United States v. State of Texas

Monitoring Team Report

Corpus Christi State Supported Living Center

Dates of Onsite Review: July 25th to 29th, 2016

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Background

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

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

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

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

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

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

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

Methodology

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

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

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

Organization of Report

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

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

Executive Summary

During the onsite review week, the Monitoring Teams witnessed and/or learned through our document review of a number of practices and, in some cases, staff inaction that placed individuals at risk, or in other cases, failed to address individuals' needs. With the assistance of State Office, Center staff put some immediate measures in place to address some of the most pressing issues identified, and continue to develop a more long-term corrective action plan, on which the Monitoring Teams have commented. The Monitoring Teams are planning an interim review of Corpus Christi SSLC.

Based on our review, individuals at CCSSLC were not safe and free from harm, and sufficient evidence was not found to show that the Center had made reasonable efforts in the areas of incident management, risk management, or quality improvement. Some examples include the following:

- The Monitoring Team identified an incident where Center staff should have reported allegations of abuse or neglect, but did not. This was an allegation of negligence at the community hospital the Medical Director made in an email to hospital staff. Incident Management staff were made aware of this and stated appropriate action would be taken to ensure it was reported.
- Some individuals experienced numerous falls that went unaddressed from an interdisciplinary team (IDT) and/or overall incident management perspective.
- Findings from the Center's medication audits showed a nurse had failed to follow individuals' Physical and Nutritional Management Plans (PNMPs), but this did not result in sufficient corrective action due to a scoring mechanism that weighted all components of the audit tool equally. This same nurse failed to follow an individual's PNMP during the onsite review week, placing the individual at significant risk.
- During an observation, an individual started coughing with struggle and potentially choking, and direct support professionals did not respond in a manner that demonstrated they were competent with regard to emergency protocols. Specifically, they encouraged the individual to drink water, and covered her mouth with a napkin. This required review from a risk management perspective to ensure that staff with direct support responsibilities have the skills they need to respond appropriately in such situations. In response to the draft report, the State submitted an investigation of the incident. In its comments, the State summarized the results as follows: "Staff reported the individual began eating and after 3 to 4 bites, she began to cough, she turned red, and her eyes began to water. Staff placed a napkin in front of, but not covering or touching, her mouth to prevent her from coughing on her peers or her peers' food. Staff reported she coughed 6 or 7 times, then stopped coughing. She returned to her normal color and wanted to continue to eat, but was redirected and her tray was removed. A nurse came to the dining room to assess the individual, listened to her lungs and checked her O2 sats, and she was cleared to finish eating. Staff requested a fresh tray and she finished all of her food and liquids without any additional issues." As is discussed in detail with regard to Outcome #6 in the Abuse and Neglect section of this report, the Facility investigation of this incident was significantly flawed, and as a result, its conclusions could not be relied upon. Amongst other concerns, the investigation was initiated after a team meeting was held about the incident and staff had discussed it as well as the Monitoring Team's concerns, and a key witness to the incident was not interviewed (i.e., the Monitoring Team member who is a Speech Language Pathologist with extensive experience working with individuals with complex physical and nutritional management needs). The Monitoring Team's

concerns about this incident have not diminished, and, in fact, are increased, given that the based on the State's response and the recommendations in the UIR, it does not appear that the Facility has taken action to ensure that staff are competent in addressing the needs of an individual showing signs and symptoms of choking or other respiratory distress.

During the onsite review, the Monitoring Team identified that the Incident Management (IM) Department had incorporated standard information into the Individual Support Plan (ISP) template to address the indicator that assesses whether or not supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury. The Center's data presentation, analysis, and follow-up were good for when an allegation, injury, or unusual incident had occurred. But, this was not occurring for all individuals for all of their many risk areas and, as a result, individuals were not protected from harm.

The Center has missed some important opportunities for quality improvement. The Monitoring Teams recognize that the Quality Improvement Department's leadership is new and State Office has not yet provided substantive guidance on quality improvement efforts. However, the Center had data and information that it should have used to identify and address areas of significant concern, but little had occurred with this information. More specifically, the Medical Director's post-hospitalization reviews provided a wealth of information that should be aggregated and analyzed to identify areas on which the Center should focus. To provide context to these reviews, early in the implementation of the Settlement Agreement, the State agreed that for individuals with unexpected hospitalizations, Centers would conduct reviews of the care and treatment provided to them in the weeks prior to the hospitalizations, as well as information from the hospital. The goal is to identify problems, if any, with the provision of care and treatment, and/or develop additional supports and services that if implemented, might reduce the likelihood of reoccurrence. Similar to the Monitoring Teams' findings, the Medical Director's findings and recommendations crossed many disciplines and addressed a variety of essential aspects of care, for example, medical care, nursing services, as well as direct support professional duties. Based on a limited analysis the Monitoring Team conducted of a sample of reviews the Medical Director conducted between November 2015 and June 2016, some of the areas that these reviews showed potentially required attention included:

- Increased communication between staff/IDT and the PCP and/or psychiatrist;
- Increased communication with the hospital;
- Staff education on variety of topics (e.g., suctioning, changing dressings, cooling febrile patients, precision of documentation, etc.);
- Further medical care/testing;
- Increased monitoring (e.g., environmental safety, clinical indicators such as bowel movements);
- Improvement in documentation/records;
- Development, review, and/or implementation of medical and nursing guidelines/protocols (e.g., for ileus, abdominal girth, constipation, bathing individuals with catheters);
- Improvement in care for individuals with catheters and/or tracheostomies;
- Accurate and timely weights;
- Following physician orders;

- Adequate fluid intake;
- Review of positioning and/or adequate mobility; and
- Re-evaluation and/or more information needed re: Do Not Resuscitate Orders.

Center staff should conduct an analysis of these reviews and use the information to help to identify areas that need to be addressed through the corrective action plan currently under development.

Qualified Intellectual Disabilities Professionals (QIDPs) were knowledgeable to a degree about some aspects of individuals' preferences and strengths, and most appeared to be sincerely caring about their work, but they were also often not able to articulate the status of various risks and needs. Overall, the QIDPs did not exhibit an understanding of the significance of many health-related concerns or their role to ensure these concerns are addressed in a timely manner.

An overall concern related to the lack of urgency and vigilance the IDTs demonstrated. QIDPs were often not assertive in their roles as team leaders and facilitators to ensure that individuals' risks and other needs were identified, assessed and addressed in a timely fashion. In addition, falls risks were not assertively identified or proactively addressed. In the most striking example, one individual had experienced at least 17 falls between November and May, including five in November and five in March, but there was no indication the IDT had addressed this. There was no update to her low risk rating in this area in the Integrated Risk Rating Form (IRRF) and no update to the related Integrated Health Care Plan (IHCP). Falls had not been addressed in an Individual Support Plan Addenda (ISPA) or discussed as a risk at the ISP Preparation meeting on 5/20/16.

Overall, the lack of quality assessments for the individuals the Monitoring Teams reviewed stymied IDTs ability to develop meaningful plans. Some examples of problems with assessments include:

- Assessments lack root cause analysis and often indicate an acceptance of an individual's decline by simply documenting the decline rather than asking why the decline occurred.
- With regard to Habilitation Therapy assessments, even when the assessors noted deficits, they offered no recommendations related to therapy options, Skill Acquisition Plans (SAPs), or informal plans that might improve the outcome for the individual.
- The Physical and Nutritional Management Team (PNMT) often lacked the needed membership to fully assess the issue impacting the individual and to provide meaningful analysis of the referred issue. For example, when conducting a comprehensive assessment for an individual with many active medical problems who is prescribed multiple medications, Pharmacy and the PCP should be active members of the PNMT.
- For some individuals, updates or screenings were completed, when comprehensive assessments were warranted.
- Only one of the nine medical assessments reviewed included a plan of care for each active medical problem, when appropriate, that were in alignment with current standards of care and the individual's needs. In addition to improving the overall quality of medical assessments, the Center should focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessments, tests, and evaluations consistent with current standards of care, and that PCPs

identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible.

- 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, 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.

All of these issues with assessments made it difficult for IDTs to develop plans that fully addressed individuals' needs and meaningfully incorporated their strengths and preferences.

IDT members work largely in silo-fashion, which means that plans developed often do not meet individuals' needs. For example, a number of individuals the Monitoring Teams reviewed had behavioral needs that prevented them from benefitting from services provided, but Behavioral Health Services (BHS) was largely absent in assessing these individuals and developing plans to address their needs. A few examples of this included:

- Individuals whose dental status was deteriorating and who clearly had behaviors that impeded dental care, but who had no BHS involvement; and
- Individuals with behaviors that contributed to falls and who were resistant to Occupational Therapy and Physical Therapy interventions, but for whom BHS did not assist in identifying preferences or developing programs to increase the individuals' participation in activities that would improve their physical status.

All IDT members need to work collaboratively to develop IHCPs. It is essential, for example, for Primary Care Practitioners (PCPs) to take a lead role in this process, and for other team members with specific expertise to take the lead in developing portions of the IHCPs that relate to their areas of practice. Integration of health care services is a key component that is missing, and is negatively impacting the individuals the Center supports.

With regard to the provision of specific clinical services and supports:

- Some examples of concerns related to the provision of nursing services included:
    - During some observations, direct-line nurses did not demonstrate competence with identifying the need for or completing ongoing assessments of individuals, such as the completion of lung sounds for an individual experiencing respiratory distress or individuals at high risk for aspiration.
    - At times, when clinical indicators, such as abnormal lung sounds or pulse rates, showed the need for further monitoring or action, nurses either did not recognize the need, or did not act.
    - The Monitoring Team observed the Nurse Educator needing to intervene when nurses incorrectly implemented procedures individuals required, such as when a nurse began to suction an individual with a tracheostomy with a non-sterile catheter.

- Problems were noted with nursing staff's implementation of PNMPs. For one individual, this resulted in a significant change in status, which placed the individual at risk. Overall, nurses did not consistently pay attention to individuals' positioning needs without the intervention of the Nurse Educator who accompanied the Monitoring Team on observations.
- Problems also were noted with infection control. For example, as noted previously, a nurse suctioned around an individual's mouth and then began to insert the contaminated catheter into her tracheostomy tube, which would introduce any bacteria present on the catheter into her tracheostomy tube. Fortunately, the Nurse Educator intervened.

It is of paramount importance that the Center quickly implements a thorough competency-based training and assessment process to ensure that nurses have the clinical skills necessary to address the needs of the individuals to whom they are assigned.

- Equipment individuals needed was not readily available. For example, a pulse oximeter was not readily present for an individual that was high risk for aspiration and respiratory compromise and had been acutely ill with episodes of respiratory distress in the recent past. For an individual with these known risks as well as who recently had been acutely ill requiring hospitalizations, a pulse oximeter should be kept on her wheelchair or bed, so that it is available wherever the individual is. In addition, as Facility staff identified, in one instance, an oxygen tank containing sufficient oxygen was not readily available.

- With regard to Habilitation Therapies (HT):
  - Although during the onsite review, staff told the Monitoring Team that HT staff were conducting monitoring of PNMP implementation, when asked for evidence, the Center could not produce data and/or analysis of data. It is essential that HT staff conduct ongoing, proactive monitoring of PNMP implementation.
  - During the week of the onsite review, one of the immediate steps the Center took at the Monitoring Team's urging was monitoring of some key aspects of care for individuals across the campus. As the Center's own data showed after one day of implementing this monitoring, numerous errors were occurring in staff's implementation of PNMPs. This was consistent with the Monitoring Team's findings.
  - PNMPs lacked consistent inclusion of triggers and identification of individualized triggers. In addition, triggers listed across documents, such as the PNMP, Dining Plan, IHCP, and Aspiration Trigger sheets often do not match. These issues made it difficult for direct support professionals to identify when an individual might be at risk, in order to make the necessary notifications to nursing staff.
  - A number of potential issues were noted regarding the proper fit of individuals' adaptive equipment. For an individual whose wheelchair was not meeting her needs and for whom the Monitoring Team saw staff engage in a number of practices that placed her at risk, it was positive to see Center staff work collaboratively with the Discipline Coordinator for Habilitation Therapies from State Office during the review week. With the Discipline Coordinator's expertise, the Center Physical Therapist's (PT's) knowledge and skills and those of the wheelchair fabrication department, as well as some thinking "outside the box" and problem-solving, in fairly short order, the individual had a more functional wheelchair that significantly improved her positioning, thereby improving her safety. More similar work is needed for other individuals at the Center.

- Quarterly Drug Regimen Reviews (QDRRs) included accurate information about anticholinergic burden, and the Pharmacist had thoroughly reviewed labs. What were missing were recommendations when the anticholinergic burden is substantial, and a review of the risks leading to metabolic syndrome for individuals prescribed atypical antipsychotics.

- Regarding behavioral health services:
    - Although the Center reported 100% data timeliness, Inter-observer Agreement (IOA), and treatment integrity when these measures were assessed, observation and review of data sheets reflected a lack of reliable and valid data. The manner in which data was recorded did not always correspond to the data presented in graphic format.
    - For one individual, an in-depth review of his PBSP revealed poor implementation of a critical component of the plan. According to his plan, a visual schedule is to be reviewed three times daily, during which time he can earn reinforcers for completing scheduled activities. Not only was this not being implemented, but also the BHS Specialist had not completed the development of the schedule almost three months after the plan was introduced.

- Regarding psychiatry services:
    - A licensed member of the psychiatric team was now routinely attending the ISP meetings. This was good to see, however, the combined behavioral assessments contained in the ISPs were variable. Three of the ISPs contained thorough documentation for all the required discussion points, but the remaining six did not.
    - All of the individuals who were new admissions had a Comprehensive Psychiatric Evaluation (CPE) completed within the required time frame. However, the available documentation indicated that a member of the medical staff did not evaluate two of the four individuals admitted within the first business day following admission. Given the degree of acuity with which these individuals presented, this could be a serious problem.
    - For two of the three episodes of chemical restraint, there was also a delay of greater than 10 days for the psychiatrist and pharmacist's review of the chemical restraint data.

The Monitors requested formal corrective action plans, and are working through State Office to ensure these are developed for the Center on a systemic level, as well as for some of the individuals the Monitoring Team's reviewed. It is essential that staff work together in an integrated manner to resolve issues and improve the protections, supports, and services afforded the individuals the Center serves. In addition, staff should bring their expertise to the table in a collaborative way, as well as welcome the expertise of others, and seek additional expertise as necessary. The Monitoring Teams look forward to seeing improvements upon their returns to the Center in a few months.

Status of Compliance with the Settlement Agreement

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

This Domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, mortality review, and quality assurance. Twelve of these indicators had sustained high performance scores and will be moved to the category of requiring less oversight. This included two outcomes: Outcome #4 and Outcome #5 for Abuse, Neglect, and Incident Management.

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

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

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

<u>Restraint</u>
The overall use of crisis intervention restraint was lower than during the last review and remained low throughout this nine-month period, ranging from four to 18 occurrences per month. Corpus Christi SSLC's census-adjusted rate was the fourth lowest in the state. It was good to see that only one individual received protective mechanical restraint for self-injurious behavior, however, his case required more attention. Six of the restraint-related indicators moved to the category of requiring less oversight, and many others may do so after the next review.

For most of the restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint. However, the nursing staff's restraint records often were incomplete. For example, problems were noted with regard to the documentation of vital signs, including respirations when individuals refused to have other vital signs taken. Mental status descriptions also often were not documented in a way that provided any more of a description than "awake and alert." On a positive note, nurses did generally document whether or not any restraint-related injuries or other negative health effects occurred.

Abuse, Neglect, and Incident Management

Six indicators related to abuse, neglect, and incident management moved to the category of requiring less oversight. This included two entire outcomes: Outcome #4 and Outcome #5. The Center's newer ISPs contained detailed relevant data, trend review, and action plans using what appeared to be a Corpus Christi SSLC standard ISP template. In addition, the Center continued to meet criteria regarding the tracking, trending, and analysis of data. Overall, the Monitoring Team could not determine if action plans that were developed were implemented, tracked to completion, and modified, if needed. Many other indicators had high scores and may move to category of requiring less oversight after the next review. Others will require more focus, such as proper reporting, ensuring that all staff named in the investigation are interviewed (or a reason provided as to why not), and conducting non-serious injury investigations when warranted.

Other

For all nine of the instances reviewed of oral pre-treatment sedation for medical treatment, pre- and post- procedure vital signs were documented, which was good to see. However, overall, pre-treatment chemical restraint practices needed more focus in order to meet the outcomes and indicators evaluated by the Monitoring Teams. For example, the Center did not provide evidence of informed consent for any of these uses of pre-treatment sedation, and for only one was there evidence of input from an interdisciplinary committee/group.

It was good to see that the Center completed clinically significant DUEs and followed up to closure on recommendations.

Center staff generally completed mortality reviews in a timely manner. In addition, the reviews contained some valuable recommendations across disciplines. More work was needed to ensure that, particularly with the nursing reviews, full reviews were completed, and when findings identified problems, recommendations were offered to correct the underlying issues. In addition, as recommendations are implemented, the Center should measure whether or not problematic practices change and/or outcomes for individuals improve.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.												
Summary: The use of crisis intervention restraint at Corpus Christi SSLC remained low as did the use of medical/dental restraint. Ongoing attention to the number of individuals who receive crisis intervention restraint and the duration of PMR-SIB usage will require continued focus. These two important indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
1	There has been an overall decrease in, or ongoing low usage of,	75%	This is a facility indicator.									

	restraints at the facility.	9/12									
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1

Comments:

1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (October 2015 through June 2016) were reviewed. The overall use of crisis intervention restraint was lower than during the last review and remained low throughout this nine-month period, ranging from four to 18 occurrences per month. Corpus Christi SSLC's census-adjusted rate was the fourth lowest in the state. The number was higher in February 2016, March 2016, and April 2016, which was somewhat accounted for by an increase in crisis intervention restraint for Individual #123 during a time of attempted reductions and changes in her psychotropic medications.

The use of crisis intervention physical restraint paralleled the overall use of crisis intervention restraint at Corpus Christi SSLC because the vast majority of crisis intervention restraints were crisis intervention physical restraints. The duration of crisis intervention physical restraints was not decreasing and was slightly higher than at the time of the last review. The facility was in the mid-range compared to the other SSLCs. The use of crisis intervention chemical restraint remained very low, and the use of crisis intervention mechanical restraint only occurred once.

The number of injuries that occurred during restraint was low (i.e., five) and all were deemed non-serious. The facility looked deeper at these data and reported that only one of these non-serious injuries was due to application of the restraint (e.g., an incorrect hold), the other four were injuries that occurred during the proper use of restraint (e.g., during correct usage of the hold, the individual fell and scraped his knee). It was good to see this detailed look at the data. Injuries that occur during proper use of restraint, however, must not be discounted and should continue to be reviewed by the restraint reduction committee and/or QA program.

The number of different individuals for whom crisis intervention restraint was used was not decreasing over the nine-month period. The facility reported that this may have been due to some new admissions. The number of individuals with protective mechanical restraint for self-injurious behavior remained low, at one (Individual #9).

At the time of the last review, data regarding the amount of time the protective mechanical restraints were applied (or not applied) were only being kept for overnight hours. A current data graph showed that, since then, data were being collected all day. This was good to see. No progress, however, had been made in reducing the use of the protective mechanical restraint. Staff reported that no efforts or discussion had occurred regarding reducing the use of the restraints and that the only time he was out of the mittens was at night, after he'd fallen asleep, and when lotion was put on his hands during the day. In addition, the Monitoring Team observed Individual #9 onsite and reviewed his current ISP, behavioral health assessment, functional assessment, PBSP, monthly QIDP review, and PBSP progress note for June 2016. The Monitoring Team has the following recommendations for the facility and the IDT:

- Conduct a new full functional behavior assessment. The current FBA was merely a review of one completed in December 2014.
- His case should be presented to external peer review. It was good to see that his BCBA had reviewed a number of pertinent research articles to learn more about how to fade mittens, but more clinical input is needed.
- Similarly, the IDT would likely benefit from a consultation with an educator with training/experience in working with individuals with vision and hearing loss. His active programming is very limited.
- Typical protections need to be put in place and documented: (a) his PBSP had expired and needs to be updated, (b) there was

no indication of HRC review, and (c) he also wore a helmet. It was not identified as PMR-SIB, and it was not in the facility's list of protective devices. This needs to be clarified.

- The Lead Monitor observed Individual #9 in his home, and DOJ staff accompanied her on this visit. At the time, Individual #9 had his arms inside his shirt, and the sleeves of his shirt were tucked behind/under him. It was unclear whether or not he could free his arms from inside his shirt, giving the appearance that this could be used as a form of restraint. When the Lead Monitor brought this to the attention of the shift lead in the home, she immediately indicated that staff should not place the sleeves of his shirt under or behind him, and indicated she would ensure staff understood. Particularly given that it appears Individual #9 sometimes keeps his arms inside his shirt and that for safety reasons, the sleeves of his shirt should not be near the wheels on his wheelchair, specific guidance and training for staff should include the need to ensure that his sleeves are not tucked behind or under him, but rather allow freedom of movement.

The use chemical and non-chemical restraint for dental procedures and for non-chemical medical procedures were low throughout the nine-month period. The use of chemical restraint for medical procedures was steadily decreasing over the nine-month period.

Thus, state and facility data showed low usage and/or decreases in nine of these 12 facility-wide measures (i.e., overall use of crisis intervention restraint; use of crisis intervention physical, chemical, and mechanical restraint; number of individuals who had crisis intervention restraint; use of chemical and non-chemical restraints for medical and dental procedures).

2. Six of the individuals reviewed by the Monitoring Team were subject to restraint. Five received crisis intervention physical restraints (Individual #123, Individual #171, Individual #300, Individual #199, Individual #120), and three received crisis intervention chemical restraint (Individual #184, Individual #199, Individual #120). Data from state office and from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for four (Individual #184, Individual #123, Individual #300, Individual #199). The other three individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period.

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

Summary: Overall, Corpus Christi SSLC implemented restraint according to most of the criteria in this outcome. For instance, six of the indicators have had high scores for multiple reviews (3, 4, 5, 6, 7, and 8). These indicators will move to the category of requiring less oversight. The other three indicators require continued focus, especially indicator 9, and will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	184	123	171	300	199	120			
3	There was no evidence of prone restraint used.	100% 10/10	1/1	2/2	2/2	1/1	2/2	2/2			
4	The restraint was a method approved in facility policy.	100% 10/10	1/1	2/2	2/2	1/1	2/2	2/2			

5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 10/10	1/1	2/2	2/2	1/1	2/2	2/2			
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 7/7	N/A	2/2	2/2	1/1	1/1	1/1			
7	There was no injury to the individual as a result of implementation of the restraint.	100% 10/10	1/1	2/2	2/2	1/1	2/2	2/2			
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 10/10	1/1	2/2	2/2	1/1	2/2	2/2			
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/2	Not rated	Not rated	0/1	Not rated	Not rated	0/1			
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	90% 9/10	0/1	2/2	2/2	1/1	2/2	2/2			
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	30% 3/10	1/1	0/2	0/2	0/1	2/2	0/2			

Comments:
The Monitoring Team chose to review 10 restraint incidents that occurred for six different individuals (Individual #184, Individual #123, Individual #171, Individual #300, Individual #199, Individual #120). Of these, seven were crisis intervention physical restraints, and three were crisis intervention chemical restraints. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

9. Because criterion for indicator #2 was met for four of the six individuals, this indicator was not scored for them. For the other two, some of the sub-indicators were occurring (e.g., a PBSP existed, individual was engaged in activities). However, there were problems with implementation of the PBSPs, an absence of staff training on the PBSP for about a third of the residential staff and all of the day program staff, and a lack of reliable data on behavioral targets.

10. For Individual #184 1/13/16 9:30 am, the required pre-chemical-restraint consultation occurred two hours after the restraint was administered.

11. The restraint consideration section of the ISP IRRFs was correctly completed for Individual #184 and Individual #199, but not for the others.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.	
Summary: Staff correctly answered questions from the Monitoring Team. Maintaining performance at criterion at the next review will likely result in this indicator moving to the category of requiring less oversight.	Individuals:

#	Indicator	Overall Score	184	123	171	300	199	120			
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 4/4	Not rated	1/1	1/1	1/1	Not rated	1/1			
Comments:											

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	184	123	171	300	199	120			
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	80% 8/10	0/1	2/2	2/2	1/1	2/2	1/2			
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Comments: 13. For two chemical restraints (Individual #184 1/13/16 9:30 am, Individual #120 1/13/16 7:00 pm), the nurse administering the restraint was also the staff listed as the restraint monitor. The administering nurse cannot also be the restraint monitor. This was discussed with facility staff while onsite. Chemical restraint was monitored correctly for Individual #199 4/26/16 4:30 pm.											

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
Summary: During this review and the last one, the Center showed good performance with the requirement to document whether or not any restraint-related injuries or other negative health effects occurred. If this level of performance continued, during the next review, Indicator b might move to the category requiring less oversight. The remaining indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	184	123	171	300	199	120			
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	30% 3/10	0/1	2/2	1/2	0/1	0/2	0/2			
b.	The licensed health care professional documents whether there are	90%	1/1	2/2	2/2	1/1	2/2	1/2			

	any restraint-related injuries or other negative health effects.	9/10									
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	30% 3/10	0/1	2/2	1/2	0/1	0/2	0/2			

Comments: The crisis intervention restraints reviewed included those for: Individual #184 on 1/3/16 at 9:30 a.m.; Individual #123 on 3/29/16 at 6:39 p.m., and 5/10/16 at 8:20 p.m.; Individual #171 at 4/22/16 at 5:20 p.m., and 4/28/16 at 4:20 p.m.; Individual #300 on 4/22/16 at 7:45 a.m.; Individual #199 on 3/4/16 at 2:31 p.m., and 4/26/16 at 4:30 p.m.; and Individual #120 on 1/13/16 at 7:00 p.m., and 5/12/16 at 8:49 a.m.

a. For nine of the 10 restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint. The exception was for Individual #199 on 3/4/16 at 2:31 p.m.

For three of the 10 restraints, nursing staff properly monitored and documented vital signs, including for Individual #123 on 3/29/16 at 6:39 p.m., and 5/10/16 at 8:20 p.m.; and Individual #171 at 4/28/16 at 4:20 p.m. For some of the remaining restraints, notes indicated that the individual had refused vital signs. However, cooperation is not necessary to obtain respirations. Sometimes, nurses should have retaken vital signs, but did not (e.g., for Individual #300 on 4/22/16). For Individual #120's restraints on 1/13/16 and 5/12/16, respirations were documented, but no other vital signs were documented.

Nursing staff documented and monitored mental status of the individuals for five of the 10 restraints. In some instances, no mental status assessment was documented or they were missing for specific timeframes (i.e., Individual #184 on 1/3/16 at 9:30 a.m., Individual #199 on 3/4/16 at 2:31 p.m., and Individual #120 on 5/12/16 at 8:49 a.m.), and in other instances, sufficient description was not provided of the individual's mental status (e.g., "awake and alert") (i.e., Individual #171 at 4/22/16 at 5:20 p.m., and Individual #199 on 4/26/16 at 4:30 p.m.).

b. No IPN was found for Individual #120's restraint on 5/12/16 at 8:49 a.m. This individual was at increased risk, due to diagnoses of hypertension, asthma, prolonged QT interval, and a history of congestive heart failure. He also was at high risk for fractures, and sustained a fractured toe two months earlier. At a minimum, the nurse should have documented an explanation as to why a full set of vital signs, as well as an assessment for injury could not be completed.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.											
Summary: Facility performance for this indicator improved over the course of the previous two reviews. With sustained performance, this indicator will likely move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	184	123	171	300	199	120			
15	Restraint was documented in compliance with Appendix A.	100% 10/10	1/1	2/2	2/2	1/1	2/2	2/2			
Comments:											

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.												
Summary: Facility performance for these indicators improved over the course of the previous two reviews. With sustained performance, these indicators will likely move to the category of requiring less oversight after the next review.			Individuals:									
#	Indicator	Overall Score	184	123	171	300	199	120			
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	90% 9/10	1/1	2/2	2/2	1/1	1/2	2/2			
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 3/3	1/1	N/A	1/1	N/A	1/1	N/A			
Comments: 16. For Individual #199 4/26/16 4:30 pm, no documentation was provided.												

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner.											
Summary: Psychiatrist involvement in crisis intervention chemical restraint needs to occur within the required 10 days. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	184	199	120						
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	33% 1/3	0/1	1/1	0/1						
48	Multiple medications were not used during chemical restraint.	100% 3/3	1/1	1/1	1/1						
49	Psychiatry follow-up occurred following chemical restraint.	100% 3/3	1/1	1/1	1/1						
Comments: 47. The restraint documentation for Individual #120 and Individual #184 indicated that the restraint documentation was not reviewed and signed by the psychiatrist and pharmacist till after the allotted 10-day period. 47-48. Each of the three episodes of chemical restraint (Individual #184, Individual #199, Individual #120) involved the use of only one psychotropic medication. There was also evidence of the subsequent review by the psychiatrist for each episode as it was reviewed in the subsequent quarterly psychiatric review.											

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
Summary: Corpus Christi scored lower on this review than the previous review, however, good progress was made in facility and IDT reviews of trends and previous occurrences. Documentation of the development, implementation, and review of actions designed to reduce the likelihood of incidents occurring could not be found. This is an area in need of focus at the facility. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	64% 7/11	0/1	1/1	0/1	1/2	1/2	1/1	1/1	1/1	1/1

Comments:

The Monitoring Team reviewed 11 investigations that occurred for nine individuals. Of these 11 investigations, seven were DFPS investigations of abuse-neglect allegations (one confirmed, five unconfirmed, one inconclusive). The other four were for facility investigations of a discovered ankle fracture, discovered leg fracture, suicide threat, and sexual incident. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #38, UIR 16-199, discovered ankle fracture, 1/16/16
- Individual #184, UIR 16-174, DFPS 44168381, unconfirmed allegation of neglect, 12/27/15
- Individual #372, UIR 16-205, discovered leg fracture, 1/24/16
- Individual #20, UIR 16-230, DFPS 44210129, inconclusive allegation of physical abuse, 2/2/16
- Individual #20, UIR 16-368, sexual incident, 4/15/16
- Individual #123, UIR 16-151, DFPS 44147563, unconfirmed allegation of physical abuse, 12/10/15
- Individual #123, UIR 16-195, suicide threat, 1/9/16
- Individual #171, UIR 16-212, DFPS 44203716, unconfirmed allegation of physical abuse, 1/28/16
- Individual #300, UIR 16-421, DFPS 44333377, unconfirmed allegation of neglect, 5/3/16
- Individual #199, UIR 16-244, DFPS 44204019, unconfirmed allegations of physical and sexual abuse, 1/22/16
- Individual #120, UIR 16-116, DFPS 44124463, confirmed and unconfirmed allegations of neglect, 11/20/15

1. For all 11 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes (a) the occurrence of staff criminal background checks and signing of duty to report forms, (b) facility and IDT review of trends of prior incidents and related occurrences, and the (c) development, implementation, and (d) revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator and other facility staff met with the Monitoring Team

onsite at the facility to review these cases as well as all of the indicators regarding incident management.

In all cases, criminal background checks were conducted and staff signed the annual acknowledgement of their reporting responsibilities. The seven investigations that met criteria were allegations of staff abuse or neglect. No trends were identified, therefore, the background checks and reporting responsibility acknowledgements were the criteria for meeting this indicator.

The four that did not meet criteria were Individual #38 UIR 16-199, Individual #372 UIR 16-205, Individual #20 UIR 16-368, and Individual #123 UIR 16-195. Two of these were for individuals who had annual ISPs that were more recent than the other two (Individual #372 UIR 16-205, Individual #123 UIR 16-195). The ISPs for these two individuals contained detailed relevant data, trend review, and action plans using what appeared to be a Corpus Christi SSLC standard ISP template. It had headings for "Summarize Data," "Identify Trends and Compare to Previous Years," and "Develop Action Plans to Minimize Risk." The Monitoring Team was impressed with the data presentation, analysis, and follow-up described in these sections of the ISP. That being said, the Monitoring Team could not identify any evidence that any actions were developed, implemented, and reviewed/revised if necessary for these two investigations or the other two investigations. While onsite, the facility was given the opportunity to provide additional information, documentation, or description of any of these activities, but none was provided to the Monitoring Team.

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

Summary: Most allegations and injuries were reported appropriately and the scoring for this review showed an improvement from the past two reviews. However, given that more work is needed, as well as the problems with the three that were not reported correctly during this review, this indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	73% 8/11	1/1	0/1	1/1	2/2	1/2	1/1	0/1	1/1	1/1

Comments:

2. The Monitoring Team rated eight of the investigations as being reported correctly. The others were rated as being reported late. All were discussed with the facility Incident Management Coordinator while onsite. This discussion along with additional information provided to the Monitoring Team informed the scoring of this indicator. Those not meeting criterion are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

- Individual #184 16-174: Both the UIR and DFPS reports showed that the incident occurred on 12/27/15 and was reported as an allegation of neglect on 12/30/15. There was no information in the UIR or facility review documents to address the circumstances associated with this delay. For instance, it might have been that the individual self-reported, or perhaps the IMRT decided to report after reviewing various documents, or perhaps a video monitor reported it. The UIR or the facility's "Review Authority Team Meeting" minutes (i.e., IMRT) should explicitly respond to a query "was this incident appropriately

reported within required timeframes?" This is an important element of incident management as required by the Settlement Agreement. The facility should be more proactive in determining, incident by incident, whether reporting requirements were met.

- Individual #123 16-195: The UIR showed that the incident occurred at 4:17 pm and was reported to the facility director/designee at 6:29 pm.
- Individual #300 16-421: The UIR and DFPS reports showed that the incident happened on 5/3/16 at 10:30 am and was reported on 5/3/16 at 6:30 am. The DFPS report, in the restatement of allegation section, said that the incident occurred on 5/2/16 at about 10:00 am and in the probable version of events section said 10:08 am. The UIR chronology had dates, but not times. Even so, none were any earlier than 5/3/16. The UIR showed facility director notification on 5/3/16 at 8:03 am. The facility needs to use the UIR to document any unclear sequence of events leading up to a report to DFPS.

The facility might create and incorporate a standard template item into the UIR to address whether or not the incident was reported correctly, including any unusual circumstances that could be subject to interpretation.

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

Summary: Corpus Christi SSLC maintained good performance across this review and the last review. Therefore, indicators 4 and 5 will move to the category of requiring less oversight. Indicator 3 will remain in active oversight, in part, due to the need for improvement in reporting.

Individuals:

#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 4/4	1/1	Not rated	1/1	1/1	1/1	Not rated	Not rated	Not rated	Not rated
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 11/11	1/1	1/1	1/1	2/2	2/2	1/1	1/1	1/1	1/1

Comments:

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

Summary: The facility met criteria for 100% of the investigations during this and also during the previous two reviews. Therefore, this indicator will move to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 11/11	1/1	1/1	1/1	2/2	2/2	1/1	1/1	1/1	1/1
	Comments:										

Outcome 5– Staff cooperate with investigations.											
Summary: Corpus Christi SSLC showed 100% performance on this indicator during this review and the last review, as well as improvement of already high scores from January 2015. Given this sustained performance, this indicator will move to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
7	Facility staff cooperated with the investigation.	100% 11/11	1/1	1/1	1/1	2/2	2/2	1/1	1/1	1/1	1/1
	Comments:										

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
Summary: These three indicators scored lower during this review than during the previous review. Given the importance of these indicators in the conduct and findings of an investigation, they will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	91% 10/11	0/1	1/1	1/1	2/2	2/2	1/1	1/1	1/1	1/1
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	64% 7/11	0/1	1/1	0/1	1/2	1/2	1/1	1/1	1/1	1/1
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	64% 7/11	0/1	1/1	0/1	1/2	1/2	1/1	1/1	1/1	1/1
	Comments: 8. All but one of the investigations met the criteria for this indicator. For Individual #38 16-199, the UIR showed that no staff were interviewed and that the investigation was based primarily on review of progress notes and behavioral data sheets. These noted that Individual #38 engaged in actions that could have resulted in the fracture. Staff on duty, or at least staff responsible for her supervision because her level of supervision was considered routine, for several shifts prior to the discovery of the injury should have been										

identified and interviewed to identify any possible cause, particularly one that could have been immediately addressed to reduce risk (e.g., furniture placement) and rule out any aggressive actions by staff or other individuals that could have caused sudden movement resulting in the injury. Additionally, some video review could have been done. While the facility investigation identified at least two likely scenarios that could explain the injury, the absence of staff interviews was a critical omission in the investigation.

9-10. Four facility investigations (Individual #38 16-199, Individual #372 16-205, Individual #20 16-368, Individual #123 16-195) did not meet criteria because not all staff identified as involved were interviewed. Furthermore, the UIR did not contain any information regarding why, in some cases, some staff were interviewed and others were not. Additionally, the facility relied primarily (in some cases exclusively) on review of IPNs to determine what happened. Moreover, there were circumstances where video review might have been useful in conducting the investigation, but wasn't used.

These problems were further exemplified with an investigation that the State submitted with its comments on the draft report. While on site, the Monitoring Team raised concerns about an individual during a mealtime. Four days after the incident, the Facility Director requested an investigation. The investigation the State submitted to the Monitors did not meet generally accepted standards for investigations with regard to collecting, weighing, analyzing, or reconciling evidence. As a result, evidence presented in the investigation was not sufficient to justify the conclusion. Some of the problems with the investigation for UIR #16-560 for Individual #38 included but were not limited to:

- Due to the delay in the request for and initiation of the investigation, the likelihood that interviews were compromised increased. For example, according to the investigation, on 7/29/16, two days before the investigation commenced, an IDT meeting was held to discuss the incident. Several conclusions were drawn at that meeting, and although the investigation did not state whether or not any of the staff at the meeting were subsequently interviewed for the investigation, it was clear from the documentation of the meeting referenced in the investigation report that the team had obtained information from at least some of those involved and that the Monitoring Team's concerns had been discussed amongst at least some of the team members.
- The Center did not ask the Monitoring Team member who witnessed the incident for an interview or written statement. He is a Speech Language Pathologist with decades of experience assessing and working with individuals with complex physical and nutritional management needs. A thorough investigation would have included a statement from him in terms of what he saw and heard. It would then have been essential to weigh his witness testimony in contrast with the other witnesses' testimony. The failure to do this was a major shortcoming of the investigation.
- The fact that most, if not all, witness statements included similar references to "she was not choking," "we never placed a napkin covering her mouth," and "we did not lift her out of the chair" called into question whether or not proper interview techniques were used. Given that these were concerns that the Monitoring Team raised while on site, it appeared that the interviews were designed to elicit this specific information as opposed to asking witnesses for an unbiased account of what they saw and heard. As noted above, the interviews likely were compromised due to previous discussions about the incident, and this might be another explanation for these similarities in supposedly independent accounts.
- Video surveillance tapes were used as part of the investigation. The limitations of the video surveillance records were not addressed in the investigation report. For example, sound is an important component in determining whether someone is choking, coughing, experiencing respiratory distress, etc. The video provided to the Monitor did not include sound. The investigation report correctly identified that the individual's back was to one camera. However, at points, both cameras had

obstructed views, and the investigation report did not clearly state this fact. For example, when a staff member reportedly attempted to get Individual #38 to stand up and the individual refused, neither camera provided a clear view of whether any staff placed their hands on Individual #38. This is not mentioned in the description of what was discerned from review of the video or the reconciliation of evidence. The investigation report also does not discuss where the Monitoring Team member was standing when this occurred (or when any of the incident occurred, for that matter).

- Even without the testimony of the Monitoring Team member as a key witness, many pieces of conflicting information were not reconciled. Some examples include: 1) the statement of the nurse who assessed Individual #38 during the mealtime indicated that she was drinking chocolate milk when the nurse arrived, but other staff and/or the ISPA stated her cup was empty and/or they removed her meal and only allowed her to eat and drink after the nurse assessed her and gave permission; 2) the video review showed staff assisting her to drink and pouring drinks for her while waiting for the nurse, but the team meeting documentation provided information to the contrary; 3) staff made statements related to not putting a napkin over her mouth while she was coughing, but the investigator's review of the video showed staff appearing to wipe her mouth in between episodes of what appeared to be her coughing; 4) staff made statements that they did not try to physically get her up out of the chair, but the investigator's summary of the review of the video review included the statement that the Physical and Nutritional Management Plan Coordinator "moves chair away from table and tries to get [Individual #38] to stand up but [Individual #38] refuses; and 5) the direct support professional working with Individual #38 indicated she had just swallowed a bite of food before the coughing began, and a number of the statements indicated what drew staff's attention to Individual #38 was her coughing, but the investigation report included no reconciliation of this evidence or analysis of the video evidence regarding who was attending to/focused on Individual #38 at what point in the incident.

To a certain extent, it is unclear what the investigation concluded, because it was unclear what the investigation question was. The "Cause" listed at the conclusion of the investigation report was: "[Individual #38] began coughing while she was eating." However, the investigation report included a number of other findings, including, for example, a finding that a Modified Barium Swallow Study that should have been done was not, and that a number of staff failed to complete timely documentation of the incident. In sum, though, the investigation process was flawed, and therefore, its conclusions were not substantiated.

Outcome 7– Investigations are conducted and reviewed as required.

Summary: All Corpus Christi investigations commenced within 24 hours of being reported for this review and the last two reviews. All but one investigation was completed within 10 days during this review and the last two reviews. Therefore, these two indicators will move to the category of requiring less oversight. Indicator 13, however, will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	184	372	20	123	171	300	199	120
11	Commenced within 24 hours of being reported.	100% 11/11	1/1	1/1	1/1	2/2	2/2	1/1	1/1	1/1	1/1
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written	91% 10/11	1/1	1/1	1/1	2/2	2/2	1/1	1/1	1/1	0/1

	extension documenting extraordinary circumstances was approved in writing).										
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	55% 6/11	0/1	1/1	0/1	1/2	1/2	1/1	0/1	1/1	1/1

Comments:
12. For Individual #120 UIR 16-116, the first of two extensions listed the reason as other: extraordinary circumstances without any description of what those were.

13. The expectation is that the facility's supervisory review process will identify the same types of issues that are identified by the Monitoring Team. In other words, a score of zero regarding late reporting or interviewing of all involved staff does not result in an automatic zero score for this indicator. Identifying, correcting, and/or explaining errors and inconsistencies contributes to the scoring determination for this indicator. That was the case for five of the 11 investigations.

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.

Summary: Sustained performance for indicator 14 will likely result in it moving to the category of requiring less oversight after the next review. On the other hand, the conduct of non-serious injury investigations remained an area in need of facility focus and, therefore, will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	184	372	20	123	171	300	199	120
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	50% 3/6	1/1	1/1	N/A	1/1	0/1	0/1	N/A	N/A	0/1

Comments:
15. For three individuals, a review of the list of injuries included some that should have been subject a non-serious injury investigation. These were a bruise/contusion to the left side of the face (Individual #123 3/31/16), a bruise/contusion to the eye (Individual #171 12/9/15), and a bruise/contusion to an unspecified body part (Individual #120 6/16/16).

In its response to the draft report, the State reported that, for all three injuries, the facility was not aware of the injury until it received notification of the injury/allegation from DFPS and that, therefore, a non-serious injury investigation could not be conducted because DFPS was now conducting an investigation. If so, this then indicates that the facility did not have an adequate system for the incident management office to be notified of injuries and/or a system to quickly review injury reports to determine whether or not an non-

serious injury investigation should be done.

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.												
Summary: Corpus Christi SSLC showed 100% performance on two of these indicators during this review and at the previous review for all three. All three indicators improved from the January 2015 review. These indicators will remain in active monitoring; with sustained performance, they will likely move to the category of requiring less oversight after the next review.			Individuals:									
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	83% 5/6	1/1	1/1	0/1	N/A	1/1	N/A	N/A	1/1	1/1
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 5/5	1/1	1/1	N/A	N/A	1/1	N/A	N/A	1/1	1/1
Comments: 16. For Individual #372 16-205, the cause of her injury was determined to be related to a seizure, that is, to an isolated incident. While this may have been true, it would have been appropriate for the IMC/IMRT to recommend that the IDT review Individual #372's seizure history, including medications, to determine if anything needed to be addressed to increase her safety.												

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

	the plan, or when the outcome was not achieved, the plan was modified.										
23	Action plans were appropriately developed, implemented, and tracked to completion.	No									

Comments:
19-21. The facility continued to meet criteria with these three indicators regarding the tracking, trending, and analysis of data.

22-23. The Monitoring Team could not determine if action plans that were developed were implemented, tracked to completion, and modified, if needed. While onsite, the facility was invited to provide additional documentation regarding this, but none was provided.

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. The Facility had a policy entitled: IV Sedations/Anesthesia (TVIA), which included dental criteria for selection of individuals for TIVA. This policy provided guidance as to which individuals would benefit from dental care under TIVA/general anesthesia. Although some dental criteria for TIVA were outlined, these often were not measurable criteria, and were not consistent with those included in the Dental Audit Tool [i.e., the following procedures must be anticipated: Deep Cleaning (D4341/D4342), Restorative (D2140-D2999), Endodontics (D3110-D3999), and Extractions (D7111-D7999). There are some procedures, such as pulling wisdom teeth or deep scaling that people in the community would expect some form of sedation. For other procedures, three failed attempts must occur first before TIVA is used. If the individual met this criterion before and has another dental need, then only one failed attempt would be necessary, utilizing any desensitization or other strategies developed for the individual. The dentist should describe in detail what issues were observed during the trials. The only exceptions to this would be emergencies. Even if there are failed attempts, teams should document discussion of the need for programmatic interventions to increase cooperation in the future.]. The Facility should modify its policy to be consistent with these guidelines.

In addition, the Facility did not have a pre-operative protocol to minimize risk from TIVA/general anesthesia, such as ensuring medical clearance by the PCP or specialists as indicated. For these individuals, because of the lack of protocol for medical clearance, the Monitoring Team could not confirm that proper procedures were followed prior to TIVA. It is noted that medical clearances were completed, but there was no formal written medical clearance protocol from which to measure compliance with this aspect of

preparation for TIVA.

For these two instances of use of TIVA, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, an operative note defined procedures and assessment completed, and post-operative vital sign flow sheets were submitted.

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

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to assess this indicator.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/9	N/A	N/A	0/8	N/A	N/A	N/A	N/A	N/A	0/1
Comments: For all nine of the instances reviewed of oral pre-treatment sedation for medical treatment, pre- and post- procedure vital signs were documented, which was good to see. However, the Center did not provide evidence of informed consent for any of these uses of pre-treatment sedation, and for only one (i.e., for Individual #141's electrocardiogram on 2/19/16) was there evidence of input from an interdisciplinary committee/group.											

Outcome 1 - Individuals' need for pretreatment chemical restraint (PTCR) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTCR.											
Summary: The facility was not yet ensuring the review, planning, and implementation of possible treatment or strategies regarding pretreatment chemical restraint. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	184							
1	IDT identifies the need for PTCR and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	50% 1/2	1/1	0/1							
2	If PTCR was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTCR, or (b) determined that any actions to reduce the use of PTCR would be counter-therapeutic for the individual.	50% 1/2	1/1	0/1							
3	If treatments or strategies were developed to minimize or eliminate the need for PTCR, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTCR, (b) in the	0% 0/2	0/1	0/1							

	ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.										
4	Action plans were implemented.	0% 0/2	0/1	0/1							
5	If implemented, progress was monitored.	0% 0/2	0/1	0/1							
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/2	0/1	0/1							

Comments:

1-5. A PTCR plan had been developed for Individual #38. It was signed by the facility director and approved by HRC. It was concerning that when this was developed in October 2015, it was noted that behavioral health services was developing a new functional assessment and behavior support plan. These were not submitted to the BSC until eight months later, in June 2016. It was noted in her ISP that she was very uncooperative during exams and any desensitization plan was not likely to be successful. She had been referred to behavioral health services, but was deemed not a candidate for desensitization. A consult with an educator of the deaf and blind is advised. Individual #184 had received TIVA for a dental exam in January 2016. His ISP contained conflicting information. One reference noted he liked going to the dentist and did not require a desensitization plan. Further in the document, it was noted that he became anxious and moved excessively at the dentist, required TIVA, but did not require a PTCR plan. When this was requested by Monitoring Team while onsite, a note was provided indicated that a PTCR plan was in the process of being developed with a desensitization plan to follow.

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: It was good to see improvement from past reviews with regard to the timeliness of the completion of clinical and administrative death reviews. In addition, the reviews contained some valuable recommendations across disciplines. More work was needed to ensure that, particularly with the nursing reviews, full reviews were completed, and when findings identified problems, recommendations were offered to correct the underlying issues. In addition, as recommendations are implemented, the Center should measure whether or not problematic practices change and/or outcomes for individuals improve. The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	189	276	57	205	335				
a.	For an individual who has died, the clinical death review is completed	80%	1/1	0/1	1/1	1/1	1/1				

	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.	4/5									
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
e.	Recommendations are followed through to closure.	0% 0/5	0/1	0/1	0/1	0/1	0/1				

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

- Individual #189 – encephalopathy, status epilepticus, and profound mental retardation;
- Individual #276 – pneumonia;
- Individual #57 – sub-acute gastrointestinal bleeding, and disseminated intravascular coagulopathy due to pneumonia;
- Individual #205 – dysphagia; and
- Individual #335 – chronic obstructive pulmonary disease.

b. through d. Some comments with regard to recommendations include:

- The Medical Director was conducting reviews of deaths. The resulting recommendations covered a wide variety of disciplines and issues.
- In addition, the Quality Assurance (QA) Nurse was conducting reviews. The QA Nurse reviews contained a considerable amount of good information, but were incomplete in that: 1) for individuals that died during a stay of more than 72 hours at the hospital, the reviews often provided no information about the care the Facility provided the individual (i.e., for individuals who are hospitalized, instead of discussing care 72 hours prior to death, the reviews should evaluate care provided 72 hours before the individual's transfer to hospital); and 2) frequently, the QA Nurse made findings that required recommendations and follow-up, but did not make a corresponding recommendation.
- Some very valuable recommendations were included in the Administrative and Clinical Death Reviews. For example, recommendations covered a wide range of disciplines, and addressed a number of issues included elsewhere in this report. Some examples of issues addressed included the need to improve the quality of Integrated Risk Rating Forms, Integrated Health Care Plans, and Individual Support Plan Addenda, particularly after individuals were hospitalized; the need for direct support professionals to have additional education about medical issues, and for their input to be considered respectfully; the need to improve the treatment and care provided to the most complex individuals the Center served; for reviews to be conducted of equipment to make sure it supported individuals' needs; for retraining of staff on issues such as the proper use of

adaptive equipment; and better coordination when individuals were hospitalized. However, as a result of the problems with the nursing reviews, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the death reviews.

e. In determining whether or not follow-up occurred with regard to recommendations, Center staff did not use measures that ensured that Center practice and/or outcomes for individuals had improved. For example, a recommendation read: "Coordinate with the teams to discuss instances of bruising on individuals that are specifically associated with the ARJO lifts and see what types of padding can be made available to keep on the homes for individuals who have had a history of injuries while utilizing the lifts." The evidence the Center submitted for completion of this recommendation included an email from the Director of Habilitation Therapy Services noting that all employees receive "hands-on" training during New Employee Orientation and every year thereafter, and that individuals are monitored monthly and on-the-spot coaching and training are provided. However, no monitoring data was provided to support this. In addition, the Habilitation Therapies Director indicated that the ARJO lifts are leased equipment and cannot be altered in any manner, as this would nullify the lease agreement. She reported that staff are trained and coached to ensure the sling is positioned correctly, and clothing is between the individual and sling. Staff may also utilize fabric items such as a pillow, towel, or blanket to provide additional padding as needed. No further action was taken regarding this recommendation. This in no way ensured that practices or outcomes for individuals changed. For example, monitoring could have been completed to determine whether or not staff were using procedures and equipment that decreased the risk of individuals bruising during transfers.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	ADRs are reported immediately.	N/A									
b.	Clinical follow-up action is completed, as necessary, with the individual.	N/A									
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A									
d.	Reportable ADRs are sent to MedWatch.	N/A									
Comments: a. through d. Facility staff had not identified and/or reported adverse drug reactions for any of the individuals reviewed.											

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.	
Summary: Given that during the last review period and during this review, the Center completed clinically significant DUEs and followed up to closure on recommendations, if this performance is sustained during the next review, this	Individuals:

Outcome likely will move to the category of requiring less oversight.		
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 3/3
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 2/2

Comments: a. and b. In the six months prior to the review, Corpus Christi SSLC completed three DUEs, including:

- A DUE on Valproate that was presented to the Pharmacy and Therapeutics (P&T) Committee on 5/25/16, for which no specific follow-up was needed. The DUE reviewed the withdrawal schedule; the diagnosis for the use of valproate; the length of therapy before discontinuation; reasons for withdrawing medication; tracking subsequent adverse effects, such as seizures, increased aggression, and agitation; and prescribing alternative medications for seizures, antipsychotic behavior, and depression. If in the future, individuals need withdrawal from the medication, then the DUE recommended a slow taper and close monitoring for adverse effects.
- A DUE on Acetaminophen that was presented to the P&T Committee on 2/24/16, which included several recommendations. On 5/25/16, follow-up data was presented to the P&T Committee. Improvement was noted in that 11% versus 16% of the orders for acetaminophen fell outside of the guidelines.
- A DUE for Bactroban that was presented to the P&T Committee on 2/24/16. On 5/25/16, follow-up data was presented to the P&T Committee at which time it was reported that prescriptions of Bactroban decreased by 72% since the meeting in February.

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Eighteen of these indicators, in psychiatry, behavioral health, medical, dental, nursing, and skill acquisition, had sustained high performance scores and will be moved the category of requiring less oversight. This included one entire outcome: Outcome #6 for Psychiatry.

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

There were many cases where IDTs did not arrange for and obtain needed, relevant assessments prior to the IDT meeting. In addition, overall, the lack of quality assessments for the individuals the Monitoring Teams reviewed stymied IDTs' ability to develop meaningful plans. In many cases, assessments lacked root cause analysis and often indicated an acceptance of an individual's decline by simply documenting the decline rather than asking why the decline occurred.

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

On a positive note, the Psychiatry Department met criteria for the completion and content of comprehensive psychiatric evaluations, for the completion of the annual updates, and for psychiatry participation in the IDT and ISP meeting. Five of the indicators moved to the category of requiring less oversight. However, more focus is needed regarding content of the annual update and the inclusion of relevant information into the ISP document.

Assessments related to behavioral health were completed on time; some focus is required regarding the content of the functional assessments. In addition, a number of individuals reviewed had behavioral needs that prevented them from benefitting from services provided, but Behavioral Health Services (BHS) was largely absent in assessing these individuals and developing plans to address their needs.

On a positive note, some improvement was seen with regard to the timeliness of medical assessments. In addition, during this review and the last two, individuals reviewed generally had diagnoses justified by appropriate criteria, so the related indicator

will move to the category of requiring less oversight. Of concern, in addition to other problems, only one of the nine medical assessments included a plan of care for each active medical problem, when appropriate, that were in alignment with current standards of care and the individual's needs. The overall quality of medical assessments is an area on which the Medical Department should focus.

It was good to see that the Dental Department completed timely dental exams and summaries for all of the individuals reviewed. Due to consistently high performance with these indicators over the past few reviews, they will move to the category of requiring less oversight. The Center also made progress on the quality of the dental exams and summaries. Dental Department staff should focus on maintaining/continuing to improve the exams and summaries.

On a positive note, for this review and the previous two reviews, nursing staff completed the quarterly nursing reviews and physical assessments in a timely manner. As a result, the related indicator will be placed in the category of 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.

Although the Center's scores varied somewhat over the last two reviews, the scores during this review generally showed improvement with regard to timely referral of individuals to the PNMT as needed, and completion of the PNMT initial review. For the two individuals who only needed a PNMT review, the reviews were of good quality. However, it was extremely concerning that for four of five individuals who needed comprehensive PNMT assessments, the PNMT did not conduct them. The Center should focus on improving the completion as well as the quality of these assessments.

Timeliness as well as the quality of the OT/PT assessments continued to be areas on which the Center needed to focus. It was encouraging to see that two of the updates reviewed included all of the necessary components, and addressed the individuals' strengths, preferences, and needs. Although much more work was needed, this was an improvement from the two previous reviews.

It was good to see some minor improvement from the previous review with regard to the timeliness of communication assessments/updates, but this was still an area needing improvement. In addition, Center staff need to focus on ensuring individuals receive the communication assessments they need, as well as improving the quality of communication assessments.

Every individual had skill acquisition programs. Only about half, however, were based on assessments. In addition, most individuals did not have updated relevant assessments and most did not include recommendations for skill acquisition.

Individualized Support Plans

Overall, personal goals for the ISPs remained very broadly stated and general in nature and/or were very limited in scope and none had individualized goals in all areas. There was some improvement in the individualization of personal goals related to living options. Despite this improvement, much work remained to establish goals that were individualized, measurable and represented personal aspirations. In addition, the set of action plans did not meet the many criteria in Outcome 3, in large part, because the personal goals were not individualized. Greater participation by all relevant IDT members in the annual meeting may also contribute to improvement.

Overall, the ISPs of the individuals reviewed did not describe how the individuals communicate, and/or include plans or strategies to meet their needs. In fact, some regression was noted from the previous two reviews.

All PBSPs were current and updated; focus is required for the content of the functional assessments and PBSPs. As noted above, BHS staff also need to assess and develop plans to address the needs of individuals whose behavioral needs prevent them from benefitting from supports designed to address their risks or health issues.

Overall, the IHCPs of the individuals reviewed were not sufficient to meet their needs. Much improvement was needed with regard to the inclusion of behavioral, psychiatric, and medical plans in individuals' ISPs/IHCPs, as well as nursing and physical and nutritional support interventions. Overall, IDT members worked largely in silo-fashion, which meant that plans developed often did not meet individuals' needs.

IDTs met frequently to respond to various events, behavioral incidents, and medical issues. This was good to see, however, IDT and QIDP reviews did not result in actions when needed, especially regarding action plans that were not implemented or not progressing.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: Corpus Christi SSLC had recently completed training in the new ISP process. ISPs did not yet set goals that were individualized and met the criteria for this outcome. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	184	123	300	120	141	162			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the	0% 0/6	1/6	0/6	0/6	0/6	1/6	0/6			

	individual on what is important to him or her.										
2	The personal goals are measurable.	0% 0/6	1/6	0/6	0/6	0/6	1/6	0/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	1/6	0/6	0/6	0/6	1/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #184, Individual #123, Individual #300, Individual #120, Individual #141, and Individual #162. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Corpus Christi SSLC campus.

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

Overall, outcomes for the six ISPs remained very broadly stated and general in nature and/or were very limited in scope and none had individualized goals in all areas. None had a comprehensive set of goals that met criterion. There was some improvement in the individualization of individuals' living options goals that were not the commonly used generic goal to live in the most integrated setting consistent with preferences, strengths and needs. Two of six individuals (Individual #184 and Individual #141) had living options goals that met criterion, in that they provided an individualized description of the community living setting based on the individual's preferences.

Despite this improvement, much work remained to establish goals that were individualized, measurable and represented personal aspirations. Examples included:

- For Individual #141, there was no relationship goal because the IDT agreed there were sufficient supports in this area. However, the PSI indicated she would like to see her family more, had no relationships at the center except staff, and no relationships with others in the community. It was also noted aggression and self-injurious behavior hindered relationships in past.
- For Individual #123, there was no relationship goal, even though she had difficulty making friends and counseling had been recommended related to separation from her twin sister.
- Individual #120's relationship goal was to "have a better understanding of empathy," and his employment goal was to "better control his anger," neither of which were measurable. His independence goal was to "know more about diabetes," but his preference was to learn to cook, which could have incorporated knowledge about diabetes.

2. Overall, personal goals for this set of ISPs did not meet the criteria described above. When a personal goal does not meet criterion, there can be no basis for assessing compliance with measurability or the individual's progress towards its achievement. The presence

of a personal goal that meets criterion is a prerequisite to this process. For two individuals, the personal goal for where to live met criterion for indicator 1. Both also met criterion for measurability, in that they provided the individualized description of the community living setting based on the individual's preferences described above.

The Monitoring Team acknowledges that the development of personal goals that will meet criteria is a work in progress at all facilities. More guidance is expected from state office. Moreover, the QIDP coordinator and the QIDP educator will be very important in supporting teams to make goals that meet criterion for compliance. To do so, they will need to provide a lot of feedback to the QIDPs and to other team members.

3. Because personal goals did not meet criterion, there was no basis for assessing whether reliable and valid data were available to determine if the individual met, or was making progress towards achieving, his/her overall personal goals. Reliable and valid data for ISP action plans was seldom available due to issues with the data collection methodologies in place at the center as well as inconsistent implementation.

For the two individuals for whom the where to live goal met criterion for indicator 1, both met criterion for this indicator because data were available, although it was notable these data indicated the related action plans had not yet been implemented.

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

Summary: When considering the full set of ISP action plans, the various criteria included in the set of indicators in this outcome were not met. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 184	123	300	120	141	162			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	1/6	0/4	0/5	0/6	0/6	0/6			

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

8. Personal goals did not meet criterion in the ISPs as described above in Indicator 1. Therefore, action plans cannot be evaluated in this context. A personal goal that meets criterion is a pre-requisite for such an evaluation. Action plans are evaluated below in terms of how they may address other requirements of the ISP process.

Two personal goals for where to live met criterion for indicator 1. Of these, neither met criterion for this indicator. The action plans for Individual #184 to participate in tour groups and a virtual tour, and for his mother to attend a provider fair described no expected awareness outcome, no methodology to promote awareness, and no data to be collected. The action plan for Individual #141 was for her LAR to be provided with a list of potential providers in San Antonio, but had no expected outcome, timeframe, or follow-up steps described. This appeared to be a missed opportunity to act upon the LAR's willingness to examine possible living options at the time of the ISP annual meeting. There was a delay on the part of Corpus Christi SSLC in providing the listing, and perhaps offering to facilitate contacts and visits in a more assertive effort, after the ISP and the LAR subsequently decided she did not have time to look for an alternative placement until a later time.

9. Overall, preferences and opportunities for choice were not well-integrated in the individuals' ISPs. Examples included:

- For Individual #184, there was no action plan related to a very important relationship with a close friend living at the center. There was no acknowledgement of this friendship in the ISP, but it could have been the basis for many social and learning opportunities. Individual #184 loved red cars, was very reinforced by matchbox cars, and had car decorations in his room. There was only minimal acknowledgment of this affinity in the ISP and no action plans that built upon it.
- Individual #300's PSI noted that she was afraid of how people would react to her in the community. The FSA recommended training on styling hair and etiquette while eating out in the community. The IDT chose to defer both because they did not consider these to be barriers to placement, but for Individual #300, both of these would have addressed her concerns about her appearance and contributed to her integration once transition took place, as well as enhanced her quality of life and satisfaction

now.

- Individual #120's preferences included moving to the community and going to church off campus, but his action plans did not state any measurable outcome or have any follow-up to ensure these preferences were actually addressed in a meaningful way. Both indicated only a staff action that, once completed, had no further activity required or being tracked.
- Individual #162 had many preferences that were not integrated into the ISP, including pep rallies, football games, being on the pep club, getting her hair done in the community, dressing up, wearing make-up and jewelry, and sleeping in on holidays and weekends.

10. ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making for five of six individuals. In one positive finding, Individual #120 had two SAPs that integrated problem-solving skills that could potentially be built upon to support informed decision-making. It was unclear if this had been conceptualized in this manner, but hopefully, the IDT will integrate these by developing additional and more advanced decision-making skills.

11. Overall, action plans did not assertively promote enhanced independence for any of the individuals. Examples included:
    - Functional Skills Assessments were not routinely being updated on an annual basis. The summary section was being updated, but was based on an assessment that was one or more years old. Working from an assumption that no change in functional skill is likely to take place over the course of a year or more lacks aspiration, to say the least, and sets a very low expectation for what individuals might be able to learn. This practice is a fundamental barrier to enhanced independence for individuals living at Corpus Christi SSLC that should be reconsidered.
    - The ISP did not accurately reflect Individual #184's independence in communication. It indicated he could hold a conversation and had no need for a communication dictionary. The Monitoring Team observed that even staff who know him well were not always able to clearly understand what he was saying. This appeared to be a source of both frustration and perhaps a trigger for falls and/or aggression, as he would try to take care of things that others were not readily understanding. This appeared to be a significant barrier to his independence in self-direction and control of his environment, as well as in establishing relationships and safety.
    - For Individual #162, augmentative communication training and programming were discontinued at the center when she was enrolled in school. For someone like Individual #162, use of augmentative communication can provide a tremendous opportunity to enhance independence and should be emphasized across all settings. There was also no other consideration for environmental control skill acquisition.

12. IDTs did not consistently integrate strategies to minimize risks in ISP action plans. Examples included:
    - The Monitoring Team was concerned that falls risks were not assertively identified or proactively addressed. In the most striking example, Individual #123 had at least 17 falls between November 2015 and May 2016, including five in November 2015 and five in March 2016, but there was no indication that this had been addressed by the IDT. There was no update to her low rating in this area in the IRRF and no update to IHCP. Falls had not been addressed in ISPA or discussed as a risk at the ISP preparation meeting on 5/20/16. Others with significant falls risks that had not been assertively addressed were Individual #120 and Individual #184.
    - Individual #300 had been referred for transition, had selected a provider, and was actively engaged in pre-transition activities. She had a history of drug use and prostitution and had expressed some concern that she might return to such activities when

she moved from the center. She had no real mental health or drug use prevention treatment since her admission, and no involvement with support groups. Thus far, there had been no strategies discussed regarding other positive and safe alternatives for relationships with others in the community. The QIDP indicated in interview that the expectation was for the foster home and day program providers to be responsible for managing these areas of risk. There was concern that the IDT allowed her level of supervision to be reduced to routine while on a visit to the potential foster home, but required 1:1 when she returned to center (related to aggression) without a risk/benefit analysis of her need for enhanced supervision in the community setting

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated. In addition to the examples provided in indicators 11 and 12 above, Individual #184's IDT needed to thoroughly examine whether he could regain ambulation through an integrated clinical approach. His preference was to be able to walk again.

14. Meaningful and substantial community integration was largely absent from the ISPs. There were no specific plans for community participation that would have promoted any meaningful integration for any individual. Examples included:

- Individual #120 was interested in attending community church, but the only action plan was for the QIDP to follow-up about churches off-campus. There was no strategy to facilitate his attendance once possible options were identified.
- Prior to transition from the Abilene SSLC, Individual #162 had been involved with school pep club, but the ISP did not include action plans for that sort of participation.

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

- Minimal consideration was given to Individual #300's on-campus employment needs. The IDT agreed she would improve her work attendance and wear her protective gear, but there was no discussion of strengths, preferences, aptitudes, etc., and no discussion at all about employment needs in the community once transition occurred.
- Individual #123's ISP indicated no goal would be established in this area until a baseline of skills was established, but there was indication the baseline/establishment of goal had been accomplished.

16. One of six individuals had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. While Individual #120's ISP did not specifically address all functional engagement opportunities for Individual #120, it was good to see that he had been participating with some regularity in a number of activities, such as biology, computer skills, culinary skills and bike shop classes, and the Aktion Club.

17. Barriers to various outcomes were not consistently identified and addressed in the ISP, including the following:

- Living options barriers were frequently not addressed with action plans.
- Individual #184's ISP did not address a significant communication barrier to his independence in self-direction and control of his environment as well as in establishing relationships and safety. The ISP did not accurately reflect Individual #184's independence in communication. It indicated he could hold a conversation and had no need for a communication dictionary. The Monitoring Team observed staff who knew him well who were not always able to clearly understand what he was saying.

In addition to limiting his ability to interact with others and develop new relationships, this appeared to be a source of both frustration and perhaps a trigger for falls and/or aggression, as he would try to take care of things that others were not readily understanding.

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

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

Summary: Criterion was met for some indicators for some individuals, but overall, more work was needed to ensure that all of the activities occurred related to supporting most integrated setting practices within the ISP. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 184	123	300	120	141	162			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	67% 4/6	1/1	1/1	1/1	1/1	0/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	67% 4/6	0/1	0/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	33% 2/6	0/1	0/1	1/1	1/1	0/1	0/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

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

Comments:

19. Four of six ISPs reviewed included a description of the individual's preference and how that was determined. Individual #141's preference was described as unknown. There was no clear basis for describing Individual #162's living options preference because she had no living options exploration.

21. None of six ISPs fully included the opinions and recommendation of the IDT's staff members. Current assessments by key staff members were sometimes not available at the time of the ISP, or did not include recommendations. The IDT did not consistently make a statement and offer a recommendation regarding living options that was consistent or independent. Examples included:

- For Individual #184, there was an essential conflict between the IDT statement and the full team statement. The IDT recommended Individual #184 should be referred, but then determined, as the entire team, that he should not be referred due to his VNS and behavioral concerns, but the entire team had the same membership as the IDT recommending referral.
- There was a statement that Individual #141 could not be served in a less restrictive setting, but it was based in part on LAR preference.
- For Individual #162, the IDT stated she could be served in the community, but recommended that she not be referred due to LAR choice.

22. Four of six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR. Those that did not accurately reflect the basis for the decision were the following:

- The IDT staff members for Individual #184 indicated he could be served in the community and made that recommendation. The IDT as a whole decided not to recommend due to individual choice, but this was not supported by his previous indication that he wished to live in a group home.
- Individual #123's full IDT made a statement indicating she could be served in the community, but recommended that she not be referred due to LAR choice. This was not reconciled with other documentation that the family did not indicate a preference.

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

- The IDT did not thoroughly address Individual #300's needs related to her history of trauma, sexual exploitation, and illegal drug use as these would potentially impact a successful transition.
- Individual #184 attended a community tour in March 2015, at which time he was asked if he would like to live in a home like that. He replied yes. There was no further exploration, or apparently any discussion, about what he liked in the home that he visited. The IDT recommended referral if a home could be found that met his needs related to having a VNS, but there was no documented discussion about availability of such home with the LIDDA representative in attendance.

- In Individual #120's ISP, there was no discussion of living options available related to his particular needs. It was noted he had participated in a virtual group home tour, but with no other detail. Likewise, it was documented he had resided in community, but no detail about that experience was offered.

24. Two of six ISPs identified a thorough and comprehensive list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed. Examples of those that did not meet criterion included:
- Individual #162's IDT identified LAR choice as the only barrier, but most IDT members indicated medical/health issues were barriers. The IDT also did not identify individual lack of awareness, but should have.
- Similarly, Individual #141's IDT identified only LAR choice, but did not indicate individual lack of awareness per the documentation that her preference was unknown.

26. None of five individuals who were not referred had individualized, measurable action plans to address identified obstacles to referral.

28. See above.

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

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

Summary: ISPs were developed in a timely manner, but not implemented. Individuals participated in their ISP preparation and annual meetings, but not all IDT members participated in the important annual meeting. One individual met criterion for all indicators in this outcome. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 184	123	300	120	141	162			
30	The ISP was revised at least annually.	100% 4/4	1/1	N/A	1/1	1/1	1/1	N/A			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 2/2	N/A	1/1	N/A	N/A	N/A	1/1			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	33% 2/6	0/1	0/1	1/1	1/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
34	The individual had an appropriately constituted IDT, based on the	17%	0/1	0/1	1/1	0/1	0/1	0/1			

	individual's strengths, needs, and preferences, who participated in the planning process.	1/6									

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

32. Action plans were implemented on a timely basis for two of six individuals. Examples in which timeliness criteria were not met included:

- For Individual #184, action plans that were not implemented timely included learning to board a bus, learning to read, and playing darts (due to darts not being available.) His PBSP and behavior contract were also not developed timely.
- For Individual #141, there were no data for her service objective to attend dances until January 2016 and her exercise program was never developed.
- Individual #162's relationship action plan was not implemented in November 2015 due to staff shortages, per the QIDP monthly review.

33. Six of six individuals attended their ISP meetings.

34. Individual #300 appeared to have an appropriately constituted IDT at her ISP annual planning meeting. Otherwise, individuals did not have an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. Examples included:

- No SLP was in attendance at Individual #184's ISP, despite significant barriers in this regard. There was no audiologist, although the MD assessment noted Individual #184 had mild to possible moderate hearing loss bilaterally and had hearing aids in past. The audiology assessment was not current. The PCP did not attend, despite a serious falls issue possibly impacted by continuing seizures.
- There was no OT/PT at Individual #162's ISP.
- There was no Habilitation Therapist at Individual #120's ISP despite his history of falls.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: Assessments that were needed were considered and identified by the IDTs for two of the four individuals. For all individuals, assessments were not always obtained prior to the ISP meeting. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	184	123	300	120	141	162			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	50% 2/4	1/1	N/A	0/1	0/1	1/1	N/A			
36	The team arranged for and obtained the needed, relevant	0%	0/1	0/1	0/1	0/1	0/1	0/1			

	assessments prior to the IDT meeting.	0/6									

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting, for two of four individuals. Individual #123 and Individual #162 were new admissions and did not have ISP preparation meetings. For Individual #300, the IDT did not consider an assessment related to drug use and possible need for treatment. For Individual #120, the ISP preparation document provided for review did not include the needed assessments.

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

- Individual #162's IDT did not provide comprehensive Habilitation Therapy or SLP assessments after her move from Abilene SSLC. Given her significant needs and a new environment, these should have been completed.
- For Individual #123, the behavioral assessment and the PSI were not available at time of ISP and the psychiatric assessment was submitted late.

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

Summary: IDT and QIDP reviews were not occurring regularly, were not based on data, and did not result in actions when needed. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	184	123	300	120	141	162			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

37. IDTs met frequently to respond to various events, behavioral incidents, and medical issues. This was good to see, but that IDTs did not consistently review progress or revise supports and services as needed. Examples included:

- Individual #123 had 17 falls between November 2015 and May 2016, including five in March 2016, but the IDT had not met to review.
- For Individual #141, the IDT did not meet to discuss lack of implementation of multiple action plans (attending dances, aquatic program, exercise program) for many months. The IDT was to meet three months after the ISP to discuss increasing time at Kaleidoscope, but did not do so.

38. QIDPs did not ensure that the individual received required monitoring/review and revision of treatments, services, and supports. QIDPs were knowledgeable, to a degree, about some aspects of individuals' preferences and strengths, and most appeared to be sincerely caring about their work, but were also often not able to articulate the status of various risks and needs. This was particularly the case for Individual #184 and Individual #162 as documented throughout this report. Overall, the QIDPs did not exhibit an

understanding of the significance of many health-related concerns or their role to ensure these concerns were addressed in a timely manner. Other examples included:

- For Individual #123, there was no implementation of her living options action plan and no action taken toward her employment goal. As noted earlier, there was also no action taken regarding her frequent falls.
- For Individual #141, the PNMP was not updated as needed for use of Velcro pads and Bolero tub until it was brought to the IDT's attention by the Monitoring Team.

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

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

#	Indicator	Overall Score	Individuals: 184	120	141	162	130	251	189	82	136
a.	The individual's risk rating is accurate.	17% 3/18	0/2	0/2	1/2	1/2	0/2	0/2	0/2	0/2	1/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	11% 2/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas [i.e., Individual #184 – falls, and weight; Individual #120 – cardiac disease, and fractures; Individual #141 – infections, and behavioral health; Individual #162 – aspiration, and constipation/bowel obstruction; Individual #130 – constipation/bowel obstruction, and urinary tract infections (UTIs); Individual #251 – dental, and falls; Individual #189 – behavioral health, and skin integrity; Individual #82 – behavioral health, and weight; and Individual #136 – weight, and infections].

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 #141 – infections, Individual #162 – aspiration, and Individual #136 – weight.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs completed IRRFs within 30 days for individuals who were newly admitted and updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs did not review the IRRFs, and make changes, as appropriate.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: The development of individualized psychiatric goals was being addressed by state office. Over the next few months, those activities should impact Corpus Christi SSLC's psychiatric goals and move them towards meeting criteria with these indicators. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: 4-7. The facility's psychiatric team indicated that their goals were contained in the quarterly review documentation. These goals were reviewed for each individual. The goals uniformly addressed a problematic behavior, such as verbal or physical aggression, self-injurious behavior, disruptive behavior, or some form of noncompliance with established routines/procedures. However, there was no information that linked these behaviors to the symptoms of the underlying psychiatric disorder, nor was it clear that behavioral factors were not contributing to the maintenance of these negative behaviors. Upcoming direction and support from state office should help in the creation of goals that meet the criteria for this outcome and its indicators.											

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
Summary: CPEs were done for each individual and they were formatted correctly. This has been the case at Corpus Christi SSLC for some time now. These two indicators will move to the category of less oversight. CPE content had improved over the past two reviews and if performance is sustained, will likely move into this category, too. There remained a need for improvement in the documentation required for indicators 15 and 16. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
12	The individual has a CPE.	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

		9/9									
13	CPE is formatted as per Appendix B	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	CPE content is comprehensive.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	50% 2/4	N/A	N/A	N/A	N/A	1/1	1/1	N/A	0/1	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.	33% 3/9	0/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1

Comments:
12-13. The psychiatry department had updated the CPEs for all of the individuals receiving psychotropic medications as many of them had originally been done three to five years ago. This was good to see and represented good practice. All of the CPEs were formatted as specified.

14. The content was comprehensive for all of the individuals, except Individual #171 for whom there were deficiencies in the physical examination and laboratory data sections as well as the biopsychosocial formulation.

15. Four of the individuals were admitted recently (Individual #199, Individual #120, Individual #123, Individual #171). A CPE had been completed within the allotted time for all of these individuals, but a note in the IPNs documenting an assessment by a member of the medical team within the first business day was not present for Individual #199 and Individual #120.

16. The psychiatric diagnosis was consistently reported in the psychiatric, behavioral, and medical sections of the record for three of nine individuals (Individual #120, Individual #123, Individual #184). For the remainder, inconsistencies in the diagnosis were noted.

Outcome 5 – Individuals' status and treatment are reviewed annually.	
Summary: Psychiatric treatment documentation was updated within the past 12 months, documentation was submitted to the IDT on time, and a licensed member of the psychiatric team attended each of the ISP meetings. These three indicators had been occurring at Corpus Christi SSLC for some time and, therefore, these three indicators (17, 19, 20) will move to the category of requiring less oversight. The other two indicators were not at criterion and reflected the need for better documentation of psychiatry's involvement in the ISP process. These will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
17	Status and treatment document was updated within past 12 months.	100% 9/9	1/1	1/1	1/1	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).	44% 4/9	0/1	0/1	1/1	1/1	1/1	0/1	0/1	1/1	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	100% 9/9	1/1	1/1	1/1	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.	33% 3/9	0/1	0/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1

Comments:
17 and 19. The document that the psychiatry department used to prepare for the annual ISP was the Psychoactive Medication Treatment Plan (PMTP). These documents were prepared within the past 12 months and were submitted to the ISP team in a timely manner for all of the individuals.

18. The PMTP contained the required information for four of the individuals. The PMTPs that were missing important information were those of Individual #184, Individual #372, Individual #171, Individual #300, and Individual #120. The primary deficits were the lack of sufficient information in the combined behaviors assessment as well as deficits in the description of non-pharmacological approaches.

20. A licensed member of the psychiatry team attended the ISP for each of the individuals and a reference to their participation in the meeting was present.

21. The final ISP documentation was missing important information for six of the individuals (Individual #120, Individual #300, Individual #171, Individual #372, Individual #184, Individual #38). The primary deficits were in the sections that discussed the combined behavioral health and psychiatric interventions. However, the documentation for the remaining three individuals (Individual #199, Individual #123, Individual #20) was excellent.

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

Summary: The use of PSPs has been appropriate at Corpus Christi SSLC at the time of this review and the January 2015 review (no PSPs were reviewed in October 2015). Therefore, this indicator will move to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120

22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
22. Only one individual (Individual #372) had a Psychiatric Support Plan rather than a PBSP. The review of this plan indicated that it met the required criteria. That being said, the facility should consider performing a functional assessment and then consider the development of a PBSP based on the results. Pending the results of that further investigation, it was felt that the PSP was appropriate for Individual #372.

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

Summary: Three of these indicators had maintained sustained high performance over previous reviews and will be moved to the category of requiring less oversight (28, 29, 32). The other two indicators will remain in active monitoring. With sustained performance, indicator 30 may move to the category of lesser oversight after the next review.

			Individuals:								
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
32	HRC review was obtained prior to implementation and annually.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
28 and 32. There was signed consent for each medication including annual consents and documentation of HRC review/approval was also present.

29-30. The information provided to the guardian or facility director was understandable and a risk benefit statement was present.

31. A pervasive problem was the lack of a reasonable discussion of the alternate non-pharmacological interventions, which might be able to reduce the need for psychotropic medications.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: Corpus Christi SSLC ensured that every individual who needed a PBSP had a PBSP and that the PBSPs had goals/objectives as per criteria. This had been the case at the facility for a number of consecutive reviews and, therefore, indicators 1 and 2 will move to the category of requiring less oversight. Ensuring that goals are measurable and based upon assessments, and that reliable and valid data are collected are areas in need of continued focus. Therefore, those three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 10/10	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 8/8	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	88% 7/8	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	0/1
4	The goals/objectives were based upon the individual's assessments.	63% 5/8	0/1	1/1	N/A	0/1	1/1	1/1	0/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	13% 1/8	1/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

1. Of the nine individuals reviewed by the behavioral health monitoring team, eight had PBSPs. The exception was Individual #372 who had a psychiatric support plan. Of the six other individuals reviewed by the physical health monitoring team, two (Individual #82, Individual #141) had PBSPs. Observation by the Monitoring Team and discussion with facility staff suggested that all of those who needed PBSPs had them in place. Even so, it is suggested that a functional assessment be completed for Individual #372 to determine whether a PBSP would be more appropriate that a PSP.

2-3. The eight individuals reviewed by the behavioral health monitoring team who PBSPs had goals related to behavioral health services. With the exception of Individual #120's unfounded allegations (to be tracked by the behavioral health specialist), all goals were measurable.

4. Five of the eight individuals had goals that were based upon their assessments. Individual #38's assessment had identified self-injury as a behavior of concern, but this was not addressed in her PBSP. Similarly, it was noted that Individual #300 displayed both self-injurious and disruptive behavior, but neither were included in her PBSP. Finally, although inappropriate physical contact was an identified target behavior in Individual #20's PBSP, there was no treatment objective.

5. The Monitoring Team determined that the data for all nine individuals were not reliable, and in some cases, were not valid. Although the facility had a policy in place to assess data timeliness and IOA each month, a review over a six-month period revealed that this had not occurred for seven of eight individuals who had PBSPs. The exception was Individual #38, whose documents indicated that these assessments of reliability had occurred, although no measures were reported for data timeliness. The Monitoring Team also reviewed data sheets while onsite and in no instance were data recorded within a two-hour period. A review of Individual #184's raw data sheets revealed daily frequencies calculated even when data were missing.

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

Summary: This outcome and its indicators required continued focus from the behavioral health services department. Although there was some progress for some of the indicators, all three will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	184	372	20	123	171	300	199	120
10	The individual has a current, and complete annual behavioral health update.	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1
11	The functional assessment is current (within the past 12 months).	78% 7/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
12	The functional assessment is complete.	50% 4/8	0/1	1/1	N/A	1/1	1/1	0/1	0/1	0/1	1/1

Comments:

10. Seven of the individuals had a current and complete behavioral health assessment. The exceptions were Individual #20, for whom there was no assessment of cognitive abilities or review of his medical/health issues, and Individual #300, whose cognitive skills were assessed using a tool not designed for this purpose.

11. Seven of the individuals had a current functional assessment. The functional assessment for Individual #38 was over one year old and referenced indirect and direct assessments completed in 2014. The facility, however, provided an updated functional assessment while the Monitoring Team was onsite. The last functional assessment for Individual #372 was completed in 2013. A staff member reported that Individual #372 will hit others and throw items when upset, and engage in repetitive behavior when staff try to work with her. An updated functional assessment is recommended.

12. Four of the functional assessments were considered complete (Individual #184, Individual #20, Individual #123, Individual #120). Dates of indirect and direct assessments were identified. Assessments also included a summary of staff interviews and/or ratings and a

description of direct observations. Functional assessments were determined to be incomplete because the assessments were out of date or not summarized (e.g., Individual #38, Individual #199), were missing (e.g., Individual #171), or did not address monitored behaviors (e.g., Individual #300).

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

Summary: PBSPs were, and have been, implemented within the required timeline for some time. Therefore, this indicator will move to the category of requiring less oversight. The other two indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 38	184	372	20	123	171	300	199	120
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	88% 7/8	1/1	0/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1
14	The PBSP was current (within the past 12 months).	100% 8/8	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

13. Seven of eight PBSPs were implemented within 14 days of required consents. The exception was Individual #184 whose plan was implemented 17 days later.

14. While all the PSBPs were current, supporting documents (e.g., functional assessment, progress note, individual book) suggested that the plans for Individual #38 and Individual #300 were outdated before the scheduled visit by the Monitoring Team. Information indicated that these plans were developed between March 2014 and April 2015 (Individual #38) or October 2014 (Individual #300). It appeared that the Monitoring Team visit triggered the development of a new functional assessment and behavior support plan for both Individual #38 and Individual #300. The revised functional assessment and PBSP for Individual #38 were submitted to the BSC on 6/16/16. Individual #300's June 2016 PBSP progress note, signed on 7/25/16, noted that her most recent PBSP was implemented in October 2014 and had expired in October 2015. Both individuals should have had new assessments and behavior support plans developed well in advance of the scheduled visit.

15. None of the eight PBSPs were complete. Problems included the poor application of positive reinforcement, insufficient opportunities for replacement behavior, incomplete treatment objectives, and weak interventions. Even for plans that included a reinforcement component, these were not implemented as written. One example is emblematic: when staff were asked to demonstrate the use of Individual #184's visual schedule that is supposed to be tied to a reward system, they were unable to do so. The behavioral health services assistant arrived, and when told of the situation, retrieved material that had been locked in an office, and began reviewing a PBSP, but this was an old PBSP. When told that there was a more current plan, he found it in the individual's notebook. Although he found the section that referenced the schedule, when asked about the icons used to represent scheduled activities, the assistant explained that the behavioral health specialist was still working on developing these. These materials should have been available at the time of implementation, that is, 5/1/16.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.												
Summary: Criteria have not been met over the course of this and previous reviews. Therefore, these indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 3/3	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/1	1/1
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	33% 1/3	N/A	N/A	N/A	N/A	0/1	N/A	N/A	0/1	1/1

Comments:

24. The IDT had recommended counseling for three of the nine individuals. Two of these individuals, Individual #199 and Individual #120, were enrolled in counseling at the time of the onsite visit. Counseling services were initiated for Individual #123, but were discontinued in 1/16.

25. For two of these three individuals who had been involved in counseling during the six-month period prior to the visit, their counseling plans and progress notes were provided. While Individual #120's plan was complete, Individual #199's goals were incomplete (i.e., the period of time [per month, per session] during which skills were to be exhibited was not identified) and a plan for generalization had not been developed.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: It was good to see improvement with the timeliness of initial (Round 9 – N/A, Round 10 - 0%, and Round 11 – 100%) and annual medical assessments (Round 9 – 67%, Round 10 – 67%, and Round 11 – 89%).			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	Not Rated									

		(NR)									

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

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

Summary: Center staff should focus on improving the quality of the medical assessments. Given that over the last two review periods and during this review, individuals reviewed generally had diagnoses justified by appropriate criteria (Round 9 – 89% for Indicator 2.e, Round 10 – 94% for Indicator 2.e, and Round 11 - 89% for Indicator 3.b), Indicator b. will move to the category of requiring less oversight. The remaining indicator for this Outcome will be assessed once the ISPs reviewed integrate the revised periodic assessment process.

#	Indicator	Overall Score	Individuals: 184	120	141	162	130	251	189	82	136
a.	Individual receives quality AMA.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	89% 16/18	1/2	1/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	NR									

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

Of particular concern, only one of the medical assessments (i.e., for Individual #130) included a plan of care for each active medical problem, when appropriate, that were in alignment with current standards of care and the individual's needs. This is an area on which the Medical Department should focus.

b. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. It was good to see that clinical justification was present for most of the diagnoses reviewed. There were two exceptions. There was a lack of documentation (including review of prior history) for the undescended testes for Individual #120. For Individual #184, there was a diagnosis of neuromuscular dysfunction of the bladder/neurogenic bladder, but there was a lack of documentation of any evaluation, which might have been done in the past, to provide further clinical information needed for treatment (such as testing to rule out urinary retention).

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

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	6% 1/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	NR									

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [Individual #184 – falls, and weight; Individual #120 – cardiac disease, and diabetes; Individual #141 – cardiac disease, and osteoporosis; Individual #162 – respiratory compromise, and skin integrity; Individual #130 – aspiration, and gastrointestinal (GI) problems; Individual #251 – seizures, and other: cancer; Individual #189 – GI problems, and osteoporosis; Individual #82 – weight, and diabetes; and Individual #136 – aspiration, and infections].

Individual #251's IHCP related to seizures sufficiently addressed the chronic condition in accordance with applicable medical guidelines, or other current standards of practice.

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

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.	
Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely dental examinations (Round 9 – 100%, Round 10 – 100%, and Round 11 - 100%) and dental summaries (Round 9 – 78%, Round 10 – 100%, and Round 11 - 100%), Indicator a will move to the category of requiring less oversight. It was good to see that the Center made progress on the	Individuals:

quality of the dental exams and summaries. Dental Department staff should focus on maintaining/continuing to improve the exams and summaries.											
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A	N/A	N/A	N/A	NR	NR	N/A	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	100% 7/7	1/1	1/1	1/1			1/1	1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 7/7	1/1	1/1	1/1			1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	71% 5/7	1/1	1/1	1/1	NR	NR	1/1	0/1	0/1	1/1

Comments: For Individual #162 and Individual #130, who were in the outcome group and were at low risk for dental, some indicators were not assessed.

a. It was positive that individuals reviewed had timely dental exams and summaries.

b. It also was positive that individuals reviewed generally had comprehensive dental exams that accurately identified their needs for dental services and supports. The exception was Individual #130 for whom inconsistencies were found within the exam and other documents related to x-rays and periodontal probing.

c. It was positive that five individuals reviewed had dental summaries that met the applicable requirements. Areas on which the Center should focus include ensuring that oral health's impact on individuals' health is discussed in the summaries, as appropriate, and summaries clearly identify individuals for whom desensitization programs or other strategies to decrease refusals and/or use of pre-treatment sedation might be beneficial.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.	
Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely quarterly nursing reviews and physical assessments (Round 9 – 100%, Round 10 – 100%, and Round 11 - 89%), Indicator	Individuals:

a.iii. will move to the category of requiring less oversight. Improvement was seen with regard to the timely completion of annual comprehensive nursing reviews (i.e., during Round 10, the Center's score was 14%). The remaining indicators require continued focus to ensure nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice.

#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	88% 7/8	1/1	1/1	0/1	N/A	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.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/16	0/2	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/1

Comments: a. It was positive that for eight of the nine individuals reviewed, nursing staff completed timely initial or annual comprehensive nursing reviews and physical assessments, and quarterly nursing record reviews and physical assessments.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #184 – falls, and weight; Individual #120 – cardiac disease, and fractures; Individual #141 – infections, and behavioral health; Individual #162 – aspiration, and constipation/bowel obstruction; Individual #130 – constipation/bowel obstruction, and UTIs; Individual #251 – dental, and falls; Individual #189 – behavioral health, and skin integrity; Individual #82 – behavioral health, and weight; and Individual #136 – weight, and infections).

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

skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

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

- In June 2016, IPNs for Individual #184 noted he had begun to lose weight, but nursing staff did not initiate an assessment.
- Individual #162 was hospitalized three times in relation to respiratory issues and/or aspiration pneumonia. However, nursing staff did not complete full respiratory assessments. Her IHCP only addressed lung sounds, even though the goal referenced oxygen saturation rates.
- Individual #130 had an ileus in May 2016. However, his IHCP did not require nursing staff to conduct regular assessments for this high-risk area, and they were not added to the IHCP even after the individual had the ileus.
- After Individual #251's ISP, he had five falls, but nursing staff did not conduct regular assessments. Similarly, Individual #184 had a number of falls, but no nursing assessments were conducted or analyses to determine the cause of the falls.
- Nursing staff did not conduct assessments of Individual #189's crying episodes to analyze her pain. Similarly, nursing staff did not assess Individual #82's mood, sleep, and/or anxiety in relation to his behavioral health.

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

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

#	Indicator	Overall Score	Individuals: 184	120	141	162	130	251	189	82	136
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: Overall, IHCPs for the individuals reviewed did not set forth the nursing supports necessary to meet individuals' needs.											

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: Although the Center's scores varied somewhat over the last two reviews, the scores during this review generally showed improvement with regard to timely referral of individuals to the PNMT as needed, and completion of the PNMT initial review. In addition, it was good to see that for the individuals reviewed who were hospitalized, RNs conducted post-hospitalization reviews, and the PNMT discussed the results. For the two individuals who only needed a PNMT review, the reviews were of good quality. However, a significant problem was the failure of the PNMT to complete PNMT assessments for individuals who needed them.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	83% 5/6	1/1	1/1	N/A	1/1	1/1	N/A	1/1	N/A	0/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	67% 4/6	1/1	0/1	N/A	1/1	1/1		0/1		1/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/5	0/1	N/A	N/A	0/1	0/1		0/1		0/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	29% 2/7	0/1	1/1	1/1	0/1	0/1		0/1		0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 2/2	N/A	N/A	N/A	1/1	N/A		1/1		N/A
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	43% 3/7	0/1	1/1	1/1	1/1	0/1		0/1		0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history;	100% 2/2	N/A	1/1	1/1	N/A	N/A		N/A		N/A

	• Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.										
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/5	0/1	N/A	N/A	0/1	0/1		0/1		0/1

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

- Individual #184 was referred to the PNMT for weight loss and skin breakdown. The PNMT held a pre-assessment meeting first in March 2015 with multiple relevant reviews, such as review of meals and positioning. However, it was not until May 2015 that the PNMT initiated a full assessment, which is considered to be late due to the fact that Individual #184's weight had already shown signs of a decreasing trend and had been below his IBW since April 2014. Overall, weight decreased from 122 pounds in January 2014 to 108 in March 2015. The PNMT also noted that his skin breakdown was related to his weight loss. Neither a member of the Behavioral Health Services staff, a Pharmacist, nor his PCP was documented as having been involved in the assessment process. Given his behavioral needs, medical needs, and the medications he was prescribed, their participation would have been essential.
- On 3/3/16, Individual #120 was referred to the PNMT due to a fracture. The PNMT did not review him until 4/5/16. It was positive that once the review was initiated, it met his needs.
- The PNMT followed Individual #141 for insomnia. The referral date was in 2014, so the Monitoring Team did not assess indicators a through c. However, it appeared the PNMT had reviewed the potential impact of physical and nutritional management issues on the insomnia, and provided recommendations for additional consultations.
- Despite a weight loss of approximately 12 pounds between February and March 2016, representing a 13 percent weight loss, as well as multiple pneumonia diagnoses, the PNMT only conducted a review of Individual #162.
- The PNMT began reviewing Individual #130 when he had pneumonia in September 2013. Reviews continued in March 2014 for skin issues and constipation, and again in September 2014, May 2015, and July 2015. Although his risk for aspiration was high and he had multiple pneumonias, the IDT had not submitted another referral and the PNMT had not conducted a thorough assessment.
- Individual #189 had multiple changes in formula, increased emesis, and significant leakage at the site of the jejunostomy (J-tube). The PNMT chose not to complete a full assessment. Due to the implications on weight, emesis, positioning, and nutrition, a PNMT assessment was warranted. In addition, the individual's head-of-bed evaluation (HOBE) was not reviewed and reassessed upon initial referral in May 2014. In December 2014, after Individual #189 was diagnosed with pneumonia, therapists redid the HOBE evaluation.
- Between November 2015 and December 2015, Individual #136 experienced a weight loss of 22 pounds, but the IDT did not make a referral to the PNMT until April 2016. Due to multiple issues occurring simultaneously, including weight loss as well as decreased stability, and decreased ability to feed himself and to self propel, a comprehensive assessment was warranted, but was not provided.

h. It was extremely concerning that for four of five individuals who needed comprehensive PNMT assessments, the PNMT did not conduct them. Moving forward, the PNMT should conduct comprehensive assessments for individuals who need them to the depth and complexity necessary to:

- Describe the presenting problem;
- Discuss pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs;
- Review applicable risk ratings, and analyze pertinent risk ratings, including discussion of appropriateness and/or justification for modification;
- Review the individual's behaviors related to the provision of PNM supports and services;
- Include discussion of medications that might be pertinent to the problem, and discussion of their relevance to PNM supports and services;
- Provide evidence of observation of the individual's supports at his/her program areas;
- Provide an assessment of current physical status.
- Discuss whether existing supports were effective or appropriate;
- Identify the potential causes of the individual's physical and nutritional management problems;
- Provide recommendations, including rationale, for physical and nutritional interventions; and
- Provide recommendations for measurable goals/objectives, as well as indicators and thresholds.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: No improvement was seen with regard to these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to	0%	0/1	N/A	0/1	0/1	0/1	0/2	0/1	N/A	0/1

	take when they occur, if applicable.	0/8									
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	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: falls, and choking for Individual #184; fractures, and GI problems for Individual #120; aspiration, and falls for Individual #141; skin integrity, and aspiration for Individual #162; skin integrity, and aspiration for Individual #130; choking, and aspiration for Individual #251; aspiration, and GI issues for Individual #189; weight, and fractures for Individual #82; and aspiration, and weight for Individual #136.

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

c. All individuals reviewed had PNMPs and/or Dining Plans. Problems varied across the PNMPs and/or Dining Plans. For example:

- Although risk areas were generally noted, the levels of risk were not provided.
- For Individual #184, inconsistencies were noted in the document, such as regarding whether or not he had a walking program, and/or toileting schedule.
- For Individual #120, changes were not made to reflect his fracture/cast, or to remove information about sleep apnea, once the PCP removed the diagnosis in April 2016.
- Individual #130's PNMP did not include pictures of his communication device.
- Individuals' PNMPs did not include complete information about their adaptive equipment (e.g., staff reported Individual #184's flag could be removed, but the PNMP did not address this issue, and his use of a shower chair was not included; Individual #141's bean bag was not listed on the PNMP; Individual #162's floor mat was not listed).
- Communication strategies were not complete (e.g., Individual #184, and Individual #120).

e. Individual #82's IHCP for weight included a clinical indicator necessary to measure if the goal/objective was met.

g. Individual #82's IHCP for weight identified the frequency of monitoring his weight.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: The Center's score for the last review was 75% for indicator a. Should the Facility sustain its progress in this area during the next review, this indicator might move to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	If the individual receives total or supplemental enteral nutrition, the	100%	N/A	N/A	N/A	1/1	1/1	N/A	1/1	N/A	N/A

	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.	3/3									
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	N/A				N/A	N/A		N/A		
	Comments: a. Clinical justification for total or supplemental enteral nutrition was found in the IRRF, and/or the ISP for the three individuals reviewed for whom this was applicable.										

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: Timeliness as well as the quality of the OT/PT assessments continued to be areas on which the Center needed to focus. It was encouraging to see that two of the updates reviewed included all of the necessary components, and addressed the individuals' strengths, preferences, and needs. Although much more work was needed, this was an improvement from the two previous reviews. All of these indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
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.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	33% 3/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	67% 6/9	1/1	1/1	0/1	0/1	1/1	1/1	0/1	1/1	1/1

c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/3	N/A	N/A	N/A	0/1	0/1	N/A	N/A	N/A	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	33% 2/6	0/1	0/1	0/1	N/A	N/A	1/1	0/1	1/1	N/A

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

- On 9/8/15, Individual #162 transferred from Abilene SSLC. She received an OT/PT update, but given Individual #162's OT/PT needs, a new assessment was warranted.
- According to Individual #184's PNMP, the PT was to complete an update that focused on resuming the walking program, but this did not appear to have been completed.
- Individual #120 had and continued to have multiple falls per month, yet the PT had not completed a consultation to address the increase in falls. He had 12 falls since February 2016, which was higher than the nine that occurred in 2015.
- Individual #141's update was completed only one day before her ISP meeting. In addition, the consultation for kneepads was requested in January 2016, but was not completed until June 2016. It also did not appear that the assessment requested at her ISP meeting that was necessary to develop an exercise program ever occurred.
- A referral was made to the PT to open up Individual #130's seat to help prevent skin breakdown. The request was of medium priority, which requires completion with 10 days. The consultation was not timely as it was initiated on 2/10/16, and was not completed until 4/1/16.
- On 2/1/16, a consultation was requested for the PT to assess the use of gloves to prevent damage to Individual #251's knuckles and fingers when she passes through doors in her wheelchair. The response from the PT indicated this strategy was assessed in May 2015, and did not work, but there was no evidence of reassessment to assist in identifying viable alternatives.

- For Individual #189, despite a number of symptoms of gastroesophageal reflux disease (GERD), the HOBE was only reviewed with no evidence of what the review consisted other than changing the date of the original HOBE completed in December 2014.

d. As noted above, Individual #162 should have had a comprehensive OT/PT assessment, but did not. On a positive note, the comprehensive assessment for the remaining two individuals addressed, as appropriate:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living; and
- For an individual that 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).

However, problems were noted with one or more of the following elements:

- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

e. It was positive that Individual #251 and Individual #82's updates included all of the necessary components, and addressed their strengths, preferences, and needs. On a positive note, the remaining updates included, as appropriate:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

With the remaining updates, problems were noted with one or more of the following elements:

- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any

changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- 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;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings; and
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services.

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

Summary: It was good to see improvement during this review and the previous one with regard to ISPs including descriptions of how the individual functions from an OT/PT perspective. If the Center is able to maintain this progress, then during the next review, the Monitor will consider moving Indicator a to the category requiring less oversight. Although ISPs/ISPAs generally included strategies/interventions included in the assessments, as noted above, the recommendations in comprehensive assessments needed improvement. The Monitoring Team will continue to review this indicator, as well as the remaining ones.

#	Indicator	Overall Score	Individuals: 184	120	141	162	130	251	189	82	136
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	78% 7/9	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	50% 1/2	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	0/1

Comments: b. For Individual #184, inconsistencies were noted in the document, such as regarding whether or not he had a walking program, and/or toileting schedule. For Individual #120, changes were not made to reflect his fracture/cast, or to remove information about sleep apnea, once the PCP removed the diagnosis in April 2016.

d. The Monitoring Team found no evidence of an ISPA meeting to discuss the consultation, dated 5/25/16, that recommended significant modifications to Individual #136's bed positioning.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: Over the last two reviews and this one, the Center's scores for the indicators related to the timeliness of communication assessments varied (Round 9 – 89%, Round 10 – 50%, and Round 11 - 67%). It was good to see some minor improvement from the previous review. However, Center staff need to consistently conduct assessments timely. In addition, Center staff need to focus on ensuring individuals receive the communication assessments they need, as well as improving the quality of communication assessments.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	75% 6/8	1/1	1/1	1/1	N/A	0/1	0/1	1/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	56% 5/9	1/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and	0% 0/2	N/A	N/A	N/A	0/1	N/A	N/A	N/A	0/1	N/A

	receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	25% 1/4	N/A	1/1	N/A	0/1	N/A	N/A	N/A	0/1	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/5	0/1	N/A	0/1	N/A	0/1	0/1	0/1	N/A	N/A

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

- On 9/8/15, Individual #162 transferred from Abilene SSLC. She received a timely screening, but needed a communication assessment, which, at the time of the Monitoring Team's onsite review, still had not been provided. Instead, CCSSLC staff used the previous assessment, but given the new environment and Individual #162's communication needs, a new assessment was warranted.
- For Individual #130, the last communication assessment was completed in 2013, but was not considered detailed enough to provide direction on methods staff could use to improve his receptive language. Based upon assessment as well as OT/PT report, sensory was an area of strength, and, therefore, should have been explored more thoroughly in the communication assessment. An update should have been completed for Individual #130.
- On 7/30/13, Individual #251's last assessment was completed, which was not timely given that she had direct communication treatment and supports in place necessitating an annual update. No annual update was provided prior to the 2015 ISP meeting.
- Individual #141 was supposed to have a consultation related to sign language. However, although a list of recommendations was provided, the SLP did not document an assessment.

d. and e. It was positive that the comprehensive assessment completed for Individual #120 included the necessary components, and sufficiently addressed his strengths, needs, and preferences. He had functional expressive and receptive skills. As noted above, three of the remaining individuals should have had updates or comprehensive assessments completed, but did not. Problems varied across the remaining assessments and updates, but in each three or more of the key components were insufficient to address the individual's strengths, needs, and preferences. Based on the problems identified in the assessments and updates reviewed, moving forward, the Facility should focus on ensuring communication assessments and updates address, and/or include updates, as appropriate, regarding:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- The individual's preferences and strengths are used in the development of communication supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and

services;

- 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;
- A comparative analysis of current communication function with previous assessments;
- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated; 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: Overall, the ISPs of the individuals reviewed did not describe how the individuals communicate, and/or include plans or strategies to meet their needs. In fact, some regression was noted from the previous two reviews. The Monitoring Team will continue to review all of these indicators.

#	Indicator	Overall Score	Individuals: 184	120	141	162	130	251	189	82	136
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.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	50% 3/6	0/1	N/A	0/1	1/1	1/1	N/A	0/1	N/A	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.	38% 3/8	0/1	N/A	1/1	0/1	0/1	0/1	1/1	0/1	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: d. Individual #141's IDT met in January 2016 to discuss a recommendation for the implementation of a sign language goal

that the SLP recommended in a consultation completed in December 2015.

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: Individuals had skill acquisition plans and they were measurable. This was the case for this review and the previous two reviews. Therefore, these two indicators will move to the category of requiring less oversight. The other three indicators will remain in active monitoring. Ensuring reliable and valid data are available is an area of focus for the facility.

#	Indicator	Overall Score	Individuals: 38	184	372	20	123	171	300	199	120
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	96% 26/27	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3	2/3
3	The individual's SAPs were based on assessment results.	63% 17/27	3/3	2/3	1/3	2/3	1/3	1/3	2/3	3/3	2/3
4	SAPs are practical, functional, and meaningful.	59% 16/27	3/3	1/3	1/3	2/3	2/3	1/3	2/3	2/3	2/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	19% 5/27	0/3	1/3	0/3	1/3	2/3	0/3	1/3	0/3	0/3

Comments:

1. It was very positive to find multiple SAPs for each of the individuals reviewed.

2. All, but one, of the 27 SAPs were identified as measurable. The exception was the anger management SAP for Individual #120 because this did not indicate the specific behavior he was to exhibit.

3. Seventeen of the 27 SAPs were based on assessments. Exceptions included plans for Individual #184 and Individual #372 to learn to sanitize their hands even though the functional skills assessment noted that they could both wash their hands independently. Similarly, Individual #300 was assessed as independent in her ability to exercise, but a SAP had been developed for her to learn this skill. In other cases, the assessment indicated that the individual could perform the skill with verbal prompting, while their SAPs indicated that a correct trial would be scored if the individual performed the skill with a more intrusive level of prompting (e.g., Individual #372 - fold clothing, Individual #171 – laundry). Individual #123 was to learn to appropriately greet others, but the rationale indicated that this SAP was developed to help her better interact with her peers.

4. Sixteen of 27 SAPs were considered to be practical, functional, and/or meaningful. Exceptions included Individual #184 learning to point to a quarter, Individual #171 labeling events that make him angry rather then learning alternative ways to respond to these events, Individual #199 who is legally blind learning to copy a number, and Individual #120 learning to ride a bus when his assessment indicated he could do so with verbal prompts.

5. Of the 27 SAPs reviewed, there was evidence that the facility had conducted a minimum of one assessment of data reliability for five SAPs over a six-month period.

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: The requirements of these indicators were not met. The facility should be able to focus upon these indicators and improve performance for the next review. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	184	372	20	123	171	300	199	120
10	The individual has a current FSA, PSI, and vocational assessment.	44% 4/9	0/1	1/1	0/1	0/1	1/1	1/1	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.	33% 3/9	1/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
12	These assessments included recommendations for skill acquisition.	56% 5/9	1/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1	1/1

Comments:

10. Although updated summaries were current, five of the nine individuals (Individual #38, Individual #372, Individual #20, Individual #300, Individual #120) had functional skills assessments that were over one year old. The facility's policy was to complete these every three years. As discussed with the facility's director of educational and training, these should be completed annually. Vocational assessments had been completed for all, but Individual #38, who was reportedly not interested in working. Similarly, a preferences and strengths inventory was available for everyone, but Individual #20.

11. As indicated by the individual's QIDP tracking data, the required assessments were available by the due date for three of the nine individuals (Individual #38, Individual #184, and Individual #171).

12. The required assessments for five individuals (Individual #38, Individual #372, Individual #20, Individual #300, Individual #120) included recommendations for SAPs. The vocational assessments for Individual #123, Individual #171, and Individual #199 noted that further assessment of the individual's baseline skills was necessary. Individual #184's vocational assessment noted that a service objective would be developed instead of a SAP.

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

This Domain contains 40 outcomes and 176 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Twenty-four of these indicators, in restraints, psychiatry, medical, dental, and OT/PT, had sustained high performance scores and will be moved the category of requiring less oversight. Five Outcomes will move entirely to less oversight: Outcomes #8, 11, 12, and 14 for psychiatry, and Outcome #7 for dental.

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

Psychiatry had not yet developed personal goals for individuals. Therefore, progress could not be determined. Behavioral health services had relevant goals/objectives and also reasonably designed data collection systems, but progress could not be determined because there were not good reliable data available.

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

Acute Illnesses/Occurrences

Psychiatry took action when an individual was experiencing or exhibiting psychiatric deterioration. There was improved and ongoing collaboration between psychiatry and behavioral health services, as well as between psychiatry and neurology consultants. Further, psychiatry met criteria with various indicators regarding quarterly clinics, interim care, and management of side effects and polypharmacy. Some of these moved to the category of requiring less oversight.

Behavioral health services also took action when an individual was experiencing behavior problems, though not all actions were implemented.

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

Overall, concerns were noted with the quality of medical practitioners' assessment and follow-up on acute issues treated at the Center and/or in other settings. On a positive note, over the last two review periods and during this review, when individuals were transferred to the hospital, the PCP or a nurse generally communicated necessary clinical information with hospital staff. In addition, over this same time period, individuals reviewed received timely treatment and/or interventions for the acute illness requiring out-of-home care. As a result, the related indicators will move to the category of requiring less oversight.

Implementation of Plans

More focus is required for implementation of PBSPs, including the training of staff, assurance of treatment implementation integrity, and graphic summaries of behavioral occurrences that can be used for treatment planning.

The requirements when an individual has had more than three crisis intervention restraints in any rolling 30-day period were only partially met. By this time, the Center should be meeting these requirements at 100%.

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

The Center needs to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessments, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible. Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. However, it was positive that for the conditions and risks reviewed, PCPs had generally implemented the limited action steps assigned to them in the individuals' IHCPs.

It was positive that over the last two review periods and during this review, for the non-Facility consultations reviewed, the PCP generally reviewed consultations and indicated agreement or disagreement. However, between this review and the last one, a decrease was seen in the timely completion of these reviews. For the individuals reviewed, PCPs generally wrote an IPN that included necessary components. However, the Center needs to focus on ensuring PCPs order all agreed-upon recommendations and refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

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

Overall, the Dental Department was making good progress. The individuals reviewed had received the necessary x-rays, and fluoride treatment as appropriate. In addition, at preventative visits, Dental Department staff provided tooth-brushing instruction to the individuals reviewed and/or their staff. The dentist also had assessed the need for dentures for individuals with missing teeth. For the individuals reviewed, restorative work was completed in a timely manner, and extractions were only done when restorative options were exhausted. These findings were consistent with the previous two reviews, so eight indicators will be placed in the category of requiring less oversight, including all indicators in Outcome #9 related to the provision of emergency dental care. The Center needs to focus on ensuring that individuals with periodontal care have treatment plans that meet their needs, and that the plans are implemented.

During this review, with few exceptions, the Corpus Christi SSLC Pharmacy Department was completing QDRRs timely, and practitioners generally reviewed them timely, and followed up on recommendations. In terms of quality of QDRRs, for the individuals reviewed, the Pharmacist consistently reviewed and made recommendations regarding laboratory reports, polypharmacy, and benzodiazepine use. However, the five risks of metabolic syndrome were not reviewed in the applicable QDRRs. In addition, despite moderate to high anticholinergic activity/burden, which the Pharmacy Department identified, there were no recommendations made to address these findings.

Often, IDTs had not developed supports to address individuals' unmet OT/PT needs, and as a result, individuals were not receiving needed supports. Adaptive equipment was generally in good working order. The related indicator will move to the category of requiring less oversight. Some improvement was seen with regard to cleanliness of adaptive equipment. Proper fit was often potentially still an issue.

Based on observations, there were still numerous instances (60% of 40 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. More specifically, individuals were positioned correctly during three out of six observations (50%). Staff followed individuals' dining plans during only 11 out of 31 mealtime observations (35%). Transfers were completed correctly two out of three times (67%). As is discussed in further detail below, during an observation of medication administration, a nurse and direct support professional did not follow an individual's PNMP related to positioning, and shortly thereafter, the individual experienced respiratory distress. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.												
Summary: This outcome and its indicators applied to two individuals. Criteria for six of the indicators were met for both individuals, and one of these had been sustained for a number of reviews and will move to the category of requiring less oversight (indicator 24). The important protections required by this outcome and its indicators require continued focus and will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	123	199								
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	100% 2/2	1/1	1/1								
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 2/2	1/1	1/1								
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	50% 1/2	1/1	0/1								
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	50% 1/2	1/1	0/1								
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	50% 1/2	1/1	0/1								
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address	50% 1/2	1/1	0/1								

	them.										
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 2/2	1/1	1/1							
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 2/2	1/1	1/1							
26	The PBSP was complete.	N/A	N/A	N/A							
27	The crisis intervention plan was complete.	100% 2/2	1/1	1/1							
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	0% 0/2	0/1	0/1							
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	100% 2/2	1/1	1/1							
Comments: 18-29. Between 12/1/15 and 5/31/16, two of the nine individuals experienced more than three crisis restraints in a rolling 30-day period. For Individual #123, this review focused on the restraints that occurred between 4/22/16 and 4/30/16. For Individual #199, the restraints occurred between 2/12/16 and 3/11/16. There was evidence that the individuals' IDTs met a sufficient number of times. However, only the team for Individual #123 conducted a systematic review/discussion of her adaptive skills, biological/medical/psychosocial issues, and environmental variables as required by these indicators. Both individuals had a PBSP that was reviewed, but treatment integrity had not been assessed on a monthly basis as indicated in the behavioral health services department policy. Individual #123 had a CIP in place at the time of repeated restraint, while a CIP was developed for Individual #199. Both plans contained the required components.											

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
Summary: Reiss screens were conducted a number of years ago. Facility policy was to conduct a Reiss screen if a change of status occurred, but also needs to require the conduct of a Reiss if an individual had never had one and was not receiving psychiatric services. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	130	136	162						
1	If not receiving psychiatric services, a Reiss was conducted.	67% 2/3	1/1	1/1	0/1						

2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A	N/A	N/A	N/A						
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A	N/A	N/A	N/A						

Comments:
1. Thirteen of the 16 individuals that were reviewed by both Monitoring Teams were followed in the psychiatric clinics. Two of the three that were not seen in the psychiatric clinic (Individual #130, Individual #136) had each had a Reiss performed in 2013 and obtained a score below the clinical cutoff. Individual #162 had not had a Reiss evaluation and was not seen in the psychiatric clinics and so was scored zero. The facility's psychiatric team, however, maintained that their policy indicated that a Reiss was no longer needed unless there was a change in status. This was not consistent with the terms of the Settlement Agreement, which requires a Reiss for every individual not receiving psychiatry services and, thus, was scored as zero. None of the three individuals who were not followed in the psychiatric clinics had experienced a significant change in status during the preceding year.

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.

Summary: Without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledged that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 6/6	N/A	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A
11	Activity and/or revisions to treatment were implemented.	100% 6/6	N/A	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A

Comments:
8-9. In the absence of adequate goals, as described in psychiatry outcome 2, it was not possible to determine if the individuals were making progress or maintaining stability.

10-11. The review of the documentation indicated that six of the nine individuals (Individual #184, Individual #20, Individual #123, Individual #171, Individual #300, Individual #199) had experienced one or more events during the course of the prior year that were responded to by an urgent psychiatric consult in addition to the usual quarterly reviews. These events involved issues, such as a significant increase in aggression or self-injury or a medication side effect. In each of these situations, the treatment intervention

recommended by the psychiatrist was implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary: Facility performance on these two indicators improved from the time of the last review. Both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
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.	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1
24	The psychiatrist participated in the development of the PBSP.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 23. The review of the behavioral and psychiatric sections of the record indicated that there was coordination between the two disciplines with the exception of Individual #199 and Individual #20 for whom the behavioral assessment and functional assessment provided little evidence of coordination in the actual documentation. 24. The psychiatric nurses were attending the behavior support committee meetings during which the PBSPs were reviewed, revised, and approved. In addition, a number of the behavioral documents referenced a discussion between the psychiatrist and a member of the behavioral health team concerning the development of the behavioral treatment plan.											

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.											
Summary: These three indicators met criterion for the last two reviews and will be moved into the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 3/3	N/A	1/1	1/1	N/A	N/A	1/1	N/A	N/A	N/A
26	Frequency was at least annual.	100% 2/2	N/A	1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 3/3	N/A	1/1	1/1	N/A	N/A	1/1	N/A	N/A	N/A
Comments: 25-26. There were three individuals for whom close collaboration between psychiatry and neurology was required (Individual #171,											

Individual #372, Individual #184). This collaboration was documented to have occurred frequently both this year and in recent years. The exception was Individual #171 for whom collaboration was not required until this year.

27. The psychiatric quarterlies routinely reviewed the results of the most recent neurological evaluation and the neurology consultation documentation referenced the psychiatric medications.

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

Summary: Quarterly reviews were completed quarterly and had been for a number of years. Therefore, this indicator (33) will be moved to the category of requiring less oversight. Although the content of the documentation of the reviews were scored as meeting criteria, observation indicated that current data were not reviewed. These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
33	Quarterly reviews were completed quarterly.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
34	Quarterly reviews contained required content.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
35	The individual's psychiatric clinic, as observed, included the standard components.	0% 0/2	0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
33-34. The psychiatric quarterlies were performed as required and the documentation was detailed, containing the necessary content.

35. During the onsite review, the Monitoring Team were able to observe the 7/26/16 psychiatric clinics for Individual #38 and Individual #372. The consensus opinion of the Monitoring Team members was that the discussion of the behavioral data was deficient in that the meeting was occurring at the end of July 2016 and the behavioral data presented only covered through June 2016. In addition, inspection of the data indicated inconsistencies between the actual data and its interpretation in the narrative review.

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

Summary: Side effect monitorings were conducted as per the criteria required for this indicator for a number of years. This indicator will be moved to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
36. Both the MOSES and the DISCUS were completed as per the criteria for this indicator for each of the nine individuals. These evaluations were also reviewed in a timely manner by the psychiatrist. This process was facilitated by the three full time psychiatric nurses, who made a significant contribution to the successful completion and review of the side effect monitoring tools.

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

Summary: The availability, provision, and documentation of emergency/urgent and/or follow/up interim clinics met the criteria required for these indicators for a number of years. These indicators will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 38	184	372	20	123	171	300	199	120
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 6/6	N/A	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 6/6	N/A	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 6/6	N/A	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A

Comments:
37-39. As noted in the comments for psychiatry outcome 6, there were signs of acute behavioral deterioration or emergent side effects for six of the individuals (Individual #184, Individual #20, Individual #123, Individual #171, Individual #300, Individual #199) during this review period. These events were promptly responded to by the psychiatrist and a note describing both the circumstances and the proposed intervention was generated at that time. There was also a further discussion in the next scheduled psychiatric quarterly.

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

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

#	Indicator	Overall Score	Individuals: 38	184	372	20	123	171	300	199	120
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
40-43. There was no indication that psychiatric medications were used for sedation or for the convenience of staff for any of the individuals. The dosages of the prescribed medications were within generally accepted ranges.

43. The facility did not use PEMA.

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: The review and management of polypharmacy met the criteria required for these indicators for a number of years. These indicators will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 38	184	372	20	123	171	300	199	120
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 6/6	1/1	N/A	1/1	1/1	1/1	1/1	N/A	1/1	N/A
45	There is a tapering plan, or rationale for why not.	100% 6/6	1/1	N/A	1/1	1/1	1/1	1/1	N/A	1/1	N/A
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 6/6	1/1	N/A	1/1	1/1	1/1	1/1	N/A	1/1	N/A

Comments:
44-46. The Monitoring Team attended the monthly meeting of the Polypharmacy meeting on 7/27/16. This meeting was attended by all three of the psychiatrists, a psychiatric RN, a primary care provider, the clinical pharmacist, and the director of behavioral health services. Each individual who was on the new admission list or was considered to be not psychiatrically stable was reviewed monthly while those who were determined to be stable and for whom the use of the medications had been clinically justified were reviewed quarterly. The individuals who were prescribed psychotropic medications that met the criteria for polypharmacy were: Individual #38, Individual #372, Individual #20, Individual #123, Individual #171, and Individual #199. All of these individuals were reviewed as required and the various criteria for these three indicators were met.

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: Given the absence of good, reliable data, progress could not be determined for all of the individuals. The Monitoring Team scored indicators 8 and 9 based upon the facility's report of progress/lack of progress as well as the ongoing exhibition of problem target behaviors. The indicators in this outcome will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
6	The individual is making expected progress	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	100% 6/6	1/1	1/1	N/A	N/A	1/1	1/1	1/1	N/A	1/1
9	Activity and/or revisions to treatment were implemented.	40% 2/5	1/1	0/1	N/A	N/A	N/A	0/1	1/1	N/A	0/1

Comments:

6. The graphs presented in the facility's monthly PBSP progress note suggested progress on most targeted problem behaviors for Individual #20 and Individual #199. While two of three target behaviors identified for Individual #184 showed improvement, a change in the data system prevented a clear determination of progress. For all others, progress was not evident. However, due to the absence of reliable data, progress could not be determined for any of the nine individuals.

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

8-9. For six of eight individuals with PBSPs, actions were identified and/or taken: a new functional assessment and/or PBSP was completed (Individual #38, Individual #184, Individual #171, Individual #300) or recommended (Individual #123), or continued staff training was advised (Individual #120). A new functional assessment and PBSP had been recently completed/implemented, and were provided to the Monitoring Team while onsite, for Individual #38 and Individual #300. Although the new PBSP for Individual #184 had a start date of 5/1/16, observation and interview with behavioral health services staff revealed that the PBSP was not fully implemented. For two individuals, the June 2016 PBSP progress note recommended ongoing monitoring the of the PBSP (Individual #171) or continued training of staff to competency (Individual #120). There was no evidence of the assessment of treatment integrity since the PBSP had been introduced in May 2016 for Individual #171 or since January 2016 for Individual #120. Because the new BCBA had been assigned to Individual #123's case in June 2016, it was too soon to assess the completion of a new functional assessment or behavior support plan.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
Summary: An area of focus for the facility are indicators 16 and 17, that is, staff training on PBSPs. This includes day and float staff, too. All three of these indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1
17	There was a PBSP summary for float staff.	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	50% 4/8	0/1	1/1	N/A	1/1	1/1	0/1	0/1	1/1	0/1

Comments:

16. For none of the individuals with PBSPs was it evident that all assigned home and day program/work site staff had been trained. Documentation indicated that between 13% (Individual #300) and 72% (Individual #171) of home staff had been trained. The facility provided dates of training for day program/work site staff for five individuals, but no staff were identified. For Individual #184, Individual #123, and Individual #300, the facility reported that day program/work site staff had not received training.

17. The behavioral health services director indicated that float staff were provided with the full plan with the exception of the administrative review. Because this was usually multiple pages in length, criterion was not met. Basic components of a summary plan were discussed.

18. Four of the eight individuals (Individual #184, Individual #20, Individual #123, Individual #199) had functional assessments and PBSPs that had been written by or reviewed and signed by a BCBA.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
Summary: Regularly reviews and good solid data, that are presented clearly, are essential for providing behavioral health supports that meet the generally accepted professional standard of care. This outcome and its indicators will continue under active monitoring. The provision of regularly occurring peer reviews was good to see and if that maintains, it is possible that indicator 23 could move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
19	The individual's progress note comments on the progress of the	63%	0/1	1/1	N/A	1/1	1/1	1/1	1/1	0/1	0/1

	individual.	5/8									
20	The graphs are useful for making data based treatment decisions.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	0% 0/2	0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	0% 0/3	N/A	0/1	N/A	N/A	0/1	N/A	N/A	0/1	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100%									

Comments:

19. For five individuals, the progress note commented on the individual's progress. Exceptions were Individual #38, whose note combined her two replacement behaviors, and Individual #199 and Individual #120, whose progress in counseling were not reviewed.

20. For none of the eight individuals with PBSPs were the graphs determined to be useful for making data-based decisions. The vertical axes were not always labeled appropriately. For example, the vertical axis was labeled frequency although data sheets indicated that a partial interval recording was used to track target behaviors for Individual #38, Individual #20, and Individual #120. Similarly, Individual #184's problem behaviors were documented using a partial interval recording system, but the graphs were labeled successful trials. Phase change lines were often absent (Individual #20, Individual #123, Individual #171, Individual #300, Individual #199) or did not indicate important events such as the introduction of a behavioral contract (Individual #120). While she did not have a PBSP (she had a PSP), it was concerning that the graph for Individual #372 was labeled as frequency measure of her social intrusion. A review of her data sheet revealed that staff were not recording behavioral frequency, but rather noting that the behavior occurred "all day." Medication changes were being made based upon these inaccurate data.

21. An observation was conducted of the psychiatric clinic for two individuals, Individual #38 and Individual #372. Although the behavioral health specialist for both women presented graphs, there were no data reviewed for July 2016. Further, Individual #372's graphs clearly displayed an ascending trend of her targeted behavior (social intrusion) since the introduction of Abilify. The behavioral health specialist repeated that Individual #372's behavior was improving since the dosage of this medication had been increased. For Individual #38, irregular sleep patterns, particularly sleeping during the day, were discussed. Although data were collected on his behavior, these were not available during her review.

22. There was evidence that three individuals had been reviewed in internal and/or external peer review over a six-month period. For one of these individuals there was evidence that the recommendations had been fully implemented. It was unclear whether Individual #184's behavioral health specialist had attended his neurology clinic; the reinforcement component of Individual #123's PBSP had not been changed to tie phone time to participation in work; and Individual #199's PBSP had not been revised to include a psychiatric indicator, among other recommendations.

23. There was evidence that between 12/1/15 and 5/31/16 internal peer review occurred at least three times each month and external peer review occurred once in each of five months.

Outcome 8 – Data are collected correctly and reliably.

Summary: It was good to see that Corpus Christi SSLC continued to have established measures and established goals for the three measures of data and treatment integrity. Even so, problems with the choice of data collection systems for target and replacement behaviors, the absence of any implementation of checking on the integrity, and the Monitoring Team's own observations will keep these indicators in active monitoring.

#	Indicator	Overall Score	Individuals: 38	184	372	20	123	171	300	199	120
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	63% 5/8	1/1	1/1	N/A	1/1	1/1	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.	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 8/8	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 8/8	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

26. For five of the eight individuals with a PBSP, data collection as described was considered adequate. For Individual #171 and Individual #300, staff were to record behavioral frequency within one block for an eight-hour shift. For Individual #120, one data sheet was provided for the week. A partial interval recording system was used, but there was only one block per hour on which to record seven days of data.

27. None of the PBSPs included adequate measures of replacement behaviors. For six individuals (Individual #38, Individual #123, Individual #171, Individual #300, Individual #199, Individual #120), the data sheet allowed staff to record one occurrence per shift or day. Individual #184 was to perform multiple tasks three times daily, but the data sheet allowed only one recording per scheduled time. Only one of two replacement behaviors were documented for Individual #20.

28-29. The behavioral health services department guidelines indicated that data timeliness, IOA, and treatment integrity were to be assessed at least once a month. Data were expected to be recorded within two hours of the data check. IOA and treatment integrity were expected to be 80% or better.

30. Data timeliness, IOA, and treatment integrity were not assessed per department guidelines for any of the eight individuals with PBSPs. It was concerning that there was no evidence of data timeliness when individual books were checked by the Monitoring Team. Individual books checked on 7/26/16 revealed either no recordings at 11:18 am (Individual #38) and 3:15 pm (Individual #184), data recorded up to 2:00 pm at 4:21 pm (Individual #123), absence of data for the previous shift (Individual #120), or a recording of "all day" (Individual #372). Individual books checked on 7/27/16 revealed a lack of documentation for the previous four to six hours (Individual #20, Individual #123, Individual #171, Individual #300, Individual #199).

Medical

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

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

#	Indicator	Overall Score	Individuals: 184	120	141	162	130	251	189	82	136
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	6% 1/18	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	33% 6/18	0/2	2/2	0/2	0/2	1/2	0/2	1/2	2/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	6% 1/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review [i.e., Individual #184 – falls, and weight; Individual #120 – cardiac disease, and diabetes; Individual #141 – cardiac disease, and osteoporosis; Individual #162 – respiratory compromise, and skin integrity; Individual #130 – aspiration, and gastrointestinal (GI) problems; Individual #251 – seizures, and other: cancer; Individual #189 – GI problems, and osteoporosis; Individual #82 – weight, and diabetes; and Individual #136 – aspiration, and infections].

From a medical perspective, the goal/objective that was clinically relevant, achievable, and measurable was for: Individual #120 – diabetes.

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used

to measure the individual's progress or lack thereof: Individual #120 – cardiac disease, Individual #141 – osteoporosis, Individual #130 – aspiration, Individual #189 –osteoporosis, and Individual #82 – weight, and diabetes.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports on these goals, including data and analysis of the data, were not available to IDTs in an integrated format (with the exception of the monthly reports for Individual #130 that provided information about the numbers of aspiration triggers). As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of medical supports and services to these nine individuals.

Outcome 4 – Individuals receive preventative care.

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

#	Indicator	Overall Score	Individuals: 184	120	141	162	130	251	189	82	136
a.	Individual receives timely preventative care:										
	i. Immunizations	67% 6/9	1/1	0/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 6/6	1/1	N/A	1/1	N/A	1/1	1/1	1/1	N/A	1/1
	iii. Breast cancer screening	100% 3/3	N/A	N/A	1/1	N/A	N/A	1/1	1/1	N/A	N/A
	iv. Vision screen	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1
	v. Hearing screen	33% 3/9	0/1	0/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1
	vi. Osteoporosis	88% 7/8	1/1	1/1	1/1	0/1	1/1	1/1	1/1	N/A	1/1

	vii. Cervical cancer screening	67% 2/3	N/A	N/A	1/1	N/A	N/A	1/1	0/1	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.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1

Comments: a. The following problems were noted:

- Individual #184's last hearing screening was completed on 7/8/14. It should have been repeated in one year.
- Individual #120's annual medical assessment recommended Tdap (i.e., dT 8/97), and varicella titer (i.e., undocumented). In addition, Individual #120's last hearing screening was completed on 2/10/15. It should have been repeated in one year.
- The date of Individual #141's pneumovax vaccine was difficult to determine, because different dates were included in different documents (e.g., 10/16/90, and 5/16/97). Similarly, several dates were provided for unsuccessful eye examinations, and it was unclear if a successful exam ever occurred.
- No audiology assessment was found for Individual #162. Even though Individual #162 was young, she was at high risk for osteoporosis due to lifelong immobility due to cerebral palsy with spastic quadriparesis. When interviewed, the PCP acknowledged the risk. When determining the preventive care she needed, it appeared the PCP had not thought of her risk for osteoporosis.
- On 12/23/15, Individual #130's PCP wrote an IPN that indicated he should receive the Prevnar 13 vaccine, but an order was never written. Individual #130's last hearing screening was completed on 6/28/12, with a recommendation to retest hearing in one year.
- On 9/3/15, Individual #189 was uncooperative with an ophthalmology appointment. The appointment was rescheduled until 1/29/16, but it was concluded that the individual needed sedation. Individual #189's last hearing screening was completed on 12/30/13, with a recommendation to retest hearing in one year. On 9/25/13, a PAP test was completed that was unsatisfactory.
- Individual #136's last hearing screening was completed on 9/9/14, with a recommendation to retest hearing in one year.

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

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
Summary: The Center had improved its performance with regard to this indicator.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	1/1	N/A	N/A

	Office Guidelines.										
	Comments: None.										

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Given that over the last two review periods and during this review, when individuals were transferred to the hospital, the PCP or a nurse generally communicated necessary clinical information with hospital staff (Round 9 – 100% for Indicator 4.f, Round 10 – 100% for Indicator 4.f, and Round 11 - 100% for Indicator 6.f), Indicator f will move to the category of requiring less oversight. In addition, given that over the last two review periods and during this review, prior to the transfer to the hospital or ED, individuals reviewed received timely treatment and/or interventions for the acute illness requiring out-of-home care (Round 9 – 86% for Indicator 4.e, Round 10 – 100% for Indicator 4.e, and Round 11 - 100% for Indicator 6.e), Indicator e will move to the category requiring less oversight. However, during this review and the previous two, other components of the quality of medical practitioners' assessment and follow-up on acute issues treated at the Facility and/or in other settings varied. The Monitoring Team will continue to review the remaining indicators.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
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.	7% 1/15	0/2	0/2	0/2	0/1	0/2	N/A	0/2	1/2	0/2
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.	50% 4/8	1/1	1/2	1/1	N/A	1/2		N/A	0/1	0/1
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.	71% 5/7	N/A	N/A	1/1	0/2	2/2	N/A	2/2	N/A	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary	50%			N/A	N/A	1/2		1/2		

	admission, the individual has a quality assessment documented in the IPN.	2/4									
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.	100% 7/7			1/1	2/2	2/2		2/2		
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 4/4			1/1	2/2	N/A		1/1		
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	50% 1/2			N/A	1/2	N/A		N/A		
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	86% 6/7			1/1	2/2	2/2		1/2		

Comments: For eight individuals reviewed in relation to medical care, the Monitoring Team reviewed 15 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #184 (abscess on 4/18/16, and laceration on 2/20/16), Individual #120 (skin lesions on 5/31/16, and fall with fracture on 11/15/16), Individual #141 (right hand swelling on 6/21/16, and cerumen impaction on 6/1/16), Individual #162 (rash on 1/6/16), Individual #130 (fever and flu on 5/26/16, and increased abdominal girth on 3/30/16), Individual #189 (hypoxia on 12/21/15, and left knee trauma on 11/2/15), Individual #82 (swollen eyelid on 6/7/16, and finger injury on 6/5/16), and Individual #136 (trauma on 6/5/16, and trauma on 5/24/16) .

a. The acute illness for which documentation was present to show that medical providers assessed the individual according to accepted clinical practice was for Individual #82's swollen eyelid on 6/7/16. For many of the remaining acute illnesses treated at the Facility that the Monitoring Team reviewed, medical providers did not cite the source of the information in assessing them. At times, a review of the history of the problem was not documented (e.g., Individual #184's abscess on 4/18/16, and Individual #162's rash on 1/6/16), and/or the most recent diagnostic tests were not summarized (e.g., Individual #120's skin lesions on 5/31/16, and Individual #141's cerumen impaction on 6/1/16).

b. The acute illnesses/occurrences reviewed for which follow-up was needed, and documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized included those for Individual #184's abscess on 4/18/16, Individual #120's fall with fracture on 11/15/16, Individual #141's cerumen impaction on 6/1/16, and Individual #130's increased abdominal girth on 3/30/16.

For four of the nine individuals reviewed, the Monitoring Team reviewed seven acute illnesses requiring hospital admission, or ED visit, including the following with dates of occurrence: Individual #141 (ED visit for laceration on 3/24/16), Individual #162 (hospitalization for tracheostomy complication on 6/10/16, and hospitalization for acute respiratory failure and bilateral pneumonia on 3/13/16), Individual #130 (Infirmary admission for ileus on 5/2/16, and Infirmary admission for abdominal distension on 2/21/16), and Individual #189 (check J-tube placement on 11/12/15, and drug overdose related to Fentanyl patch on 10/2/15).

c. For Individual #162 (hospitalization for tracheostomy complication on 6/10/16, and hospitalization for acute respiratory failure and bilateral pneumonia on 3/13/16), no PCP IPNs were found related to these hospitalizations.

e. For the acute illnesses reviewed, it was positive the individuals reviewed received timely treatment at the SSLC.

f. It was positive that for the individuals reviewed documentation was submitted to confirm that the PCP or nurse communicated necessary clinical information with hospital staff.

g. On 4/4/16, Individual #162 returned from her hospitalization for acute respiratory failure and bilateral pneumonia. However, the IDT did not hold an ISPA meeting until 5/13/16.

h. For the individuals reviewed, upon their return to the Facility, there was generally evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness. The exception was Individual #189 (check J-tube placement on 11/12/15) for whom no PCP IPN

documentation was submitted to show follow-up.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: Given that over the last two review periods and during this review, for the consultations reviewed, the PCP generally reviewed consultations and indicated agreement or disagreement (Round 9 – 92%, Round 10 – 94%, and Round 11 – 93%), Indicator a will move to the category of requiring less oversight. Between the last review and this one, a decrease was noted in PCPs' timely review of consultations (Round 9 – N/A, Round 10 – 88%, and Round 11 – 73%). Since the last review, it was good to see improvement in PCPs writing an IPN that included the necessary components (Round 9 – 85%, Round 10 – 71%, and Round 11 – 87%). An area requiring focused efforts was ensuring PCPs ordered all agreed-upon recommendations (Round 9 – 100%, Round 10 – 67%, and Round 11 – 58%). The Center also 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	184	120	141	162	130	251	189	82	136
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	93% 14/15	2/2	2/2	2/2	1/2	2/2	2/2	1/1	N/A	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	73% 11/15	0/2	2/2	1/2	1/2	2/2	2/2	1/1		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.	87% 13/15	2/2	2/2	2/2	1/2	2/2	1/2	1/1		2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	58% 7/12	1/1	0/1	1/2	1/1	0/2	1/2	1/1		2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1		N/A
Comments: For eight individuals reviewed, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed included those for Individual #184 for orthopedics on 3/8/16, and neurology on 4/14/16; Individual #120 for orthopedics on 3/17/16, and ear, nose, and throat (ENT) on 2/3/16; Individual #141 for urology on 12/18/15, and neurology on 4/14/16; Individual #162 for surgery on 4/26/16, and pulmonary on 1/26/16; Individual #130 for pulmonary on 5/17/16, and pulmonary on 1/26/16; Individual #251 for oncology on 2/25/16, and neurology on 5/11/16; Individual #189 for ophthalmology on 9/3/15; and Individual #136 for											

neurology on 3/10/16, and urology on 12/9/15.

a. and b. It was positive that PCPs generally reviewed and initialed the consultation reports reviewed, and indicated agreement or disagreement with the recommendations. The exception was the consultation for Individual #162 for surgery on 4/26/16. However, a number of these reviews did not occur timely, including those for Individual #184 for orthopedics on 3/8/16, and neurology on 4/14/16; Individual #141 for neurology on 4/14/16; and Individual #162 for surgery on 4/26/16.

c. No PCP IPNs were found with regard to the consultations for Individual #162 for surgery on 4/26/16, and Individual #251 for neurology on 5/11/16.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, for the following: Individual #184 for neurology on 4/14/16; Individual #141 for urology on 12/18/15; Individual #162 for pulmonary on 1/26/16; Individual #251 for neurology on 5/11/16; Individual #189 for ophthalmology on 9/3/15; and Individual #136 for neurology on 3/10/16, and urology on 12/9/15.

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

Summary: The Center needs to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessment, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
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.	39% 7/18	0/2	1/2	1/2	1/2	1/2	2/2	0/2	0/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #184 – falls, and weight; Individual #120 – cardiac disease, and diabetes; Individual #141 – cardiac disease, and osteoporosis; Individual #162 – respiratory compromise, and skin integrity; Individual #130 – aspiration, and GI problems; Individual #251 – seizures, and other: cancer; Individual #189 – GI problems, and osteoporosis; Individual #82 – weight, and diabetes; and Individual #136 – aspiration, and infections).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #120 – cardiac disease; Individual #141 – cardiac disease; Individual #162 – skin integrity; Individual #130 – aspiration; Individual #251 – seizures, and other: cancer; and Individual #136 - infections. The following provide a few examples of concerns noted regarding medical assessment, tests, and evaluations:

- On 5/3/16, Individual #136 completed a modified barium swallow study that indicated moderate oral and pharyngeal dysphagia. He had lost considerable weight due to spillage as he attempted to feed himself. This was due to his worsening myoclonus, but was not recognized until considerable weight loss had occurred (approximately 30 to 35 pounds). Once assistance with eating was implemented, his weight stabilized. He had a history of GERD and gastritis, but there was no information concerning the present degree of GERD and associated sequelae, such as Barrett's esophagus. His last esophagogastroduodenoscopy (EGD) was seven years ago in 2009. There was no information concerning whether gastroparesis existed. He took Benztropine for sialorrhea in an attempt to reduce his oral secretions. He had a high anticholinergic burden, because he was prescribed several medications with anticholinergic activity. However, there were no recommendations from pharmacy to the PCP concerning this issue and whether a reduction in these other medications or changing to alternative medications was an option. It was not clear whether or not his IDT had determined if his mouth was excessively dry and whether, at times, he had thick mucus with the inability to clear his secretions or whether the drying effect was making his dysphagia more problematic. Submitted information did not indicate a thorough assessment of his risk of aspiration (e.g., severity of GERD, presence or not of gastroparesis, high anticholinergic burden). Findings from a thorough evaluation would be the basis for providing treatment consistent with currently generally accepted standards.

- For Individual #130, an EGD in 2012 found ulcerations in the stomach. In 2013, a repeat EGD was done. There was no narrative except for the placement of a G-tube, but the photos did not suggest any acute pathology. However, the recent severity of GERD was unclear, and there was no further evaluation, despite a recent increase in aspiration triggers. It appeared that evaluation for a surgical resolution was not considered (such as fundoplication/hiatal hernia repair), which might have been due to the individual having the potential to be at high risk for surgical/anesthesia complications.

  Individual #130 had repeated bouts of symptomatic colon distention. No colon motility studies had been done. There was a remote history of colon surgery with anastomosis. The PCP was unable to clarify the reason for the prior colon surgery. The anastomotic site might have been a potential area of hypomotility. Surgical consultation recommended a colectomy, if the clinical course did not resolve. In the meantime, the current treatment of bowel rest with Pedialyte had repeatedly resolved the distention when it occurred. One week prior to the Monitoring Team's visit, a GI consultation was completed, and the recommendation was to have increased motion of his abdomen and lower extremities as tolerated. This included pumping the individual's legs when bathing. This had been done in the past with success in reducing hypomotility, but such actions had not occurred since December. Fiber was also stopped, resulting in less distention. Although there were currently many unknowns (e.g., degree of GERD, hypomotility of bowel), the PCP continued to adjust medications, and nutrition/hydration, and continued to seek guidance from the GI consultant.

- Individual #82 was at risk with regard to weight, and diabetes. Since his admission approximately 18 months ago, his weight had varied and it was unclear if the weights recorded were accurate, but overall little change had occurred (from 172 pounds upon admission, 172 pounds in June 2016, and 165 pounds in July 2016. The nutritional assessment did not recommend a change in caloric intake. For example, it did not appear the IDT discussed whether a 2000-calorie diet could be reduced to 1800 calories per day, or whether he would accept such a change. The goal from the Nutritional Assessment, dated 11/6/15, indicated he should work towards a weight loss of two to four pounds per month. Considering Individual #82's ability to contribute, it was not clear the IHCP goal(s) included his perspective and participation, which might have increased his

motivation. Reportedly, Individual #82 enjoyed participation in an exercise club in the evenings, but the QIDP monthly report did not indicate the level of participation (i.e., frequency, actual time engaged in activity versus sitting and observing, etc.). For example, measuring calories burned during his active participation at the exercise club would provide him guidance as to ways to expand this opportunity to decrease his weight and ultimately improve his health. He also periodically attended classes to learn about diabetes and diet, but it was not clear if or how this learning was incorporated into daily actions/habits. The Behavioral Plan, dated 11/16/15, did not address motivation to exercise and adherence to his diet, which were key to reducing his risk. There was no information as to how the direct support professionals were trained to encourage him to choose healthful options/portions. Individual #82's waist circumference was not routinely measured as part of monitoring for metabolic syndrome risk, which would have been important given that he was prescribed an atypical antipsychotic. He continued to smoke less than 10 cigarettes a day, and refused to consider stopping, but the Center did not submit evidence to show any steps taken to encourage him to discontinue this habit that was detrimental to his health. The active participation of the PCP in the ISP process was needed to guide the IDT in addressing these issues and incorporating them into the IHCP.

- Individual #141 had osteoporosis and had been treated by Calcitonin, Reclast, and Prolia in the past, although records did not document well or at all the reason for the changes in choice of medications for osteoporosis. There was no formal exercise program, although she did ambulate in the home and for short distances. On 8/6/15, her Vitamin D level was 31. Her Vitamin D was subsequently discontinued for undocumented reasons. This was concerning, because her level was low normal on supplementation. The PCP was unaware the Vitamin D had been discontinued. There was no further Vitamin D level ordered. In order for Individual #162's health and safety needs to be addressed, close teamwork and cooperation between many departments was needed. Individual #162 had a difficult transition from ABSSLC and was hospitalized several times. Except for the transfer package, there did not appear to be any or sufficient communication and coordination between the ABSSLC and CCSSLC IDTs. In addition, for the six months prior to the review, the PCP did not appear to have much presence at the ISPA meetings in that the PCP only attended one of 11 ISPA meetings. The PCP's guidance was essential for the IDT to develop and implement plans to improve care for Individual #162. There was miscommunication concerning positioning at one IDT meeting, which might have been prevented if the PCP had attended and provided medical guidance to the IDT.

  The IDT did not appear to have developed a plan for the future regarding Individual #162's health. For example, when asked if she were to continue to aspirate and develop infections, what would be done next, there was no clear next step or direction to be taken. Based on submitted documentation, it could not be determined whether the recent thoraco-abdominal surgery had altered the integrity of the prior fundoplication, and, more specifically, whether there was information to confirm that it was functioning, and intact, or whether further testing was indicated to determine if it had become unwrapped and needed intervention. Based on record review and discussion with the PCP, there was no response to this concern and/or any analysis of the impact it might have had on the recent aspirations. Individual #162 had been hospitalized repeatedly in recent months, but the answer to the critical question of what steps could be taken to prevent the next illness requiring hospitalization was left unanswered.

- Individual #184 had many potential causes for his falling. Based on the records provided, whether there was a component of imbalance leading to falls could not be determined, but testing for balance might be indicated, due to the number of falls. His vision appeared to be challenged by cataracts. There was no information readily available to the IDT about his depth perception

or visual fields. He was overdue for an audiological evaluation. There also was the concern that the falls might be related to side effects of antiepileptic drugs (AEDs) or psychotropic medications, or cumulative effects of anticholinergic burden. The PCP did not appear to have addressed these in a methodical way and documented findings in IPNs, the AMA, or quarterly medical reviews. Individual #184 has lost his functional ambulation ability over time, but there was no information as to the timeline or the etiology. Such an analysis might provide additional information as to the cause of falls.

- For Individual #184, it also was difficult to determine whether the changes in weight reflected reality or whether some of the readings were inaccurate. There was little information submitted indicating the PCP monitored these weight variations closely. The dietitian made several changes based on that department's monitoring the weights. A PCP IPN from 6/21/16 indicated the PCP communicated with the dietitian concerning a weight increase from 108 pounds to 144 pounds in 12 months. No consultation requests were made for weight change, nor did the IDT hold ISPA meetings to address weight concerns from 12/1/15 through 6/14/16. There was little information about his activity level. There was no information to show that medical causes for changes in weight were investigated. There was no comment about the prescribed atypical antipsychotic or anti-epileptic medication as potentially contributing causes to the weight gain. There had been changes in the anti-epileptic medications that had contributed to worsening behavior. A review of the amount of calories actually ingested versus an estimate of calories expended might have been valuable in determining etiology. The PCP did not mention the potential contribution of depression or anxiety/irritability to weight loss or gain. Although the PCP appeared to recognize the considerable weight gain late, the PCP provided no differential diagnosis or initial evaluation.

- Individual #189 was reported to have many episodes of crying for unknown reasons. She was fed via a jejunostomy tube (J-Tube). The diet fluids and supplemental feeding orders included a constant rate for six hours continuous in the morning, and eight hours in the evening. Flushes were done of 125 cubic centimeters (cc) before and after feeding and flushes of 200 cc four times a day with passes. If given as boluses, flushes might have contributed to distress, because flushes would have the potential to rapidly distend the narrow jejunum. During an EGD in 2014, gastroparesis was noted. The individual was started on Reglan, and head-of-bed elevation was ordered. There was no further information as to how this had been monitored, and/or additional treatment options or consultations considered for this individual with complex needs. For example, there was no information that motility or other studies or consultation had been considered to determine the etiology of the gastroparesis and resolve it. Individual #189 remained at high risk for reflux and aspiration.

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. Although documentation often was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs, the Monitoring Team will continue to review this indicator until IHCPs include necessary action steps and they are implemented.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	The individual's medical interventions assigned to the PCP are	85%	2/2	2/2	2/2	0/1	N/A	1/2	2/2	N/A	2/2

	implemented thoroughly as evidenced by specific data reflective of the interventions.	11/13									
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed generally were implemented. The exceptions were the completion of a referral to Individual #162 to an allergist, and a mammogram and ultrasound for Individual #251, who was prescribed medication for cancer.											

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; recommendations are made about any necessary additional laboratory testing regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.											
Summary: NR			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	NR									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	NR									
Comments: The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.											

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
Summary: During the previous two reviews and this one, the Center's scores for these indicators varied. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	QDRRs are completed quarterly by the pharmacist.	89% 16/18	2/2	2/2	2/2	1/2	1/2	2/2	2/2	2/2	2/2
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2

	ii. Benzodiazepine use;	100% 8/8	N/A	N/A	N/A	2/2	N/A	N/A	2/2	2/2	2/2
	iii. Medication polypharmacy;	100% 10/10	1/1	N/A	1/1	1/1	1/1	2/2	N/A	2/2	2/2
	iv. New generation antipsychotic use; and	0% 0/8	0/2	0/2	0/2	N/A	N/A	N/A	N/A	0/2	N/A
	v. Anticholinergic burden.	0% 0/17	0/2	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	89% 16/18	2/2	2/2	2/2	2/2	2/2	2/2	0/2	2/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 10/10	2/2	2/2	2/2	N/A	N/A	2/2	N/A	2/2	N/A
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	91% 10/11	1/1	2/2	2/2	1/1	1/1	N/A	1/1	0/1	2/2
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	NR									

Comments: b. The five risks of metabolic syndrome were not reviewed in the applicable QDRRs.

Despite moderate to high anticholinergic activity/burden, which the Pharmacy Department identified, there were no recommendations made to address this finding.

c. For the individuals reviewed, it was good to see that prescribers were generally reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations. The exceptions were for Individual #189.

d. When prescribers agreed to recommendations for the individuals reviewed, they generally implemented them. The exception was Individual #82 for whom the Clinical Pharmacist recommended a screening for nephropathy annually due to diabetes mellitus Type II, and the PCP agreed, but neither an order nor results were found.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	0/1	N/A	0/1	N/A	N/A	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	17% 1/6	0/1		0/1			0/1	0/1	1/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/6	0/1		0/1			0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/6	0/1		0/1			0/1	0/1	0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/1		0/1			0/1	0/1	0/1	0/1
Comments: a. and b. The Monitoring Team reviewed six individuals with medium or high dental risk ratings. Although Individual #82's goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof. c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, progress reports on existing goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For these six individuals, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services. Individual #120 was in the core group, so a complete review was completed for him. For Individual #162 and Individual #130, who were at low risk for dental and who were in the outcome sample, the "deep review" items were not scored, but other items were scored.											

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: These are new indicators, which the Monitoring Team will continue to review.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	Individuals have no diagnosed or untreated dental caries.	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

		9/9									
b.	Since the last exam:										
	i. If the individual had gingivitis (i.e., the mildest form of periodontal disease), improvement occurred, or the disease did not worsen.	N/A									
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	86% 6/7	1/1	1/1	1/1	N/A	N/A	0/1	1/1	1/1	1/1
c.	Since the last exam, the individual's fair or good oral hygiene score was maintained or improved.	NR									
Comments: c. As indicated in the dental audit tool, This indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will be marked "N/A." At the time of the review, State Office had not yet developed a process to ensure inter-rater reliability with the Centers.											

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: Based on scores of 100% for tooth brushing instruction, dental x-rays, restorative work, and extractions, Indicators b, c, f, and g will move to the category of requiring less oversight. The remaining indicators are new and/or need improvement, and will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	100% 4/4	N/A	N/A	1/1	N/A	N/A	1/1	N/A	1/1	1/1
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	50% 4/8	0/1	1/1	0/1	1/1	N/A	0/1	1/1	1/1	0/1
f.	If the individual has need for restorative work, it is completed in a	100%	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A

	timely manner.	1/1									
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: None.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: Given that the Center had attained 100% scores for these indicators during this and the previous two reviews, indicators a through c will move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 1/1								1/1	
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	100% 1/1								1/1	
Comments: a. through c. For the individual reviewed for which a dental emergency occurred, the Dental Department provided emergency dental care in a timely manner.											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: These indicators were not applicable to the individuals reviewed during this and the previous review. They will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	N/A	N/A	N/A	N/A	NR	N/A	N/A	N/A	N/A	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	N/A									
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	N/A									
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	N/A									

Comments: For Individual #162, who was in the outcome group and was at low risk for dental, some indicators were not assessed.

Outcome 9 – Individuals who need them have dentures.											
Summary: For the past two reviews and this one, the Center received scores of 100% for Indicator a. It will move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	100% 3/3	1/1	1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: None.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Nursing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis for acute illnesses/occurrences remained an area on which the Center needs to focus. It is also important that nursing staff timely notify the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification. Nursing acute care plans needed improvement. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	50% 6/12	1/1	0/2	1/1	0/2	1/2	N/A	1/2	2/2	N/A
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	55% 6/11	0/1	0/2	1/1	0/1	1/2		2/2	2/2	
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing	8% 1/12	0/1	0/2	0/1	0/2	1/2		0/2	0/2	

	assessments.										
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	50% 1/2	N/A	N/A	N/A	1/2	N/A		N/A	N/A	
e.	The individual has an acute care plan that meets his/her needs.	8% 1/12	0/1	0/2	0/1	0/2	0/2		0/2	1/2	
f.	The individual's acute care plan is implemented.	8% 1/12	0/1	0/2	0/1	0/2	1/2		0/2	0/2	

Comments: The Monitoring Team reviewed 12 acute illnesses and/or acute occurrences for seven individuals, including Individual #184 – impaired skin integrity on 4/18/16; Individual #120 – otorrhea (ear drainage) on 2/5/16, and right great toe fracture on 3/31/16; Individual #141 – conjunctivitis on 2/17/16; Individual #162 – impaired skin integrity on 2/3/16, and post-operative care for hernia repair on 3/12/16; Individual #130 – ileus on 5/2/16, and abdominal distension on 2/21/16; Individual #189 – unintentional and accidental opioid overdose on 10/2/15, and UTI on 10/5/15; and Individual #82 – superficial ocular infection to the left eye on 12/28/15, and dental abscess on 5/17/16.

a. The individuals displaying signs and symptoms of an acute illness and/or acute occurrence for whom nursing staff performed assessments (physical assessments) in alignment with nursing guidelines and the individuals' needs were Individual #184 – impaired skin integrity on 4/18/16, Individual #141 – conjunctivitis on 2/17/16, Individual #130 – abdominal distension on 2/21/16, Individual #189 – UTI on 10/5/15, and Individual #82 – superficial ocular infection to the left eye on 12/28/15, and dental abscess on 5/17/16.

b. The acute illnesses/occurrences for which documentation showed licensed nursing staff timely informed the practitioner/physician of signs/symptoms were: Individual #141 – conjunctivitis on 2/17/16; Individual #130 – abdominal distension on 2/21/16; Individual #189 – unintentional and accidental opioid overdose on 10/2/15, and UTI on 10/5/15; and Individual #82 – superficial ocular infection to the left eye on 12/28/15, and dental abscess on 5/17/16.

e. and f. The acute care plan for Individual #82's superficial ocular infection to the left eye on 12/28/15 met the individual's needs, which was good to see. Unfortunately, evidence was not present to show it was implemented.

Common problems with the remaining acute care plans reviewed included a lack of: instructions regarding follow-up nursing assessments that were consistent with the individuals' needs (the exceptions were Individual #184 – impaired skin integrity on 4/18/16, Individual #120 – otorrhea on 2/5/16, Individual #141 – conjunctivitis on 2/17/16, Individual #162 – impaired skin integrity on 2/3/16, and Individual #130 – ileus on 5/2/16, and abdominal distension on 2/21/16); alignment with nursing guidelines (the exceptions were Individual #162 – impaired skin integrity on 2/3/16, and Individual #130 – ileus on 5/2/16, and abdominal distension on 2/21/16); specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; clinical indicators nursing would measure; and the frequency with which monitoring should occur (the exceptions were Individual #184 – impaired skin integrity on 4/18/16, Individual #162 – impaired skin integrity on 2/3/16, and Individual #130 – ileus on 5/2/16, and abdominal distension on 2/21/16).

f. The individual whose acute care plan was implemented was Individual #130 for abdominal distension on 2/21/16.

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

- IPNs, dated 2/3/16, indicated that during an off-campus doctor's appointment, the physician noted Individual #120 had drainage from both ears and prescribed eardrops. No nursing assessments of his ears were documented in the days prior to this appointment, and an acute care plan was only initiated after the eardrops were ordered. Moreover, on 2/3/16 and 2/4/16, the nursing IPNs did not address drainage from Individual #120's ears, but rather focused on a fall that occurred while Individual #120 was at his appointment on 2/3/16. The acute care plan, dated 2/5/16, did not specify the criteria for assessment, including visualizing the tympanic membranes and documenting an assessment per protocol for an ear assessment. This is a major part of an ear assessment for nursing staff. Documented nursing assessments did not use consistent assessment criteria. As a result, it was not possible to determine if healing or resolution was progressing appropriately. In fact, a nursing IPN, dated 2/12/16, noted white discharge from the left ear and an order from the PCP to continue the ear drops twice daily for five more days. However, no nursing assessments were conducted after 2/12/16.
- On 3/23/16, an IPN noted a bruise on Individual #120's foot, but it was unclear whether the PCP was notified. On 3/24/16, Individual #120 was diagnosed with a fracture to his great right toe, but the nursing acute care plan was not initiated until 3/31/16. However, on 3/28/16, nursing staff noted that the acute issue was resolved, prior to initiating the plan. No documentation was submitted supporting resolution of the acute issue. Moreover, no nursing IPNs were found for the period between 3/24/16 and 4/11/16.
- For Individual #162, nursing staff did not develop an acute care plan or document monitoring after the surgical repair of her hiatal hernia for which she had a 7.5-inch suture line. After returning to CCSSLC from the hospital on 3/12/16, on 3/13/16, she was readmitted to the hospital for a fever and respiratory distress. She was discharged from the hospital on 4/4/16, but the post-hospital assessment did not mention the incision from the surgery for the hiatal hernia.
- The acute care plan for Individual #189 for the accidental opioid overdose did not include all of the necessary nursing assessment criteria. For example, this individual was at higher risk of aspiration due to the decreased respiratory status from the effects of the Ativan/morphine patch. In addition to checks of his respiratory status, the acute care plan should have included assessments of intake and output, neurological checks, skin checks for rashes or hives, etc., but did not.

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.

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

#	Indicator	Overall Score	Individuals: 184	120	141	162	130	251	189	82	136
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	39% 7/18	0/2	2/2	0/2	1/2	1/2	2/2	0/2	1/2	0/2

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

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #184 – falls, and weight; Individual #120 – cardiac disease, and fractures; Individual #141 – infections, and behavioral health; Individual #162 – aspiration, and constipation/bowel obstruction; Individual #130 – constipation/bowel obstruction, and UTIs; Individual #251 – dental, and falls; Individual #189 – behavioral health, and skin integrity; Individual #82 – behavioral health, and weight; and Individual #136 – weight, and infections).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #120 – cardiac disease, and fractures; Individual #162 – aspiration; Individual #130 – UTIs; Individual #251 – dental, and falls; and Individual #82 - weight.

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

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.											
Summary: Given that over the last three review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/1
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

IHCPs to address them.

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

The following provide a few examples of concerns noted:

- Individual #162 was in the hospital with weight loss, mild malnutrition, and Clostridium difficile (C-diff) with an episode of constipation on 5/1/16. However, the IDT did not add regular proactive nursing assessments to the IHCP. The Medical Director conducted a review of Individual #162's 2/27/16 hospitalization, and determined she needed to have a constipation protocol with interventions implemented earlier than three days given that she was at high risk of complications due to a dilated colon. No intervention was initiated in response to the Medical Director's recommendation.
- Individual #130's IHCP was not updated after he experienced a second ileus. No ISPA to address this episode was submitted.
- Individual #189 had long-term issues with skin excoriation due to J-tube leakage, but his IHCP did not require nursing staff to conduct proactive assessments of his skin.
- Individual #82's IDT rated him as being at high risk with regard to behavioral health. However, his IHCP did not contain proactive nursing assessments (e.g., mood, sleep patterns, pain, anxiety, aggression, blood sugars). In May 2016, he was assigned one-to-one staffing due to the risk of self-injury or suicide, and he had several episodes of unauthorized departures from the Center. However, the IDT did not make changes to his IHCP interventions.
- Individual #82 continued to gain weight, but the IDT did not add assertive interventions to the IHCP. No ISPAs were submitted that addressed the weight gain, and no analysis was found in the documents submitted.
- In May and June 2016, Individual #136 continued to lose weight, but the IDT did not increase the frequency with which weight measurements were obtained. No analysis of the individual's weight loss was found in the documents submitted. Of note, it had been difficult to obtain accurate weights for Individual #136 due to his large wheelchair and tremors. It was unclear why the IDT waited until his ISP meeting in April 2016 to obtain a scale that would allow more accurate measurement of his weight. By this time, his weight had become a high-risk issue.

Outcome 6 – Individuals receive medications prescribed in a safe manner.	
Summary: As was illustrated during the onsite review, breaches in required medication administration practices have the potential to place individuals at significant risk. As discussed on site and further confirmed through document review, nurses were passing Medication Observations conducted at the Center despite failures in key areas (e.g., PNMP implementation, completion of lung sounds for individuals at high risk for aspiration with recent respiratory issues), and/or follow-up checks were not completed for lengthy periods of time (e.g., over a month later). As a result, the Center did not have a system for identifying and addressing	Individuals:

significant concerns related to medication administration. Given the importance of these indicators to individuals' health and safety the Monitoring Team will continue to review them until the Center's quality assurance/improvement mechanisms related to medication administration can be fully assessed and are deemed to meet the requirements of the Settlement Agreement.											
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	Individual receives prescribed medications in accordance with applicable standards of care.	75% 12/16	2/2	2/2	2/2	0/2	2/2	2/2	0/1	1/1	1/2
b.	Medications that are not administered or the individual does not accept are explained.	57% 4/7	1/1	N/A	1/1	0/1	N/A	1/1	0/1	1/1	0/1
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).	86% 6/7	1/1	1/1	1/1	0/1	1/1	1/1	N/A	N/A	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	N/A									
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	0% 0/2	N/A	N/A	N/A	0/1	0/1	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.	29% 2/7	N/A	0/1	0/1	0/1	1/1	N/A	0/1	1/1	0/1
f.	Individual's PNMP plan is followed during medication administration.	86% 6/7	1/1	1/1	1/1	0/1	1/1	1/1	N/A	N/A	1/1

g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	86% 6/7	1/1	1/1	1/1	0/1	1/1	1/1	N/A	N/A	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/A									
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/A									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	44% 4/9	1/1	1/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1
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.	17% 1/6	N/A	N/A	1/1	0/1	0/1	0/1	0/1	N/A	0/1

Comments: The Monitoring Team conducted record reviews for nine individuals and observations of seven individuals, including Individual #184, Individual #120, Individual #141, Individual #162, Individual #130, Individual #251, Individual #189 (deceased so no observation), Individual #82 (record review only), and Individual #136.

a. and b. Problems noted included:

- As discussed in more detail below, prior to administering Individual #162's medications, the nurse placed Individual #162 in a position that was inconsistent with her PNMP. Individual #162 experienced respiratory distress, and the nurse did not react to the distress, and the Nurse Educator needed to prompt the nurse regarding how to complete lung sounds and to suction the individual. Her medications were not administered. This was considered a failed medication pass.
- On 6/10/16, Individual #162's MAR noted that the Scopolamine patch TD 3 every three days was removed due to finding one already on her right arm. No variance form was submitted. In addition, on 5/13/16, there was a MAR blank also for the patch with no explanation.
- The MARs for Individual #I89 were illegible, at times. In addition, there were some unexplained MAR blanks, and some blanks circled without explanation. There were blanks on the pain scale ratings for Morphine. As a result of the blanks and illegibility, the effectiveness of the medications could not be determined.
- For Individual #136, a number of omissions and/or documentation errors occurred, and it was unclear whether or not nursing staff notified the PCP.

d. During the onsite observation, Individual #162 began coughing and showing other signs of respiratory distress after the Nurse Educator noted her current position was not in alignment with the PNMP pictures, and staff tried to reposition her. More specifically, the medication nurse along with direct support professional staff let the back of the wheelchair down to pull her up in her chair. The

nurse did not engage the brake. The Monitoring Team member observing noted the brake was not engaged, and also asked why Individual #162 was placed in a position that looked like it was flat, which was not consistent with the PNMP. Once Individual #162 was seated upright, the medication nurse felt behind her back and stated there was still a gap, but it was "close enough." The Nurse Educator then noted Individual #162 still did not look like she was in the correct position and prompted the nurse to again reposition her. By this time, the individual was starting to cough intermittently and after the residual was checked, the Nurse Educator prompted the nurse to listen to her lungs sounds. The nurse initially tried to listen over the individual's clothing, but then randomly placed the stethoscope on the skin. The Nurse Educator intervened by instructing the medication nurse to start at the top and compare one side to the other. While Individual #162 continued to actively demonstrate signs and symptoms of respiratory distress, the medication nurse, when prompted by the Nurse Educator began looking for a pulse oximeter, and when one was not found in the room, she had to leave the room to find one. Upon her return, a pulse oximeter was placed on the individual and the initial reading was 90% oxygen (O2) saturation rate with a heart rate of 50. The individual continued to cough more frequently with struggle and an audible gurgle and congestion was noted without a stethoscope. The Nurse Educator directed the medication nurse and direct support professional to take the individual to her room to be suctioned, which they promptly did. However, after the nurse placed the suction catheter by and around the individual's mouth, she began to insert it into the tracheostomy tube. The Nurse Educator said: "No," and proceeded to open a new sterile suctioning kit and began to suction the individual. Her O2 saturation rate during this time was 85% with the intermittent suctioning, and the Nurse Educator instructed staff to call a 6333 (i.e., emergency code) in response to the individual's increased struggle to breathe and struggle in her wheelchair. At one point, the individual's O2 saturation rate was 79% and her heart rate was down to 44. As staff arrived in response to the 6333, the Monitoring Team member exited from the room. After a meeting with the Nurse Educator and Lead Monitor, the Lead Monitor requested a meeting with the Facility Director. A meeting was held with the Facility Director, Assistant Director of Programs (ADOP), Lead Monitor, and nurse on the Monitoring Team within the hour of the incident. Thus, although the administration of medication was not directly observed, the concerns observed related to inappropriate positioning, inability of the medication nurse to obtain accurate lung sounds, problems with suctioning, and insufficient response to an episode of respiratory distress constituted a failed medication observation. The Nurse Educator's Observation form included findings that were in alignment with the Monitoring Team member's findings.

Based on the Monitoring Team's review of the Tracheostomy Suctioning Skills Checklists from October and November 2015, and January through June 2016, it appeared that the methodology for determining nurses' competence with this skill was to have the nurse verbalize the steps/process, as opposed to observing nurses suctioning individuals with tracheostomies. If this interpretation of the data the Center provided is correct, then the Center is not using a valid methodology to determine the nurses' competence, especially for those nurses who work with individuals that have tracheostomies and require suctioning. Interestingly, for all the Checklists reviewed for eight months, all nurses "observed" passed the skills checklist with 100% success.

For Individual #130, the medication nurse initially tried to assess lung sounds over the individual's clothes, which is an inappropriate procedure. When asked if she heard anything from the lung sound assessments, she reported she heard rales in the upper lobe. However, she did not note this prior to medication administration and had to be prompted to complete a full respiratory assessment in response to the abnormal findings.

e. At times, nursing staff did not document the individual's reaction or the effectiveness of the PRN or STAT medication.

f. As discussed above, the medication nurse for Individual #162 did not follow the PNMP. Subsequently, Individual #162 experienced respiratory distress.

g. With one significant exception, for the individuals observed, nursing staff followed infection control practices. The exception was for Individual #162, for whom the nurse began to suction her tracheostomy with a non-sterile catheter. Fortunately, the Nurse Educator intervened.

h. For the records reviewed, evidence was not present to show that nursing staff provided instructions to the individuals and their staff regarding new orders or when orders changed.

i. When a new medication was initiated, when there was a change in dosage, and after discontinuing a medication, documentation was not present to show individuals were monitored for possible adverse drug reactions.

j. and k. For the individuals reviewed, Facility staff did not identify any possible ADRs.

l. Examples of problems noted with regard to medication variances included:

- Individual #162 and Individual #130 had a number of missed doses of medications, but the variance forms did not indicate the PCP was notified.
- For Individual #251, the PCP was notified of a missed dose, but it was unclear whether or not the PCP provided further instruction.
- For Individual #189, in addition to the concerns noted above with regard to the MARs, documentation was found indicating that she experienced an unintentional Opioid overdose on 10/2/15.
- As noted above, for Individual #136, a number of omissions and/or documentation errors occurred, and it was unclear whether or not nursing staff notified the PCP. This was particularly concerning, because it appeared her respiratory status was declining, when some of the omissions were for medications prescribed to address her respiratory diagnoses. In fact, in a post-hospitalization review, the Medical Director suggested changes to antibiotics, as well as medications prescribed to address her bronchitis and asthma. If the problem or part of the problem was that nursing staff were not properly administering these medications, then action should have been taken immediately to ensure Individual #136 received her prescribed medications.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.	
Summary: It was good to see that referrals were made to the PNMT for 83% of individuals reviewed that met criteria. This was an improvement from the last two reviews, when 67% and 60% of individuals were appropriately referred. Overall, though, IDTs and/or the PNMT did not have a way to measure outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.	Individuals:

#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/13	0/2	0/1	0/2	0/1	0/1	0/2	0/1	0/2	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	31% 4/13	0/2	0/1	0/2	1/1	0/1	1/2	0/1	1/2	1/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/13	0/2	0/1	0/2	0/1	0/1	0/2	0/1	0/2	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/13	0/2	0/1	0/2	0/1	0/1	0/2	0/1	0/2	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/13	0/2	0/1	0/2	0/1	0/1	0/2	0/1	0/2	0/1
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	83% 5/6	1/1	1/1	N/A	1/1	0/1	N/A	1/1	N/A	1/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	0/1	0/1		0/1	0/1		0/1		0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	33% 2/6	0/1	1/1		0/1	1/1		0/1		0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/6	0/1	0/1		0/1	0/1		0/1		0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/6	0/1	0/1		0/1	0/1		0/1		0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/1	0/1		0/1	0/1		0/1		0/1
Comments: The Monitoring Team reviewed 13 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: falls, and choking for Individual #184; gastrointestinal (GI) problems for Individual #120; aspiration, and falls for Individual #141; skin integrity for Individual #162; skin integrity for Individual #130; choking, and aspiration for Individual #251; aspiration for Individual #189; weight, and fractures for Individual #82; and aspiration for											

Individual #136.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: GI problems for Individual #120, skin integrity for Individual #162, choking for Individual #251, fractures for Individual #82, and aspiration for Individual #136.

b.i. The Monitoring Team reviewed six areas of need for six individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: weight for Individual #184, fractures for Individual #120; aspiration for Individual #162; aspiration for Individual #130, GI problems for Individual #189, and weight for Individual #136.

The PNMT began reviewing Individual #130 when he had pneumonia in September 2013. Reviews continued in March 2014 for skin issues and constipation, and again in September 2014, May 2015, and July 2015. Although his risk for aspiration was high and he had multiple pneumonias, the IDT had not submitted another referral and the PNMT had not conducted a thorough assessment.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT had not developed clinically relevant, achievable, and measurable goals/objectives for these five individuals. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: fractures for Individual #120, and aspiration for Individual #130.

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

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.

Summary: The Center made no progress, and with regard to IDTs taking immediate action when the PNM risk to the individual warranted it, some regression was noted. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 184	120	141	162	130	251	189	82	136
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.	6% 1/18	1/2	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	17%	N/A	1/1	N/A	0/1	0/1	N/A	0/2	N/A	0/1

	status, there is evidence the team took immediate action.	1/6									
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, the IHCP for which documentation was found to confirm the implementation of the PNM action steps that were included was for choking for Individual #184.

b. The following summarizes problems related to IDTs' responses to changes in individuals' PNM status:

- Despite significant weight loss between February and March 2016, as well as multiple pneumonia diagnoses, the PNMT only conducted a review of Individual #162.
- The PNMT began reviewing Individual #130 when he had pneumonia in September 2013. Reviews continued in March 2014 for skin issues and constipation, and again in September 2014, May 2015, and July 2015. Although his risk for aspiration was high and he had multiple pneumonias, the IDT had not submitted another referral and the PNMT had not conducted a thorough assessment.
- Individual #189 had multiple changes in formula, increased emesis, and significant leakage at the site of the J-tube. The PNMT chose not to complete a full assessment. Due to the implications on weight, emesis, positioning, and nutrition, a PNMT assessment was warranted. In addition, the individual's head-of-bed evaluation (HOBE) was not reviewed and reassessed upon initial referral in May 2014. In December 2014, after Individual #189 was diagnosed with pneumonia, therapists redid the HOBE evaluation.
- Between November 2015 and December 2015, Individual #136 experienced a weight loss of 22 pounds, but the IDT did not make a referral to the PNMT until April 2016. Due to multiple issues occurring simultaneously, including weight loss as well as decreased stability, and decreased ability to feed himself and to self propel, a comprehensive assessment was warranted, but was not provided.

c. For Individual #120, an ISPA was not found documenting his discharge from the PNMT, sharing of information with the IDT, and changes, as appropriate to his IHCP(s).

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.	
Summary: During numerous observations, staff failed to implement individuals' PNMPs as written. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.	

#	Indicator	Overall Score

a.	Individuals' PNMPs are implemented as written.	40% 16/40
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.	25% 1/4
Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during three out of six observations (50%). Staff followed individuals' dining plans during 11 out of 31 mealtime observations (35%). Transfers were completed correctly two out of three times (67%).		

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: N/A			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
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									
Comments: 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: For individuals reviewed, IDTs overall did not have a way to measure outcomes related to formal OT/PT services and supports, and often IDTs had not developed supports to address unmet needs. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	13% 1/8	0/1	0/1	0/1	0/1	0/1	1/1	0/1		0/1
c.	Integrated ISP progress reports include specific data reflective of the	13%	0/1	0/1	0/1	0/1	0/1	1/1	0/1		0/1

	measurable goal.	1/8									
d.	Individual has made progress on his/her OT/PT goal.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1

Comments: a. and b. Individual #82 had functional motor and self-help skills, so a goal/objective was not indicated. A number of individuals reviewed had OT/PT needs that were not addressed through the provision of services and supports.

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

Individual #82 was part of the core group, and so the Monitoring Team conducted full monitoring of his supports and services. For the remaining eight individuals, full reviews were conducted due to a lack of clinically relevant, achievable, and measurable goals/objectives to address areas of OT/PT need, and/or because integrated ISP progress reports did not provide an analysis of related data.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: Minimal improvement was seen from the last review with the Center's scores for these indicators (i.e., 0% for a, and 0% for b). The Monitoring Team will continue to review them.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	40% 2/5	0/1	N/A	N/A	0/1	0/1	1/1	1/1	N/A	N/A
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/2	0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. Some examples of the problems noted included:

- Lack of evidence in integrated ISP reviews that supports were implemented.
- Summaries indicated lapses in or lack of implementation.

b. Problems noted included:

- For Individual #184, there was no evidence that the IDT met to discuss putting the walking program on hold or discontinuing it.

- For Individual #141, no ISPA was found to show that the IDT discussed discharging her from direct PT therapy services.

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

Summary: Given that for Round 9 and during this review, individuals observed generally had adaptive equipment that was in working order (Round 9 – 89%, Round 10 – not rated, and Round 11 - 95%), Indicator b will move to the category requiring less oversight. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's varying scores (Round 9 – 78%, Round 10 – not rated, and Round 11 - 68%), this indicator will remain in active oversight. The Center's scores for the indicator rated to cleanliness varied (Round 9 – 78%, Round 10 – not rated, and Round 11 - 86%), so it will also remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators.

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

#	Indicator	Overall Score	Individuals: 311	111	190	67	128	372	56	200	91
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	86% 32/37	1/1	1/1	1/1	2/2	1/1	0/1	1/1	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	95% 35/37	1/1	1/1	1/1	2/2	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	68% 25/37	1/1	0/1	1/1	2/2	0/1	1/1	0/1	1/1	1/1
		Individuals:									
#	Indicator		278	194	307	9	280	376	334	272	236
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	2/2	0/1	1/1	2/2	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	2/2	1/1	1/1	2/2	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	2/2	1/1	1/1	2/2	1/1	1/1
		Individuals:									
#	Indicator		303	222	50	163	356	68	328	250	154

a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1	0/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
		Individuals:									
#	Indicator		340	44	297	209	290	229	207		
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	1/1	1/1	1/1		
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	1/1	1/1	1/1	1/1		
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	1/1	1/1	1/1	1/1	1/1	1/1		

Comments: a. The Monitoring Team conducted observations of 37 pieces of adaptive equipment. Individual #372 had what appeared to be dried food on her lap tray. Individual #280 had dried food in the seat of the wheelchair and between the cushion and frame. Individual #50's footrest had what appeared to be tears on it. Individual #68's footrest pad was ripped and dirty. Individual #154's left footrest was torn.

b. Individual #68's footrest continuously slid off the chair, resulting in the individual banging her heels against the rest. Individual #328's Heelbos continuously slid down the individual's forearm.

c. Based on observation of Individual #111, Individual #303, Individual #50, Individual #163, Individual #356, Individual #250, Individual #154, and Individual #340 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors. In addition, Individual #56's elbow pads appeared loose, and slid down on her forearm while she was hitting her elbow against her wheelchair. Individual #328's Heelbos continuously slid down the individual's forearm.

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

This Domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition, and communication. None of these indicators will be moved the category of requiring less oversight.

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

When personal goals are developed for all areas of the ISP, IDTs will be able to assess progress.

Skill acquisition plans existed for each individual, but only a few had reliable data from which progress could be determined. Only one of these was progressing. This might be due to the finding that skill acquisition plans were inadequate in terms of content and implementation quality. It was, however, good to see that IDTs were using whatever data they did have, including graphic summaries, to help inform decision making about their SAP programming.

Most individuals were regularly engaged in activities. The Center had a reasonable system for measuring engagement in activities, and had set reasonable goals, but these were not yet met.

For the individual reviewed for whom this was applicable, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals.

IDTs generally did not have a way to measure clinically relevant outcomes with regard to individuals' communication skills. No improvement was seen with regard to staff's implementation of communication strategies and actions plans for the individuals reviewed. In addition, it was concerning that individuals observed did not have access to nor were they using augmentative and alternative communication (AAC)/ Environmental Control (EC) devices functionally.

It was good to see improvement with regard to IDTs meeting to discuss termination of communication services and supports, as needed for the individuals reviewed.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.	
Summary: Given that goals were not yet individualized and did not meet criterion with ISP indicators 1-3, the indicators of this outcome also did not meet criteria.	Individuals:

The handful of goals that were developed were not implemented and/or not reviewed. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	184	123	300	120	141	162			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

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

4-7. Overall, personal goals did not meet criterion as described above, therefore, there was no basis for assessing progress in these areas. See Outcome 7, Indicator 37 for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans.

For the two living options goals that met criterion for indicator 1, neither met criterion with these indicators because there had been no implementation of related action plans.

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	184	123	300	120	141	162			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
39. Staff knowledge regarding individuals' ISPs was insufficient to ensure the implementation of the ISP, based on observations, interviews, and lack of consistent implementation. That being said, some direct support professionals, particularly for Individual #141, were knowledgeable of many supports in some areas. This was positive to see.

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

Skill Acquisition and Engagement

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

Summary: The facility was unable to demonstrate progress, in part, due to inadequate data collection. Even so, actions were usually not taken when an individual was not making progress. It was, however, good to see that IDTs were using whatever data they did have to help inform decision making about their SAP programming. These four indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	184	372	20	123	171	300	199	120
6	The individual is progressing on his/her SAPS	4% 1/27	0/3	0/3	0/3	0/3	0/3	0/3	1/3	0/3	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	33% 4/12	1/2	0/1	0/1	0/2	0/3	1/1	N/A	1/1	1/1
9	Decisions to continue, discontinue, or modify SAPs were data based.	100% 27/27	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3

Comments:

6. Good, reliable data were available for five SAPs (see skill acquisition indicator 5). One of these was progressing (Individual #300 – tobacco cessation). The facility reported that there was progress in 14 other SAPs. This included two programs for Individual #184 (sanitize hands, play darts) that had been in place for three months and reflected stable performing, Individual #20's learning to communicate with others in the community, laundry and street crossing SAPs for Individual #171, and the other two SAPs for Individual #300.

7. The facility's monthly review for Individual #372 noted that she could independently fold her clothes. There was no evidence that this SAP was updated or replaced with an alternative plan.

8. There was evidence of action planned or taken for four of 12 SAPs in which progress was not noted. This included a plan for the team to meet (Individual #38 – fan use), a plan to talk with the individual about his refusal to participate (Individual #120 – bus use), or a revision to the SAP (Individual #171 – anger management, Individual #199 – money management).

9. In all 27 SAPs, there was evidence that data were reviewed by the individuals' teams. As discussed with the director of education and training, it would be helpful to consider prompt levels when reporting on progress or the lack thereof. In some cases, reviewed in indicator 17 below, there was evidence that successful trials were reported regardless of the level of prompt utilized to obtain a correct response.

Outcome 4- All individuals have SAPs that contain the required components.												
Summary: As noted in the comments below, some good progress was observed. With continued efforts and progress, it is possible that higher scores will be obtained at the time of the next review. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
13	The individual's SAPs are complete.	0% 0/27	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3

Comments:

13. Although none of the SAPs were considered complete, there were some very positive components of these plans.
    - Reinforcers identified in the SAPs were individualized with standard practice being to offer the individual a choice.
    - Maintenance and generalization plans were clearly outlined and appropriate to the SAP.
    - Complete behavioral objectives and clear operational definitions were provided in most of the SAPs.

Areas in need of improvement include providing clear instructions in how to teach the skill (including how to set up the learning environment), increased opportunities for SAP training to occur, and clearer descriptions of steps to take when errors occur. Staff are also advised to ensure that prompt levels acceptable for correct responding correspond to those identified in the behavioral objective.

The facility is commended for the ongoing review of SAPs conducted by the Skill Acquisition Review Committee. An observation of the weekly meeting of this committee revealed good discussion with an openness to consider suggestions made by all participants. Staff are advised to conduct baseline assessment of the individual's performance on the terminal objective before training begins. This will ensure that repeated exposure to the SAP does not result in skill acquisition. Further, staff are advised to conduct periodic probes of the individual's performance on the terminal objective after training has begun to determine whether the individual has mastered the skill (e.g., Individual #123 – socialization, Individual #120 – anger management). Lastly, staff are advised to review Cooper, Heron, and Heward (2007) to ensure there is a clear understanding of the difference between shaping a behavior and learning a behavioral chain.

Outcome 5- SAPs are implemented with integrity.											
Summary: Ensuring SAP integrity is a very important aspect of this domain. Much more progress will be needed for these indicators to meet criteria. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
14	SAPs are implemented as written.	33% 2/6	N/A	N/A	0/1	N/A	1/1	0/1	1/1	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	19% 5/27	0/3	1/3	0/3	1/3	2/3	0/3	1/3	0/3	0/3

	achieved.										

Comments:
14. Two of the six SAPs that were observed were implemented as written. These were the socialization SAP for Individual #123 and the tobacco use cessation SAP for Individual #300. For the four other SAPs, either the staff member did not introduce the training as indicated (Individual #372 – hand sanitizing), additional prompting was not provided as required (Individual #171 – anger management), a model was used that was not identified in the SAP (Individual #199 – money management), or the individual was asked to verbalize his response rather than demonstrating his response (Individual #120 – anger management). Of the remaining three individuals, the SAP for Individual #38 had been recently discontinued, Individual #184 had left his home at the scheduled observation time, and Individual #20 declined to participate.

15. As of 6/13/16, SAP integrity monitoring occurred three times per week in each home. This was increased from the previous standard of two checks per week per home. A goal level of 75% had been established. Of the individuals reviewed, there was evidence that at least one integrity check had been completed one or two SAPs for four individuals (Individual #184, Individual #20, Individual #123, Individual #300). An observation of SAP integrity checks conducted during scheduled SAP training revealed immediate feedback to staff, with positive and constructive feedback provided immediately after training.

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

Summary: These two indicators received high scores on this review and the previous review. However, given that the indicators related to SAP data and SAP implementation integrity were far from meeting criteria, these two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	184	372	20	123	171	300	199	120
16	There is evidence that SAPs are reviewed monthly.	96% 26/27	2/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3
17	SAP outcomes are graphed.	93% 25/27	3/3	3/3	3/3	3/3	3/3	3/3	2/3	2/3	3/3

Comments:
16. All, but one SAP, were reviewed in the individual's monthly review. The exception was Individual #38's use of a fan in her home.

17. In 25 of 27 SAPs, data were presented in graphic format in the monthly review. The exceptions were the tobacco cessation program for Individual #300 in which data were presented in a table, but not graphed, and the community seatbelt program for Individual #199 in which it was noted that data were missing for May 2016, although data were included for July 2016 on the graph. Consistently, more than one data path was presented on the graphs without explanation. Further, in at least one case (Individual #184), raw data reflected varying levels of prompting used to support correct responding (e.g., verbal prompts and partial physical prompts used during hand sanitizing training). This was not clearly presented in graphic format because all trials were grouped together to indicate "frequency of successful trials." Staff are advised to carefully label the vertical axes on all graphs to ensure that independent versus prompted performance can be determined.

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
Summary: It was good to see that Corpus Christi SSLC measured engagement and had goals for engagement and, moreover, that most individuals were meaningfully engaged when observed by the Monitoring Team. The latter was an improvement from the last review. The facility, however, did not meet its goal levels. Likely, the facility will continue to work on these indicators. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
18	The individual is meaningfully engaged in residential and treatment sites.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

18. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. All, but one individual (Individual #38), were actively engaged during the majority of observations.

19. As reported by the facility, engagement was assessed three times each week in each home. Prior to 6/13/16, engagement was assessed twice in each home. Engagement in day programs and work sites was to be assessed weekly.

20. Established goal engagement levels were 75% for the Atlantic unit, 65% for the Pacific unit, 50% for the Coral Sea unit, and 90% in the day program and work sites.

21. While the data provided indicated that goal levels had been achieved in all of the individual's residences over a six-month period, data were not reported for the day program and work sites.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.	
Summary: Community outings occurred, but did not meet criteria for this indicator. Community SAP training occurred for some individuals, but also did not meet criteria. It was good to see that outings were occurring. With additional work, it is likely that the facility can make progress on these indicators. All three will remain	Individuals:

in active monitoring.											
#	Indicator	Overall Score	38	184	372	20	123	171	300	199	120
22	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
22. Although none of the individuals had goal frequencies of community recreational activities identified in their ISPs, the director of educational and training explained that the expectation was for residents of the Atlantic unit to go out twice weekly, residents of the Pacific unit to go out twice monthly, and residents of the Coral Sea unit to go out once monthly. There was evidence that multiple trips occurred for all of the individuals over a six-month period or since admission (i.e., Individual #199).

23. Similarly, none of the individuals had goal frequencies of SAP training in the community included in their ISPs. The expectation was for community-based training to occur once each week for residents of the Atlantic unit, twice each month for residents of the Pacific unit, and one each month for residents of the Coral Sea unit. There was evidence that monthly community-based SAP training had occurred for five individuals (Individual #184, Individual #372, Individual #20, Individual #171, Individual #300).

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
Summary: This indicator was not assessed during this review because there were no individuals who were entitled to, or received, educational services. This indicator will remain in active monitoring so that it can be assessed if applicable at the next review.			Individuals:								
#	Indicator	Overall Score									
25	The student receives educational services that are integrated with the ISP.	N/A									

Comments:
25. None of the nine individuals were of school age. The facility reported that there were no individuals in residence who were participating in school.

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
Summary: For the individual reviewed with dental refusals, the IDT did not have a way to measure clinically relevant outcomes related to the refusals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/1								0/1	
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/1								0/1	
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/1								0/1	
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/1								0/1	
Comments: According to documentation the Facility submitted, on 3/21/16, Individual #82 refused to allow the dentist to perform an oral health rating. The only response in the ISP was to indicate that direct support professionals should "encourage" the individual to attend all of his dental appointments and notify the nurse if he did not.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: The Center had made no progress on these indicators. They will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	184	120	141	162	130	251	189	82	136
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	25% 2/8	0/1	N/A	1/1	0/1	0/1	0/1	0/1	0/1	1/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	38% 3/8	0/1	N/A	1/1	0/1	1/1	0/1	0/1	0/1	1/1

c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	13% 1/8	0/1	N/A	1/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. Individual #120 had functional expressive and receptive skills, so a goal/objective in this area was not needed. The goals/objectives that were clinically relevant, as well as measurable were Individual #141's goal/objective related to independently signing to use the bathroom, and Individual #136's goal/objective related to making a choice using a sign, single word approximation, or picture representation.

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #130's goal to turn his head towards the light.

c. through e. Although Individual #141's goal/objective was measurable and appeared to be clinically relevant, progress had not been made. The plan called for successful completion of 25 out of 30 trials per month, but Individual #141 had only completed 20 in February 2016, 10 in March 2016, and zero in April and May 2016. No action steps had been taken, including, for example, a team meeting to determine the reason for the lack of trials/exposure and possible modifications to the goal/objective.

Individual #136's Integrated ISP reviews did not include data on his direct therapy goal/objective, despite the fact that it appeared the Speech Language Pathologist (SLP) was collected data.

Individual #120 was part of the core group, so a full review was completed. For the remaining eight individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives, and/or a lack of IDT analysis and/or action when progress did not occur.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.

Summary: No improvement was seen with regard to staff's implementation of measurable communication strategies and actions plans for the individuals reviewed. It was good to see improvement with regard to IDTs meeting to discuss termination of communication services and supports, as needed for the individuals reviewed. The Center's score during the previous review was 0%. The Facility will need to demonstrate sustained improvement with this indicator.

#	Indicator	Overall Score	Individuals: 184	120	141	162	130	251	189	82	136
a.	There is evidence that the measurable strategies and action plans	17%	N/A	N/A	0/1	0/1	0/1	N/A	0/1	0/1	1/1

	included in the ISPs/ISPAs related to communication are implemented.	1/6									
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	100% 4/4	N/A	N/A	1/1	1/1	N/A	1/1	N/A	N/A	1/1

Comments: a. Examples of problems included:

- As noted above, Individual #141's plan called for successful completion of 25 out of 30 trials per month, but Individual #141 had only completed 20 in February 2016, 10 in March 2016, and zero in April and May 2016. No action steps had been taken, including, for example, a team meeting to determine the reason for the lack of trials/exposure and possible modifications to the goal/objective.
- In December 2015, Individual #162 was discharged from direct therapy with a recommendation to resume direct therapy in May 2016. However, there was no evidence this occurred in May 2016, and no reason provided as to why it did not occur. On 7/14/16, the SLP reinitiated direct therapy, but this was two months after it was slated for initiation, and after the Center received the list of individuals the Monitoring Team would review.
- For Individual #130, monthly reports indicated his SAP related to responding to lights had not been implemented for the months of April and May 2016.

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: Given the low scores from this review, Center staff should focus on ensuring individuals' AAC/EC devices are available in all appropriate settings, individuals use them functionally, and staff are competent in the use of the devices in relevant contexts and settings.

#	Indicator	Overall Score	Individuals: 162	136	222	372	154	91	251		
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	0% 0/8	0/2	0/1	0/1	0/1	0/1	0/1	0/1		
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	0% 0/8	0/2	0/1	0/1	0/1	0/1	0/1	0/1		
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	0% 0/5									

Comments: a. and b. It was concerning that individuals' AAC devices often were not present or readily accessible, and that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them.

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

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

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

Although some supports in the CLDP reviewed were measurable, more work was needed in this area. Many pre- and post-move supports were missing from the CLDP reviewed, and this should be a focus for Center staff.

It was positive that the Post-Move Monitor conducted timely monitoring for the individual reviewed. Areas in which further efforts were needed related to the PMM basing decisions about supports on reliable and valid data (i.e., it is important that the CLDPs clearly define such data), and IDTs following up in a timely and thorough manner when the PMM notes problems with the provision of supports.

Improvements were needed with regard to the timeliness and quality of transition assessments. Although Center staff provided training to community provider staff, the CLDP did not define the training well, and the training did not appear to meet the individual's needs.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.											
Summary: Although some supports in the CLDP reviewed were measurable, more work was needed in this area. Many pre- and post-move supports were missing from the CLDP reviewed, and this should be a focus for Center staff. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	33								

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

Comments: 1. The IDT developed 38 pre- and post-move supports for Individual #33. The nine pre-move supports were primarily about delivering information and documents to the provider and met criterion in that they were worded in a way that the Post-Move Monitoring (PMM) (and the provider) could determine if the support was provided. The Monitoring Team noted that the CLDP did not contain all necessary pre-move requirements. For example, the pre-move supports did not define any required provider training. Supports should have described training for specific provider staff that included details regarding the content, who was to provide the training, the method for teaching (e.g., didactic, role play, in vivo) and how competency would be assessed (e.g., quiz, verbal report, demonstration). The only training-related support was for the PMM to receive a copy of the final in-service.

Many supports were not measurable and did not provide the Post Move Monitor with criteria or indicators that could be used to ensure supports were being provided as needed. Only five of 29 post-move supports met criterion. Supports that did not meet criterion included 11 that had no evidence defined for review, ostensibly because they were due after the 90-day PMM period. This CLDP should have included specific evidence that would guide the provider's understanding of how the fulfillment of the support could be determined, even if post-move monitoring had concluded. It was encouraging that for individuals with transitions occurring after January 1, 2016, the PMM will conduct periodic monitoring for a year rather than 90 days.

Many of the remaining supports that were not measurable called for participation only, but provided no criteria (e.g., frequency of participation, timeframe to begin, desired outcome) for that participation. Other supports also failed to define criteria or indicators. For example, one support called for the PMM to review the home's menu, but the IDT had included no indicators or criteria by which the PMM would measure success. The only behavioral support was for the PMM to review staff notes for any behavioral issues, but there were no specific indicators describing behaviors for which the provider staff should observe and document or that the PMM should note.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for this indicator to be scored as meeting criterion.

a. Past history, and recent and current behavioral and psychiatric problems: Neither the ISP nor assessments provided sufficient history regarding Individual #33's behavioral and psychiatric needs, and as a result, the CLDP did not sufficiently address them. Examples included:
   - Minimal information was provided about the diagnosis of sexual abuse as a child, his history of self-injury, his prior psychiatric hospitalizations, or the recent allegation of rape/sexual contact. There were several references to pending charges that had delayed the CLDP and were then dismissed, but no detail was provided regarding the nature or recency of the events leading to those charges. Sufficient supports were not included in the CLDP to protect Individual #33 or the community.
   - The ISP and both psychiatric and psychological CLDP assessments called for continuation of the psychiatric support plan (PSP) related to intermittent explosive disorder. The Behavioral Health Specialist (BHS) indicated at the CLDP meeting that the PSP was no longer needed due not only to Individual #33's improved behavior, but also in response to

provider staff indicating PSPs were not used in community settings. This was in contraindication to the Psychiatrist's response to follow-up requesting reconsideration of her recommendations that the PSP be continued. The IDT did not provide sufficient justification for not continuing this support in the community.
    - There was no support requiring specific in-service and/or staff knowledge of Individual #33's behavioral or psychiatric history or any indicators to monitor his status.
    - The only behavioral support called for staff progress notes to be reviewed for any evidence of "behaviors" to be tracked by the community provider for the first 30 days. There were no details regarding the types or nature of behaviors that should be documented.
    - Individual #33 was taking two psychiatric medications, but there was no support for staff knowledge of side effects to be monitored. This was particularly concerning in light of the IDT decision not to implement the psychiatrist's original recommendation for completion of the MOSES/DISCUS.
    - A support called for visits with Individual #33's mother and indicated such visits would require "supervision." There was no rationale or detail about the level of supervision, who should provide it, or why.

b. Safety, medical, healthcare, therapeutic, risk, and supervision needs: There were a number of concerns identified by the Monitoring Team in this area. Examples included:
    - Individual #33's need for supervision was not well defined in the CLDP. There was no support regarding the supervision level, but the narrative indicated he needed basic staff supervision. This was described as staff having knowledge of his whereabouts at all times and that he would be responsible for letting staff know where he was going before he left his house. This appeared to be a definition of the level of supervision he received at the Center, but could have been interpreted, or misinterpreted as the case may be, to be the required level in the community as well. The referral ISPA on 8/17/15 stated Individual #33 required 24-hour awake staff, but no bed checks. It was unclear whether or not the IDT considered how his potential for exploitation, for which he was receiving ongoing training, and the recent allegation of rape were factored into this assessment. The FSA also noted that Individual #33 had recently engaged in sexual contact with a peer on campus and that he might benefit from training related to inappropriate bargaining for items in return for sexual favors. The CLDP did not address this potential. There was also no support for appropriate sexual interactions and no support for staff knowledge related to exploitation/sexual exploitation.
    - There was no support defined for the ophthalmological visit due on 1/28/16, a need noted in the RN assessment.
    - The Dietitian's recommendation for a nutritional assessment within 30 days of transition and annually thereafter was not addressed. It was not reflected in the Nutrition Summary of the CLDP. The IDT agreed to supports to report if he exceeded his estimated desired weight range (EDWR) by 15 pounds and for the PMM to review the menu, but the latter support provided no indication of what the review should include.
    - As noted above, there was a support for Individual #33 to have visits with his mother, but it noted these visits would require supervision. There was no information as to why supervision was needed, by whose authority the supervision was imposed, and/or what the level of supervision should be.
    - There were also no supports regarding staff knowledge of Individual #33's allergy to cedar or his risk for fractures.

c. What was important to the individual: There was some emphasis in the CLDP about what was important to the individual. This was positive. Supports addressed his desire for work, the relationships important to him, participation in Special Olympics, and many of his preferred activities. On the other hand, there was no support that addressed opportunities to visit with friends and staff at CCSSLC, despite his stating he had three friends there whom he wanted to continue to visit. His stated interests in

participating in Boy Scouts and learning to cook were not addressed.

d. Need/desire for employment, and/or other meaningful day activities: The only support related to employment was for Individual #33 to take part in school job explorations. CCSSLC transition staff agreed this was not sufficiently detailed in terms of outcome or measurability. There was a very positive employment outcome, however, in that he had a job exploration trial at Salvation Army and then obtained a job at Gatti's Pizza on his own initiative.
e. Positive reinforcement, incentives, and/or other motivating components to an individual's success: Although not specifically addressed as such, supports referenced many of the things that represented his preferences and picture of a good life. These are motivating factors and this aspect was considered to have met criterion.
f. Teaching, maintenance, participation, and acquisition of specific skills: The CLDP called for continuation of training on exploitation, how to say no, money management, street safety, and using a planner. There was no support included for prompting tooth brushing or daily hygiene. There was also no support developed for cooking, which was indicated as a preference in his PSI and would have taken advantage of an opportunity for community skill-building that was not so readily available at the center.
g. All recommendations from assessments are included, or if not, there is a rationale provided: There were a number of recommendations that were either not addressed or did not have an adequate rationale provided for not being included. These included, for example:
    - Recommendations for verbal prompts for tooth brushing and avoiding sugary snacks were not addressed.
    - Several recommendations in the Nutrition assessment for access to a registered dietitian, an initial assessment within 30 days, and monthly weights were either not addressed or an adequate rationale provided. In the latter case, for example, the IDT based its decision to recommend quarterly weights on the input from the RN Case Manager at the CLDP meeting, but the dietitian was not in attendance nor was her input solicited. OT/PT recommendations for SAPs for hand washing and dining etiquette were not discussed or otherwise included.
    - As discussed above, the IDT did not provide an adequate rationale for not including the psychiatrist's recommendation for continuation of a PSP, or an equivalent.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.

Summary: It was positive that the Post-Move Monitor conducted timely monitoring for the individual reviewed. Areas in which further efforts were needed related to the PMM basing decisions about supports on reliable and valid data (i.e., it is important that the CLDPs clearly define such data), and IDTs following up in a timely and thorough manner when the PMM notes problems with the provision of supports. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	33								
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	100 1/1	1/1								

4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/1	0/1								
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/1	0/1								
6	The PMM's scoring is correct based on the evidence.	100% 1/1	1/1								
7	If the individual is not receiving the supports listed/described in the CLDP, the IDT/Facility implemented corrective actions in a timely manner.	0% 0/1	0/1								
8	Every problem was followed through to resolution.	0% 0/1	0/1								
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A	NA								
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A	NA								

Comments: 3. Post-move monitoring was completed for three visits for Individual #33. Each of these post-move monitoring visits were within the required timeframes, included all locations where the individual lived or worked, were done in the proper format and included comments regarding the provision of every support. The comments were very helpful for the reader to understand how supports were provided and how they were assessed by the PMM.

6. Based on the supports defined in the CLDP, the PMM correctly scored whether supports were correct based on the evidence in most cases. The only exception was a notation at the 90-Day visit on 3/21/16 that Individual #33 had not gained 15 pounds. No weights had been taken since 1/26/16, so there was no basis for that determination. Other evidence also noted he was eating two plates of pizza every day at work and pizza bites for breakfast, which conceivably could have resulted in some weight gain.

The Monitoring Team also noted that the CLDP failed to identify a support regarding level of supervision needs, as it should have. While the PMM had engaged the IDT regarding potential problems with regard to supervision needs related to Individual #33's employment, this did not appear to have been a deliberative process and did not provide a sufficient basis for the PMM to assess whether the individual was receiving supervision appropriate to his needs.

7. through 8. Although the PMM made a good faith effort toward following up on any support that was not being provided, evidence was lacking that the IDT met as needed to deliberate and take action regarding several supports, including the requirement for a medical assessment of ear wax, or for the required supervision levels as described in the paragraph above. A support to visit with his mother had also not occurred. This support was ill-defined, indicating only that it would be ongoing, but the IDT took no action to

facilitate an opportunity for Individual #33 to visit with his mother. 9. through 10. Post move monitoring did not occur during the week of the onsite review. Therefore, these two indicators could not be scored.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of preventable negative events following transition into the community.											
Summary: It was positive that the Center did not report any potentially disrupted community transition events for the one individual reviewed. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	33								
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	100% 1/1	1/1								
Comments: 11. The Facility did not report any PDCT events for Individual #33.											

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.											
Summary: Improvements were needed with regard to the timeliness and quality of transition assessments. Although Center staff provided training to community provider staff, the CLDP did not define the training well, and the training did not appear to meet the individual's needs. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	33								
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/1	0/1								
13	The CLDP or other transition documentation included documentation	0%	0/1								

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

Comments: 12. Twelve assessments were provided for Individual #33's transition. The Center did not review or update the IRRF, but should have, or should have indicated that the IRRF was reviewed and no updates were required. The IRRF section of the ISP typically contains a great amount of information. The Admissions Placement Coordinator (APC) should ensure that the IDTs review the status of the IRRF as part of the transition assessment process.

- Nine of 12 assessments were completed within 45 days of Individual #33's transition. Those that were not within that timeframe included the Medical assessment, completed in July 2015; the Functional Skills assessment, which the CLDP indicated was completed on 7/28/15, but which was signed in 2014; and, the Audiological assessment, which the CLDP indicated was completed on 1/10/15, but the document itself was dated in 2013.
- Assessments were not consistently adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. For example, they did not provide recommendations regarding level of supervision or the potential need for support for safe sexual relationships and how either of these could be implemented in the community.
- Five of Individual #33's assessments provided a reasonable history of his stay at the Center. These were dental, OT/PT, psychiatry, nutritional, and vocational.

13. a) There was documentation the IDT provided training to provider staff. On the other hand, the CLDP summary of transition narrative made a statement that the IDT visited the day habilitation and group home to ensure both provided the supports as required, but there was no documentation of this provided; b) the CLDP did not define staff responsible to provide training or an implementation date; c) the CLDP was reviewed with Individual #33 and he actively participated in the process.

14. Some community provider staff training was completed, but there was insufficient documentation that Center staff provided training that met the needs of the individual. For example, the CLDP narrative stated training was to be provided by the BHS on behaviors to be monitored and how to respond to aggression and property destruction, but no support was defined. The related training documentation provided only included a copy of the Quarterly Psychiatric Review dated 9-17-15. That document referred to an active PBSP to address these symptoms, but no PBSP or any related details were included. The training roster indicated there was only a verbal test for competency, but there was no documentation of results.

15. through 16. These two indicators only apply as needed. Individual #33's CLDP did not, but needs to, indicate that the IDT considered these transition activities, even if there was a determination that the activity was not needed for the individual.

17. For the most part, documentation showed good communication between provider staff and the PMM, who in turn was diligent in her efforts to communicate with the IDT.

18. It was concerning that the Local Intellectual and Developmental Disabilities Authority (LIDDA) had not been invited to the referral meeting. CCSSLC transition staff indicated during the on-site interview this practice would be modified and the LIDDA would be invited in the future.

19. The Pre-Move Site Review indicated some pre-move supports were not in place at the time the review took place, including his planner having been provided and the copy of the final in-service received. The Day of Move Checklist did not provide evidence these were in place at that time, either.

Outcome 5 – Individuals have timely transition planning and implementation.											
Summary: It was positive that for the one individual reviewed a timely transition to the community occurred. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	33								
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	100% 1/1	1/1								
Comments: Individual #33 moved in less than 180 days after referral. His referral date was 7/11/15, and he moved on 12/29/15.											

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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