist as well as an infectious disease specialist remain involved. There were several tests of cure when he was asymptomatic, leading to additional courses of antibiotics with increasing resistance of the bacteria. Going forward, it would be important to have recommendations from these consultants to determine the need/role of tests of cure to ensure practice consistent with current generally accepted standards. Additionally, during the hospitalization, on 8/16/21 (i.e., one year and seven months after the prior imaging study), he had a follow up CT of the abdomen that showed the left renal hypodensity. Although the radiology report referenced a comparison with a 2019 CT, it did not state whether the renal hypodensity was unchanged/stable, and there was no PCP IPN discussing follow-up to clarify this concern. Additionally, the plan of care section of the AMA did not discuss a plan for ongoing serial follow-up imaging of the Bosniak 2F cysts, which is suggested in the medical literature (i.e., six-month initial follow-up, which was missed in this case, then annually for five years).

- Individual #134 has spastic quadriplegia, right foot drop, flexion contracture of both knees, and a history of osteoporosis as far back as 2010 (i.e., DEXA scan with T score of -2.5). From 2011 through 2013, he was prescribed Forteo injections. From 2013 to February 2017, he was prescribed Prolia. From 10/13/17 onward, he was prescribed IV Reclast annually. It appeared he received his 2017 and 2018 dosages, but his dosage due in August 2019 was delayed pending a dental procedure, which subsequently did not occur. On 1/5/20, he was given a dosage, and in January 2021, he missed his dose. The submitted document did not indicate that it had been given since that time, because he was still pending extraction of four teeth.

  The plan of care section of the AMA indicated that in October 2017, he received IV Reclast, and then starting in October 2018, oral bisphosphonate, but that did not appear therapeutically consistent with an IV dose of Reclast given on 1/5/20. Overall, he appeared to have missed either an annual IV dosage in 2021 or routine oral doses over an extended period of time. There was no documentation of coordination with the Dental Department regarding whether bisphosphonate therapy should have been resumed, if there were potential significant delays for general anesthesia due to COVID 19 precautions, or whether the dental procedure could have been scheduled as a priority so as not to miss treatments for osteoporosis over extended periods of time.

  Based on serial DEXA scans, his diagnosis of osteoporosis improved over the years, indicating the positive impact of the various treatments provided. In the plan of care section of the AMA, the PCP noted that referral to endocrinology was being considered. In the meantime, he continued to be prescribed Vitamin D and calcium supplementation. However, once dental procedures were placed on hold, there needed to be a plan in place for monitoring the ongoing delay in treatment for prescribing

antiresorptive therapy, to determine the best timing of treatment in improving and maintaining bone health. Additionally, according to the AMA, the individual's Vitamin D level was last updated on 6/3/21; however, the plan of care should identify the frequency of the Vitamin D level testing (e.g., annually, every six months) as a part of comprehensive recommendations for this risk.

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

Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. For 15 of the chronic conditions/risk areas reviewed, the IDT assigned no interventions to the PCP. However, for one of the 18 IHCPs reviewed, documentation was found to show implementation of those few action steps that IDTs had assigned to PCPs and included in IHCPs/ISPs. Due to ongoing problems with the quality of the medical plans included in IHCPs, this indicator did not provide an accurate picture of whether or not PCPs implemented necessary interventions. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.

| # | Indicator | Overall Score | Individuals: 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions. | 33% 1/3 | N/A | 0/2 | N/A | N/A | N/A | 1/1 | N/A | N/A | N/A |

Comments: a. As noted above, none of the 18 IHCPs reviewed included a full set of action steps to address individuals' medical needs. The remaining IHCPs did not include a full set of medical interventions as necessary to meet the individuals' needs. For 15 of the chronic conditions/risk areas reviewed, the IDT assigned no interventions to the PCP. However, the action steps assigned to the PCPs were implemented for the following: Individual #159 – osteoporosis (i.e., review DEXA scan, and order pre-treatment sedation as needed.

Individual #448's IHCPs for GI problems, and seizures included action steps for the completion of IMRs every three months. Based on the documentation submitted, the PCP did not complete IMRs.

Due to ongoing problems with the quality of the medical plans included in IHCPs, this indicator did not provide an accurate picture of whether or not PCPs implemented necessary interventions.

## Dental

In a letter, dated 8/23/21, the Monitor notified the parties that the Center achieved substantial compliance with most of the requirements of Section Q of the Settlement Agreement. The exceptions are: 1) implementation of a policy/clinical guideline that is consistent with current generally accepted standards of care on perioperative assessment and management of individuals needing TIVA/general anesthesia for dental work, which the Monitoring Team will continue to assess and apply the findings to paragraphs H.7 of the Settlement Agreement; and 2) personal goals/objectives for individuals who are at risk for dental problems, as well as the development and implementation of plans for individuals who require suction tooth brushing, which the Monitoring Team will assess as part of Section F. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Brenham SSLC exited from the other requirements of Section Q of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the related outcomes and indicators.

## Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.

Summary: Nursing assessments at the onset of signs and symptoms of acute illnesses/occurrences that are in alignment with applicable guidelines is an area on which the Center needs to focus. It was positive that in most instances reviewed, nursing staff timely notified the practitioner/physician of individuals' signs and symptoms. Often, though, they did not document the specific information they shared with the providers in IPNs, as required by the relevant nursing guidelines.

For the six acute illnesses/occurrences reviewed, nursing staff developed acute care plans. Three of them met the criteria for quality, but one of these three was initiated late, which did not meet the individual's needs. The remaining three included some of the necessary interventions, but they were missing key interventions. Nurses thoroughly implemented only one of the six acute care plans. Currently, these indicators will remain in active oversight.

| # | Indicator | Overall Score | Individuals: 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
|---|---|---|---|---|---|---|---|---|---|---|---|

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed. | 17%<br>1/6 | 0/1 | 0/1 | 0/1 | 0/1 | N/R | 1/1 | 0/1 | N/R | N/R |
| 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. | 33%<br>2/6 | 0/1 | 1/1 | 0/1 | 0/1 | | 1/1 | 0/1 | | |
| c. | For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments. | 50%<br>1/2 | N/A | N/A | N/A | 0/1 | | 1/1 | 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. | 60%<br>3/5 | 0/1 | 1/1 | 1/1 | 1/1 | | N/A | 0/1 | | |
| e. | The individual has an acute care plan that meets his/her needs. | 33%<br>2/6 | 0/1 | 1/1 | 0/1 | 1/1 | | 0/1 | 0/1 | | |
| f. | The individual's acute care plan is implemented. | 17%<br>1/6 | 0/1 | 0/1 | 0/1 | 1/1 | | 0/1 | 0/1 | | |

Comments: The Monitoring Team reviewed six acute illnesses and/or acute occurrences for six individuals, including Individual #33 – urinary tract infection (UTI) on 4/5/21; Individual #448 – status epilepticus on 6/25/21; Individual #567 – seizures, pneumonia, and COVID-19 positive on 4/24/21; Individual #566 – fracture of left index finger on 6/10/21; Individual #159 – fracture of left ulnar shaft on 5/17/21; and Individual #508 – aspiration pneumonia and severe sepsis on 6/7/21.

a. through f. The following provide some examples of findings related to this outcome:

- The acute illness/occurrence for which nurses performed initial nursing assessments (physical assessments) in accordance with applicable nursing guidelines was for Individual #159 – fracture of left ulnar shaft on 5/17/21.
- On 4/5/21, Individual #33 presented with lethargy, and slept through class. He did not want to eat lunch, and would only drink some fluids. Based on documents submitted, nursing staff did not complete an assessment. According to an IPN, at 12:39 p.m., the PCP ordered his transfer to the ED. It was unclear what information nursing staff provided to the PCP. The individual had a blood sugar of 57, and was diagnosed with a UTI.

  Upon his return to the Center, nursing staff did not conduct an assessment consistent with the nursing guidelines for ED transfers. The assessment was limited to vital signs, a pain assessment, and a note that the individual was "alert."

  The acute care plan was not consistent with the nursing guidelines for a UTI. It was positive that it included interventions for the assessment of vital signs, and pain, including the frequency. However, it did not include interventions to assess the individual's abdomen, intake and output, voiding patterns, and/or characteristics of his urine. Nursing staff did not conduct necessary follow-up assessments.

- Beginning at 2:58 a.m., on 6/25/21, Individual #448 experienced status epilepticus. His first seizure began at 2:58 a.m. He had additional seizures at 3:38 a.m., 3:59 a.m., 4:15 a.m., 4:32 a.m., 4:40 a.m., and 4:51 a.m. At 3:34 a.m., and 3:53 a.m., the nurse called the PCP, who ordered the Diastat during the later call. At 4:00 a.m., the nurse administered the Diastat, and administered O2 at 4:25 a.m. At 4:17 a.m., and 4:34 a.m., the individual had episodes of emesis. At 4:39 a.m., following the emesis, the nurse called the PCP again, who ordered the individual's transport to the ED.

  In terms of the nursing assessments, the nurse conducted the first assessment at 3:08 a.m. This assessment did not meet the nursing guidelines, because it was missing precipitating factors, lung sounds, last bowel movement, and the individual's level of consciousness other than to say "alert." At 3:40 a.m., and 4:02 a.m., the nurse entered the additional IView assessments. All of them were missing the same elements.

  Nursing staff promptly notified the provider, and provided information in accordance with the nursing guidelines for notification. It was positive that nursing staff developed an acute care plan that met the individual's needs, as well as the criteria for quality. Based on the documentation submitted, nurses did not assess and/or document the individual's breath sounds every shift (i.e., they were only noted on 7/1/21).
- On 4/23/21, Individual #567 experienced emesis six times, and nursing staff initiated and followed the emesis guidelines. The noon feeding was held. At 4:00 p.m., the individual tolerated the feeding, despite having a residual of 210 cubic centimeter (cc). When it was time for the 7:00 p.m. feeding, though, there was still a residual of 210 cc. The PCP ordered nursing staff to hold the feeding. Following each emesis, nursing staff notified the PCP. On 4/24/21, at 5:40 a.m., the individual had an episode of emesis, and then, seizures at 5:50 a.m. for 30 seconds, and at 6:00 a.m. for one minute and 40 seconds. According to an IPN, the individual had another seizure at 6:14 a.m., but the nurse did not document this in alignment with the seizure guidelines. At 6:18 a.m., the individual had a seizure for one minute, and at 6:35 a.m., and 6:43 a.m., she had 30-second seizures. At 6:45 a.m., the nurse called the PCP, who ordered the individual's transfer to the ED. Nursing staff did not follow the guidelines with regard to documenting the information provided to the PCP. At 6:51 a.m., the individual had a one-minute seizure with the "same characteristics of previous." While the individual was on the Emergency Medical Services (EMS) stretcher, she had another seizure. Nursing staff did not follow the guidelines in describing this seizure.

  It was positive that nursing staff developed an acute care plan, and that contained a number of necessary interventions. It was inconsistent with the guidelines relevant to a respiratory impairment, though, in that it did not include interventions to conduct abdominal assessments, and check the residuals. The individual also had a non-productive, infrequent cough, but the plan did not include interventions to address her cough. Based on documentation submitted, nursing staff did not check her lung sounds each shift, but instead checked them only once daily.
- On 6/10/21, when Individual #566 fractured his finger, nursing staff did not check the capillary refill, which is standard for an injury with swelling. Although nursing staff notified the PCP, they did not document the notification according to the nursing guidelines, and did not document the specific information they told the provider. He remained at the Center for 24 hours prior to his transport to the ED. During this time, nurses assessed him each shift for pain and swelling, but they did not consistently check his range of motion and/or capillary refill.

It was positive that prior to and upon his return from the ED, nursing staff conducted and documented assessments consistent with the related guidelines. Nursing staff also developed an acute care plan that met the individual's needs, as well as the criteria for quality. Nurses also implemented the plan.

- On 4/28/21, Individual #159 had swelling of his left forearm and hand. Nursing staff assessed him immediately in accordance with the nursing guidelines for a suspected fracture. Nursing staff notified the PCP, who ordered that nursing staff monitor the individual. Nursing staff continued to monitor him in accordance with the guidelines through 5/3/21, at which point they documented that the swelling had resolved. Until 5/16/21, nurses conducted no further assessments. The individual's mother then expressed concern that his arm "still looks swollen." At this time, a nurse conducted an immediate assessment according to guidelines, and notified the on-call PCP. The following day, the individual went out for an x-ray, and was diagnosed with a left ulnar shaft fracture.

  The acute care plan did not follow nursing standards or the nursing guidelines for fractures. For example, it included an intervention to check circulation and report changes, but it did not say how often. Based on review of IPNs and IView entries, nursing staff did not note that a splint had been applied until 5/19/21. It was unclear if he had a splint on his arm or leg. The plan also sis not include interventions to monitor for swelling, or to elevate his arm/hand and/or apply ice, as needed. In terms of implementation of the acute care plan, it included an intervention for the RNCM to review the care plan daily, and for staff to monitor him for pain every four hours. No documentation was found to show that the RNCM reviewed care plan daily. IPNs showed monitoring for pain every shift, as opposed to every four hours.
- On 6/7/21, at 12:15 p.m., staff discovered that Individual #508 was gurgling, and was unable to clear his throat or cough. The nurse only assessed his blood pressure and oxygen saturation, which were 155/98, and 57% on room air, respectively. Based on IView entries, nursing staff did not document his pulse, temperature, or respirations, except that IView stated irregular respirations and regular heart rate. Other inconsistencies with the respiratory distress/aspiration nursing guidelines were the lack of assessments of the individual's lung sounds, abdomen, and/or skin. Although the nurse notified medical staff, they did not document the information that was shared.

  Upon the individual's return from the hospital, no skin assessment was completed and/or documented. Although the acute care plan met the criteria for quality, nursing staff developed it late. More specifically, on 6/13/21, at 12:05 p.m., the individual returned to the Center, but it was not until 6/14/21, at 1:14 p.m., that nursing staff initiated the acute care plan. Given the diagnoses of aspiration pneumonia, and severe sepsis, this delay of over 24 hours did not meet the individual's needs.

  The acute care plan required the completion of lung sounds every shift for seven days. Nursing staff assessed his lung sounds only once on 6/16/21, and once on 6/18/21, and not at all on 6/19/21. The next breath sounds were not done until 6/29/21, and the acute care plan was closed on 6/30/21.

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.

The Monitoring Team no longer rates this outcome. The Center's responsibilities for these goals/objectives are now assessed as part of the Section F – ISP audit tool.

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 that were sufficient to address individuals' at-risk conditions, and even for those included in the IHCPs, documentation often was not present to show nurses implemented them. A significant problem was the lack of measurability of the supports.

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.

| # | Indicator | Overall Score | Individuals: 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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. | 8% 1/12 | 0/2 | 0/2 | 1/2 | 0/2 | N/R | 0/2 | 0/2 | N/R | N/R |
| b. | When the risk to the individual warranted, there is evidence the team took immediate action. | 10% 1/10 | 0/2 | 0/1 | 1/2 | 0/2 | | 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). | 8% 1/12 | 0/2 | 0/2 | 1/2 | 0/2 | | 0/2 | 0/2 | | |

Comments: As noted above, the Monitoring Team reviewed a total of 12 specific risk areas for six individuals, and as available, the IHCPs to address them.

a. and c. As noted above, for individuals with medium and high mental health and physical health risks, 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 nurses implemented them. 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 nurses implemented the interventions thoroughly. The exception was for Individual #566 for aspiration.

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

In other instances, nurses/staff did not consistently document specific data required by the nursing interventions included in individuals' IHCPs. At times, this placed individuals at significant risk. For example:

- Individual #508's IHCP for aspiration/respiratory compromise included an intervention for nursing staff to instruct direct support professional staff to notify nursing immediately of any signs of respiratory distress during meal intake. Another

intervention required nursing staff to assess lung sounds every shift for 72 hours related to respiratory compromise and signs and symptoms of distress/emesis. On 6/15/21, staff notified the direct care nurse that they heard rattling noises while the individual was having lunch. Based on the documentation submitted, it was unclear what time staff notified the nurse. At 12:24 p.m., the direct care nurse arrived to assess the individual, and noted more adventitious sounds. The nurse did not document whether feeding had stopped, or approval was sought/provided for him to continue his lunch. On 6/17/21, he was diagnosed with aspiration pneumonia again.

b. As illustrated below, a continuing problem at the Center was the lack of urgency with which IDTs addressed individuals' 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, and modifications to plans to address their needs. The following provide some examples of IDTs' responses to the need to address individuals' risks:

- Individual #33's IDT rated him at high risk for aspiration/respiratory compromise. A contributing factor was his ongoing rumination/emesis. During the month of March 2021, he had 18 episodes of emesis/rumination. According to an ISPA, on 3/31/21, the IDT met and recommended Neurontin to assist with rumination. The team did not meet again until 5/5/21, at which time they discussed his weight loss. The IDT documented no review of whether the Neurontin was implemented, and if it was, what the outcome was. While his IDT conducted a "root cause analysis" regarding weight loss, they did not review the times of days when emesis/rumination occurred, or analyze whether these episodes were linked to foods he ate or medications he took.
- On 4/5/21, Individual #33 was sent to the ED due to lethargy and low blood sugar. He was diagnosed with a urinary tract infection (UTI). Previously, he had an ED visit on 1/27/21, for a UTI, and on 1/28/21, he was hospitalized to treat the UTI. Based on documentation submitted, the IDT did not meet after the UTI in April to review and/or revise the IHCP. As reflected elsewhere in this report, his IHCP for infections did not meet his needs. At his ISP meeting on 6/15/21, the only nursing interventions the IDT included in his infections IHCP were to provide DSP instructions about signs and symptoms of UTIs that they should report to nursing, monitor labs as ordered by the PCP, and conduct skin assessments quarterly (which are required for all individuals). No evidence was found to show that the IDT looked at possible causes of the UTIs, and included/revised interventions in the IHCP to prevent UTIs to the extent possible.
- From 4/24/21 to 4/30/21, Individual #567 was hospitalized following four episodes of emesis on 4/23/21, and one on 4/24/21, as well as status epilepticus on 4/24/21. She was diagnosed with pneumonia and COVID-19. On 5/3/21, the IDT met, but did not address the multiple episodes of emesis prior to her hospitalization. On 5/11/21, the IDT met again and noted that she received Zofran for emesis during the hospitalization. On 5/25/21, the IDT held her annual ISP meeting, and developed IHCPs. As reflected elsewhere in this report, her IHCP for aspiration/respiratory compromise did not meet her needs. Specifically, it did not address how to minimize the risk of emesis, which can be a strong contributing factor for aspiration for the individual. Although it addressed positioning, it did not include an intervention for nurses to check for residuals prior to medication administration/feedings.
- On 7/29/21, staff discovered a Stage 3 pressure injury on Individual #566's right ischial tuberosity. On 8/5/21, the IDT met, made a referral to the PNMT, and also made changes to his IHCP. On 9/9/21, the IDT met to review the PNMT recommendations.

  The CoS IHCP was not as specific enough to meet his needs. For example, the IDT included an intervention to monitor the cushions for use on hard-sitting surfaces, and order replacements when they were torn/worn. However, the IDT did not define

who specifically would be responsible. The revised IHCP did not address check and change every two hours. It was not specific about the wound care that would be done, or when the injury would be reassessed. The IDT included an intervention to remind the individual to change positions "frequently," but did not identify how frequently he should change positions.

- In June 2021, Individual #566 fell twice. The IDT did not meet to discuss these falls. During an ISPA meeting, on 6/21/21, that the IDT held to discuss a finger fracture, which he sustained by slamming the finger in the car door, they mentioned one of the falls, and indicated that he had not sustained any injuries. This was not accurate. During one of the falls, he sustained a scratch as well as bruising to his head, which required nursing staff to implement mild head injury neurological checks. The IDT should have taken this opportunity to review his IHCP for falls, which did not meet his needs. More specifically, his IHCP for falls included a preventive intervention of ensuring his environment was free of clutter and had optimal lighting, which was positive. However, the IDT did not address the fact that his ball "caused" some of his with interventions to avoid this cause of his falls.
- Individual #159 experienced a number of recent fractures, including: on 3/10/21, a closed fracture of the right hip; on 4/5/21, a displaced oblique fracture of the shaft of his right femur; and on 5/17/21, a subacute fracture of the distal ulnar shaft of his left arm. On 5/27/21, the IDT met to conduct a "root cause analysis" for multiple fractures. While they decided he needed a new goal to show improvement in his DEXA score by 2023, improvement in DEXA results is a long-term goal and will not help to reduce his fracture risk in the short-term, which was individual's immediate problem. In addition, he had an IHCP discontinued on 5/28/21. On 5/28/21, the IDT planned the second set of IHCP interventions, but it was not until 8/31/21, that it was initiated. This left a three-month gap during which the individual did not have an active IHCP to address this risk. In addition, the interventions were not measurable and did not support decreasing fractures. The IHCP included no preventive interventions, nor did it include proactive nursing assessments.
- According to his IRRF, dated 3/24/21, Individual #508 was at high risk related to aspiration/respiratory compromise. In the discussion section, the IDT documented: "Recommendations to remain High due to diagnosis of dysphagia, pureed diet texture, (1) hospitalization related to diagnosis of Respiratory compromise/aspiration this annual review… OT/SLP recommend High risk due to diagnosis of seizures; recurrent 'episodes of near syncope;' diagnosis of GERD and constipation; moderate oropharyngeal dysphagia with aspiration on thin liquid and abnormal mastication per MBS; dependent for positioning; at times is distracted/vocalizes/laughs while eating and drinking; history of pneumonia…" On 9/12/20, he was discharged from the hospital with a diagnosis of aspiration pneumonia. His annual IHCP, initiated on 4/1/21, included the following nursing assessment intervention: "Assess lung sounds Q Shift x 72 hours r/t Respiratory comp s/o distress/Emesis." It also included an intervention for the RNCM to complete quarterly and annual respiratory assessments, which is an expectation for all individuals. Given this individual's heightened risk, and ongoing oral intake, these interventions did not represent a proactive approach to respiratory assessments to identify potential problems early.

  On 6/17/21, he was diagnosed with aspiration pneumonia again. On 6/11/21, the IDT held an ISPA meeting to discuss his return from the hospital, and they met again on 6/14/21, at which time they referred him to the PNMT. The change of status IHCP, initiated on 6/22/21, included the same interventions for respiratory assessments as the annual IHCP. The only changes made were to revise the goal (i.e., because he did not meet the previous one due to the aspiration pneumonia diagnosis), and the IDT added an intervention for DSPs to notify nursing staff if the individual was coughing or gurgling. On 8/2/21, he was again diagnosed with aspiration pneumonia. On 8/17/21, he died with cause of death listed as aspiration pneumonia.

- On 4/27/21, staff discovered that Individual #508 had a Stage 2 pressure injury on his right greater trochanter. The IDT did not meet to discuss it until 5/11/21. They changed the goal (i.e., because he did not meet the previous one with the discovery of the pressure injury). They made no other changes to the interventions in his skin integrity IHCP. The IHCP included no interventions to address pressure-relieving activities. It did not include the frequency for check and change, a positioning schedule, etc. The IDT provided no specifics as to when the RNCM or nurse would evaluate him for signs and symptoms of skin integrity issues. This individual had a history of pressure injuries to one specific area, which should have been identified for specific monitoring with the frequency identified to individualize plan.

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

Summary: Improvements are needed with regard to medication nurses following the nine rights, as well as infection control procedures. In addition, in IHCPs, IDTs need to include interventions for respiratory assessments for individuals with high risk for respiratory compromise that are consistent with the individuals' level of need, and the implementation of such nursing supports. At this time, all of the remaining indicators will continue in active oversight.

| # | Indicator | Overall Score | Individuals: 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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). | 50% 4/8 | 0/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | | 0/1 | 0/1 |
| | i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s). | 100% 4/4 | 1/1 | N/A | N/A | 1/1 | N/A | N/A | | 1/1 | 1/1 |
| | ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action. | 100% 4/4 | 1/1 | N/A | N/A | 1/1 | N/A | N/A | | 1/1 | 1/1 |
| d. | In order to ensure nurses administer medications safely: | | | | | | | | | | |
| | i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs. | 20% 1/5 | 0/1 | 0/1 | 1/1 | 0/1 | N/A | N/A | 0/1 | N/A | N/A |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define. | 67% 2/3 | N/A | N/A | 2/2 | N/A | N/A | N/A | 0/1 | N/A | N/A |
| | a. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s). | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | b. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action. | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| e. | If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response. | N/R | | | | | | | | | |
| f. | Individual's PNMP plan is followed during medication administration. | Due to the Center's sustained performance, this indicator moved to the category requiring less oversight. | | | | | | | | | |
| | i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s). | | | | | | | | | | |
| | ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action. | | | | | | | | | | |
| g. | Infection Control Practices are followed before, during, and after the administration of the individual's medications. | 50% 4/8 | 1/1 | 0/1 | 0/1 | 1/1 | 1/1 | 1/1 | | 0/1 | 0/1 |
| | i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s). | 50% 2/4 | N/A | 1/1 | 0/1 | N/A | N/A | N/A | | 0/1 | 1/1 |
| | ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action. | 50% 2/4 | N/A | 1/1 | 0/1 | N/A | N/A | N/A | | 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 #33, Individual #448, Individual #567, Individual #566, Individual #242, Individual #159, Individual #143, and Individual #134. Individual #508 passed away prior to the remote review.

c. For four of the eight individuals the Monitoring Team member observed during medication passes, nursing staff followed the nine rights of medication administration. For the remaining four, medication nurses did not complete one or more of the three medication checks to make sure the individuals received the correct medication and dosage. In each instance, the Center's nurse auditor identified the problem, and took necessary action.

d. For the individuals reviewed, the Monitoring Team identified a number of concerns related to necessary respiratory assessments. The following provide examples of the Monitoring Team's findings:

- Individual #33's IDT rated him at high risk for aspiration/respiratory compromise due to rumination syndrome. However, the only respiratory assessment the IDT included in his IHCP was for nursing staff to: "Assess breath sounds Q shift x 48 hrs. for coughing during feeding/signs of resp distress." Given his ongoing rumination, this intervention was insufficient to meet the individual's needs, and reduce his risk to the extent possible.
- Individual #448's IDT rated him at high risk for respiratory compromise. They included an intervention in his IHCP to perform an aspiration/respiratory/focused assessment if an aspiration episode occurs. However, they did not define signs and symptoms of aspiration, which can be silent. As a result, this was not a measurable, proactive intervention sufficient to meet the individual's needs.
- According to Individual #566's IRRF, his "Most recent MBS [Modified Barium Swallow Study] obtained on 8/19/15 indicated moderate-severe oropharyngeal dysphagia with severe risk of aspiration with all PO intake. Recommendations were for ethical decision making discussion regarding quality of life vs NPO status (see MBS). Team has agreed to continue oral nutrition/hydration with suggested pureed diet, nectar-thick liquids, dining strategies, precautions, adaptive equipment, and modification to medication administration… [He] continues to receive all nutrition/hydration orally on this diet texture but he does remain at high risk for choking/aspiration based on MBS findings." The nursing assessment intervention in the IHCP read: "N-DCN [Nursing - Direct Care Nurse] to eval lung sounds with any report of choking/aspiration." However, the IDT did not define signs and symptoms of aspiration, which can be silent. As a result, this was not a measurable, proactive intervention sufficient to meet the individual's needs.

- According to his IRRF, dated 3/24/21, Individual #508 was at high risk related to aspiration/respiratory compromise. In the discussion section, the IDT documented: "Recommendations to remain High due to diagnosis of dysphagia, pureed diet texture, (1) hospitalization related to diagnosis of Respiratory compromise/aspiration this annual review… OT/SLP recommend High risk due to diagnosis of seizures; recurrent 'episodes of near syncope;' diagnosis of GERD and constipation; moderate oropharyngeal dysphagia with aspiration on thin liquid and abnormal mastication per MBS; dependent for positioning; at times is distracted/vocalizes/laughs while eating and drinking; history of pneumonia…" On 9/12/20, he was discharged from the hospital with a diagnosis of aspiration pneumonia. His annual IHCP, initiated on 4/1/21, included the following nursing assessment intervention: "Assess lung sounds Q Shift x 72 hours r/t Respiratory comp s/o distress/Emesis." It also included an intervention for the RNCM to complete quarterly and annual respiratory assessments, which is an expectation for all individuals. Given this individual's heightened risk, and ongoing oral intake, these interventions did not represent a proactive approach to respiratory assessments to identify potential problems early.

  On 6/17/21, he was diagnosed with aspiration pneumonia again. The change of status IHCP, initiated on 6/22/21, included the same interventions for respiratory assessments as the annual IHCP. On 8/2/21, he was again diagnosed with aspiration pneumonia. On 8/17/21, he died with cause of death listed as aspiration pneumonia.

g. Some problems were identified with regard to medication nurses following infection control practices. At times, when problems occurred, the Center's nurse auditor identified them, and took corrective action as needed. The following concerns were noted:

- The medication nurse for Individual #448 engaged in the following problematic practices, all of which the Center's nurse auditor identified: did not apply sanitizer between fingers; and did not sanitize the water pitcher, but used it four times during the medication pass. Although the nurse sanitized their hands before each pour, they then touched the contaminated pitcher handle.
- When using hand sanitizer, the nurse for Individual #567 did not apply the gel between their fingers. The Center's nurse auditor did not identify this concern.
- The medication nurse for Individual #143 engaged in the following problematic practices that the Center's nurse identified: applied soap to dry hands and washed hands under the water, did not clean the computer keyboard, and when using sanitizing gel, did not apply it between their fingers. The medication nurse also did not wipe down the refrigerator and retrieved items from it, but did not sanitize afterwards. The Center's nurse auditor did not identify this concern.
- For Individual #134, the Center's nurse auditor identified and corrected the relevant issues, including that the medication nurse did not clean the drawer that was used; obtained water out of the faucet without donning gloves, and then filled it with flavoring and MiraLAX without applying gel; and did not consistently apply gel between their fingers.

## Physical and Nutritional Management

| Outcome 1 – Individuals' at-risk conditions are minimized. |
|---|
| The Monitoring Team no longer rates most of the indicators related to this outcome. The Center's responsibilities for PNM-related personal goals/objectives are now assessed as part of the Section F – ISP audit tool. Information about the Center's compliance related to the referral of individuals to the PNMT is provided below |

| Summary: It was positive that the seven individuals in the review group who met criteria were referred to the PNMT. If the Center maintains its progress in this area, after the next review, Indicator b.i might move to the category requiring less oversight. | | Individuals | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
| b. | Individuals are referred to the PNMT as appropriate: | | | | | | | | | | |
| | i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate; | 100% 7/7 | 1/1 | 1/1 | N/A | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A |
| Comments: b.i. The Monitoring Team reviewed seven areas of need for six individuals that met criteria for PNMT involvement. These areas of need included those for: Individual #33 – weight loss, Individual #448 – aspiration, Individual #566 – skin integrity, Individual #242 - fractures, Individual #159 – fractures, Individual #508 – aspiration, and Individual #143 – falls. It was positive that all of these individuals were referred to the PNMT. | | | | | | | | | | | |

| 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. Many of the PNM action steps that were included were not measurable, making it difficult to collect specific data. Substantially more work is needed to document that individuals receive the PNM supports they require. In addition, in over half of the instances reviewed, IDTs did not take immediate action, when individuals' PNM risk increased or they experienced changes of status.<br><br>For the individuals reviewed whom the PNMT had discharged, the IDTs held ISPA meetings during which the PNMT shared information from its reviews/assessments. Given the Center's sustained performance over time, Indicator c will move to the category requiring less oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
| 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. | 30% 3/10 | 1/2 | 0/2 | N/A | 0/1 | 1/1 | 0/1 | 0/1 | 1/2 | N/A |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| c. | If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT. | 100% 5/5 | 1/1 | 1/1 | N/A | N/A | 1/1 | 1/1 | 1/1 | N/A | N/A |

Comments: a. As noted above, none of the IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Monthly integrated reviews generally provided no specific information or data about the status of the implementation of the action steps. One of the problems that contributed to the inability to determine whether or not staff implemented PNM supports was the lack of measurability of many of the action steps.

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

- In September 2020, Individual #33's weight loss began. Prior to the referral to the PNMT in April 2021, the interventions that the IDT employed to address his weight loss were not clear. It was not until 5/5/21, that the IDT held a "root cause analysis" meeting.
- It was positive that Individual #33's IDT reviewed his positioning as it related to rumination, and its impact on aspiration.
- In June 2021,when Individual #448's returned from the hospital, Habilitation Therapy staff conducted a bedside swallow assessment. However, no evidence was found of a positioning assessment to mitigate the risk of emesis associated with his seizures. In addition, the IDT noted poor safety awareness in the IRRF as a factor that increased his risk of aspiration, but they put no program in place to improve his safety awareness.
- On 12/8/20, Individual #448 was sent to the ED due to having a seizure associated with a fall and a head injury. At that time, he sustained a nondisplaced left temporal bone fracture of his skull. On 12/23/20, the Physical Therapist recommended a soft shell helmet consult to prevent skull fractures, but the submitted documents provided no evidence that this was carried over and implemented. It was mentioned in the IRRF, but no other notes were submitted. No helmet was included in his PNMP.
- On 6/6/21, Individual #566 sustained a fractured finger. The IDT met and planned for rehabilitation of the hand, but they did not address the potential impact on other aspects of the individual's plan of care. The IDT did not identify the potential impact of the individual's decreased inability to ambulate and transfer until a Stage 3 pressure injury was noted on 7/29/21.
- On 2/15/21, Individual #242 fractured her left tibia and fibula. Following her return from the hospital on 2/18/21, it was positive that the OT and PT conducted assessments on 2/22/21. She was placed on non-weight-bearing status, and Habilitation Therapy staff educated direct support professional staff on the use of the air sleeve/cast.
- On 3/17/21, Individual #159 fractured his right femur. It was positive that Habilitation Therapy staff made a modification to the handling instructions in his PNMP. On 4/5/21, he was diagnosed with a displaced oblique fracture of the shaft of his right femur. It was positive that they made a modification to his mattress to reduce the risk of his falling out of bed again. However, the IDT did not address the individual's safety awareness issues, which would have been key to reducing his risk to the extent possible.
- At an ISPA meeting on 7/20/21, the IDT identified the need to educate Individual #508's the Legally Authorized Representative (LAR) regarding solid food items that in reality are thin liquids. However, there was no evidence that this was ever completed prior to the individual's death. On 8/2/21, he was admitted to the hospital and diagnosed with aspiration pneumonia. On 8/17/21, he died with cause of death listed as aspiration pneumonia.
- In the six months prior to the Monitoring Team's review, Individual #143 fell at least 15 times (i.e., 3/10/21, 3/18/21, 3/29/21, 3/30/21, 4/26/21, 4/30/21, 5/9/21, 5/14/21, 5/20/21, 5/30/21, 6/10/21, 7/21/21, 7/24/21, 8/1/21, and 8/30/21). On 6/1/21, he was referred to the PNMT due to more than 10 falls in 90 days. However, on 6/8/21, the referral was

rescinded, because three of the falls occurred while he was playing ball on the playground, which were considered typical under the circumstances. However, based on the ISPAs submitted, the IDT did not meet to discuss the falls, including the several falls that did not occur when this 18-year-old was playing. Based on the data provided, the IDT held no ISPA meeting to discuss the falls that continued after the PNMT's rescinded referral.

- It was positive that when Individual #143 received an MBSS, the IDT met to discuss the results. The recommendation was for him to continue a ground diet with nectar-thickened liquids. However, the rationale for an MBSS was not clearly noted within an ISPA, so it was unclear what triggered the completion of the MBSS.

c. For the individuals reviewed whom the PNMT discharged, the IDTs held ISPA meetings during which the PNMT shared information from its reviews/assessments.

| 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 the one transfer observed correctly. However, efforts are needed to continue to improve Dining Plan implementation, as well as positioning. Often, the errors that occurred (e.g., staff not intervening when individuals took large bites, and/or ate at an unsafe rate) placed individuals at significant risk of harm. Center staff, 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 or effectively (e.g., competence, accountability, need for skill training for individuals, etc.), and address them. These indicators will continue in active oversight. | | | |
| # | Indicator | Overall Score | |
| a. | Individuals' PNMPs are implemented as written. | 68%<br>27/40 | |
| 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. | N/R | |

Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs/Dining Plans. Based on these observations, individuals were positioned correctly during 11 out of 14 observations (79%). Staff followed individuals' dining plans during 15 out of 25 mealtime observations (60%). 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, and that adaptive equipment was correct, and with one exception, staff and the individuals observed were positioned correctly at mealtime.

- With regard to positioning, the three problems all had to do with staff not using needed equipment, or not using it correctly.
- For one transfer observed, staff completed the transfer correctly.

**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 | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
| 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 | | | | | | |
| Comments: a. None. | | | | | | | | | | | |

**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: The Center demonstrated some continuing progress toward developing clinically relevant goals/objectives for the applicable individuals reviewed, but work remained to address the needs for formal OT/PT services for everyone who needed them, and to ensure those goals/objectives were measurable. To move forward, it will be important for IDTs and OTs/PTs to work together to ensure recommendations for clinically relevant and measurable goals/objectives are considered, and that, as needed, goals/objectives are developed, and implemented. It will also be important for OTs/PTs to work with QIDPs to include data and analysis of data on those OT/PT goals/objectives in the QIDP integrated reviews. These indicators will remain in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
| a. | Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions. | 86% 6/7 | N/A | N/A | N/A | 1/1 | 2/2 | 2/2 | N/A | 0/1 | 1/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| b. | Individual has a measurable goal(s)/objective(s), including timeframes for completion. | 14% 1/7 | | | | 0/1 | 0/2 | 0/2 | | 0/1 | 1/1 |
| c. | Integrated ISP progress reports include specific data reflective of the measurable goal. | 14% 1/7 | | | | 0/1 | 0/2 | 0/2 | | 0/1 | 1/1 |
| d. | Individual has made progress on his/her OT/PT goal. | 14% 1/7 | | | | 0/1 | 0/2 | 0/2 | | 0/1 | 1/1 |
| e. | When there is a lack of progress or criteria have been achieved, the IDT takes necessary action. | 14% 1/7 | | | | 0/1 | 0/2 | 0/2 | | 0/1 | 1/1 |

Comments: a. and b. Individual #33, Individual #448, Individual #567, and Individual #508 had OT/PT supports (e.g., each had a PNMP in place), but they did not require direct therapy or formal goals/objectives.

The goal/objective that was clinically relevant and achievable, as well as measurable was for Individual #134 (walk with hands-on assistance at gait belt). The goals/objectives that were clinically relevant, but not measurable, were for Individual #566 [i.e., tolerate gentle passive range of motion (PROM) exercises during OT visits], Individual #242 [i.e., will participate with passive and active assistance in range of motion (ROM) to left ankle, and perform stand pivot transfers], and Individual #159 (i.e., transfer to/from all surfaces, and ambulate with platform walker and two-person assistance for 30 feet). Overall, the goals/objectives that were not measurable lacked clear definitions (e.g., for terms such as "tolerate"), and/or did not provide a clear expectation about the number of trials or the duration of participation.

It was positive that some individuals had goals/objectives that were clinically relevant and/or measurable. It was also positive that the IDT for Individual #134 integrated his goal/objective into the ISP/ISPA. Otherwise, though, IDTs generally did not integrate individuals' goals/objectives into the individuals' ISPs/ISPAs. This was an important missing piece to ensure that an individual's IDT approved the OT/PT goals/objectives, and was aware of the progress with regard to their implementation, and could build upon and integrate those goals/objectives into a cohesive overall plan.

c. through e. It was positive that for Individual #134, the QIDP monthly integrated progress report included data and analysis of the data for his goal/objective. It was also positive that the IDT tracked his progress on the goal/objective and took necessary action when he achieved criteria. Otherwise, for the remaining goals/objectives, although data were sometimes submitted to show therapists implemented goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format and/or in a timely manner. This made it difficult for IDTs to track progress on the goals/objectives, or when progress was not occurring, to ensure that the IDTs took necessary action. The Monitoring Team conducted full reviews for all nine individuals, including the four individuals, as identified above, who did not require formal goals/objectives, but did have OT/PT supports, and for Individual #134, who was part of the core review group.

| Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely. | |
|---|---|
| Summary: For most applicable individuals reviewed, evidence was not found in ISP integrated reviews to show that OT/PT supports in the ISP/ISPA were implemented. Indicator a will continue in active oversight. However, due to | Individuals: |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| sustained progress (Round 15 -100%, Round 16 – 100%, and Round 17 – 100%), Indicator b will move to the category requiring less oversight. | | | | | | | | | | | |
| # | Indicator | Overall Score | 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
| a. | There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented. | 100% 1/1 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 1/1 |
| b. | When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change. | 100% 3/3 | N/A | N/A | N/A | N/A | 2/2 | N/A | N/A | N/A | 1/1 |

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. As described above with regard to Outcome 1, many of the goals/objectives were not measurable. In addition, although therapists sometimes included data related to the implementation of goals/objectives in IPNs, most individuals' ISPs did not include those strategies and action plans. Three individuals had at least one measurable goal/objective. However, only Individual #134's IDT specifically included the goal/objective in the ISP/ISPA. This resulted in an overall false positive score for this indicator. OTs and PTs should work with IDTs to ensure that goals/objectives, including formal therapy plans, meet criteria for measurability and are integrated in individuals' ISPs through a specific action plan.

b. It was positive to see that when termination of an OT/PT service or support was recommended outside of an annual ISP meeting, the applicable individuals' IDTs held ISPA meetings to discuss and approve the changes.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs. | | | | | | | | | | | |
| Summary: Thirty-five out of 39 individuals observed had assistive/adaptive equipment that appeared to be the proper fit. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's varying scores (Round 15 - 78%, Round 16 – 96%, and Round 17 - 90%), this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators.<br><br>[**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 | 97 | 91 | 332 | 428 | 335 | 446 | 84 | 474 | 95 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Assistive/adaptive equipment identified in the individual's PNMP is clean. | Due to the Center's sustained performance, these indicators moved to the category requiring less oversight. | | | | | | | | | |
| b. | Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition. | | | | | | | | | | |
| c. | Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual. | 90% 35/39 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| | | Individuals: | | | | | | | | | |
| # | Indicator | | 287 | 527 | 92 | 148 | 478 | 597 | 254 | 493 | 475 |
| c. | Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual. | | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 0/1 | 1/1 | 1/2 | 1/1 |
| | | Individuals: | | | | | | | | | |
| # | Indicator | | 134 | 86 | 41 | 243 | 43 | 413 | 21 | 471 | 573 |
| c. | Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual. | | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 |
| | | Individuals: | | | | | | | | | |
| # | Indicator | | 333 | 504 | 135 | 321 | 156 | 140 | 570 | 26 | 194 |
| c. | Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual. | | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| | | | Individuals: | | | | | | | | |
| # | Indicator | | 377 | 155 | | | | | | | |
| c. | Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual. | | 1/1 | 1/1 | | | | | | | |

c. Based on observations of 39 pieces of assistive/adaptive equipment, most appeared to be the proper fit for the individuals. The following describes exceptions noted:

- Center staff could not locate the required assistive/adaptive equipment identified in the PNMP for Individual #148 (i.e., knee pads), or Individual #597 (i.e., soft shoes).
- For Individual #493, and Individual #471, their wheelchairs were not a proper fit. However, Center staff reported that new wheelchairs had been ordered.

**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.

As a result of the movement of the responsibility for dental goals/objectives to Section F, this Domain currently contains 10 outcomes and 26 underlying indicators in the areas of ISP implementation, and skill acquisition. At the time of the last review, two of these indicators had sustained high performance scores sufficient to move to the less oversight category. Presently, no additional indicator will move to the category of less oversight.

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

All SAPs contained many of the important components, but no SAPs contained all of them. Some aspects of the SAPs were not relevant or practical upon implementation.

Staff implemented SAPs professionally and pleasantly. For almost all of the SAPs, one or two aspects of implementation needed improvement (e.g., initial instruction, scoring of prompt level). SAP integrity checks were occurring, but not at the level set by the Center.

For most of the SAPs, there was evidence that they were reviewed monthly. For most of the SAPs, outcomes were graphed.

Progress was being made on two of 13 SAPs.

Regarding public school, it was positive to learn that Center staff have worked with public school staff to improve collaborative efforts to provide educational services. For example, one individual had returned to in-school learning with plans to expand her schedule to a full day as she acclimated to the environment. Although another individual's educational program was limited to four hours per week, it was positive that his teacher came to the Center to work with him. For both individuals, one of the six sub-indicators was not occurring, resulting in the zero scores (report card review, QIDP participation in IEP/ARD meeting).

For most individuals observed, their AAC/EC devices were present and readily available in each observed setting and the individuals were using the devices or language-based supports in a functional manner.

**ISPs**

Outcome 2 (indicators 4-7) and Outcome 8 (indicators 39-40) now appear within domain #2 above.

**Skill Acquisition and Engagement**

| Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Performance was the same/lower than at the last review. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
| 6 | The individual is progressing on his/her SAPs. | 0% 0/13 | 0/2 | 0/2 | 0/2 | | | 0/1 | 0/2 | 0/1 | 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. | 14% 1/7 | 0/2 | | | | | 0/1 | 0/2 | 1/1 | 0/1 |
| 9 | (No longer scored) | | | | | | | | | | |

Comments:

6. Based upon a review of data presented in the Client SAP Training Progress Note, it was determined that progress was being made on two of 13 SAPs. These were Individual #219's pay cashier SAP and Individual #199's job application SAP. However, due to the lack of data reliability, these were scored zero. Progress was not evident on the remaining 11 SAPs that had been implemented for a minimum of three months.

Staff should bring SAP graphs with them to the ISP preparation and ISP meetings. In some cases, staff reported progress or mastery that was not supported by the data. For example, at Individual #448's ISP preparation meeting, a staff member reported that he had mastered his greeting SAP. However, graphed data indicated he had independently completed 4%, 10%, and 18% of implemented trials between June and August 2021.

7. The data that were presented indicated that no one had mastered their identified SAPs.

8. Based upon the information provided, it was determined that action should have been taken on seven SAPs in which progress was not evident.

In the most recent graphic report, it was noted that staff may be incorrectly scoring Individual #448's greeting others SAP. Rather than acknowledging his independent response to the initial discriminative stimulus, staff were documenting a verbal prompt. Behavioral health services staff were going to discuss this with the home manager and provide retraining if warranted.

The other six SAPs were: Individual #336 showering and washing his hair, Individual #493 operating the joy player, Individual #135 washing her clothing and dialing a telephone, and Individual #199 identifying his medication.

| |
|---|
| The remaining SAPs had either been recently introduced or lack of progress had been evident for one month only. If lack of progress continued, the IDT should meet to determine whether changes to the SAP are necessary. |

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

Summary: All SAPs contained many of the important components, but no SAPs contained all of them. As described in the comments below, some aspects of the SAPs were not relevant or practical upon implementation. This indicator will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 13 | The individual's SAPs are complete. | 0% 0/17 | 0/3 23/30 | 0/2 15/20 | 0/2 16/20 | 0/1 8/10 | 0/1 6/10 | 0/1 8/10 | 0/3 24/29 | 0/1 6/10 | 0/3 20/28 |

Comments:

13. Although none of the 17 SAPs were considered complete, better than 70% included:
    - a task analysis (where appropriate),
    - an operational definition of the skill (often embedded in the task analysis),
    - a relevant discriminative stimulus,
    - a schedule for training opportunities,
    - consequences following correct and incorrect responding, and
    - guidelines for documentation.

    Specific feedback is provided below.
    - Several SAPs included objectives that did not specify whether the individual would perform the skill independently or with prompting.
    - Discriminative stimuli were not always the most appropriate to the task. For example, Individual #219 could learn to respond to the cashier rather than the staff member telling her the amount of her purchase; Individual #493 could be instructed to play the music, as music may be more meaningful to her than the joy player; Individual #135 could be asked to name the pictured building; and Individual #448 could learn to reciprocate a greeting versus being told to say hello to someone.
    - None of the SAPs included adequate instructions for teaching the skill. Most simply stated "teach," without any explanation as to how this should be done.
        - Some SAPs addressed chains of behavior, but rather than guiding the individual through all steps of the chain following his/her performance on the specified step, staff were to complete the activity (e.g., Individual #336 showering and hair washing, Individual #199 completing a job application). This does not allow the person to learn the entire chain. Some of the same SAPs addressing behavioral chains, did not provide guidelines for actions to take should the individual not perform "known" steps.
        - Other SAPs required more specificity in the instruction section. For example, it would be important to indicate whether the individual has a hand preference that would influence how they complete the skill (e.g., Individual #33 operating the joy player).

- Similarly, some SAPs involved fairly elaborate skills, but only one step was identified (e.g., Individual #219 and Individual #199 completing an outing and job application forms, respectively).

- It was positive to find guidelines for encouraging Individual #493 to first explore the buttons on the joy player with her fingers, but it did not make sense for her to be learning to operate buttons based upon their color because she was visually impaired.
- Individual #135 was supposed to be working on step 4 of a clothes washing program, but the instructions suggested she was working on step 1.
- If Individual #33 did not respond to the initial instruction and a subsequent verbal prompt, staff were instructed to point to the power button on the device. This is not an appropriate prompt for a visually impaired learner.
- If Individual #199 did not respond correctly on both his medication SAP and address SAP, the guidelines indicated that partial physical prompting and manipulation could be used. These types of prompt are not applicable when the skill requires a verbal response.
- The current training step was not indicated in the report section of the SAPs, however, the director of behavioral health services noted that this information was in the kiosk. If this was in the individual's I-Book, it might help to ensure that staff know which step is being trained.

Outcome 5- SAPs are implemented with integrity.

Summary: Staff implemented SAPs professionally and pleasantly. For almost all of the SAPs, one or two aspects of implementation needed improvement (e.g., initial instruction, scoring of prompt level). With attention to these details, indicator 14 is likely to score higher in future reviews. SAP integrity checks were occurring but not at the level set by the Center. Both indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 14 | SAPs are implemented as written. | 0% 0/6 | 0/1 | 0/1 | 0/1 | Refused | 0/1 | Poor video | Refused | 0/1 | 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. | 31% 4/13 | 0/2 | 0/2 | 2/2 | | | 0/1 | 1/2 | 0/1 | 1/3 |

Comments:

14. An observation of one teaching session was scheduled for each of the nine individuals. Individual #436 and Individual #135 refused to participate in their SAP teaching session, and due to the poor video quality, the accuracy of SAP implementation could not be determined for Individual #493. Feedback on six observations is provided below. Overall, staff were very professional, supportive, patient, and personable with each individual.

- The staff member teaching Individual #336 to address an envelope was very supportive and patient. However, she did not use the discriminative stimulus that was indicated in the SAP and she repeated her verbal prompting. Although she also utilized some pointing prompts, she reported that she would score this as requiring verbal prompting.

- When it was suggested to Individual #219 that she complete an outing form, she independently transitioned to the kitchen and obtained a form (the current step). She was able to complete the form, only needing help determining the duration of the outing. The staff member was very supportive throughout. The staff member reported that she would record a verbal prompt in the kiosk (even though the individual's performance was independent).
- The letter puzzle was presented to Individual #119 as indicated. The staff member then verbally identified the letter "S" as she presented it to Individual #119. She then encouraged Individual #119 to complete the puzzle in the correct order, handing letters to Individual #119. The staff member indicated she would document a verbal prompt in the kiosk, however, she employed a more intrusive prompt when she handed the correct puzzle piece to Individual #119.
- Individual #33 was observed learning to turn on his joy player. The switch was out of his reach and he was repeatedly told to reach for the switch. Although the SAP indicated that he would be seated at a table with the joy player in front of him, this did not occur. The staff member correctly noted that hand over hand assistance would be documented.
- The staff member working with Individual #448 did not use the discriminative stimulus indicated in the SAP, however, what was presented was more appropriate. When Individual #448 was greeted, he responded in kind. The staff member noted a verbal prompt would be recorded, but he responded to the initial greeting without requiring an additional prompt.
- The staff member working with Individual #199 as he completed a job application was very supportive and encouraging. Rather than providing a pen to complete this task, Individual #199 was given a marker. The discriminative stimulus was delivered as written. The staff member indicated she would record a verbal prompt, although Individual #199 was able to complete most of the form without assistance. Staff should probe the terminal objective of this SAP because Individual #199 appeared to have the skill. It is also recommended that he be provided an identification card, so that he can have a reference if needed.

15. The facility had a policy of assessing each SAP for treatment integrity at a minimum of once every six months. The identified minimum level of correct implementation was 80%. Feedback and retraining were provided if this was not achieved. Evidence provided indicated that four of 15 SAPs had been assessed for integrity as per this policy. These were the following: Individual #119 - operate television and complete name puzzle; Individual #135 - wash clothes; and Individual #199 - identify address. Although Individual #448's greet others SAP had been monitored, it was not clear whether this was completed through role play or observation. For this reason, it was scored zero. Four SAPs that had just recently been introduced (Individual #336 - address envelope; Individual #436 - clean glasses; Individual #33 - operate joy player; and Individual #135 - identify buildings) were excluded from this analysis.

| Outcome 6 - SAP data are reviewed monthly, and data are graphed. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Both indicators showed improvement since the last review. They will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
| 16 | There is evidence that SAPs are reviewed monthly. | 82% 14/17 | 3/3 | 2/2 | 2/2 | 0/1 | 0/1 | 1/1 | 3/3 | 0/1 | 3/3 |
| 17 | SAP outcomes are graphed. | 76% 13/17 | 2/3 | 1/2 | 2/2 | 1/1 | 0/1 | 1/1 | 3/3 | 1/1 | 2/3 |

Comments:
16. There was evidence of a monthly review of progress in the QIDP report for 14 of the 17 SAPs. The exceptions were the following: a) the report indicated that for three consecutive months (May-July 2021), Individual #436's clean glasses SAP had not been approved, however, the graph suggested it had been implemented in June, b) the step was not indicated in the review of Individual #33's joy player SAP, and c) the report indicated that Individual #448's greeting SAP had not been implemented due to social distancing, yet there were data presented in the graph.

17. Although there were graphs for all 17 SAPs, four of these were scored zero due to incorrect or missing information. Individual #336's showering SAP noted the wrong step, Individual #219's pay cashier SAP noted the incorrect number of steps, and Individual #33's joy player SAP and Individual #199's job application SAP incorrectly noted these were single step programs. When an individual advances a step, this should be indicated on the graph.

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

Summary: Both indicators scored higher than in previous reviews. Both will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 18 | The individual is meaningfully engaged in residential and treatment sites. | 56% 5/9 | 1/1 | 1/1 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 | 1/1 | 1/1 |
| 19 | The facility regularly measures engagement in all of the individual's treatment sites. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | |
| 20 | The day and treatment sites of the individual have goal engagement level scores. | | | | | | | | | | |
| 21 | The facility's goal levels of engagement in the individual's day and treatment sites are achieved. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |

Comments:
18. Multiple observations of the nine individuals were conducted during the review week. Observations spanned the hours of 9:00 am to 4:00 pm. Of the nine individuals reviewed, five were found to be meaningfully engaged during the majority of the observations. These were Individual #336, Individual #219, Individual #135, Individual #448, and Individual #199. The remaining four individuals, Individual #119, Individual #436, Individual #33, and Individual #493, were often sitting or walking without any meaningful activity.

During the review week, an observation was completed of the ISP preparation meeting for Individual #448 and the ISP meeting for Individual #199. At both meetings, teams recommend goals continued from the previous one to two years without adequate discussion and consideration of the individual's interest and barriers to his achieving the goal. Even when Individual #199 advocated for himself, team members appeared reluctant to consider his input.

19-20. The facility had a plan for monitoring engagement in all homes during odd months of the year, and in all day program and work sites during even months of the year. An engagement goal of 75% was established for all home, vocational, and day program sites.

21. The facility provided evidence of engagement monitoring each month between March and August 2021 for the homes in which the nine individuals resided. Engagement consistently met or exceeded the established goal in the homes of Individual #336, Individual #119, Individual #135, Individual #448, and Individual #199. The engagement goal was met or exceeded in at least four of the six months in the homes of Individual #219, Individual #436, Individual #33, and Individual #493, with averages consistently above 75%. Engagement in day programs and work sites were excluded from this analysis due to limited access to these areas during the COVID-19 pandemic.

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

Summary: Due to COVID-19 restrictions, community outings and trainings were suspended for the majority of the review period.

Individuals:

| # | Indicator | Overall Score | 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 22 | For the individual, goal frequencies of community recreational activities are established and achieved. | Not rated due to COVID | | | | | | | | | |
| 23 | For the individual, goal frequencies of SAP training in the community are established and achieved. | Not rated due to COVID | | | | | | | | | |
| 24 | If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct. | Not rated due to COVID | | | | | | | | | |

Comments:
22-24. Facility staff provided information that indicated each of the nine individuals had established goal frequencies for community recreational activities. Due to the COVID-19 pandemic, no outings occurred in March and April 2021. Teams met to approve and gradually reintroduce regular outings. Evidence indicated that seven of the nine individuals had participated in at least one outing by the end of August 2021. The exceptions were Individual #33 and Individual #493. Based upon the restrictions that remained in place and the gradual reintroduction of community-based outings and training opportunities, these indicators are rated as not applicable for this review.

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

Summary: There was a good working relationship between the public school and the Center. For both individuals, one of the six sub-indicators was not occurring, resulting in the zero scores (report card review, QIDP participation in IEP/ARD meeting). This indicator will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 336 | 219 | 119 | 436 | 33 | 493 | 135 | 448 | 199 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 25 | The student receives educational services that are integrated with the ISP. | 0%<br>0/2 | | | 0/1 | | | | | | 0/1 |

Comments:
25. Two of the nine individuals reviewed by the behavioral health monitoring team were participating in special education services at the time of the review. Individual #119 was attending the local public high school from 10:30 am to 3:30 pm with plans to extend her day as she acclimated to the environment. Individual #199 was receiving home bound services provided by the public special educator for two hours twice weekly. Considering this reduced time in school, the IDT should develop additional supports to help him achieve his high school diploma.

For both individuals, their ISPs included school-based information and action plans to support the IEP. There was evidence of discussion regarding inclusion and an extended school year. For Individual #119 there was evidence that her QIDP had participated in her IEP meeting. Similar evidence was not found in Individual #199's IEP. The most recent QIDP monthly report for Individual #199 included a review of his report card, however, Individual #119's QIDP monthly report indicated that there were no report cards or progress notes to review. This included the end of the school year when reports would be most expected.

It was positive to learn from facility staff that they had met with new special education administrative staff within the district. Staff reported that these public school staff were committed to serving residents of the State Supported Living Center to the same degree and with the same level of commitment as any other student in the district. Facility staff reported that there was better communication overall, with school personnel willing to share pertinent information with facility staff. It was also positive to learn that school personnel visited the facility to observe the students in their home environments. Finally, the director of behavioral health services reported that her staff were expected to visit the school at least once each month. Hopefully, the improved communication between the school and facility staff will be sustained throughout the year and result in enhanced special education services to the school-aged individuals. The Center should work with families and educational staff to ensure continued special education services past the student's 18th birthday, when appropriate.

**Dental**

In a letter, dated 8/23/21, the Monitor notified the parties that the Center achieved substantial compliance with most of the requirements of Section Q of the Settlement Agreement. The exceptions are: 1) implementation of a policy/clinical guideline that is consistent with current generally accepted standards of care on perioperative assessment and management of individuals needing TIVA/general anesthesia for dental work, which the Monitoring Team will continue to assess and apply the findings to paragraphs H.7 of the Settlement Agreement; and 2) personal goals/objectives for individuals who are at risk for dental problems, as well as the development and implementation of plans for individuals who require suction tooth brushing, which the Monitoring Team will assess as part of Section F. With the understanding that these topics are covered elsewhere in the

Settlement Agreement, Brenham SSLC exited from the other requirements of Section Q of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the related outcomes and indicators.

**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: Substantial work is still required to provide individuals with clinically relevant and measurable goals/objectives to meet their communication needs. It also will be important for SLPs to work with QIDPs to include data and analysis of data on communication goals/objectives in the QIDP integrated reviews. These indicators will remain under active oversight.

| # | Indicator | Overall Score | Individuals: 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions. | 33% 3/9 | 1/1 | 0/1 | N/A | 0/1 | 0/1 | 0/1 | 2/2 | 0/1 | 0/1 |
| b. | Individual has a measurable goal(s)/objective(s), including timeframes for completion | 33% 3/9 | 0/1 | 0/1 | | 0/1 | 0/1 | 0/1 | 2/2 | 1/1 | 0/1 |
| c. | Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s). | 0% 0/9 | 0/1 | 0/1 | | 0/1 | 0/1 | 0/1 | 0/2 | 0/1 | 0/1 |
| d. | Individual has made progress on his/her communication goal(s)/objective(s). | 0% 0/9 | 0/1 | 0/1 | | 0/1 | 0/1 | 0/1 | 0/2 | 0/1 | 0/1 |
| e. | When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action. | 0% 0/9 | 0/1 | 0/1 | | 0/1 | 0/1 | 0/1 | 0/2 | 0/1 | 0/1 |

Comments: a. and b. Individual #567 did not have needs identified that would require formal communication goals/objectives, but she did require communication supports (i.e., Communication Dictionary, communication strategies). The remaining eight individuals reviewed each had needs for formal communication services and supports, but only three had related goals/objectives.

The two goals/objectives that were both clinically relevant and measurable were for Individual #508 (i.e., independently read a story, and independently touch a symbol to choose music).

The following goal/objective was measurable, but not clinically relevant: Individual #143 (i.e., make the sign for ball). The following goal/objective was clinically relevant, but it was not measurable, because it did not include the criteria for achievement (e.g., over how many months): Individual #33 (i.e., press the communication button independently).

It was positive that some individuals had goals/objectives that were clinically relevant and/or measurable. It was also good to see that the IDTs for Individual #508 and Individual #143 integrated these into their ISPs/ISPAs. However, Individual #33's IDT did not integrate his goal/objective into his ISP/ISPA. This was an important missing piece to ensure that an individual's IDT approved the OT/PT goals/objectives, and was aware of the progress with regard to their implementation, and could build upon and integrate those goals/objectives into a cohesive overall plan.

c. through e. The QIDP monthly integrated progress reports for Individual #508 and Individual #143 included some data for their skill acquisition plans (SAPs). However, for both individuals, those monthly reports showed that Center staff were not implementing their respective SAPs with the required frequency. The QIDP did not provide analysis to assist the IDT to understand why or how this was impacting progress. In addition, the IDTs did not take steps to address the lack of required frequency or the lack of progress. The Monitoring Team completed full reviews for all nine individuals, including Individual #567, who did not have a need for a formal communication goal/objective, but did have communications supports.

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. These indicators will remain in active oversight.

| # | Indicator | Overall Score | Individuals: 33 | 448 | 567 | 566 | 242 | 159 | 508 | 143 | 134 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented. | 0% 0/4 | 0/1 | N/A | N/A | N/A | N/A | N/A | 0/2 | 0/1 | N/A |
| b. | When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination. | 50% 1/2 | 1/1 | N/A | N/A | N/A | N/A | N/A | 0/1 | 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 needs were implemented. As described above with regard to Outcome 1, only three of eight applicable individuals had at least one measurable goal/objective, and the IDTs for only two of those individuals (i.e., Individual #508 and Individual #143) specifically included the goals/objectives in the ISPs/ISPAs. For those two individuals, the IDTs did not provide evidence to show that their measurable action plans (i.e., SAPs) were implemented with the required frequency. SLPs should work with IDTs to ensure that assessments include recommendations for measurable strategies and action plan for the IDTs to consider, and that resulting goals/objectives meet criteria for measurability and are integrated in individuals' ISPs through a specific action plan.

b. For one of the two applicable individuals for whom termination of therapy goals was recommended, the IDT met to discuss and approve the termination. For Individual #508, on 4/8/21 the Behavior Health Assistant (BHA) discontinued the SAP (i.e.,

| |
|---|
| independently touch symbol), but the QIDP requested reinstatement. No ISPA was found to show the initial termination of the SAP. On 5/24/21, it was reinstated. |

| 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: Ten of 11 individuals reviewed had their AAC/EC devices present and readily available and were observed to use them in a functional manner. These indicators will remain in active monitoring.<br><br>[**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 | 570 | 97 | 91 | 332 | 428 | 92 | 197 | 21 | 475 |
| a. | The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual. | 91% 10/11 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 |
| b. | Individual is noted to be using the device or language-based support in a functional manner in each observed setting. | 91% 10/11 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 |
| | | | Individuals | | | | | | | | |
| # | Indicator | | 143 | 293 | | | | | | | |
| a. | The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual. | | 1/1 | 1/1 | | | | | | | |
| b. | Individual is noted to be using the device or language-based support in a functional manner in each observed setting. | | 1/1 | 1/1 | | | | | | | |
| 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. | N/R | | | | | | | | | |
| Comments: a. and b. For most individuals observed, their AAC/EC devices were present and readily available in each observed setting and the individuals were using the devices or language-based supports in a functional manner. The exception was for Individual #197 for whom his AAC device (i.e., tobi-dynavox) was being repaired. Center staff reported the device was often unavailable due to the need for repairs, but they had not provided any alternative. | | | | | | | | | | | |

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

This Domain contains five outcomes and 20 underlying indicators. At the time of the last review, three moved to the category requiring less oversight. Based on information the Center provided, between the time of the Monitoring Team's last review and the Tier II request, none of the individuals at Brenham SSLC transitioned to the community. As a result, none of the outcomes or indicators in Domain #5 were scored.

| 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: N/A | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | | |
| 1 | The individual's CLDP contains supports that are measurable. | N/A | | | | | | | | | | |
| 2 | The supports are based upon the individual's ISP, assessments, preferences, and needs. | N/A | | | | | | | | | | |
| Comments: None. | | | | | | | | | | | | |

| Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: N/A | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | | |
| 3 | Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date | N/A | | | | | | | | | | |
| 4 | Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports. | N/A | | | | | | | | | | |
| 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. | N/A | | | | | | | | | | |
| 6 | The PMM's assessment is correct based on the evidence. | N/A | | | | | | | | | | |
| 7 | If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner. | N/A | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 8 | Every problem was followed through to resolution. | N/A | | | | | | | | | | |
| 9 | Based upon observation, the PMM did a thorough and complete job of post-move monitoring. | N/A | | | | | | | | | | |
| 10 | The PMM's report was an accurate reflection of the post-move monitoring visit. | N/A | | | | | | | | | | |
| Comments: None. | | | | | | | | | | | | |

| Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: N/A | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | | |
| 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. | N/A | | | | | | | | | | |
| Comments: None. | | | | | | | | | | | | |

| 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: N/A | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | | |
| 12 | Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. | N/A | | | | | | | | | | |
| 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 | Due to the Center's sustained performance, this indicator moved to the category requiring less oversight. | | | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | regarding the supports and services to be provided at the new setting. | | | | | | | | | | |
| 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. | N/A | | | | | | | | | |
| 15 | When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual. | N/A | | | | | | | | | |
| 16 | SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs. | N/A | | | | | | | | | |
| 17 | Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual. | N/A | | | | | | | | | |
| 18 | The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition. | Due to the Center's sustained performance, this indicator moved to the category requiring less oversight. | | | | | | | | | |
| 19 | Pre-move supports were in place in the community settings on the day of the move. | N/A | | | | | | | | | |
| Comments: None. | | | | | | | | | | | |

| Outcome 5 – Individuals have timely transition planning and implementation. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: N/A | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | |
| 20 | Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided. | Due to the Center's sustained performance, this indicator moved to the category requiring less oversight. | | | | | | | | | |
| Comments: None. | | | | | | | | | | | |

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.
  - HHSC PI 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 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 within past two years, 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 HHSC PI 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 |
| HHSC PI | Health and Human Services Commission Provider Investigations |
| 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 |
| PNA | Psychiatric nurse assistant |
| 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 |
| SUR | Safe Use of Restraint |
| TIVA | Total Intravenous Anesthesia |
| TSH | Thyroid Stimulating Hormone |
| UTI | Urinary Tract Infection |
| VZV | Varicella-zoster virus |