United States v. State of Texas

Monitoring Team Report

Corpus Christi State Supported Living Center

Dates of Onsite Review: April 24th to 28th, 2017

Date of Report: July 19, 2017


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## Table of Contents

## Background

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

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

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

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

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

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

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

**Methodology**

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

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

## Organization of Report

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

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

## Executive Summary

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

At the time of the Monitoring Team's last review in July 2016, a number of serious issues were identified. In the interim, working in conjunction with State Office, the Center implemented corrective action plans to address the issues identified. Although as staff at the Center recognize, much work still needs to be done, it was encouraging to see initial progress in some important areas at Corpus Christi SSLC. Many of these changes relate to laying the foundations of a strong system, including working to ensure individuals are safe and that staff throughout the Center embrace the philosophy that the role of the Center is to promote individuals' growth and development. For example, for a couple of the individuals that the Monitoring Teams have identified as being in need of attention for some time,

staff recently developed and began to implement plans, some of which showed promise in improving outcomes. Again, more work is needed, but this shift is an essential one. The Monitors encourage the leadership staff as well as staff throughout the Center to continue their efforts and sustain the significant momentum that they have built over the last few months. Sustained change takes time, but the Monitors are hopeful that the Center is on a path to meaningful improvement.

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at Corpus Christi SSLC for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Teams during the onsite review. The Facility Director supported the work of the Monitoring Teams, and was available and responsive to all questions and concerns. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

**Status of Compliance with the Settlement Agreement**

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

This domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, mortality review, and quality assurance. Twelve of these, all in incident management, were moved to the category of requiring less oversight after the last review. During this review three other indicators had sustained high performance scores and will be moved to the category of requiring less oversight. These were in the areas of restraint, 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>
Errors in the recording of the frequency of crisis intervention physical restraints rendered it impossible to determine if progress had or had not occurred or to compare to census-adjusted numbers of other facilities. There were, however, only a few crisis intervention chemical restraints and only one occurrence of crisis intervention mechanical restraint (wristlet, with no subsequent applications). There was one restraint-related injury reported, non-serious. One individual had PMR-SIB implemented (mittens), which was the same as during the last review, and progress was occurring in fading its usage. Restraint documentation was, for the most part, completed correctly. Proper reviews of restraint with associated recommendation and follow-up were not, however, occurring at the levels required by the criteria.

The interim Incident Management Coordinator described administrative systems being put in place to ensure improved organization and oversight in the future. She had only been in the position for a couple of weeks. Even so, she seemed to have a good idea of what was needed and how to move forward.

The restraint reduction committee had not been active for some time and was recently re-initiated. The Monitoring Team was encouraged after hearing/reading about the committee's activities and hopes that it will have a beneficial impact upon restraint usage and management at Corpus Christi SSLC.

Some significant concerns were noted with regard to nursing's documentation related to chemical restraint, which called into question the safety of administration as well as monitoring after administration. Some of the other areas in which nursing staff need to focus with regard to restraint monitoring include: monitoring and documenting individuals' respirations, even when they refuse other vital signs; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and documenting whether or not individuals have injuries as a result of restraint and follow-up for restraint-related injuries.

Abuse, Neglect, and Incident Management

All allegations were reported correctly, timely, and to the required people, resulting in a 100% score on this indicator. Investigations were complete as required (with two exceptions), and included relevant testimony from other individuals when applicable and credible staff interviews to follow-up on the DFPS abbreviated investigation. Seventy percent of investigations were not completed within the required timelines or with approved appropriate extensions, resulting in indicator 12 moving back into active monitoring. Serious injury audits and non-serious injury investigations were not implemented when required.

Other

It was good to see that the IDTs for the two individuals who had pretreatment sedation discussed the use of the PTS. In both cases, they justifiably noted that a plan for reducing future use, based on the need for PTS in the previous year, was not warranted.

**Restraint**

| Outcome 1- Restraint use decreases at the facility and for individuals. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Errors in the recording of the frequency of crisis intervention physical restraints rendered it impossible to determine if progress had or had not occurred or to compare to census-adjusted numbers of other facilities. Therefore, some of the sub-indicators of indicator 1 were scored as not meeting criteria as were the scores for each of the seven individuals who had restraints during this review period. These two indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
| 1 | There has been an overall decrease in, or ongoing low usage of, restraints at the facility. | 50% 6/12 | This is a facility indicator. | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2 | There has been an overall decrease in, or ongoing low usage of, restraints for the individual. | 22% 2/9 | 0/1 | 1/1 | 1/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (June 2016 through February 2017) were reviewed. During the onsite review, the Monitoring Team found that the facility was not recording the frequency of crisis intervention physical restraints correctly. For instance, the restraint for Individual #135 2/24/17 was recorded as a single 19-minute crisis intervention physical restraint, but it was instead five restraints that occurred within a 19-minute period. Thus, the frequency of the use of crisis intervention restraints, crisis intervention physical restraints, and the average duration of a crisis intervention physical restraint could not be validly determined (and any census-adjusted comparisons with other facilities was not possible). The Monitoring Team spoke with the interim director of behavioral health services and this will be fixed going forward.

Even so, there were few crisis intervention chemical restraints and one occurrence of crisis intervention mechanical restraint in July 2016 with no subsequent applications (wristlet to prevent pulling out a g-tube). There was only one restraint-related injury reported, non-serious. This was an improvement from the last review. The number of individuals who had a crisis intervention restraint implemented was increasing over the nine-month period.

One individual had PMR-SIB implemented (Individual #9, mittens), same as during the last review. In the last report, the Monitoring Team outlined a number of recommendations regarding the use of PMR-SIB for this individual. In the weeks prior to this onsite review, staff had initiated a fading program and, in that short amount of time, had achieved some reductions in the need/use of PMR-SIB. This was good to see.

The facility reported zero uses of non-chemical restraint for medical or for dental procedures. Chemical restraint for medical (medication) and dental procedures (oral medications, TIVA) was used for many individuals. The facility was not keeping any trended data regarding usage.

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

The restraint reduction committee had not been active for some time and was re-initiated two weeks prior to this onsite review, meeting twice. The Monitoring Team talked with the interim director of behavioral health services about this committee and read the minutes from both meetings. The minutes showed that there was extensive review of selected restraints and development of individual-specific plans. The Monitoring Team recommends that the committee also review facility-wide data, such as the set discussed in this indicator. Overall, however, the Monitoring Team was encouraged after hearing/reading about the committee's activities and hopes that it will have a beneficial impact upon restraint usage and management at Corpus Christi SSLC (and as detailed in the indicators below in this section of the report.

2. Seven of the individuals reviewed by the Monitoring Team were subject to restraint. Of these, all seven received crisis intervention physical restraints (Individual #186, Individual #197, Individual #46, Individual #123, Individual #227, Individual #216, Individual

#135) and two also received crisis intervention chemical restraint (Individual #123, Individual #135). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for three of the seven (Individual #186, Individual #197, Individual #46). Data collection of frequencies of crisis intervention restraint described above in indicator 1, however, make it impossible to determine valid numbers for these seven individuals. The other two individuals reviewed by the behavioral health Monitoring Team had no occurrences of crisis intervention restraint and were scored positively for this indicator.

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: Indicators 3 through 8 were in the category of requiring less oversight and will remain so, though attention needs to be paid to ensure that restraints are counted correctly and fully documented within the electronic health record. Indicators 9, 10, and 11 will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 186 | 197 | 46 | 123 | 227 | 216 | 135 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 3 | There was no evidence of prone restraint used. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | |
| 4 | The restraint was a method approved in facility policy. | | | | | | | | | | |
| 5 | The individual posed an immediate and serious risk of harm to him/herself or others. | | | | | | | | | | |
| 6 | If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others. | | | | | | | | | | |
| 7 | There was no injury to the individual as a result of implementation of the restraint. | | | | | | | | | | |
| 8 | There was no evidence that the restraint was used for punishment or for the convenience of staff. | | | | | | | | | | |
| 9 | There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment. | 0% 0/4 | Not rated | Not rated | Not rated | 0/1 | 0/1 | 0/1 | 0/1 | | |
| 10 | Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. | 89% 8/9 | 1/1 | 1/1 | 1/1 | 1/2 | 1/1 | 1/1 | 2/2 | | |
| 11 | The restraint was not in contradiction to the ISP, PBSP, or medical orders. | 67% 6/9 | 0/1 | 0/1 | 1/1 | 2/2 | 0/1 | 1/1 | 2/2 | | |

Comments:
The Monitoring Team chose to review nine restraint incidents that occurred for seven different individuals (Individual #186, Individual #197, Individual #46, Individual #123, Individual #227, Individual #216, Individual #135). Of these, seven were crisis intervention physical restraints, and two 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.

5-8. These indicators, all under less oversight, maintained high scores, but at less than the 100% scored in previous reviews. The restraint documentation for Individual #135 2/24/17 was missing a lot of information (and as noted in indicator 1 above was really five restraints). This was the major contributor to these reduced scores.

9. When criterion for indicator 2 is met, this indicator is not scored. That was the case for three of the seven individuals, however, the problems with frequency recording noted in indicator 1 above were identified late in the onsite week, too late for this indicator to be rated for them. Many sub-indicators were met for all four of the other individuals, however problems with assessments (e.g., PBSP timeliness and completeness), implementation of the PBSP, and/or implementation of counseling led to a 0 score for this indicator for them.

10. Less restrictive measures and attempts were not made before crisis intervention chemical restraint was implemented for Individual #123 2/5/17.

11. The IRRF for two individuals did not correctly identify whether there were any restraint contraindications.

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

Summary: High performance was seen at this review and the last review. Given the recording problems described above, this indicator will remain in active monitoring, however, with sustained high performance, it might be moved to the category of requiring less oversight after the next review.

| # | Indicator | Overall Score | Individuals: 186 | 197 | 46 | 123 | 227 | 216 | 135 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 12 | Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions. | 100% 6/6 | 1/1 | 1/1 | Not rated | 1/1 | 1/1 | 1/1 | 1/1 | | |

Comments:
12. All staff answered all questions correctly.

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.

Summary: Both indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 186 | 197 | 46 | 123 | 227 | 216 | 135 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 13 | A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor. | 89% 8/9 | 1/1 | 1/1 | 1/1 | 2/2 | 1/1 | 1/1 | 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 | N/A | | |
| Comments:<br>13. The restraint for Individual #135 2/24/17 was fraught with documentation, frequency count, and data entry problems. | | | | | | | | | | | |

| Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Some significant concerns were noted with regard to nursing's documentation related to chemical restraint, which called into question the safety of administration as well as monitoring after administration. Some of the other areas in which nursing staff need to focus with regard to restraint monitoring include: monitoring and documenting individuals' respirations, even when they refuse other vital signs; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and documenting whether or not individuals have injuries as a result of restraint and follow-up for restraint-related injuries. All of these indicators will remain in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 186 | 197 | 46 | 123 | 227 | 216 | 135 | | |
| a. | If the individual is restrained, nursing assessments (physical assessments) are performed. | 0%<br>0/8 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/2 | | |
| b. | The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects. | 38%<br>3/8 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 | 0/2 | 2/2 | | |
| c. | Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual. | 0%<br>0/8 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/2 | | |
| Comments: The crisis intervention restraints reviewed included those for: Individual #186 on 1/3/17 at 3:40 p.m.; Individual #197 on 1/10/17 at 7:45 a.m.; Individual #46 on 12/3/16 at 1:20 p.m.; Individual #123 on 2/5/17 at 2:20 p.m.; Individual #227 on 2/5/17 at 11:30 a.m.; Individual #216 on 12/5/16 at 7:53 a.m.; Individual #135 on 11/18/16 at 3:28 p.m., and 2/24/17 at 1:14 p.m.<br><br>a. For one of the eight crisis intervention restraints reviewed (i.e., Individual #227 on 2/5/17 at 11:30 a.m.), nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint.<br><br>For two restraints (i.e., Individual #186 on 1/3/17 at 3:40 p.m., and Individual #135 on 11/18/16 at 3:28 p.m.), nursing staff monitored and documented vital signs according to accepted standards.<br><br>Some of the problems noted included: | | | | | | | | | | | |

- For individuals that refused assessments, nurses did not document the time(s) at which the individual refused;
- No respirations recorded, even when individuals refused other vital signs (i.e., the individual's cooperation is not needed to obtain respirations);
- Lack of evaluation of individuals' mental status, or incomplete descriptions of mental status (e.g., "alert and awake");
- Discrepancies between IPNs and flow sheets; and
- Documentation that appeared to be cut off.

Problems noted with regard to chemical restraint included:

- For the chemical restraint of Individual #123 on 2/5/17 at 2:20 p.m., it was difficult to determine the series of events due to problems with the documentation the Center provided. However, the restraint checklist indicated that Ativan 2 milligrams (mg) by mouth (PO) was given as the chemical restraint. No time was provided to indicate when nursing staff administered the chemical restraint. The physician order that was provided did not include an order for Ativan. In fact, no medication was included in the order provided. A document identified as "Medication Details" indicated that on 2/5/17 at 2:16 p.m., Ativan 2 mg intramuscular (IM) was administered. However, there was no documentation of the rationale or follow-up regarding effectiveness. The Center did not provide a corresponding IPN documenting that nursing staff administered an IM injection of Ativan and/or why it was required at the time it was administered. On 2/5/17 at 9:04 p.m., an IPN noted Ativan 1 mg IM was given at 2:45 p.m., which was not consistent with some of the other documentation regarding the dosage and time. In addition, the IPN indicated that the individual refused vital signs at 1:15 p.m., which was before the chemical restraint was given, 3:15 p.m., and 9:00 p.m. However, there were no refusals indicated on the flowsheets provided. There was no indication that nursing staff monitored the status of this individual according to accepted standards of care after administering the chemical restraint. The injury report did not identify whether or not injuries identified occurred during the restraint procedure. The lack of specific information contained in the documentation provided as well as the discrepancies noted above are of major concern with regard to the safe administration of chemical restraints. In addition, it did not appear that the Center identified these significant issues in its review of the restraint and Debriefing documentation.
- For Individual #135 on 11/18/16 at 3:28 p.m., nursing staff did not document in an IPN that a chemical restraint was administered. No physician's order was provided for the chemical restraint. A Pre-Chemical Restraint note, dated 11/18/16 at 4:57 p.m., (i.e., unable to determine what discipline wrote the note; no title next to name) indicated that: "The chemical restraint was initially going to be administered IM however, staff were unable to safely restrain client to administer the chemical restraint. Client would accept it PO only however [sic], he continued his aggression towards staff waiting to get the medication PO." It was unclear from this note if the individual actually received the chemical restraint (i.e., Benadryl 25 mg and Zyprexa 5 mg per Restraint Checklist). The "Medication Details" form indicated that the medications were given PO. However, no documentation was provided justifying the need for the chemical restraint or its effectiveness. Although there were vital signs present on the flowsheets provided, the documentation should be clear as to whether or not a chemical restraint was actually administered.

b. Often nurses did not document whether or not the individuals sustained injuries as a result of the restraint. In other cases, injuries were noted, but nursing documentation did not provide an explanation of whether or not they occurred during the course of the restraint.

c. At times, follow-up was not completed for abnormal vital signs. In addition, due to the lack of documentation as noted above, it was unclear whether or not follow-up needed to occur.

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

Summary: Corpus Christi SSLC had high performance on this indicator for previous reviews, however, one restraint was so fraught with problems in documentation and count that this indicator will remain in active monitoring. With correct, and with sustained high performance, it might be moved to the category of requiring less oversight after the next review.

Individuals:

| # | Indicator | Overall Score | 186 | 197 | 46 | 123 | 227 | 216 | 135 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 15 | Restraint was documented in compliance with Appendix A. | 89% 8/9 | 1/1 | 1/1 | 1/1 | 2/2 | 1/1 | 1/1 | 1/2 | | |

Comments:
13. The restraint for Individual #135 2/24/17 was fraught with documentation, frequency count, and data entry problems.

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

Summary: Performance on both indicators decreased markedly for both indicators compared with the previous two reviews. Both indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 186 | 197 | 46 | 123 | 227 | 216 | 135 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 16 | For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy. | 44% 4/9 | 1/1 | 1/1 | 0/1 | 1/2 | 0/1 | 0/1 | 1/2 | | |
| 17 | If recommendations were made for revision of services and supports, it was evident that recommendations were implemented. | 57% 4/7 | 0/1 | 1/1 | N/A | 1/2 | 0/1 | N/A | 2/2 | | |

Comments:
16. Many restraints were not reviewed as required by the unit and IMRT.

17. Documentation was provided onsite to show implementation of recommendations for some, but not all, of the restraint recommendations.

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)

Summary: Two of these indicators, 48 and 49 were at 100% performance for this review and the two previous reviews, too. Therefore, both indicators will be moved

Individuals:

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| to the category of requiring less oversight. Improvement was seen in completion of the requiring administration documentation. That related indicator, 47, will remain in active monitoring. | | | | | | | | | | | |
| # | Indicator | Overall Score | 123 | 135 | | | | | | | |
| 47 | The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint. | 100% 2/2 | 1/1 | 1/1 | | | | | | | |
| 48 | Multiple medications were not used during chemical restraint. | 100% 2/2 | 1/1 | 1/1 | | | | | | | |
| 49 | Psychiatry follow-up occurred following chemical restraint. | 100% 2/2 | 1/1 | 1/1 | | | | | | | |

Comments:
47. Individual #135 and Individual #123 both had episodes of chemical restraint during this review period. The consultation and review documentation was completed within the allotted time frame for both.

48. Only one medication was used during each episode of chemical restraint.

49. There was documentation of additional clinical review by psychiatry following the administration of the chemical restraint.

**Abuse, Neglect, and Incident Management**

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|---|---|---|---|---|---|---|---|---|---|---|---|
| Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury. | | | | | | | | | | | |
| Summary: Seven incidents received review of trends and prior occurrences (or determination that there were none). Three investigations failed to meet criteria because an up to date signed duty to report form was not completed. One of these also did not have a thorough review of trends and prior occurrences. This indicator will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 186 | 275 | 46 | 123 | 227 | 216 | 135 | | |
| 1 | Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury. | 70% 7/10 | 2/2 | 0/2 | 1/1 | 0/1 | 1/1 | 1/1 | 2/2 | | |

Comments:
The Monitoring Team reviewed 10 investigations that occurred for seven individuals. Of these 10 investigations, seven were DFPS investigations of abuse-neglect allegations (one confirmed, four unconfirmed, one unfounded, one administrative referral). The other three were for facility investigations of a serious injury (laceration), a response to a medical emergency, and a 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 #186, UIR 17-115, DFPS 44964502, confirmed physical and verbal abuse, 11/12/16
- Individual #186, UIR 17-126, discovered laceration to leg, 11/15/16
- Individual #275, UIR 17-097, DFPS 44917001, unconfirmed allegation of physical abuse, 10/25/16
- Individual #275, UIR 17-188, medical emergency response, 12/28/16
- Individual #46, UIR 17-179, DFPS 45016246, administrative referral of verbal abuse allegation, 12/21/16
- Individual #123, UIR 17-181, DFPS 45020647, unfounded allegation of physical abuse, 12/24/16, streamlined investigation
- Individual #227, UIR 17-212, DFPS 45102045, unconfirmed allegation of verbal abuse, 1/17/17
- Individual #216, UIR 17-238, DFPS 45127240, unconfirmed allegation of neglect, 1/27/17
- Individual #135, UIR 17-270, DFPS 45162753, unconfirmed allegation of neglect, 2/21/17
- Individual #135 and Individual #216, UIR 17-088, sexual incident, 10/21/16

1. For all 10 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.

Seven of the investigations met all four of the sub-indicators for this indicator. Two of the other three did not meet criteria solely because an up to date signed duty to report form was not completed. The third investigation did not include a thorough review of previous occurrences and trends.

Nineteen individuals at Corpus Christi SSLC were designated as chronic callers. There was confusion among the facility staff regarding how an individual was placed on the chronic caller list, how an individual might be removed from the list, the responsibilities of the SSLC, and the streamlined investigation process. The staff said that a meeting was scheduled for the week after the onsite review to discuss all of this.

| Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: All allegations were reported correctly, that is, timely and to the required people. Corpus Christi SSLC is one of only three facilities to have scored 100% on this indicator. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring. | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | 186 | 275 | 46 | 123 | 227 | 216 | 135 | | |
| 2 | Allegations of abuse, neglect, and/or exploitation, and/or other | 100% | 2/2 | 2/2 | 1/1 | 1/1 | 1/1 | 1/1 | 2/2 | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | incidents were reported to the appropriate party as required by DADS/facility policy. | 10/10 | | | | | | | | | |
| | Comments: | | | | | | | | | | |

| Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Scoring for indicator 3 was at 100% for this review and for the past two reviews, however, given the handful of incorrect answers, it will remain in active monitoring. With sustained high performance, it might be moved to the category of requiring less oversight after the next review. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 186 | 275 | 46 | 123 | 227 | 216 | 135 | | |
| 3 | Staff who regularly work with the individual are knowledgeable about ANE and incident reporting | 100% 3/3 | Not rated | 1/1 | Not rated | 1/1 | 1/1 | Not rated | Not rated | | |
| 4 | The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | |
| 5 | If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action. | | | | | | | | | | |
| Comments:<br>3. Because indicator #1 was met for four of the individuals, this indicator was not scored for them. For the other three, a total of 10 staff were interviewed. Overall, the majority of questions were answered correctly, resulting in the 1 scores above. The handful of errors were that the facility director also needed to be notified and that reporting needed to occur within one hour (some staff said as soon as possible). The facility had included ANE reporting in its April 2017 Coaching Guide, which likely contributed to the high level of correct answers. | | | | | | | | | | | |

| Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | |
| 6 | Following report of the incident the facility took immediate and appropriate action to protect the individual. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| Comments:<br>6. An emotional assessment for one individual was not, but should have been, conducted (Individual #46 17-179) | | | | | | | | | | | |

| Outcome 5– Staff cooperate with investigations. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | | |
| 7 | Facility staff cooperated with the investigation. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | | |

Comments:
7. For Individual #123 17-181, some nursing staff were noted by DFPS to not be cooperative. The facility did follow-up training with the staff.

| Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Performance improved for indicators 9 and 10 and remained about the same for indicator 8. Some additional work on the details required by these indicators may result in higher overall performance. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 186 | 275 | 46 | 123 | 227 | 216 | 135 | | |
| 8 | Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized. | 80% 8/10 | 2/2 | 2/2 | 0/1 | 0/1 | 1/1 | 1/1 | 2/2 | | |
| 9 | Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled. | 80% 8/10 | 2/2 | 2/2 | 0/1 | 0/1 | 1/1 | 1/1 | 2/2 | | |
| 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) | 80% 8/10 | 2/2 | 2/2 | 0/1 | 0/1 | 1/1 | 1/1 | 2/2 | | |

Comments:
8-10. With two exceptions, investigations were complete as required by the various criteria and sub-indicators of this outcome. Moreover, investigations incorporated relevant testimony for other individuals when applicable (e.g., Individual #186 17-155) and included credible staff interviews documented in the UIR to follow-up on the DFPS abbreviated investigation (e.g., Individual #227 17-212). The two investigations that did not meet criteria with these indicators are described below.

- Individual #46 UIR 17-179: The UIR primarily stated the chronology of events; it did not record questioning of witnesses. Given there was nothing that documented the content of witness interviews, all relevant evidence was not collected. The absence of relevant testimonial evidence suggests that the conclusions drawn cannot be supported with evidence.
- Individual #123 UIR 17-181: A DFPS abbreviated investigation was conducted. The facility's subsequent follow-up investigation included just one interview and the UIR did not report the date, time, or content of that interview. The lack of content in the UIR (referenced above) with respect to the interview with the alleged perpetrator makes it impossible to validate that all relevant evidence was collected and that the facility investigation conclusion was supported by evidence.

| Outcome 7– Investigations are conducted and reviewed as required. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Investigations continued to be commenced within 24 hours. There were, however, problems with completion in three of the 10 investigations. This was discovered during the Monitoring Team's overall review of the investigations. The supervisory review process did not identify problems with investigations. This indicator (13) will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 186 | 275 | 46 | 123 | 227 | 216 | 135 | | |
| 11 | Commenced within 24 hours of being reported. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.<br><br>However, due to poor performance, indicator 12 will be moved back to active monitoring. | | | | | | | | | |
| 12 | Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing). | | | | | | | | | | |
| 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. | 20%<br>2/10 | 2/2 | 0/2 | 0/1 | 0/1 | 0/1 | 0/1 | 0/2 | | |

Comments:

12. Although this indicator was moved to the category of requiring less monitoring after the last review, the Monitoring Team found that three of the investigations were not completed with the 10 calendar day requirement and/or did not have proper extension approvals. They were Individual #186 17-126, Individual #275 17-188, and Individual #135 17-088. During the onsite visit, the facility's incident management department said that they were developing a case tracking and filing system to ensure that all cases were completed and finalized timely. The Monitoring Team would like to see this system and its effects during the next review.

13. Two investigations met criteria with this indicator. The expectation is that the facility's supervisory review process will identify the same types of issues that are identified by the Monitoring Team. Identifying, correcting, and/or explaining errors and inconsistencies contributes to the scoring determination for this indicator. The facility used a Supervisory Review Checklist. This was a good practice and can show thorough review, though more attention to implementation and content was needed (e.g., perhaps include a prompt related to alleged perpetrator reassignment).

Reconciliation of contradictory findings did not occur for two investigations. For Individual #186 17-115, DFPS confirmed physical abuse whereas OIG investigated, but had no findings. For Individual #275 17-097, DFPS unconfirmed physical abuse whereas OIG determined that abuse did occur. There was no attempt to reconcile the difference of opinions by the two investigative agencies.

For many investigations, supervisory reviews were three to four months after conclusion of the investigation and there was no evidence of post-investigation review by the IMRT.

| 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: Corpus Christi SSLC demonstrated the ability to properly conduct serious injury audits and non-serious injury investigations. However, failure to implement both processes resulted in poor scores for both of these indicators. Both indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 186 | 275 | 46 | 123 | 227 | 216 | 135 | | |
| 14 | The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation. | 0% 0/7 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | |
| 15 | For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported. | 43% 3/7 | 1/1 | 0/1 | 1/1 | 0/1 | 1/1 | 0/1 | 0/1 | | |

Comments:

14. Audits of significant injuries were not conducted at Corpus Christi SSLC from March 2016 through November 2016. An audit done for Individual #227 in March 2017 was acceptable, but an audit done in the same month for Individual #135 did not indicate if any follow-up was, or was not, needed (i.e., the entry space was blank).

15. The three individuals scored as meeting criteria had no identified injuries that needed a non-serious injury investigation. For the other four, each had one or more discovered injuries that should have been, but were not, subjected to a non-serious injury investigation. Three of these four individuals, however, also had one or more non-serious injury investigations that, when completed, were done correctly and thoroughly.

| Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: For the most part, investigations included recommendations and they were implemented. For disciplinary recommendations, actions were taken for all cases for this review and the previous two reviews, too. Therefore, indicator 17 will be moved to the category of requiring less oversight. The other two indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 186 | 275 | 46 | 123 | 227 | 216 | 135 | | |
| 16 | The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case. | 89% 8/9 | 1/1 | 2/2 | 1/1 | 1/1 | 1/1 | 0/1 | 2/2 | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 17 | If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely. | 100% 5/5 | 1/1 | N/A | 1/1 | 1/1 | 1/1 | N/A | 1/1 | | |
| 18 | If the investigation recommended programmatic and other actions, they occurred and they occurred timely. | 88% 7/8 | 1/1 | 2/2 | 1/1 | 1/1 | 1/1 | N/A | 1/2 | | |

Comments:
16. Recommendations weren't, but should have been, included in the investigation for Individual #216 17-238.

17. During this review period, there were five investigations that included a confirmation of physical abuse category 2. In each case, the employment of the confirmed staff member was not maintained.

18. For one investigation, Individual #135 17-270, there was no documentation to show that the recommendations were implemented.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.

Summary: This outcome consists of facility indicators. Actions to address these indicators were recently re-initiated. These indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 19 | For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending. | No | | | | | | | | | |
| 20 | Over the past two quarters, the facility's trend analyses contained the required content. | No | | | | | | | | | |
| 21 | When a negative pattern or trend was identified and an action plan was needed, action plans were developed. | No | | | | | | | | | |
| 22 | There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified. | No | | | | | | | | | |
| 23 | Action plans were appropriately developed, implemented, and tracked to completion. | No | | | | | | | | | |

Comments:
19-23. Criteria were not met, however, the facility recently (April 2017) created an Injury Audit Trend Report that displays a variety of sets of data that should be useful in analyzing trends and in developing proactive actions to reduce injury rates for specific individuals subjected to this review.

**Pre-Treatment Sedation/Chemical Restraint**

| Outcome 6 – Individuals receive dental pre-treatment sedation safely. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: The Monitoring Team will continue to review these indicators. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed. | 0% 0/1 | N/A | N/A | 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. As discussed in the last report, the Center's policies with regard to criteria for the use of TIVA, as well as medical clearance for TIVA need to be expanded and improved. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures. Given the risks involved with TIVA, it is essential that such policies be developed and implemented.

For the one instance of the 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 signs were documented according to the requirements of the related policy.

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: This indicator will remain in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed. | 75% 3/4 | N/A | 3/3 | N/A | N/A | N/A | N/A | N/A | 0/1 | N/A |

Comments: Informed consent was not provided for the pre-treatment medical sedation of Individual #70 on 9/21/16 for an ophthalmology appointment. In addition, neither pre-procedure nor post-procedure vital signs were found in IPNs or IView documentation.

| Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: It was good to see that the IDTs for the two individuals who had PTS discussed the use of the PTS. In both cases, they justifiably noted that a plan for reducing future use, based on the need for PTS in the previous year, was not warranted. These two indicators will remain in active monitoring. | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | 311 | 216 | | | | | | | | |
| 1 | IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics. | 100% 2/2 | 1/1 | 1/1 | | | | | | | | |
| 2 | If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual. | 100% 2/2 | 1/1 | 1/1 | | | | | | | | |
| 3 | If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format. | N/A | N/A | N/A | | | | | | | | |
| 4 | Action plans were implemented. | N/A | N/A | N/A | | | | | | | | |
| 5 | If implemented, progress was monitored. | N/A | N/A | N/A | | | | | | | | |
| 6 | If implemented, the individual made progress or, if not, changes were made if no progress occurred. | N/A | N/A | N/A | | | | | | | | |

Comments:

1-6. Of the nine individuals reviewed by the behavioral health Monitoring Team, two had received PTS for medical or dental procedures in the last 12 months. Individual #311 had undergone several exams/procedures that required sedation to prior history. These included appointments with an ophthalmologist, a podiatrist, and a urologist. It was determined by his IDT that other supports would not mitigate the need for PTS. For Individual #216, PTS was utilized for dental work, including restoration of several teeth. It was agreed that the procedure would cause significant pain. She had a service objective to help support good oral health.

Overall, Corpus Christi SSLC was not monitoring the frequency of use of PTS. Moreover, no individual had a strategy for reducing future use of PTS, such as desensitization or other more informal procedures.

**Mortality Reviews**

| Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: The Monitoring Team will continue to assess these indicators. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 101 | 273 | 93 | 340 | | | | | |
| a. | For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review. | 50% 2/4 | 1/1 | 0/1 | 0/1 | 1/1 | | | | | |
| b. | Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement. | 0% 0/4 | 0/1 | 0/1 | 0/1 | 0/1 | | | | | |
| c. | Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement. | 0% 0/4 | 0/1 | 0/1 | 0/1 | 0/1 | | | | | |
| d. | Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement. | 0% 0/4 | 0/1 | 0/1 | 0/1 | 0/1 | | | | | |
| e. | Recommendations are followed through to closure. | 0% 0/4 | 0/1 | 0/1 | 0/1 | 0/1 | | | | | |

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

- On 8/2/16, Individual #73 died at the age of 59 of hypotension, staphylococcal bacteremia, and end stage renal disease;
- On 9/23/16, Individual #101 died at the age of 75 of heart failure;
- On 10/9/16, Individual #278 died at the age of 86 of aspiration pneumonia;
- On 12/3/16, Individual #273 died at the age of 49 of pulmonary fibrosis;
- On 12/6/16, Individual #93 died at the age of 78 of hydrocephalus, malnutrition, dysphagia, and adult failure to thrive;
- On 12/22/16, Individual #190 died at the age of 62 of metastatic carcinoma of the liver;
- On 12/30/16, Individual #179 died at the age of 35 of respiratory failure;
- On 1/30/17, Individual #122 died at the age of 62 of aspiration pneumonia, and acute-on-chronic hypoxemic respiratory failure, and sepsis; and
- On 3/19/17, Individual #340 died at the age of 50 of sepsis, and recurrent aspiration pneumonia.

b. through d. Overall, opportunities were missed for identifying recommendations to make improvements. Some examples of problems noted included:

- Most of the nursing death reviews were not thorough, and did not represent a review of nursing practice over the six months prior to the individuals' deaths.
- The nursing death review for Individual #273, completed on 12/16/16, showed some considerable improvements. For example, it identified areas where the IDT should have included more specific data in the IRRF, discrepancies in the data presented, pertinent information that was missing, and risk areas that were not rated in alignment with the data provided in the IRRF. In addition, the report noted that a Change of Status IRRF and IHCP found in the computer was not in the active record (prior to IRIS). It also concluded that the Change of Status IRRF/IHCP was "lengthy but did not provide many additional supports." A review of the IHCP identified a number of issues such as discipline annual assessment information that was not included in the IRRF and recommended action steps were not included in the IHCP. Other areas that were included in the report were Acute Care Plans, Comprehensive nursing review, ISPA review, PCP order review, IPN review for the last six months (which was very brief; two sentences), bowel movement (BM) tracking, PNMP review, Diet Consult review/Weights monitoring review, and a section for recommendations. Although some of the recommendations were not written in a measurable manner that allowed the development of action steps, unfortunately, none of the recommendations generated were included in the Administrative Death Review recommendations. Thus, Center staff did not initiate follow-up for the issues identified. In addition, this review required improvements in terms of including a more structured timeline of events, as well as reviewing the six months prior to the individual's death as opposed to selected days.
- With regard to the medical reviews of deaths, opportunities to identify areas for clinical improvement were missed. A couple examples of some of the areas that should have been pursued and recommendations offered included:
    - For Individual #340, wound care, gastroesophageal reflux disease (GERD) evaluation and treatment, sepsis, and the benefits of suction tooth brushing three times a day;
    - For Individual #93, failure to thrive with an individual without a feeding tube; and
    - For Individual #101, the clinical needs of an individual on hospice.

e. For a number of recommendations, the Center did not submit documentation to show completion of the follow-up activity, or consideration of alternative solutions to address underlying problems. For example, in relation to Individual #273's death, a recommendation was made for Behavioral Health Services staff to revise the Level of Supervision sheet. The Behavioral Health Services staff responded that the change could not be made due to the electronic system. However, the problem remained without resolution or the development of alternatives to address it.

In addition, as noted above, many recommendations that should have been addressed were not. It will be important as recommendations are developed to ensure that action plans are written in a way that allows measurement of the outcome of implementation. In other words, measures should be in place to determine whether or not the action taken addressed the underlying issue, and the outcomes for individuals have improved.

**Quality Assurance**

| Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs. | |
|---|---|
| Summary: It was good to see that the ADR process was implemented correctly for | Individuals: |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| the one ADR reviewed. The Monitoring Team will continue to review these indicators. | | | | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | ADRs are reported immediately. | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| b. | Clinical follow-up action is completed, as necessary, with the individual. | 100% 1/1 | | | | | | | | 1/1 | |
| c. | The Pharmacy and Therapeutics Committee thoroughly discusses the ADR. | 100% 1/1 | | | | | | | | 1/1 | |
| d. | Reportable ADRs are sent to MedWatch. | 100% 1/1 | | | | | | | | 1/1 | |
| Comments: a. through d. Individual #70 experienced a potential ADR while hospitalized. Upon his return to the Center, the Pharmacy and Therapeutics Committee determined it was an ADR, and the Center needed to report it. A report was sent to MedWatch. | | | | | | | | | | | |

| 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: At the time of the last review, the Center completed clinically significant DUEs and followed up to closure on recommendations, and this progress had been sustained since the prior review. The Monitor indicated that if this performance was sustained during this current review, this Outcome likely would move to the category requiring less oversight. Unfortunately, the Center did not sustain its performance. These indicators will remain in active oversight. | | Individuals: |
| # | Indicator | Score |
| a. | Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly. | 50% 1/2 |
| b. | There is evidence of follow-up to closure of any recommendations generated by the DUE. | 0% 0/1 |
| Comments: a. and b. In the six months prior to the review, Corpus Christi SSLC completed one DUE. A DUE on proton pump inhibitors (PPIs) was presented to the Pharmacy and Therapeutics (P&T) Committee on 9/21/16, and a follow-up DUE on these medications was presented on 12/21/16. However, based on the documents provided to the Monitoring Team, for the fourth quarter of calendar year 2016, Center staff did not initiate/complete a DUE. In its comments on the draft report, the State indicated that on 12/21/16, another DUE was presented to the P&T Committee, but acknowledged that Center staff did not include this information in the documents provided for the Monitoring Team's review. | | |

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the last review, 18 of these indicators, in psychiatry, behavioral health, medical, dental, nursing, and skill acquisition, were moved the category of requiring less oversight. For this review, three other indicators were moved to this category, in ISPs, psychiatry, and OT/PT. Two indicators in behavioral health were moved back into active monitoring.

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

The IDT considered what assessments the individual needed for most individuals. IDTs did not, however, always arrange for and obtain these assessments prior to the IDT meeting.

Comprehensive psychiatric evaluation content was at criteria for all individuals and this indicator was moved to the category of requiring less oversight. Documentation prepared by psychiatry for the annual ISP was complete.

Not all individuals who should have had a PBSP, had one. Instead, they had psychiatric support plans (PSP). PSPs are not designed to address the kinds of behaviors that these individuals were exhibiting. Thirty-three of the 101 individuals who were currently prescribed psychotropic medication had a PSP instead of a PBSP. This might be worthy of review by the directors of behavioral health and psychiatry. This was also mentioned in the last review.

Behavioral and functional assessments needed to be done, updated, and complete with all required content. PBSPs were current, but their content required a lot of attention, fixing, additions, and work (e.g., eight points are bulleted under indicator 15 below). The Interim Director of Behavioral Services described administrative control systems being put in place to ensure improved organization and oversight in the future. She had only been in the position for a few weeks, and seemed to have a good understanding of what was needed to move forward.

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

For the individuals reviewed, Medical Department staff completed the medical assessments in a timely manner.

The quality of medical assessment needed improvement. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history, childhood illnesses, past medical histories, updated active problem lists, and plans of care for each active medical problem, when appropriate.

It was positive that six individuals' dental exams included all of the necessary components, and that seven of the eight dental summaries met criteria.

Due to previous high performance with regard to the completion of nursing quarterly record reviews and physical assessments, the related indicator moved to the category requiring less oversight. However, based on the nursing quarterlies the Monitoring Team used for other elements of its review, problems were noted with regard to the timely completion or completion at all of quarterlies for some quarters for some individuals; completion of complete physical assessments, including Braden scores and weights; and/or thorough reviews of the individuals' risk areas. As a result, the related indicator will move back to active monitoring.

It was positive that many of the annual nursing assessments reviewed included status updates of the current medical and behavioral/mental health risks. However, focus needs to be placed on ensuring nurses analyze health risks, and include recommendations regarding treatment, interventions, strategies, and programs in annual nursing assessments. Nurses conducted assessments in accordance with nursing protocols or current standards of practice in relation to 50% of the changes in status reviewed, which was an improvement from the last review (i.e., Round 11 – 0%).

Since the last review, some important progress was noted with regard to the Physical and Nutritional Management Team (PNMT) documenting more discussion related to attempts to identify the etiology of the individual's condition or risk area. However, more in-depth analysis was needed when the root or underlying cause was not immediately apparent. This will require the PNMT to involve other disciplines, such as pharmacy and behavioral health, as well as medical.

Since the last review, progress was noted with regard to the timeliness of OT/PT assessments, as well as the completion of the correct type of OT/PT assessments (e.g., comprehensive assessment, update, consultation) in accordance with the individuals' needs. The quality of OT/PT assessments continues to be an area on which Center staff should focus.

Individuals' ISPs generally included a description of how the individual functioned from an OT/PT perspective, so the related indicator will move to the category requiring less oversight.

It was good to see progress with regard to the timeliness of communication assessments and screenings. However, some individuals' screenings revealed the need for a more complete assessment, but such assessments were not completed. The

quality of the assessments and updates required improvement. Of significant concern, communication assessments often indicated that alternative and augmentative communication (AAC) options were not appropriate for the individual due to his or her intellectual or developmental disability diagnosis. As a result, no further assessment was conducted. Similarly, screenings often stated that the individual's communication deficits were consistent with his/her diagnosis and then offered no further investigation. This is not consistent with current generally accepted standards.

Individualized Support Plans

The development of individualized personal goals in six different areas was not yet at criteria, but much progress was evident. All six ISPs, for instance, included one or more goals that met criteria, and two ISPs had goals that met criteria in five of the six areas (i.e., all except health/wellness). Further, about half of these goals were written in measurable terms. Regarding the full set of ISP action plans, the various criteria included in the set of 11 indicators in Outcome 3 were not met, though five of the 11 indicators showed some improvement since the last review. Unfortunately, goals and action plans were not implemented sufficiently, correctly, and with adequately collected data to determine progress. QIDPs had not been completing monthly reviews.

Individualized psychiatry-related personal goals need to be created that defined psychiatric indicators regarding problematic symptoms, as well as psychiatric indicators regarding positive pro-social behaviors. It was encouraging to see some progress along these lines.

Corpus Christi SSLC maintained performance in the presence of SAPs and measurability of SAPs. Their basis in assessment, practicality, functionality, and meaningfulness remained below criteria. The number of SAPs that had reliable data dropped to 0%.

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

## ISPs

| Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable. | |
|---|---|
| Summary: The development of individualized, meaningful personal goals in six different areas, based on the individual's preferences, strengths, and needs was not yet at criteria, but much progress was evident as described below. All six ISPs, for instance, included one or more goals that met criteria, and two ISPs had goals that met criteria in five of the six areas (i.e., all except health/wellness IHCP goals) for a total of 16 goals that met criteria. This was very good progress since the last | Individuals: |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| review. Further, about half of these 16 goals were written in measurable terms, also demonstrating good progress. Unfortunately, only one was implemented sufficiently, correctly, and with adequately collected data to determine progress. These indicators will remain in active monitoring. | | | | | | | | | | | |
| # | Indicator | Overall Score | 311 | 275 | 123 | 216 | 162 | 333 | | | |
| 1 | The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her. | 0%<br>0/6 | 2/6 | 1/6 | 5/6 | 2/6 | 5/6 | 1/6 | | | |
| 2 | The personal goals are measurable. | 0%<br>0/6 | 0/6 | 1/6 | 4/6 | 0/6 | 2/6 | 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%<br>0/6 | 0/6 | 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 #311, Individual #275, Individual #123, Individual #216, Individual #162 and Individual #333). 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.

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

None of the six individuals had individualized goals in all areas, therefore, none had a comprehensive set of goals that met criterion. The Center's QIDPs had received training on Writing Good Goals and the Monitoring Team did identify some progress in the development of personal goals that were aspirational and reflective of individualized preferences and strengths, as described below.

1. It was an indicator of progress that the IDTs had defined some personal goals that were individualized and clearly based on the individual's preferences and strengths. Overall, 16 personal goals met criterion for this indicator.

- Two individuals (Individual #162, Individual #123) had goals that met criterion in five of the six personal goal areas, which was a very positive sign and demonstrated the hard work of the QIDP department and the IDTs. These individuals' personal goals for leisure/recreation, relationships, independence, job/school/work, and living options reflected their preferences and were based on an expectation that they would learn new skills and have opportunities to try new things. As the Center continues to work toward developing personal goals for health and safety in the Individual Health Care Plan (IHCP), it will have the opportunity to meet criterion overall for this indicator.

- Other personal goals that met criterion included Individual #311's leisure and relationships goals, Individual #275's independence goal, Individual #216's work and independence goals, and Individual #333's relationship goal.

Other goals often failed to define an outcome that was aspirational. More often they appeared to be action plans that might be related to a more aspirational outcome, but the IDT did not specify what that might be. For example, Individual #275's personal goal for work, as defined by the IDT, was to attend work eight out of 10 times per week. Individual #311 had a personal goal to sort socks; while this might have been an action plan toward managing his own wardrobe, it did not reflect aspiration. It was not even clear it reflected his actual preferences.

The Center had just initiated a Preferences and Strengths (PSI) Review Committee to address issues related to the development of individualized, functional, and meaningful goals. In this process, QIDPs were to submit a draft PSI with proposed tentative goals to the QIDP Coordinator for review and feedback prior to the ISP Preparation meeting. The week before the ISP Preparation meeting, the PSI Review Committee was to meet to review the draft and feedback, and make revisions of tentative goals as needed.

This process had just begun, so it was too soon to fully evaluate its effectiveness, but it appeared to hold promise for improving the development of truly meaningful and functional personal goals. A similar process had been underway at another center for several months and had shown some good early results. This information was shared with the QIDP Coordinator in the event she might want to collaborate with staff from the other center. This process could also to begin to engage the rest of the IDT in the goal development process, such as inviting habilitation therapists to participate in PSI Review Committee meetings when individuals have significant physical and nutritional management needs.

2. Of the 16 personal goals that met criterion for indicator 1, seven also met criterion for measurability. These goals were:
   - Individual #275's goal for applying make-up. It was positive the IDT had developed a skill acquisition plan (SAP) to support this goal that met criterion for measurability as well as identified additional make-up items that will be added over time, to achieve the full intent.
   - Individual #123's work, leisure, living options, and independence goals.
   - Individual #162's job/school and living options.

3. For the 16 personal goals that met criterion in indicator 1, one had reliable and valid data. The QIDPs had not been consistently monitoring ISPs. Monthly QIDP reviews were almost totally non-existent for the period September 2016 through November 2016. Those that were available for review, primarily for December 2016 through March 2017, had generally been late by two or more months, so even these had not been used for timely monitoring. Individual #162's living options goal was the sole exception, as the IDT had met frequently in ISPA and documented ongoing activity. The remaining personal goals did not meet the above criteria, therefore, 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.

| 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. That being said, five of the 11 indicators showed some improvement since the last review and none showed a decrease. A focus area for the facility (and its QIDP department) is to ensure the actions plans meet these various 11 items. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 311 | 275 | 123 | 216 | 162 | 333 | | | |
| 8 | ISP action plans support the individual's personal goals. | 0%<br>0/6 | 0/6 | 1/6 | 2/6 | 0/6 | 1/6 | 0/6 | | | |
| 9 | ISP action plans integrated individual preferences and opportunities for choice. | 33%<br>2/6 | 0/1 | 0/1 | 0/1 | 1/1 | 1/1 | 0/1 | | | |
| 10 | ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making. | 17%<br>1/6 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 | 0/1 | | | |
| 11 | ISP action plans supported the individual's overall enhanced independence. | 33%<br>2/6 | 0/1 | 0/1 | 1/1 | 1/1 | 0/1 | 0/1 | | | |
| 12 | ISP action plans integrated strategies to minimize risks. | 0%<br>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%<br>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%<br>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. | 67%<br>4/6 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | | | |
| 16 | ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs. | 33%<br>2/6 | 0/1 | 1/1 | 1/1 | 0/1 | 0/1 | 0/1 | | | |
| 17 | ISP action plans were developed to address any identified barriers to achieving goals. | 0%<br>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%<br>0/6 | 0/6 | 0/6 | 0/6 | 0/6 | 1/6 | 0/6 | | | |
| Comments: | | | | | | | | | | | |

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

8. ISP goals generally did not have a clear set of action plans that would serve as a road map for their ultimate achievement. Three personal goals met criterion. These were the employment and greater independence goals for Individual #123 and the living options goal for Individual #162. Examples of those that did not meet criterion included:

- Individual #162's leisure goals were to take her to visit the Selena museum and to purchase Selena make-up. The ISP action plans were limited to emailing CIS, without any specific steps for completing the actual activities. The Monitoring Team also noted Individual #162 had multiple options to expand communication, including a Tobbi eye gaze, picture cards, eye gaze board, and a Voca Bracelet, yet there were no SAPs in place to address their usage.
- Individual #216 had a goal to work at a restaurant, but the only related action plan was to apply for the on-campus apprenticeship program. The IDT did not specify any additional steps that related to obtaining employment in a restaurant.

9. The Center had made some progress in the integration of preferences and opportunities for choice in the identification of personal goals for the ISPs. Both Individual #216 and Individual #162 had action plans that clearly integrated preferences. Examples of those that did not meet criterion included:

- Individual #123 had an SSO for attending a Catholic Church of her choice, but it did not include any staff instructions for offering or promoting choice. The instructions indicated staff should tell Individual #123 which church they would be attending and what time they would be going.
- Individual #275 did not have any action plan for promoting opportunity for choice of living option.
- Individual #333 did not have opportunities for choice integrated in his SAPs and SSOs.

10. One ISP, for Individual #162, clearly addressed decision-making skills. Overall, Individual #162's IDT addressed, in the ICA review, its assessment of her current capacity and identified training and supports to be implemented that would assist her with informed decision-making. Otherwise, ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making for five of the six individuals. Examples included:

- The ISPs for Individual #216 and Individual #275 did not provide a clear description of either individual's strengths, needs, and barriers related to informed decision-making. The printable format in IRIS did not indicate the specific areas that were being addressed.
- For Individual #311, the IDT did not document any discussion of additional training/supports to assist him in decision making. It only indicated his deficits and barriers, stating for most areas, the "IDT believes Individual #311's limited verbal speech, mental disabilities and short attention span all contribute to areas of weakness which impair his ability to understand..."

11. The ISPs for Individual #123 and Individual #216 met criterion for this Indicator. For example, Individual #123 had multiple SAPs and action plans related to work, laundry care, identifying healthy portions, and street safety. Otherwise, action plans did not assertively promote enhanced independence for the other individuals. Examples included:

- The IDT did not develop a communication goal for Individual #311. He had a picture communication board, but a goal was not developed that addressed its use. Other areas, such as topic maintenance, ability to protest, and turn taking were all noted in the screening as being below functional limits, but no goals were developed.

- Individual #275 was noted to eat too fast and overfill her spoon. Given her significant risks for aspiration and choking, and the potential for needing a g-tube, the IDT should have prioritized an action plan to address these dining issues.

12. IDTs did not consistently integrate strategies to minimize risks in ISP action plans as described throughout this report. Overall, IDTs still needed to be much more assertive when addressing health, safety and behavioral needs of individuals living at Corpus Christi SSLC. For example:

- IDTs did not consistently address falls risk as needed. For example:
  - Two of six individuals (Individual #216, Individual #275) had a significant number of falls, but the IDTs had not completed a falls analysis.
  - The IDT for Individual #123 had focused some effort on her falls, which was positive to see. Her falls appeared to be decreasing, but the Monitoring Team was concerned that the falls data may not be reliable. Some ISPAs noted that the Unit Director should be alerted that not all falls were being reported. In addition, a fall described in an ISPA that occurred on 4/16/17 was not included in the falls report requested by the Monitoring Team on 4/24/17.
- Individual #123 had begun to ingest inedible items, and this emerging behavior was increasing in frequency and severity. Recent ingestions included batteries, for example. The IDT had not developed a comprehensive plan that included immediate and ongoing protection, as well as strategies to reduce the behavior. For example, there was not a clearly defined and followed process for implementing and fading 1:1 supervision for her protection related to ingestion. The most recent ISPA reference indicated 1:1 supervision would be faded if she went for a week without ingestion. Without getting into whether this was interval was sufficient to ensure her safety, Individual #123 swallowed two batteries (confirmed by imaging) on 3/16/17 and was placed on 1:1 at that time, but had to be put back on 1:1 on 3/23/17 after swallowing seashells. There was no evidence the IDT had met to discuss whether 1:1 should be discontinued during the interim between swallowing batteries and swallowing seashells. This needed to be addressed immediately, and this was shared with Corpus Christi SSLC administration during the onsite week.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated, also as described throughout this report. In addition to the examples provided in #11 and #12 above, other examples included:

- IDTs did not assertively identify and address communication needs for Individual #311 and Individual #333.

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

- Individual #162 had an action plan to take classes at a nearby community college, which was a good example of meaningful community integration, particularly since she had recently graduated from high school. It was disappointing that this action plan, which had been continued from previous ISPs, had never been accomplished.
- Both Individual #123 and Individual #216 had interests in being involved in church activities in the community. Individual #123's action plan did not include any strategies for meaningful integration with a church community and Individual #216's IDT did not develop a goal or action plan for this preference.
- Individual #333 had an action plan to learn to use earbuds in the community, but this did not describe any ways this might support participation or integration.

15. Four of six ISPs considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. These included the ISPs for Individual #123, Individual #275, Individual #216, and Individual #162.

The best example in this area was for Individual #123, who had completed a situational assessment in the on-campus gardening program prior to the ISP and was being offered job introduction opportunities in the community. She was doing well working in the gardening area and reported she liked the work. She also reported she was going on a job introduction in the community the next day. The remaining ISPs minimally addressed vocational and day programming needs.

16. Two of six ISPs, for Individual #275 and Individual #123, 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. Examples of those that did not included:

- One of six leisure action plans for Individual #311 had a SAP or SSO for implementation.
- Individual #216 had leisure action plans for learning the keyboard and attending music class, but both had been discontinued for lack of interest. The IDT did not consider any additional action plans for developing leisure skills.

17. The IDT did not consistently address barriers to achieving goals. Examples included:

- IDTs did not effectively address barriers to community transition with individualized and measurable action plans as described in indicator 26 below.
- Individual #162's ISP did not address barriers to use of her TOBII for communication in daily living. The action plan continued to focus only on use in a therapy setting.
- Individual #216 did not have any recreation or leisure goals in her current ISP and those from the previous ISP had been discontinued because she did not show interest in them. Documentation indicated her outings were planned by staff, which should have alerted the IDT to a need to learn leisure planning skills. Her behavioral health assessment also recommended structured leisure activities that incorporated a social component as a means of establishing appropriate relationships and boundaries. A well-constructed leisure goal could have included planning outings with a peer or friend while also serving as a vehicle for implementing and generalizing appropriate boundaries.

18. ISPs did not consistently include collection of enough or the right types of data to make decisions regarding the efficacy of supports. SAPs were often missing key elements, as described elsewhere in this report. Living options action plans often had no measurable outcomes related to awareness. In another example, Individual #123's new PBSP did not allow objective tracking of dangerous behaviors, such as SIB, ingesting non-edibles, and aggression.

| 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. Primary areas of focus are ensuring that each individual's preferences are assessed and that they are | Individuals: |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| clarified by the IDT, and the development of individualized action plans. These indicators will remain in active monitoring. | | | | | | | | | | | |
| # | Indicator | Overall Score | 311 | 275 | 123 | 216 | 162 | 333 | | | |
| 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). | 50% 3/6 | 0/1 | 0/1 | 1/1 | 1/1 | 1/1 | 0/1 | | | |
| 20 | If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner. | 100% 1/1 | 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. | 100% 6/6 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | | | |
| 23 | The determination was based on a thorough examination of living options. | 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). | 67% 4/6 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | | | |
| 25 | For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition. | 100% 1/1 | 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. | 17% 1/6 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 | 0/1 | | | |
| 27 | For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition. | 0% 0/1 | N/A | N/A | N/A | N/A | N/A | N/A | | | |
| 28 | ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options. | 0% 0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |
| 29 | The IDT developed action plans to facilitate the referral if no significant obstacles were identified. | N/A | N/A | N/A | N/A | N/A | N/A | N/A | | | |

Comments:

19. Three of six ISPs (Individual #123, Individual #216, Individual #162) included a description of the individual's preference for where to live and how that was determined. Examples of those that did not were:

- Individual #311's preference was unknown. He had not engaged in any community tours due to LAR preference.
- For Individual #275, the ISP included a long description of her response to the CLOIP visit, in which she viewed a virtual group

home tour and stated repeatedly her preference for transitioning to the community. This was consistent with statements Individual #275 had made in the past. The narrative noted that she started crying and said she wanted to pack her bags and go right now. The ISP then went on to indicate that the IDT asked Individual #275 where she wanted to live and she indicated her current residence. The ISP did not describe an effort to evaluate her different responses. The IDT then selected Individual Choice as the barrier, stating the individual had been provided with information about alternate community living options and was not interested. This was not reflective of the available data. The only documented instance of being provided with such information was through the CLOIP interview described above and at that time she explicitly indicated she wanted to move to the community. During this monitoring visit, Individual #275 showed the Monitoring Team a list she had written that included her desire to live in a group home and asked if the Monitoring Team could help her. The QIDP and IDT needed to meet and develop an action plan for a concerted effort toward providing Individual #275 with additional opportunities to visit potential community living opportunities and to further assess her current preferences in this area.

- Individual #333 had been on two tours. The IDT members concluded they could not tell what his reaction was, although the detail of one tour indicated (a) he did not respond negatively in any way and (b) the fountain at the home seemed to have a soothing effect. On the other tour, documentation noted he seemed happy, vocalized and smiled, but gave no real indication of his understanding. Given that Individual #333 had a goal for community living in the previous ISP, the IDT had ample time to offer more opportunities if they did not feel that his apparent positive responses to these two tours were sufficient for determining his preferences.

20. The Monitoring Team observed Individual #46's annual ISP meeting. The IDT provided a description of where he wanted to live based on his stated preferences for his desire to live in an apartment by himself.

21. Overall, 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. Those that were present provided a statement of the opinion and recommendation of the respective team member, though, which was an indicator of progress.
    - ISPs did not all include independent recommendations from each staff member on the team that identified the most integrated setting appropriate to the individual's needs. Examples included:
        - Individual #311's ISP did not have a behavioral health recommendation.
        - ISPs provided in the IRIS format were very difficult to assess, as it was not clear which discipline was making a recommendation. For Individual #216, though, no vocational or Primary Care Physician (PCP) recommendations were evident.
        - ISPs for Individual #162 and Individual #333 did not provide recommendations from vocational or day program staff members,

22. The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, for six of six individuals.

23. None of six individuals had a thorough examination of living options based upon their preferences, needs, and strengths. Examples of those that did not included:

- The IDT for Individual #123 did not document any discussion of available options that might meet her needs, nor did it address the of feasibility of Individual #123 returning to mom's home, per her stated preference. The IDT did not complete the discussion/rationale section under the individual's living option preferences, such as what progress she had made or what data supported the determination.
- The ISP included details about needs Individual #311 would have if he were to transition, which was positive, but the ISP did not include a discussion of available community living options that might meet those needs.

24. Four of six ISPs identified a thorough and comprehensive list of obstacles to referral in a manner that should allow for the development of relevant and measurable goals to address the obstacle. Examples of those that did not meet criterion were:

- The IDT for Individual #311 identified LAR Choice as a barrier, but did not identify Individual Choice as an additional barrier even though the ISP acknowledged his living preference and level of awareness were unknown.
- For Individual #333, the IDT identified Individual Choice and medical issues as obstacles, but did not include LAR Choice, even though documentation indicated his LAR was not in favor.

25. The Monitoring Team observed Individual #46's ISP annual meeting while onsite. The IDT identified LAR Choice and Behavior/Psychiatric needs as barriers.

26. Individual #162 had an active community referral and the IDT had met several times to address barriers to transition. The IDT developed an action plan to review and identify five providers in the desired area to contact to explore whether they could meet Individual #162's extensive needs. While this was an appropriate and measured action plan, as far as it went, the Monitoring Team remained concerned that the IDT would have to be very cautious and precise in identifying all potential barriers related to Individual #162's physical and nutritional management and other significant health care needs. None of the remaining five individuals had individualized, measurable action plans to address obstacles to referral. Examples included:

- Individual #333 did not have an action plan related to LAR Choice as a barrier. The action plans to address individual awareness did not have individualized measurable action plans with learning objectives or outcomes.
- The ISP did not quantify the goals that would need to be met for Individual #123 to be able to live in the community or be referred for transition.
- Individual #216's ISP did not define measurable outcomes needed to demonstrate her behavioral/psychiatric and awareness obstacles had been addressed; rather it only offered broad statements that she would have an anger management SAP, attend group home tours, be encouraged to attend provider tours, and have the support of a PBSP.

27. The Monitoring Team observed Individual #46's annual ISP meeting. Action plans that addressed his awareness and learning needs regarding community living were not clearly spelled out, nor were any action plans developed to address the obstacle of LAR Choice. The IDT did discuss a series of action plans to address behavioral and psychiatric needs, including a SAP for anger management, attending anger management class, his PBSP and psychiatric treatment plan, and a consult for counseling, but did not discuss or quantify the goals that would need to be met for Individual #46 to be able to live in the community or be referred for transition.

It is important for individuals to have a clear understanding of the expectations they need to meet in order to achieve them and to serve as motivation. For Individual #46, the IDT used language that was not motivational. For example, the IDT set a goal for him to live in a

group home near his family, "however long that takes." Vocational staff deferred to the parents, but indicated he might be able to move five years from now. This was consistent with the overall tone of the ISP meeting.

28. None of six ISPs had individualized and measurable plans for education. Examples included:
- While Individual #162 was referred and her ISP had an action plan for identifying potential providers, it did not include any specific strategy for educating Individual #162 or her LAR about the community living options.
- Individual #123 had action plans for group home tours and provider fair attendance, but they did not include individualized and measurable outcomes or learning objectives.
- Individual #216 had no formal action plans for education developed.

29. Five of six individuals had obstacles to referral identified at the time of the ISP. The sixth person (Individual #162) had been referred.

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

Summary: ISPs were revised annually. This has been the case for some time at Corpus Christi SSLC, therefore, indicator 30 will be moved to the category of requiring less oversight. ISPs, however, were not implemented in a timely manner, and some aspects were not implemented at all. Not all IDT members participated in the important annual meeting. These other indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 311 | 275 | 123 | 216 | 162 | 333 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 30 | The ISP was revised at least annually. | 100% 6/6 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | | | |
| 31 | An ISP was developed within 30 days of admission if the individual was admitted in the past year. | N/A | N/A | N/A | N/A | N/A | N/A | N/A | | | |
| 32 | The ISP was implemented within 30 days of the meeting or sooner if indicated. | 0% 0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |
| 33 | The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able). | 83% 5/6 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | | | |
| 34 | The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. | 17% 1/6 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 | 0/1 | | | |

Comments:
30-31. ISPs were developed on a timely basis. None of these individuals had been newly admitted.

32. It could not be verified that ISPs were implemented on a timely basis, within 30 days of the ISP meeting, for any of six individuals, in part because of the lack of QIDP monthly reviews. For example, Individual #123's ISP was held in August 2016, but there were no QIDP monthly reviews completed for September 2016 through November 2016, and later monthly reviews provided no data. Both Individual #275 and Individual #216 had ISP meetings in mid-February 2017, but their SSOs and SAPs were not available for review at the time of the document request fulfillment on 3/31/17. This would indicate the ISPs were not implemented within 30 days.

33. Six of six individuals participated in their ISP meetings. Three of four individuals who could participate in interview (Individual #162, Individual #123, Individual #216) were knowledgeable of the personal goals, preferences, strengths, and needs articulated in their individualized ISPs. Individual #333 and Individual #311 were not able to participate in this kind of interview. The Monitoring Team interviewed Individual #275 and did not find that she had an understanding of the living options personal goal included in her ISP. During the interview, Individual #275's primary focus was her desire to move to a group home in San Antonio. She had spent the morning preparing letters and lists for her QIDP and others stating her goal of moving to a group home. She indicated her IDT was helping her with this, but the IDT had determined that she should stay at Corpus Christi SSLC and was not actively pursuing transition.

34. One of six individuals (Individual #162) had an appropriately constituted IDT that participated in the planning process, based on their strengths, needs, and preferences. Examples of those did not included:

- No OT/PT staff attended Individual #275's ISP, despite frequent falls. No dietitian attended, despite her recent weight loss.
- For Individual #311, no SLP, OT, PT, dietitian, vocational or day program, or PCP attended.
- For Individual #216, no habilitation therapy staff attended, despite multiple falls. No nutritionist attended, despite significant unplanned weight loss over the last year.

When evaluating this indicator, the Monitoring Team also considers whether the QIDP was knowledgeable of the goals, preferences, strengths, and needs articulated in the individualized ISP. The Center's CAP had focused on improving QIDP knowledge of individuals' risk areas. The process included providing training to the QIDPs and then testing their knowledge through a guided interview. The interviews used a standardized tool that focused on health and safety risks. QIDPs who did not score at an acceptable level were re-trained and then re-interviewed. It was positive to see improvement in this area overall, although additional improvement continued to be needed.

| Outcome 6: ISP assessments are completed as per the individuals' needs. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Indicator 35 showed a large increase in performance since the last review, whereas indicator 36 remained at 0%. Both indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 311 | 275 | 123 | 216 | 162 | 333 | | | |
| 35 | The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting. | 83% 5/6 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | | | |
| 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 five of six individuals. The IDT should have requested an updated Structural and Functional Assessment for Individual #275.

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

- For Individual #333, the communication assessment lacked the needed components to be considered adequate and he did not have a current vocational/day program assessment.
- Individual #216 did not have an OT/PT assessment provided other than a screening, despite frequent falls. Instead she had a screening, but it did not mention falls.
- Several individuals did not have a current vocational or day program assessment, including Individual #333, as indicate above, Individual #162, and Individual #311.
- For Individual #311, a Communication assessment was not provided but should have been based upon the deficits noted in his screening.

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

Summary: The need for conduct of monthly reviews was evident. These indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 311 | 275 | 123 | 216 | 162 | 333 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 37 | The IDT reviewed and revised the ISP as needed. | 0%<br>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%<br>0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |

Comments:
Overall, consistent implementation and monitoring of ISP action steps continued to be areas of significant concern. QIDPs had not been completing monthly reviews, as described below. The Center had not had a process in place to consistently monitor the work of the QIDPs and implement corrective action as needed, but had recently initiated some strategies in this area, as also described below.

This was positive and appeared to be resulting in early improvements, but it was too early to assess success and consistency.

37. IDTs did not review and revise the ISPs as needed. The QIDP department was in the early stages of implementing CAP improvement initiatives for ensuring ISPAs were held as needed and for QIDPs knowledge of individuals' risk areas. These were positive developments. Still, ISPAs were not being held as needed. The Center's ISPA data indicated those meetings were held when

needed about 50 % of the time, based on a review of Team Integration Meetings, morning meetings, IMRT, IPNs, and QIDP Monthly Reviews. The QIDP department was just about to implement an ISPA tracking process (ISPA Tracker Log) focused on improving this response rate and timely completion of ISPA meetings. An ISPA Quality Review Checklist had also been developed to sample the quality of the meetings. The Monitoring Team looks forward to reviewing the results of these efforts at the next monitoring visit.

The IDTs also did not consistently complete assessments needed due to significant changes, a necessary component to ensuring the ISP is current. Examples included:

- For Individual #216, the Physical/Nutritional Management Team (PNMT) did not complete a review or assessment of her weight loss despite concern expressed by both nursing and nutrition that it needed to be halted. For example, the nursing quarterly (July 2016 to October 2016) stated no further weight loss was needed, but Individual #216 lost another 11 pounds the following quarter. The PNMT should have at least reviewed and assisted the IDT in determining cause and potential response.
- As described above, two of six individuals (Individual #216, Individual #275) had a significant number of falls, but the IDTs had not completed a falls analysis.

On a positive note, in response to a thorough record audit by the Quality Assurance department, the IDT for Individual #333 had addressed two important issues (oral intake/weight and mobility) that had been identified by the Monitoring Team across several previous monitoring periods. Both had had initial positive outcomes. After starting Megace (an appetite stimulant), Individual #333 was eating 75% at most meals and had gained seven pounds. He had also begun to participate in mobility training using a platform walker and was doing well, without refusals, after modifications of his AFOs. IDTs needed to apply this more assertive approach to identifying and addressing needs across the board, and not just for Individual #333, but also for all individuals.

38. In addition to not ensuring IDTs met to review and revise the ISP as needed, it was not possible to confirm that the QIDPs had been consistently knowledgeable of the goals, preferences, strengths, and needs articulated in the individualized ISP, as evidenced by their failure to track implementation of individuals' ISP action plans for many months. None of these six individuals had QIDP monthly reviews for the period of September 2016 through November 2016, and even later reviews were not typically completed on a timely basis. Action plans had not been implemented with consistency on a timely basis, if at all, as also described elsewhere in this report.

Still, in interview, three of six QIDPs were currently knowledgeable about individuals' preferences and needs. This was true, even though the Center had made many QIDP assignment changes in the past several months. This was an encouraging trend and likely a result of another CAP activity to enhance the knowledge of QIDPs in the area of risk through training and monitoring. It was good to see the QIDP department working collaboratively with the QA department to achieve these positive results.

| 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 | Individuals: |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| days. These indicators will remain in active oversight. | | | | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | The individual's risk rating is accurate. | 22% 4/18 | 1/2 | 0/2 | 1/2 | 1/2 | 0/2 | 1/2 | 0/2 | 0/2 | 0/2 |
| b. | The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs. | 39% 7/18 | 0/2 | 0/2 | 0/2 | 1/2 | 1/2 | 2/2 | 2/2 | 1/2 | 0/2 |

Comments: For nine individuals, the Monitoring Team reviewed the IRRFs for a total of 18 specific risk areas [i.e., Individual #216 – dental, and weight; Individual #311 – respiratory compromise, and skin integrity; Individual #191 – infections, and falls; Individual #239 – fractures, and skin integrity; Individual #241 – gastrointestinal (GI) problems, and weight; Individual #162 – fractures, and skin integrity; Individual #122 – fractures, and cardiac disease; Individual #70 – falls, and skin integrity; and Individual #333 – constipation/bowel obstruction, and osteoporosis].

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 #216 – dental, Individual #191 – falls, Individual #239 – fractures, and Individual #162 – fractures.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs generally completed IRRFs for individuals within 30 days of admission and updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #239 – fractures; Individual #241 – GI problems; Individual #162 – fractures, and skin integrity; Individual #122 – fractures, and cardiac disease; and Individual #70 – skin integrity.

**Psychiatry**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments. | | | | | | | | | | | |
| Summary: This outcome requires individualized diagnosis-specific personal goals be created for each individual and that these goals reference/measure psychiatric indicators regarding problematic symptoms of the psychiatric disorder, as well as psychiatric indicators regarding positive pro-social behaviors. It was encouraging to see some progress along these lines. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
| 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%<br>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%<br>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%<br>0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

Comments:

4. All of the individuals had identified target behaviors that were somewhat related to their psychiatric disorder. The primary target for everyone, except Individual #311, was physical and/or verbal aggression. Those identified for Individual #311 were agitation and anxiety. However, none of these were formulated as goals for which measurable outcomes with benchmarks for progress could be constructed. There were fewer references to pro-social behaviors that could be translated into positive goals. The individuals that had identified positive pro-social behaviors to increase were Individual #46 and Individual #186.

- To reiterate, there need to be personal goals that target the undesirable symptoms of the psychiatric disorder and that are tied to the diagnosis, and personal goals that would indicate improvement in the individual's psychiatric status.
- The goals need to be measurable, have a criterion for success, be presented to the IDT… appear in the IHCP, and be tracked/reviewed in subsequent psychiatry documents as well as be part of the QIDP's monthly review.

5. Neither the positive nor the negative behaviors were defined in a manner that could easily be formulated into measurable goals.

6. The facility performed periodic thorough assessments in the form of the PTPs as well as the annual updates to the CPEs. The negative target behaviors were based on these assessments, but as described above the target behaviors did not constitute measurable goals.

7. The data that were generated at Corpus Christi SSLC were not found to be reliable.

| Outcome 4 – Individuals receive comprehensive psychiatric evaluation. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Indicators 12 and 13 were moved to the category of requiring less oversight after the last review and will remain so. CPE content was at criteria for all individuals for this review and the last two reviews with one exception. Given this sustained high performance, this indicator (14) will also be moved to the category of requiring less oversight. Indicator 15, with sustained high performance might move to the category of requiring less oversight after the next review. Consistency in diagnostics across the record needs improvement and, therefore, indicator 16 will also remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
| 12 | The individual has a CPE. | Due to the Center's sustained performance, these indicators were moved to the | | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 13 | CPE is formatted as per Appendix B | category of requiring less oversight. | | | | | | | | | |
| 14 | CPE content is comprehensive. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 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. | 100% 4/4 | N/A | N/A | N/A | 1/1 | N/A | 1/1 | N/A | 1/1 | 1/1 |
| 16 | All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation. | 44% 4/9 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 |

Comments:

14. The facility has adopted the policy of revising and updating the CPEs for each individual on an annual basis so that the information remained current. These revisions were in addition to the annual Psychiatric Treatment Plan that is performed each year in conjunction with the ISP. The content of the revised CPEs continued to meet the content standards.

15. Individual #197, Individual #123, Individual #216, and Individual #135 were admitted to the facility since 1/1/14. For each of these individuals, there was evidence of an integrated progress note prepared by a member of the medical department on the day of admission as well as a CPE completed by a member of the psychiatric department with 30 days of admission.

16. The psychiatric diagnoses were consistent throughout the medical record for four individuals. The psychiatric diagnoses in the records of Individual #275, Individual #197, and Individual #311 were consistent in the psychiatric and behavioral health sections of the record, but the diagnoses in the annual medical assessment were different. For Individual #227, the diagnoses in the psychiatric and medical sections were consistent, but differed from those in the behavioral section. The psychiatric diagnoses for Individual #186 differed in all three of these sections of the record.

| Outcome 5 – Individuals' status and treatment are reviewed annually. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Three indicators were moved to the category of requiring less oversight after the last review and will remain there. Performance in the other two indicators improved, including to 100% for the annual ISP documentation content. These two indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
| 17 | Status and treatment document was updated within past 12 months. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| 18 | Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP). | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 19 | Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | | |
| 20 | The psychiatrist or member of the psychiatric team attended the individual's ISP meeting. | | | | | | | | | | | |
| 21 | The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting. | 67% 6/9 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 0/1 |

Comments:
18. The annual clinical update with information for the ISP primarily appears in the psychiatric treatment plan (PTP), although the Psychiatry department also updates the CPE annually as well. It is the PTP that is prepared in sequence with the ISP. These documents uniformly contained the required information.

21. The documentation in the ISPs was found to contain the essential elements for all of the individuals, except Individual #275, Individual #227, and Individual #135. The discussion of the side effects was detailed in all of the ISPs. The deficits in these three involved the lack of the justification for the conclusion that the interventions were the least intrusive as well as the integration of behavioral and pharmacological treatments.

| Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Two individuals had PSPs that had the required content, however, they should have had PBSPs instead due to the nature and severity of their behavioral presentations. | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | | |
| 22 | If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | | |

Comments:
22. Individual #311 and Individual #275 had PSPs, but should have had PBSPs (see psychology/behavioral health indicator 1). Thirty-three of the 101 individuals who were currently prescribed psychotropic medication had a PSP instead of a PBSP. This might be worthy of review by the directors of behavioral health and psychiatry. This was also mentioned in the last review.

| Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications. | |
|---|---|
| Summary: There was good improvement in the incorporation and referencing of alternate and/or non-pharmacological interventions into the consent process. Some additional details regarding risk of the potential cumulative side effects of taking multiple psychiatric medications. Both indicators will remain in active monitoring. | Individuals: |

| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 28 | There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | |
| 29 | The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable. | | | | | | | | | | |
| 30 | A risk versus benefit discussion is in the consent documentation. | 78% 7/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 0/1 | 1/1 | 1/1 |
| 31 | Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 32 | HRC review was obtained prior to implementation and annually. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |

Comments:
30. There was a risk benefit discussion in the consent for each of the individuals, however, for Individual #123 and Individual #227, this discussion did not contain a discussion of the risk of the cumulative side effects of the multiple psychotropic medications that they were prescribed.

31. The references to alternate non-pharmacological interventions contained in the consents for each individual were specific to the individual and referenced a number of different potential interventions.

**Psychology/behavioral health**

| Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments. | |
|---|---|
| Summary: Not all individuals who should have had a PBSP, had one. Instead, they had psychiatric support plans (PSP). PSPs are not designed to address the kinds of behaviors that these individuals were exhibiting. This indicator (1) was placed in the category of requiring less oversight after the last review, even with one individual needing further assessment at that time. Given this, and given the absence of this very important support (i.e., a PBSP) for some individuals, this indicator will be placed back into active monitoring. This became evident to the Monitoring Team in reviewing the behavioral health and psychiatric supports provided to these individuals. Indicator 2, however, will remain in the category of requiring less oversight. Goals in PBSPs were measurable, so with sustained high performance, indicator 3 might be moved to the category of requiring less oversight after the next review. Improvement was seen in indicator 4. However, without reliable data, indicator 5 remained at 0% performance again. Indicators 3, 4, and 5 | Individuals: |

| will remain in active monitoring. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
| 1 | If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.<br><br>Given the number of individuals with PSPs rather than PBSPs, indicator 1 was moved back under active monitoring. | | | | | | | | | |
| 2 | The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs. | | | | | | | | | | |
| 3 | The psychological/behavioral goals/objectives are measurable. | 100%<br>7/7 | 1/1 | N/A | N/A | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 4 | The goals/objectives were based upon the individual's assessments. | 71%<br>5/7 | 1/1 | N/A | N/A | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | 0/1 |
| 5 | Reliable and valid data are available that report/summarize the individual's status and progress. | 0%<br>0/7 | 0/1 | N/A | N/A | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

Comments:

1. Seven of the nine individuals reviewed by the behavioral health Monitoring Team had PBSPs. The exceptions were Individual #311 and Individual #275, both of whom had psychiatric support plans. Observation by the Monitoring Team, review of documents, and discussion with staff suggested that these two individuals should have an updated functional assessment completed with the corresponding development of a PBSP. Specifically, Individual #311 was reported to throw items and his PNMP noted aggression and pulling on his pump. ISPAs for Individual #275 noted a recent increase in her SIB, aggression, undressing, verbal threats, and a recent occurrence of pica.

Of the six individuals reviewed by the physical health Monitoring Team, three (Individual #241, Individual #333, Individual #191) had PBSPs. During the onsite visit, it was determined that of these six individuals, those who needed PBSPs had these in place. It should be noted that neither Individual #241 nor Individual #333 were included in the master list of those individuals with PBSPs. Further, Individual #241's plan was his admission PBSP with goals identified through 1/31/17. This plan should have been updated following the completion of a functional assessment. The facility reported he did not have an FBA. Individual #333's plan had just recently been developed in spite of repeated concerns expressed by the Monitoring Team regarding his challenging behaviors.

3. All seven individuals who had PBSPs had measurable goals for behavior change.

4. For five of the seven individuals (Individual #186, Individual #197, Individual #46, Individual #227, Individual #216) the behaviors identified in their PBSPs were based upon their functional assessments. Individual #123's functional assessment did not address emerging behaviors, including pica, that were addressed in her PBSP. Individual #135's PBSP included two potentially serious

monitored behaviors, self-injury and unauthorized departure, that were not addressed in his functional assessment.

5. Based upon a review of reported assessment of data timeliness and IOA, concerns regarding data accuracy reported in progress notes, and interview with the acting director of behavioral health services, it was determined that the data were not reliable.

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

Summary: Attention needs to be paid to behavioral and functional assessments being done, updated to be current, and complete with all required content. These indicators did not show any progress since the last review. All three will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 10 | The individual has a current, and complete annual behavioral health update. | 11% 1/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 | 0/1 | 0/1 |
| 11 | The functional assessment is current (within the past 12 months). | 57% 4/7 | 1/1 | N/A | N/A | 1/1 | 0/1 | 0/1 | 1/1 | 1/1 | 0/1 |
| 12 | The functional assessment is complete. | 57% 4/7 | 1/1 | N/A | N/A | 1/1 | 1/1 | 0/1 | 0/1 | 0/1 | 1/1 |

Comments:

10. Eight of the nine individuals had a current behavioral health assessment (BHA). The exception was Individual #46, whose assessment was dated 4/8/16. His ISP was held the week of the onsite visit, during which time his BHA was updated. The BHA for Individual #227 was determined to be complete. All others lacked a review of the individual's physical health over the previous year and Individual #135's BHA did not include an assessment of his cognitive abilities.

11. Four of the nine individuals had a current functional assessment. Individual #46's was completed in February 2016, Individual #123's was a review of an assessment completed in February 2016, and Individual #135's assessment was from February 2016. Functional assessments should be completed at a minimum of once annually and should include both indirect and descriptive assessments.

When the IDT is considering a change from a PBSP to a PSP (e.g., Individual #311 and Individual #275) or when new challenging behaviors are observed (e.g., Individual #123), these are advised more frequently. Individual #311's assessment was completed in July 2015, Individual #275's was dated May 2015 and was a review of an assessment completed in October 2012,

12. The functional assessments for four of the seven individuals who had PBSPs (Individual #186, Individual #197, Individual #46, Individual #135) were considered complete. Missing from the other assessments was a clear identification of antecedent variables or a clear summary statement.

| Outcome 4 – All individuals have PBSPs that are current, complete, and implemented. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: PBSPs were current for almost all individuals, but their content required a lot of attention, fixing, additions, and work for them to meet the criteria for indicator 15, as well as generally accepted standards in behavior analysis. These two indicators will remain in active monitoring. Corpus Christi SSLC was unable to maintain criteria with indicator 13, which is about timely implementation, in fact, performance dropped to 43%. Therefore, this indicator (13) will be moved back into active monitoring. The Monitoring Team found this information when reviewing data for these individuals. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
| 13 | There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.<br><br>Given the considerate decrease in performance, it will be moved back under active monitoring. | | | | | | | | | |
| 14 | The PBSP was current (within the past 12 months). | 86%<br>6/7 | 1/1 | N/A | N/A | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 |
| 15 | The PBSP was complete, meeting all requirements for content and quality. | 0%<br>0/7 | 0/1 | N/A | N/A | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

Comments:

13. The PBSPs for three individuals (Individual #197, Individual #46, Individual #227) were implemented within 14 days of all necessary consents/approvals. For Individual #186 and Individual #216, the plans were implemented before consent was obtained and, for Individual #123 and Individual #135, plan implementation occurred more than 14 days after the last consent.

14. The PBSP was current for six of the seven individuals. The exception was Individual #135 whose plan had been developed over a year prior to the onsite visit.

15. None of the PBSPs were considered complete.
    - All were missing the use of positive reinforcement in a manner likely to be effective.
    - There were not sufficient training opportunities for replacement behaviors.
    - Several plans included monitored behaviors, but there were no clear indications of when these behaviors would be reviewed so they could be addressed in the plan.
    - In Individual #123's plan, target behaviors were grouped by function, which did not allow for a review of improvement or worsening of several potentially harmful behaviors.
    - Antecedent and consequent strategies were not always specified. For example, in Individual #216's plan, prevention and

intervention sections addressed escape- and attention-motivated behaviors, suggesting that staff could identify the function of each of her targeted problem behaviors.

- Data collection procedures were often not described in detail. For example, verbal aggression exhibited by Individual #46 was to be tracked using a partial interval recording, but this was not possible in the electronic record.
- Less than half of the plans included baseline data.
- While not part of his plan, Individual #46 was suspended from work for two weeks. This suspension was not reviewed and approved by either the HRC or the facility director.

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

Summary: Not all individuals who needed counseling, were receiving counseling. And those that were did not have treatment plans that met the criteria. Both indicators showed a decrease in performance compared with the last review. Both indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 24 | If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service. | 50% 3/6 | N/A | N/A | N/A | 0/1 | 1/1 | 1/1 | 0/1 | 0/1 | 1/1 |
| 25 | If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes. | 0% 0/3 | N/A | N/A | N/A | N/A | 0/1 | 0/1 | N/A | N/A | 0/1 |

Comments:

24. Based upon information contained in the ISP or reviewed in an ISPA, there were six individuals who had been referred for counseling. Three of these individuals (Individual #46, Individual #123, Individual #135) were receiving this service. For three others, it appeared that there was a breakdown in communication among IDT members. In Individual #197's case, counseling was an identified service noted in his ISP from December 2016. A referral to counseling was included in Individual #227's IRRF from September 2016, but additional documents indicated that his plan had been discontinued by the behavior support committee in October 2016 while awaiting completion of his functional assessment. Notes from an ISPA in February 2017 indicated that the IDT was not aware that he had been accepted into counseling. Lastly, documents indicated that a referral to counseling for Individual #216 had been sent in November 2016, but this had not been reviewed by the behavior support committee. Subsequent ISPAs from November 2016 and January 2017 referenced the IDT's recommendation that counseling be pursued.

25. A review of documentation revealed goal directed services with measurable objectives and treatment expectations, data-based review of progress, criterion that would trigger a review and revision of the plan, and procedures for generalizing skills learned. The missing element was reference to evidence-based practices.

**Medical**

| Outcome 2 – Individuals receive timely routine medical assessments and care. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: It was positive that individuals reviewed had timely new-admission or annual medical assessments. If the Center maintains its progress with the timeliness of such assessments, Indicators a and b might move to the category requiring less oversight at the time of the next review. Center staff should ensure individuals' ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| 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 | N/A | 1/1 | 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. | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | N/A | 1/1 | 1/1 | 1/1 | 1/1 |
| c. | Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| Comments: a. and b. It was positive that individuals reviewed had timely new-admission or annual medical assessments.<br><br>c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." Interval reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interval reviews will need to occur more frequently. The ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. | | | | | | | | | | |

| Outcome 3 – Individuals receive quality routine medical assessments and care. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Center staff should focus on improving the quality of the medical assessments. Indicators a and c will remain in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| 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. | Due to the Center's sustained performance with this indicator, it has | | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | moved to the category requiring less oversight. | | | | | | | | | |
| c. | Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |

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 pre-natal histories, social/smoking histories, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Most, but not all included complete interval histories, and allergies or severe side effects of medications. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history, childhood illnesses, past medical histories, updated active problem lists, and plans of care for each active medical problem, when appropriate.

c. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #216 – weight, and falls; Individual #311 – aspiration, and gastrointestinal problems (GI) problems; Individual #191 – respiratory compromise, and falls; Individual #239 – aspiration, and GI problems; Individual #241 – weight, and cardiac disease; Individual #162 – aspiration, and osteoporosis; Individual #122 – respiratory compromise, and osteoporosis; Individual #70 – fractures, and aspiration; and Individual #333 – weight, and osteoporosis].

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

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

Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations. | 0% 0/17 | 0/1 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| b. | The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. | 6% 1/17 | 0/1 | 0/2 | 1/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |

Comments: a. Medical interventions generally were not included in individuals' IHCPs.

b. As noted above, the ISPs/IHCPs reviewed did generally not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. The exception was Individual #191's IHCP for falls.

**Dental**

| Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: The Center should continue its focus on improving the quality of dental exams and summaries. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| 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. | Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight. | | | | | | | | | |
| | ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days. | | | | | | | | | | |
| | iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting. | | | | | | | | | | |
| b. | Individual receives a comprehensive dental examination. | 67% 6/9 | 0/1 | 1/1 | 0/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 |
| c. | Individual receives a comprehensive dental summary. | 88% 7/8 | 1/1 | 1/1 | 1/1 | N/R | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 |

Comments: Individual #239 was at low risk for dental issues and was part of the outcome group, so a limited review was conducted.

b. It was positive that six individuals' dental exams included all of the necessary components (one of these individuals was edentulous – Individual #311). It was also positive that all of the dental exams reviewed included the following:

- A description of the individual's cooperation;
- An oral cancer screening;
- An oral hygiene rating completed prior to treatment;
- Sedation use;
- Periodontal charting;
- A description of periodontal condition;
- An odontogram:
- Caries risk;
- Periodontal risk;
- Specific treatment provided;
- The recall frequency; and
- A treatment plan.

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

- Information regarding last x-ray(s) and type of x-ray, including the date; and
- A summary of the number of teeth present/missing.

c. It was very positive that seven of the eight dental summaries addressed all of the necessary components. For Individual #333, the summary provided no information about dental conditions that adversely affect systemic health.

## Nursing

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

Summary: Due to previous high performance with regard to the completion of nursing quarterly record reviews and physical assessments, Indicator a.iii moved to the category requiring less oversight. However, based on the nursing quarterlies the Monitoring Team used for other elements of its review, problems were noted with regard to the timely completion or completion at all of quarterlies for some quarters for some individuals; completion of complete physical assessments, including Braden scores and weights; and/or thorough reviews of the individuals' risk areas. As a result, Indicator a.iii will move back to active monitoring. It was positive that many of the annual nursing assessments reviewed included status updates of the current medical and behavioral/mental health risks. However, focus needs to be placed on ensuring nurses analyze health risks, and include recommendations regarding treatment, interventions, strategies, and programs in annual nursing assessments. Nurses conducted assessments in accordance with nursing protocols or current standards of practice in relation to 50% of the changes in status reviewed, which was an improvement from the last review (i.e., Round 11 – 0%). The Center should continue to focus on this important area of nursing practice. All of these indicators will remain in active oversight.

| # | Indicator | Overall Score | Individuals: 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Individuals have timely nursing assessments: | | | | | | | | | | |
| | i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission. | 0% 0/1 | N/A | N/A | N/A | N/A | 0/1 | 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 | 63% 5/8 | 0/1 | 1/1 | 0/1 | 1/1 | N/A | 1/1 | 0/1 | 1/1 | 1/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 10 days prior to the ISP meeting. | | | | | | | | | | |
| | iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due. | Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.<br><br>However, due to poor performance, Indicator a.iii will move back to active monitoring. | | | | | | | | | |
| 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%<br>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. | 50%<br>7/14 | 0/1 | 0/1 | 1/2 | 1/2 | 0/2 | 2/2 | 1/1 | 1/1 | 1/2 |

Comments: a. Problems included:

- For Individual #241, the admissions nursing assessment did not include a complete assessment or Braden score.
- For Individual #216, the physical assessment was not provided for the annual comprehensive nursing assessment, dated 2/7/17.
- For Individual #191, the annual nursing assessment did not include a full physical assessment with a Braden score. The copy the Center provided to the Monitoring Team was 60 pages long with the majority of the information crossed out.
- For Individual #122, the physical assessment was not provided for the annual comprehensive nursing assessment, dated 7/19/16, nor was a Braden score completed.

Based on the Monitoring Team's use of nursing quarterlies for other elements of its review, problems were noted for four of the nine individuals (i.e., Individual #241, Individual #162, Individual #122, and Individual #70) with regard to the timely completion or completion at all of quarterlies; completion of complete physical assessments, including Braden scores and weights; and/or thorough reviews of the individuals' risk areas. As a result, Indicator a.iii will move back to active monitoring.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #216 – dental, and weight; Individual #311 – respiratory compromise, and skin integrity; Individual #191 – infections, and falls; Individual #239 – fractures, and skin integrity; Individual #241 – GI problems, and weight; Individual #162 – fractures, and skin integrity; Individual #122 – fractures, and cardiac disease; Individual #70 – falls, and skin integrity; and Individual #333 – constipation/bowel obstruction, and osteoporosis).

None of the nursing assessments sufficiently addressed the risk areas reviewed. However, on a positive note, many of the nursing assessments reviewed included status updates of the current medical and behavioral/mental health risks. In fact, 12 out of 18 risks had status updates. The ones that did not were those for: Individual #216 – dental, and weight; Individual #311 – skin integrity; Individual #241 –weight; Individual #162 – fractures; and Individual #70 – skin integrity. Common problems with the nursing assessments included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; 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. Since the last review, good progress was seen with this indicator. Nurses conducted assessments in accordance with nursing protocols or current standards of practice in relation to 50% of the changes in status reviewed (i.e., for the last review, adherence to this standard was 0%). This included changes for Individual #191 – falls; Individual #239 – fractures; Individual #162 – fractures, and skin integrity; Individual #122 – fractures; Individual #70 – falls; and Individual #333 – constipation/bowel obstruction. The following provide a few of examples of concerns:

- Although the documentation indicated that Individual #216's RN Case Manager sent a referral regarding her weight loss on 9/22/16 (i.e., a 45-pound weight loss in six months), no nursing assessment was found to correspond with the referral.
- For Individual #311, on 2/8/17 at 12:30 p.m., an IPN noted labored breathing that a nurse observed during medication pass. IView documentation did not indicate that lung sounds were assessed at this time.
- On 11/14/16, an IPN indicated that Individual #191 pulled out two toenails on his right foot and had pulled out his great toe toenail on left foot during the night. The nursing assessment did not include a description of the areas, whether or not the individual expressed pain, mental status and mood, what strategies were in place to prevent him from pulling out other nails, whether or not behavioral health services staff was notified and aware, and/or why the individual had pulled the nails out.
- On 11/22/16, an IPN from an RN noted that an LVN reported coffee ground emesis coming from Individual #239's mouth. No note or assessment was found from the LVN on this date addressing the coffee ground emesis.

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

| Summary: Given that over the last four review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight. | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| b. | The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| c. | The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working). | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| d. | The IHCP action steps support the goal/objective. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| e. | The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements). | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| f. | The individual's ISP/IHCP identifies the frequency of monitoring/review of progress. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| Comments: a. through f. Significant work was needed to ensure that IHCPs included nursing interventions to comprehensively address individuals' chronic conditions and at-risk conditions. | | | | | | | | | | | |

**Physical and Nutritional Management**

| Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: It was positive that as needed, a Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results. Since the last review, some important progress was noted with regard to the PNMT documenting more discussion related to attempts to identify the etiology of the individual's condition or risk area. However, more in-depth analysis was needed when the root or underlying cause was not immediately apparent. This will require the PNMT to involve other disciplines, such as pharmacy and behavioral health, as well as medical. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT. | 75% 6/8 | 0/1 | N/A | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 |
| b. | The PNMT review is completed within five days of the referral, but sooner if clinically indicated. | 88% 7/8 | 0/1 | | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| c. | For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely. | 50% 3/6 | 0/1 | | 1/1 | 0/1 | N/A | 0/1 | N/A | 1/1 | 1/1 |
| d. | Based on the identified issue, the type/level of review/assessment meets the needs of the individual. | 75% 6/8 | 0/1 | | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| e. | As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results. | 100% 6/6 | N/A | | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A |
| f. | Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue. | 50% 4/8 | 0/1 | | 1/1 | 0/1 | 1/1 | 0/1 | 1/1 | 1/1 | 0/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| g. | If only a PNMT review is required, the individual's PNMT review at a minimum discusses:<br>• Presenting problem;<br>• Pertinent diagnoses and medical history;<br>• Applicable risk ratings;<br>• Current health and physical status;<br>• Potential impact on and relevance to PNM needs; and<br>• Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan. | 33%<br>1/3 | N/A | | 0/1 | N/A | 0/1 | N/A | 1/1 | N/A | N/A |
| h. | Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary. | 0%<br>0/6 | 0/1 | | 0/1 | 0/1 | N/A | 0/1 | N/A | 0/1 | 0/1 |

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

- Individual #216's RN Case Manager and the nutritionist expressed concerns about her continued weight loss. The nursing quarterly review, for the period from July 2016 to October 2016, stated that no further weight loss was needed, but Individual #216 lost another 11 pounds the following quarter. The PNMT should have conducted an assessment and assisted the IDT in determining the cause and potential response.
- For Individual #191, the PNMT conducted a review with regard to weight, and a comprehensive assessment related to recurrent pneumonia. During an observation of a meal, the Registered Dietician (RD) noted that Individual #191 was coughing. However, the PNMT review for weight loss lacked follow-up on this finding. The RD was also supposed to notify the Occupational Therapist that Individual #191 wanted to have his chicken whole with the bone, but the review did not include a recommendation for a consultation.
- For Individual #239, the goal/objective that the IDT developed was to reduce the number of aspiration triggers to less than 15. When this goal/objective was not met and Individual #239 experienced 20 aspiration triggers, the IDT should have sought the assistance of the PNMT for at least a review. However, they did not, and the PNMT only reviewed him in December 2016, after he had a pneumonia diagnosis in November 2016. Moreover, due to Individual #239's ongoing issues with recurrent pneumonias (both aspiration and bacterial), a comprehensive assessment was warranted that looked at all aspects of care. This should have included assessments and not just observations of head-of-bed elevation, positioning tolerance, review of enteral nutrition, and gastric emptying in various positions.
- The PNMT review for Individual #241 for multiple pneumonias in November 2016 and January 2017 did not clearly discuss the potential impact of his PNM-related issues, such as weight on respiration.
- On 7/27/16, the PNMT initiated Individual #162's comprehensive assessment, but did not complete it until 10/7/16. The PNMT did not provide a rationale for the extensive delay. Anxiety was theorized to impact her physical health, but the PNMT did not appear to have involved Behavioral Health Services staff in her assessment. In addition, a medical provider was not involved to lead the medical discussion.
- The PNMT assessed Individual #122 in response to a left humeral fracture and potential aspiration pneumonia. The PNMT review included observations in multiple facets of care, including the relevance and adequacy of what the PNMT already

conducted.

- The PNMT assessed Individual #70 in response to multiple pneumonias. The assessment showed much more promise in that it was more thorough than assessments the Monitoring Team reviewed during previous visits. Still missing from the assessment were the development of measurable goals for implementation post assessment and the adequate review of medications.
- For Individual #333, the PNMT did not define individualized re-referral criteria. This was important due to Individual #333's significant history of weight loss and the difficulty he had regaining the weight once he lost it. A more individualized and proactive approach was needed that would have triggered a PNMT review or assessment earlier than the six-month weight loss mark. Although the PNMT identified multiple medications that had the potential to impact appetite or cause stomach pain, which could influence intake, a Pharmacy review was not part of the PNMT comprehensive assessment.

h. As noted above, two individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #216, and Individual #239). The following summarizes some of the findings related to the four assessments that the PNMT completed:

- On a positive note, since the last review, the PNMT was documenting more discussion related to attempts to identify the etiology of the individual's condition or risk area. However, more in-depth analysis was needed when the root or underlying cause was not immediately apparent. Individual #333's assessment was a good example of this lack of further analysis. The PNMT identified meal refusals and medications as being potentially root causes for his weight issues. However, to get to the actual root cause, the PNMT needed to do more investigation to determine what was causing the meal refusals, and if medications were suspect, then the PNMT needed to involve both Pharmacy Department staff and a medical provider in the assessment and investigation process. In addition, Individual #333's assessment lacked a review of the impact of the dining setting on his intake, as well as a preference assessment and analysis of various items provided through food services or other sources.
- Similarly, for Individual #162, as noted above, anxiety was theorized to impact her physical health, but the PNMT did not appear to have involved Behavioral Health Services staff in her assessment to further assess whether or not this was an underlying cause.
- The review of individuals' medications and their potential or realized side effects was a problem across all assessments reviewed. Although the assessments listed medications that were potentially pertinent to the issues, the PNMT did not determine whether or not the individual was experiencing any of the potential side effects.
- All of the assessments were missing recommendations for measurable, clinically relevant goals/objectives. This was exacerbated by the lack of in-depth root cause analysis discussed above. Until the PNMT identifies the underlying cause of the issue, it is difficult, if not impossible, to develop a clinically relevant goal/objective.
- The PNMT assessment for Individual #70 was missing the two key elements listed above. That being said, his assessment was much improved from those seen during previous reviews.
- On a positive note, all of the PNMT assessments included the following:
  - Presenting problem;
  - Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs;
  - Review of the applicable risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification;
  - Assessment of current physical status; and
  - Discussion as to whether existing supports were effective or appropriate.

| Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. These indicators will remain in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| 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. | 11% 2/18 | 0/2 | 0/2 | 1/2 | 0/2 | 0/2 | 1/2 | 0/2 | 0/2 | 0/2 |
| f. | Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable. | 13% 1/8 | 0/1 | 1/1 | N/A | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| g. | The individual ISP/IHCP identifies the frequency of monitoring/review of progress. | 24% 4/17 | 0/2 | 0/2 | 1/1 | 0/2 | 0/2 | 2/2 | 0/2 | 0/2 | 1/2 |

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: choking, and weight for Individual #216; aspiration, and GI problems for Individual #311; weight, and aspiration for Individual #191; skin integrity, and aspiration for Individual #239; aspiration, and GI problems for Individual #241; skin integrity, and aspiration for Individual #162; skin integrity, and aspiration for Individual #122; fractures, and aspiration for Individual #70; and aspiration, and weight for Individual #333.

a. and b. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP, and/or include preventative physical and nutritional management interventions to minimize the individuals' risks. The IHCPs consistently lacked the needed integrated actions steps to mitigate risk. Action steps remained extremely vague and not clearly linked to the risk at hand. Action steps should reflect in detail the relevant strategies outlined in the PNMP (i.e., the ISP should set forth the strategies the individual needs, and the PNMP should be the "cheat sheet" for staff), as well as measurable objectives Habilitation Therapy staff identify that will contribute to minimizing the risk. In addition, the steps should include criteria or thresholds the PNMT or other therapists developed.

c. All individuals reviewed had PNMPs and/or Dining Plans. Although the PNMPs included a number of the required components, there were three areas on which the Center needs to focus:

- Risk levels related to supports and individual triggers, if applicable: At times, risks that individuals had were missing from the list (e.g., weight, and behavior for Individual #216; respiratory, falls, and weight for Individual #191; and constipation for Individual #162). In addition, often, risk areas were listed, but the assigned severity was not listed;
- Oral Hygiene, including positioning and brushing instructions: For most of the individuals reviewed, sufficient detail was not included in this section (e.g., who should provide the service, how it should be provided, when nursing staff needed to be involved, need for staff prompting, etc.); and
- Communication (staff and individual): For approximately half the individuals reviewed, communication instructions did not reflect important information from the communication assessment (e.g., format by which staff should make a request, use of specialized techniques to enhance the individual's understanding, reference to AAC devices, etc.), and/or provided information using clinical jargon (e.g., pre-linguistic levels of speech), which detracts from staff's ability to understand.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for skin integrity for Individual #239, and aspiration for Individual #162.

f. The IHCP that identified triggers and actions to take should they occur was for aspiration for Individual #311. In a number of cases, aspiration triggers were mentioned in the action plans, but the action plans did not define what to do should they occur, and/or the triggers were not specific enough to ensure staff consistently identified them, and/or were inconsistent with those in the PNMP.

g. The IHCPs that defined the frequency of monitoring were those for weight for Individual #191; skin integrity, and aspiration for Individual #162; and weight for Individual #333.

**Individuals that Are Enterally Nourished**

| Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs. | | | | | | | | | | | |
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| Summary: These indictors will remain in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake. | 17% 1/6 | N/A | 0/1 | N/A | 0/1 | N/A | 1/1 | 0/1 | 0/1 | 0/1 |
| b. | If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely. | 0% 0/4 | | 0/1 | | N/A | | N/A | 0/1 | 0/1 | 0/1 |

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| Comments: a. and b. For a number of individuals reviewed, their IRRFs and/or PNMT assessments did not provide clear descriptions of why the individuals could not eat and only stated that there were no plans to return to oral intake. For Individual #70 (about whom the State had questions in its comments on the draft report), while the PNMT assessment contained a history of modified barium swallow study (MBSS) results, the assessment did not contain a current review of the individual's functioning. Additionally, the information noted in the PNMT assessment was not integrated into the IRRF. Details should include, as appropriate to the individual, any previous trials with oral intake, review of the individual's current status or noted changes in status, whether or not less restrictive options have been considered or are feasible, and if not, whether or not there would be benefits to oral motor strengthening. In making improvements, Center staff should refer to the Monitoring Team's audit tool for guidance about assessment information needed. |

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

| Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Since the last review, progress was noted with regard to the timeliness of OT/PT assessments, as well as the completion of the correct type of OT/PT assessments (e.g., comprehensive assessment, update, consultation) in accordance with the individuals' needs. The quality of OT/PT assessments continues to be an area on which Center staff should focus. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| 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. | N/A | | | | | N/R | | | | |
| | 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. | 75% 6/8 | 0/1 | 1/1 | 0/1 | 1/1 | | 1/1 | 1/1 | 1/1 | 1/1 |
| b. | Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs. | 88% 7/8 | 0/1 | 1/1 | 1/1 | 1/1 | | 1/1 | 1/1 | 1/1 | 1/1 |
| c. | Individual receives quality screening, including the following:<br>• Level of independence, need for prompts and/or | 0% 0/1 | 0/1 | N/A | N/A | N/A | | N/A | N/A | N/A | N/A |

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| | supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills;<br>• Functional aspects of:<br>▪ Vision, hearing, and other sensory input;<br>▪ Posture;<br>▪ Strength;<br>▪ Range of movement;<br>▪ Assistive/adaptive equipment and supports;<br>• Medication history, risks, and medications known to have an impact on motor skills, balance, and gait;<br>• Participation in ADLs, if known; and<br>• Recommendations, including need for formal comprehensive assessment. | | | | | | | | | | |
| d. | Individual receives quality Comprehensive Assessment. | 50%<br>1/2 | 0/1 | N/A | N/A | N/A | | N/A | N/A | N/A | 1/1 |
| e. | Individual receives quality OT/PT Assessment of Current Status/Evaluation Update. | 0%<br>0/6 | N/A | 0/1 | 0/1 | 0/1 | | 0/1 | 0/1 | 0/1 | N/A |

Comments: a. through c. Six of the eight individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status. The following concerns were noted:

- Since September 2016, Individual #216 fell at least eight times. There was no evidence that an OT/PT had conducted a consultation in response to the falls, or that the IDT met to discuss the underlying cause(s) of the falls. She had only had an OT/PT screening, but should have had an assessment. The screening did not mention the falls, and noted that she did not have gait or balance problems.
- For Individual #191, the timeliness with which the OT/PT conducted a consultation regarding back support when lifting heavy objects could not be determined. The consultation form did not list the referral date.

d. As noted above, Individual #216 should have had a comprehensive assessment, but did not. The Monitoring Team reviewed the comprehensive OT/PT assessment for Individual #333, and found that it included all of the required components, met the needs of the individual, and incorporated his strengths, and preferences.

e. Center clinicians are encouraged to use the audit tool as a checklist as they complete their assessments, and to focus on the following areas that were identified as problematic in assessments or updates that did not meet criteria:

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: The levels of severity of the risks were not listed for one individual;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: For two individuals, the updates did not identify whether or not the individual experienced potential side effects,

and/or provide an analysis the possible impact on OT/PT 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: Two assessments did not provide a functional description of the individuals' skills;
- 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): For one individual, the necessary rationale for the adaptations to the adaptive equipment was not included in the update;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: All of the updates reviewed had concerns noted with this sub-indicator. Often, the updates provided no review of monitoring findings. At times, conclusions were drawn that because an individual had not been sick that the supports were effective. Lack of illness should generally not be the only measure of effectiveness;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services: Because individuals often did not have goals/objectives that were clinically relevant and measurable, the updates often did not include evidence regarding progress, maintenance, or regression; 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: Some updates did not address identified needs through recommendations, provide the necessary detail to allow IDTs to develop meaningful programs, and/or recommend integration of OT/PT supports into other programs.

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

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services; and
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments.

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

| Summary: Given that over the last two review periods and during this review, individuals' ISPs generally included a description of how the individual functioned from an OT/PT perspective (Round 10 – 89%, Round 11 – 89%, and Round 12 - 88%), Indicator a will move 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. | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |

| | | Score | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | The individual's ISP includes a description of how the individual functions from an OT/PT perspective. | 88% 7/8 | 0/1 | 1/1 | 1/1 | 1/1 | N/R | 1/1 | 1/1 | 1/1 | 1/1 |
| b. | For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate. | 100% 8/8 | 1/1 | 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. | 86% 6/7 | N/A | 1/1 | 1/1 | 1/1 | | 0/1 | 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. | 75% 3/4 | N/A | N/A | 0/1 | N/A | | N/A | 1/1 | 1/1 | 1/1 |

Comments: a. Individual #216's ISP stated she required some assistance with some activities of daily living, but provided no further details.

c. and d. Examples of concerns noted included:

- For Individual #191, evidence was not found of an ISPA meeting to discuss the initiation of lower back exercises that the OT recommended.
- For Individual #162, the IDT implemented a plan to track her position every 20 minutes. However, based on review of the documentation, if Individual #162 needed repositioning more frequently than at the 20 minute intervals, staff were not tracking this information. In addition, there was no evidence of analysis of acquired data. Tracking the need for repositioning is vital to determining the appropriateness of the wheelchair and related supports.

**Communication**

| Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports. | |
|---|---|
| Summary: It was good to see progress with regard to the timeliness of communication assessments and screenings. However, some individuals' screenings revealed the need for a more complete assessment, but such assessments were not completed. The quality of the assessments and updates required improvement. Of significant concern, communication assessments often indicated that alternative and augmentative communication (AAC) options were not appropriate for the individual due to his or her intellectual or developmental disability diagnosis. As a result, no further assessment was conducted. Similarly, | Individuals: |

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| screenings often stated that the individual's communication deficits were consistent with his/her diagnosis and then offered no further investigation. This is not consistent with current generally accepted standards. These indicators will remain in active oversight. | | | | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | Individual receives timely communication screening and/or assessment: | | | | | | | | | | |
| | i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment. | 100% 1/1 | N/A | N/A | N/A | N/A | 1/1 | N/A | N/A | N/A | N/A |
| | ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission. | 100% 1/1 | N/A | N/A | N/A | N/A | 1/1 | 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. | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | N/A | 1/1 | 1/1 | 1/1 | 1/1 |
| b. | Individual receives assessment in accordance with their individualized needs related to communication. | 56% 5/9 | 1/1 | 0/1 | 1/1 | 0/1 | 1/1 | 1/1 | 0/1 | 0/1 | 1/1 |
| c. | Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following:<br>• Pertinent diagnoses, if known at admission for newly-admitted individuals;<br>• Functional expressive (i.e., verbal and nonverbal) and receptive skills;<br>• Functional aspects of:<br>▪ Vision, hearing, and other sensory input;<br>▪ Assistive/augmentative devices and supports;<br>• Discussion of medications being taken with a known impact on communication;<br>• Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and<br>• Recommendations, including need for assessment. | 0% 0/4 | N/A | 0/1 | N/A | 0/1 | N/A | N/A | 0/1 | 0/1 | N/A |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| d. | Individual receives quality Comprehensive Assessment. | 0%<br>0/8 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | N/A |
| e. | Individual receives quality Communication Assessment of Current Status/Evaluation Update. | 0%<br>0/1 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 0/1 |

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

- Individual #311 had a picture communication board, so he should have received an assessment instead of a screening. In addition, the screening, identified a number of areas in which the individual was below functional limits, such as topic maintenance, ability to protest, and turn-taking, which should have resulted in further assessment. It was particularly concerning that an option for the SLP to mark on the screening template was that the skills (in this case deficits) were consistent with the individual's intellectual disability diagnosis, and, therefore, no further training or assessment was needed.
- Based upon the findings of Individual #239's screening, the SLP should have completed an assessment to investigate areas of deficit further, for example, joint attention, and responding to directives or methods to gain attention. As noted above, it was concerning that the individual's diagnosis was used to try to justify the decision to provide no further assessment or training. In addition, the screening did not meet expectations with regard to review of medications, explanation of communication issues in functional terms, and recommendations.
- Individual #122 had severely limited means of expressive and receptive language. The screening did little to explore methods to expand her world and bridge the gap between her and others. In addition, the screening did not meet expectations with regard to review of medications, explanation of communication issues in functional terms, and recommendations. Given her needs, the screening should have recommended an assessment.
- For Individual #70, the SLP should have completed an assessment to investigate areas of deficit identified through the screening. In addition, the screening provided no discussion regarding whether potential side effects of medication were noted, and offered no detail regarding which AAC device(s) was investigated.

d. Based on screening results, Individual #311, Individual #239, Individual #70, and Individual #122 should have had assessments, but did not. Center clinicians are encouraged to use the audit tool as a checklist as they complete their assessments, and to focus on the following areas that were identified as problematic in assessments or updates that did not meet criteria:

- The individual's preferences and strengths are used in the development of communication supports and services: For most of the assessments reviewed, individuals' preferences were not meaningfully addressed in the assessments;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services: Although the assessments listed the individuals' medications and potential side effects, most lacked discussion of whether such side effects had been noted for the individual being assessed;
- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills: Most assessments lacked clear functional descriptions of how the individuals expressed and received communication. Strengths were not clearly developed into potential avenues of communication;
- The effectiveness of current supports, including monitoring findings: For the most individuals, results of monitoring/observations over the previous year were not cited, and/or the assessors concluded that supports were effective, but provided no data to support this conclusion;

- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services: Individual #162's assessment met criterion for this sub-indicator. For Individual #216 and Individual #241, it was not applicable. Individual #191's PNMP indicated that he became frustrated when asked to repeat himself when listeners did not understand him. It was unclear whether or not other strategies had been investigated;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated: Two assessments met the criterion for this indicator. Two indicated that Behavioral Health Services staff were consulted, but provided no detail other than stating that the replacement behavior was appropriate; 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: Individual #162's assessment met criterion for this sub-indicator. The remaining assessments often did not offer recommendations for identified needs. In addition, they often did not offer recommendations related to integrating communication strategies into other programs or SAPs.

On a positive note, all four assessments provided:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication; and
- A comparative analysis of current communication function with previous assessments.

e. The Monitoring Team reviewed the update for Individual #333. The only sub-indicator that met criterion was: Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication. Some of the problems noted with the update included: Individual #333's preferences were not noted or integrated into the update; medications that might be pertinent to the problem(s) were not reviewed; the update offered limited to no discussion about the potential expansion of skills; the assessor did not review monitoring data to support statements or the effectiveness of current strategies; the update provided no review or assessment of AAC, other than to make a statement that due to his diagnosis of intellectual disability, AAC was not an option; and the update offered limited recommendations.

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

| Summary: These indicators will remain in active oversight. | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| 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. | 67% 6/9 | 0/1 | 0/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| b. | The IDT has reviewed the Communication Dictionary, as appropriate, | 17% | N/A | 1/1 | N/A | 0/1 | N/A | 0/1 | 0/1 | 0/1 | 0/1 |

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| | and it comprehensively addresses the individual's non-verbal communication. | 1/6 | | | | | | | | | |
| c. | Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment. | 60% 6/10 | 0/1 | 0/1 | 0/1 | 1/1 | 0/1 | 2/2 | 1/1 | 1/1 | 1/1 |
| d. | When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation. | 50% 1/2 | 0/1 | N/A | N/A | N/A | N/A | 1/1 | N/A | N/A | N/A |
| Comments: a. The information in Individual #191's ISP about his communication was not consistent with the information in his PNMP. Individual #216 and Individual #311's ISPs provided vague and incomplete information about the individuals' communication skills.<br><br>b. Individual #216's ISP indicated that a trial of direct therapy would be conducted, but no ISPA was found to show that it occurred and/or the results. | | | | | | | | | | | |

**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: Corpus Christi SSLC maintained performance in the presence of SAPs and measurability of SAPs. Their basis in assessment, practicality, functionality, and meaningfulness remained about the same, that is, below criteria. The number of SAPs that had reliable data dropped to 0%. These three indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
| 1 | The individual has skill acquisition plans. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | |
| 2 | The SAPs are measurable. | | | | | | | | | | |
| 3 | The individual's SAPs were based on assessment results. | 67% 18/27 | 1/3 | 3/3 | 2/3 | 0/3 | 2/3 | 2/3 | 3/3 | 2/3 | 3/3 |
| 4 | SAPs are practical, functional, and meaningful. | 37% 10/27 | 2/3 | 1/3 | 1/3 | 0/3 | 1/3 | 2/3 | 2/3 | 0/3 | 1/3 |
| 5 | Reliable and valid data are available that report/summarize the individual's status and progress. | 0% 0/27 | 0/3 | 0/3 | 0/3 | 0/3 | 0/3 | 0/3 | 0/3 | 0/3 | 0/3 |
| Comments:<br>1-2. All of the individuals had multiple skill acquisition plans and they remained measurable. It was good to see that every individual had at least three SAPs. | | | | | | | | | | | |

3. Many, but not all, of the SAPs were based upon assessments. For example, several individuals had SAPs that focused on skills that he or she had already mastered as indicated by the Functional Skills Assessment (e.g., Individual #186 - scheduling an event, Individual #275 - money management, Individual #197 - money management, reading, and rules of basketball, Individual #46 - exercise, Individual #216 - healthy snack). In Individual #123's case, she was to verbalize positive qualities in response to a recent emergence of pica behavior. This was based on an assumption that she engaged in the behavior to copy others.

4. Many of the SAPs were not practical, functional, or meaningful. For example, many of the SAPs chosen by the facility for the Monitoring Team to observe did not focus on the development of new skills. These consisted of verbal reports of events that made the individual angry (Individual #46), positive qualities (Individual #123), behaviors that would show respect for others (Individual #227), ways one could be exploited (Individual #216), and consequences of engaging in property destruction (Individual #135). In other words, Many SAPs looked for the individual to talk about appropriate social behavior or consequences for inappropriate behavior. Verbal report does not necessarily result in a change in behavior. Other SAPs were not functional because they did not teach a useful skill (e.g., Individual #311 - learning to press a button on a camera held by staff, Individual #275 - learning to place clothing on a model of a person, Individual #216 - learning to eat a snack that she prepared).

5. Data were not reliable. Absent were monthly data based reviews of the individual's progress.

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: All three important assessments to set the occasion for there being the types of SAPs that can meet indicators 3 and 4 were not completed for most individuals at the required criteria. Indicators 10 and 11 showed decreased performance, and indicator 11 showed increased performance, compared with the last review. All three indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 10 | The individual has a current FSA, PSI, and vocational assessment. | 33% 3/9 | 1/1 | 1/1 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 | 0/1 | 0/1 |
| 11 | The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP. | 78% 7/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 0/1 | 1/1 |
| 12 | These assessments included recommendations for skill acquisition. | 22% 2/9 | 0/1 | 1/1 | 1/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

Comments:

10. Three of the nine individuals (Individual #186, Individual #311, Individual #227) had current Functional Skills Assessments.

11. Required assessments were available to the IDT at least 10 days prior to the ISP meeting for everyone, but Individual #227 and

Individual #216.

12. Recommendations for the acquisition of new skills were provided in the Functional Skills Assessment for all nine individuals. Conversely, the vocational assessment for Individual #275 only provided this recommendation. Individual #311's vocational assessment was excluded from this indicator because he was not working and was of retirement age.

**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. At the last review, 24 of these indicators, in restraints, psychiatry, medical, dental, and OT/PT, were moved to the category of requiring less oversight. For this review, two other indicators were added to this category, in psychiatry and dental. In medical, however, one indicator was moved back to the category of active monitoring.

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

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.

When there were more than three restraints in a rolling 30-day period, the IDTs did not meet for all individuals to review their restraints. For those who were reviewed, not all of the required aspects of the review occurred.

Every individual who was not being seen by psychiatry had a Reiss screen completed. Content of the quarterly psychiatry documentation met criteria.

In behavioral health, regarding PBSPs and PSPs, given the absence of good, reliable data, progress could not be determined for all of the individuals. Data-laden progress reviews are an important part of the provision of behavioral health services. Data collection systems for the occurrence of problem target behaviors need much attention.

Acute Illnesses/Occurrences

Based on interview with the Chief Nurse Executive (CNE), nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected.

The Center should focus on ensuring that individuals with acute illnesses or injuries have quality medical assessments documented in the IPNs, ISPA meetings are held post-hospitalization, and IDTs address follow-up medical and healthcare supports to reduce risks and enhance early recognition, and that PCPs conduct necessary follow-up.

Without measurable psychiatry-related goals, progress could not be determined. Even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals.

Implementation of Plans
Psychiatry and behavioral health coordinated treatment.

Behavioral services had developed PBSP summaries for all seven individuals. There was documentation to show that less than half of the regular staff were trained in the implementation of the individual's PBSP.

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

Since the last review, the efforts and training the Nursing Educators and nursing staff undertook was evident in the exceptional medication administration sessions observed for all eight individuals. In addition, it was extremely positive that during observations, medication nurses completed lung sounds for applicable individuals. However, because the IHCPs did not define these assessments, the Center did not meet criteria for the related indicators. Nursing staff are encouraged to continue this practice during medication passes, and RN Case Managers should ensure that individuals' IHCPs and/or acute care plans define the assessments individuals need.

Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. On a positive note, documentation generally was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs. Additional work is needed to ensure 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. These treatments, interventions, and strategies need to be included in IHCPs, and PCPs need to implement them timely and thoroughly.

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

At the time of the last review, the Center had sustained good performance with regard to a number of indicators related to the provision of dental care and treatment, so these indicators moved to the category of less oversight. Based on this review, the indicator related to prophylactic care also will move to the less oversight category. Areas on which the Center should focus are

suction tooth brushing, and the development and implementation of care plans for individuals with periodontal disease. Both of these will require the cooperation of the Dental Department as well as other members of individuals' IDTs.

It was good to see improvement with regard to the timeliness as well as the quality of the QDRRs. In addition, when prescribers indicated agreement with recommendations, they implemented them. However, it was concerning that prescribers had not consistently reviewed QDRRs timely, and documented agreement or provided a clinical justification for lack of agreement with Pharmacy's recommendations.

**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: The IDTs for two individuals did not meet to review their restraints as required by this outcome. For those who were reviewed, not all of the required aspects of the review occurred. These indicators will remain in active monitoring (except for indicator 24 which was moved to the category of active monitoring after the last review and will remain in that category). | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 197 | 123 | 227 | 216 | 135 | | | | |
| 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. | 60%<br>3/5 | 1/1 | 0/1 | 1/1 | 0/1 | 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. | 60%<br>3/5 | 1/1 | 0/1 | 1/1 | 0/1 | 1/1 | | | | |
| 20 | The minutes from the individual's ISPA meeting reflected:<br>1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues,<br>2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them. | 67%<br>2/3 | 0/1 | N/A | 1/1 | N/A | 1/1 | | | | |
| 21 | The minutes from the individual's ISPA meeting reflected:<br>1. a discussion of contributing environmental variables,<br>2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them. | 0%<br>0/3 | 0/1 | N/A | 0/1 | N/A | 0/1 | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 22 | Did the minutes from the individual's ISPA meeting reflect:<br>1. a discussion of potential environmental antecedents,<br>2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them? | 33%<br>1/3 | 1/1 | N/A | 0/1 | N/A | 0/1 | | | | |
| 23 | The minutes from the individual's ISPA meeting reflected:<br>1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint,<br>2. and if any were hypothesized to be relevant, a plan to address them. | 0%<br>0/3 | 0/1 | N/A | 0/1 | N/A | 0/1 | | | | |
| 24 | If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| 25 | If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP). | 60%<br>3/5 | 1/1 | 1/1 | 0/1 | 0/1 | 1/1 | | | | |
| 26 | The PBSP was complete. | N/A | N/A | N/A | N/A | N/A | N/A | | | | |
| 27 | The crisis intervention plan was complete. | 0%<br>0/3 | 0/1 | 0/1 | N/A | N/A | 0/1 | | | | |
| 28 | The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity. | 60%<br>3/5 | 1/1 | 1/1 | 0/1 | 1/1 | 0/1 | | | | |
| 29 | If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP. | 60%<br>3/5 | 1/1 | 0/1 | 1/1 | 0/1 | 1/1 | | | | |

Comments:

18-19. Based upon the information provided in the master list of crisis restraints, five of the nine individuals were placed in restraint more than three times in a rolling 30-day period. There was evidence that the IDT met within 10 business days and a sufficient number of times for Individual #197, Individual #227, and Individual #135. Although Individual #123 and Individual #216 also had multiple restraints, their IDTs failed to meet to review these restraints.

It is important to note that there was a discrepancy between the number of crisis intervention restraints reported on the master list and those identified in ISPAs. For example, the master list noted that Individual #135 had been restrained once on 2/24/17 for 19 minutes. An ISPA conducted on 3/9/17, indicated that a total of five restraints had occurred in a 19-minute period. Similarly, an ISPA held for Individual #197 on 10/20/16 indicated that he had been restrained five times two days earlier. The master list reflected only one restraint. This discrepancy was discussed with the acting director of behavioral services and the acting facility director. It was reported that this was not an anomaly, that is, episodes of restraints were typically reported in the master list. The acting director of behavioral health services agreed that individual restraints would need to be reported in the future.

20. The IDTs for Individual #227 and Individual #135 discussed the potential role of adaptive skills, and biological, medical, and psychosocial issues.

21. The IDTs for Individual #197 and Individual #135 discussed contributing environmental variables. Individual #197's team was to request additional work hours, but it did not appear that this was implemented because he was only working one hour per day, three days per week. Individual #135's team noted that one restraint was due to his becoming upset over a lack of clothing, but there were no recommendations to address this issue.

22. Individual #197's team identified his watching frightening movies and not having access to his phone as antecedents to restraint. Staff were going to be advised to encourage alternative movies and to charge his phone while he was at class or work. Although Individual #227's team noted that repeated calls to his family were made to the wrong number, there were no plans to help him with this matter. Possible antecedent conditions for Individual #135 were identified from a functional assessment that was completed shortly after his admission in 2015. There were no recommendations to complete a new assessment.

23. While Individual #135's team noted that the primary function of his problem behaviors was to escape or gain access to tangibles, neither of these were addressed. Individual #227's team noted that a functional assessment was being formulated, nearly six months after his admission. This assessment was completed one month after this discussion.

24. All of the five individuals had a current PBSP at the time of the repeated restraints. Individual #227's admission PBSP was still in place. As noted above, a functional assessment should have been completed with the subsequent development of a new PBSP.

25 and 27. Three of the five individuals, Individual #197, Individual #123, and Individual #135, had a Crisis Intervention Plan. These were not complete as the definition of a crisis was aggressive behavior as defined in their PBSPs.

28. Treatment integrity had been assessed during the month the repeated restraints occurred for Individual #197, Individual #123, and Individual #216.

29. There was evidence that the IDTs for Individual #197, Individual #227, and Individual #135 had reviewed their PBSPs.

## Psychiatry

| Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Corrections were made since the last review, such that every individual who was not being seen by psychiatry had a Reiss screen completed. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 70 | 333 | 122 | 239 | 162 | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | If not receiving psychiatric services, a Reiss was conducted. | 100% 5/5 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | | | | |
| 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 | 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 | N/A | N/A | | | | |

Comments:
1-3. Of the 16 individuals reviewed by both Monitoring Teams, five were not followed by the psychiatric team. All of these individuals had undergone screening with the Reiss instrument and had received scores that were below the clinical cutoff score indicating that no further action was required. No change of status events requiring re-implementation of the Reiss occurred.

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, acknowledges 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 | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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% 4/4 | N/A | N/A | N/A | 1/1 | N/A | 1/1 | N/A | 1/1 | 1/1 |
| 11 | Activity and/or revisions to treatment were implemented. | 100% 4/4 | N/A | N/A | N/A | 1/1 | N/A | 1/1 | N/A | 1/1 | 1/1 |

Comments:
8. It was not possible to determine if the individual was making progress because the existing goals did not meet criteria with indicator 4 and because they did not identify precise measurable criteria that would make this possible.

9. As noted above, it was not possible to determine if goals were being met because adequate goals had not been developed.

10. Although adequate goals had not been possible, the review of the records indicated that when an individual's clinical status was deteriorating, emergency/interim consults would be conducted and these interventions resulted in recommendations to revise their pharmacological treatment plan. The specific evidence to support this was found in the records of Individual #197, Individual #216, Individual #123, and Individual #135.

11. The records of these four individuals also indicated that the recommendations to increase the dosage of existing medications or switch to a different medication were implemented.

| Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Psychiatry and behavioral health coordinated treatment as per the criteria for these two indicators. With sustained high performance, both indicators might be moved to the category of requiring less oversight after the next review. They will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
| 23 | Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors. | 89% 8/9 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 24 | The psychiatrist participated in the development of the PBSP. | 100% 7/7 | 1/1 | N/A | N/A | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |

Comments:

23. The documentation in the psychiatric section of the record routinely referenced the behavioral aspects of the individual's presentation. The behavioral health assessment as well as the functional assessment described the impact of the individual's psychiatric disorder on their behavioral presentation for every individual, except Individual #186 for whom there was insufficient discussion of this topic in the behavioral sections of the record.

24. The PBSP contained a reference to the discussion between the psychiatrist and the behavioral specialist about the development of the PBSP including the date of the discussion, which usually occurred in context of a psychiatric clinical review. Individual #311 and Individual #275 had PSPs rather than PBSPs and, thus, this observation was not relevant for them.

| 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: | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | |
| 25 | There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | |
| 26 | Frequency was at least annual. | | | | | | | | | | |
| 27 | There were references in the respective notes of psychiatry and | | | | | | | | | | |

| | | | |
|---|---|---|---|
| | neurology/medical regarding plans or actions to be taken. | | |
| Comments: | | | |

| Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Content of the quarterly documentation met criteria for all individuals for this review and for the two previous reviews, with but one exception in October 2015. Therefore, indicator 34 will be moved to the category of requiring less oversight. Psychiatry clinic content improved compared with the last review. Its related indicator, 35, will remain in active monitoring. | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
| 33 | Quarterly reviews were completed quarterly. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| 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. | 100% 1/1 | N/A | 1/1 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Comments:<br>34. The content of the quarterly documentation for the nine individuals contained the required content.<br><br>35. During the onsite review, the Monitoring Team observed the psychiatric clinic for Individual #311 on 4/24/17 and observed that the standard components of an acceptable clinical review were present. | | | | | | | | | | | | |

| Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | | |
| 36 | A MOSES & DISCUS/MOSES was completed as required based upon the medication received. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | | |
| Comments: | | | | | | | | | | | | |

| Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | | |
| 37 | Emergency/urgent and follow-up/interim clinics were available if | Due to the Center's sustained performance, these indicators were moved to the | | | | | | | | | | |

| | | |
|---|---|---|
| | needed. | category of requiring less oversight. |
| 38 | If an emergency/urgent or follow-up/interim clinic was requested, did it occur? | |
| 39 | Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information? | |
| | Comments: | |

| Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: These important indicators continued to meet criteria. They will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
| 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:<br>40-41. There is no indication that the psychotropic medications are used for sedation, as punishment, or for the convenience of staff to substitute for treatment.<br><br>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: | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | |
| 44 | There is empirical justification of clinical utility of polypharmacy medication regimen. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | |
| 45 | There is a tapering plan, or rationale for why not. | | | | | | | | | | |
| 46 | The individual was reviewed by polypharmacy committee (a) at least | | | | | | | | | | |

| | | |
|---|---|---|
| | quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified. | |
| Comments: | | |

**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 | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
| 6 | The individual is making expected progress | 0% 0/7 | 0/1 | N/A | 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. | 20% 1/5 | N/A | N/A | N/A | 0/1 | 0/1 | 1/1 | N/A | 0/1 | 0/1 |
| 9 | Activity and/or revisions to treatment were implemented. | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Comments:<br>6. The graphs presented in the individual's progress report suggested improvement for Individual #186, Individual #123, and Individual #227. However, due to the lack of data reliability, progress cannot be assessed for any of the individuals.<br><br>7. Based upon the data provided, none of the individuals had met their goals/objectives.<br><br>8-9. For the five individuals whose graphs suggested a lack of progress, there was evidence of corrective actions suggested and implemented for Individual #123. However, due to concerns regarding her new PBSP, an immediate revision was suggested and discussed with the acting director of behavioral health services, therefore, she was scored N/A for indicator 9. | | | | | | | | | | | |

| Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained. | |
|---|---|
| Summary: All three indicators showed improvement from the time of the last review, especially the PBSP summaries, which increased to 100%. All three indicators will remain in active monitoring. | Individuals: |

| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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. | 43% 3/7 | 1/1 | N/A | N/A | 0/1 | 1/1 | 0/1 | 0/1 | 1/1 | 0/1 |
| 17 | There was a PBSP summary for float staff. | 100% 7/7 | 1/1 | N/A | N/A | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 18 | The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework. | 86% 6/7 | 1/1 | N/A | N/A | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 |

Comments:

16. A comparison was made between staff rosters and training records provided by the facility. Additional training documents were provided while the Monitoring Team was onsite. As a result, there was evidence that over 80% of the staff assigned to work with Individual #186, Individual #46, and Individual #216 had been trained on their PBSPs. For the remaining four individuals with PBSPs, between 28% and 71% of their assigned staff had been trained. As there were no rosters provided for day program/work staff, it was unclear whether these individuals had been trained.

17. Behavioral services had developed PBSP summaries for all seven individuals. This was an improvement from the last review. Individual #227's was available prior to the onsite visit, the remaining six were provided while the Monitoring Team was at the facility. These summaries consisted of Do's and Don'ts as guidelines for working with the individual. All of the summaries included antecedent and consequent strategies, as well as a brief reference to the individual's replacement behavior(s). Summaries for three individuals (Individual #197, Individual #123, Individual #216) included operational definitions of the targeted problem behaviors. Staff are advised to date these summaries to ensure they remain current with the individual's PBSP.

18. For six individuals, their functional assessments and PBSPs were developed by a BCBA or by a staff person who had completed or was enrolled in coursework. If the author was not yet certified, a BCBA had reviewed and signed off on the document. The one exception was Individual #227. Although there was evidence that the Behavior Support Committee had reviewed both the functional assessment and PBSP, the author was not certified and was not actively pursuing certification.

A CAP was developed with a goal of behavioral health services staff spending 20% of their time in the individuals' homes and day programs. A sample of five behavioral health services staff showed that two staff were able to meet this goal over a four-week period.

| Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Data-laden progress reviews are an important part of the provision of behavioral health services. Overall, performance decreased when looking at this set of indicators as a whole. The indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 19 | The individual's progress note comments on the progress of the individual. | 57% 4/7 | 1/1 | N/A | N/A | 1/1 | 1/1 | 0/1 | 0/1 | 0/1 | 1/1 |
| 20 | The graphs are useful for making data based treatment decisions. | 29% 2/7 | 0/1 | N/A | N/A | 1/1 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 |
| 21 | In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions. | 50% 1/2 | N/A | 1/1 | N/A | N/A | 0/1 | N/A | N/A | N/A | N/A |
| 22 | If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review. | 0% 0/3 | N/A | N/A | N/A | N/A | N/A | 0/1 | N/A | 0/1 | 0/1 |
| 23 | This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months. | 0% | | | | | | | | | |

Comments:

19. Progress notes were requested from September 2016 through February 2017. Additionally, the March 2017 progress report was requested onsite. For four of the seven individuals with PBSPs (Individual #186, Individual #197, Individual #46, Individual #135), it was determined that their monthly behavioral health progress report commented on the individual's progress. The progress note from September 2016 was unavailable for Individual #123. Individual #227's progress notes through March 2017 continued to address objectives that were to be met by the end of September 2016. Individual #216's progress notes from September 2016 and October 2016 were not available. Although she had a new PBSP implemented in September 2016, her progress notes from November 2016 through March 2017 continued to report on objectives identified in her previous PBSP, even though this error was identified in November 2016.

20. The graphs included in the progress notes were determined to be useful in making data-based treatment decisions for Individual #197 and Individual #135. For all others, either phase change lines were not included or one axis was not labeled. It should be noted that all graphs depicted monthly data. While this is acceptable for meeting criteria with this indicator, graphs that depict weekly or daily rates of behavior may be more informative in determining response to intervention.

21. The Monitoring Team attended the psychiatric clinic for Individual #311. During his meeting, behavioral health services staff presented data up until three days before the meeting. Staff would be advised to display the graphs, so those present can view progress and trends over time. When limited progress was noted on his participation goal, behavioral health services staff suggested reducing the criterion, rather than assessing variables that may be contributing to his limited participation. At Individual #46's ISP meeting, members of the IDT frequently raised concerns regarding his verbal aggression, however, there was no review of the data that were collected on this target behavior.

22. Although four of the seven individuals were presented in peer review during the six-month period prior to the onsite visit, the minutes were reviewed for three of these individuals (Individual #123, Individual #216, Individual #135). The recommendations for Individual #227 related to his interim PBSP and a new plan had been developed since that time. Individual #123 and Individual #216's

reviews did not result in the completion of a new functional assessment, although new, targeted problems behaviors were discussed and, for Individual #135, there was no evidence that several variables (including need for more clothing, pursuit of a job, and possible thyroid imbalance) identified during the review were later addressed.

23. Internal peer review occurred between two and four times each month between September 2016 and February 2017. External peer review occurred five times between September 2016 and February 2017. The facility is advised to note the date on the meeting minutes.

Outcome 8 – Data are collected correctly and reliably.

Summary: Data collection systems for the occurrence of problem target behaviors need much attention; acceptable measures of behavioral occurrences form the foundation of good behavioral health/behavior analysis services. This set of indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 26 | If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites. | 14% 1/7 | 0/1 | N/A | N/A | 1/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| 27 | If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites. | 100% 7/7 | 1/1 | N/A | N/A | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 28 | If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity. | 0% 0/7 | 0/1 | N/A | N/A | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| 29 | If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be). | 100% 7/7 | 1/1 | N/A | 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% 0/7 | 0/1 | N/A | N/A | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

Comments:

26. The data collection identified in the PBSP for Individual #197 was considered adequate for his targeted behaviors. For all other individuals with a PBSP, data collection was not identified for monitored behaviors (Individual #186, Individual #46, Individual #216, Individual #135), not all targeted problem behaviors were addressed in the documentation section (Individual #227), documentation did not allow for tracking of individual problem behaviors (Individual #123), or the identified data system did was not available in the electronic record (Individual #46).

27. It was determined that the data collections system as described was adequate in tracking the replacement behaviors identified in the PBSPs for all seven individuals.

28. While the system described for assessing IOA and treatment integrity appeared adequate for all seven individuals, the acting director of behavioral health services reported that measures of data timeliness remained a challenge. Staff are advised to make every

effort to assess treatment integrity by observing staff working with the individual. Several reports indicated this measure was assessed via interview.

29. For each of the seven individuals, the PBSP indicated that data timeliness, IOA, and treatment integrity were to be assessed monthly. Scores of 80% or better were required, and if not met, re-training was to be provided.

30. Based on reports provided, goal frequencies and levels were not achieved for any of the seven individuals who had PBSPs.

## Medical

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

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

| # | Indicator | Overall Score | Individuals: 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions. | 0% 0/17 | 0/1 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| b. | Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions. | 12% 2/17 | 0/1 | 0/2 | 0/2 | 0/2 | 0/2 | 1/2 | 0/2 | 0/2 | 1/2 |
| c. | Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s). | 0% 0/17 | 0/1 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| d. | Individual has made progress on his/her goal(s)/objective(s). | 0% 0/17 | 0/1 | 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% 0/17 | 0/1 | 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 #216 – weight, and osteoporosis (i.e., did not require a goal/objective, because she was at low risk); Individual #311 – aspiration, and GI problems; Individual #191 – respiratory compromise, and falls; Individual #239 – aspiration, and GI problems; Individual #241 – weight, and cardiac disease; Individual #162 – aspiration, and osteoporosis; Individual #122 – respiratory compromise, and osteoporosis; Individual #70 – fractures, and aspiration; and Individual #333 – weight, and osteoporosis].

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 #162 – osteoporosis, and Individual #333 – weight.

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. 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: Three of the nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators. In addition, the Center's quality assurance/improvement mechanisms related to preventative care need to meet the requirements of the Settlement Agreement. 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.

Individuals:

| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Individual receives timely preventative care: | | | | | | | | | | |
| | i. Immunizations | 89% 8/9 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| | ii. Colorectal cancer screening | 33% 1/3 | N/A | 1/1 | N/A | N/A | N/A | N/A | 0/1 | 0/1 | N/A |
| | iii. Breast cancer screening | 0% 0/1 | N/A | N/A | N/A | N/A | N/A | N/A | 0/1 | N/A | N/A |
| | iv. Vision screen | 89% 8/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 |
| | v. Hearing screen | 67% 6/9 | 0/1 | 1/1 | 0/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 |
| | vi. Osteoporosis | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | N/A | 1/1 | 1/1 | 1/1 | 1/1 |
| | vii. Cervical cancer screening | 33% 1/3 | 0/1 | N/A | N/A | N/A | N/A | 0/1 | 1/1 | 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. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

Comments: a. The following problems were noted:

- Individual #216's pap smear was pending, but no appointment date was provided. No audiological exam was submitted.
- It was unclear when Individual #191's last audiological appointment occurred.
- Individual #241 did not have spleen, so should have been administered Prevnar 13.
- For Individual #162, no pap smear was recorded, and no audiological appointment had occurred.
- Individual #122 had not had a colonoscopy, or a mammogram. On 11/19/15, she had an ophthalmology appointment with a recommendation for a follow-up appointment in a year, but this did not occur.
- On 1/19/12, Individual #70 had a colonoscopy, which was to be repeated in January 2017. However, evidence was not found to show it was completed.

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 Monitoring Team will continue to review this indicator. | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines. | 100% 2/2 | N/A | N/A | N/A | 1/1 | N/A | N/A | 1/1 | N/A | N/A |

Comments: Individual #239 received hospice services, because all medical and surgical treatments have been exhausted to eliminate his risk of aspiration, which has contributed and exacerbated his chronic respiratory failure, with additional complications of bradycardia from a vasovagal response to the aspiration through a non-repairable fistula. This is considered an irreversible condition and meets criteria for DNR status per DADS policy.

On 7/5/16, Individual #122's IDT reviewed her DNR. The qualifying conditions were chronic respiratory failure, and Down's dementia (the severity and terminal nature is reflected in loss of functional abilities in walking and feeding herself, becoming motionless, lack of voluntary movements, somnolent much of the day). Her condition is considered irreversible and terminal.

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

| Summary: As the Monitoring Team reviewed documentation related to hospitalizations, problems were noted with regard to two indicators that previously moved to the category requiring less oversight. More specifically, Indicator e will move back to active oversight due to significant concerns related to the quality of medical care provided for one individual prior to her transfer to the hospital. In addition, some issues were noted with regard to PCPs and/or nurses | Individuals: |
|---|---|

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| communicating information to hospital staff prior to individuals' transfers. If such issues are not corrected, then Indicator f might move back to active monitoring at the time of the next review. The Monitoring Team will continue to review the remaining indicators. | | | | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| 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. | 15% 2/13 | N/A | 0/2 | 0/2 | 0/2 | N/A | 1/2 | 0/2 | 1/1 | 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. | 70% 7/10 | | 0/1 | 1/1 | 2/2 | | 2/2 | 1/1 | 1/1 | 0/2 |
| c. | If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition. | 75% 6/8 | N/A | 2/2 | N/A | N/A | 1/1 | 1/2 | 0/1 | 2/2 | N/A |
| d. | As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN. | 86% 6/7 | | 2/2 | | | 1/1 | 1/1 | 0/1 | 2/2 | |
| e. | Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care. | Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.<br><br>Given that significant concerns were noted with regard to the treatment and interventions provided to one individual prior to transfer to the hospital, Indicator e will move back to active oversight. | | | | | | | | | |
| f. | If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff. | | | | | | | | | | |
| g. | Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate. | 50% 3/6 | | 0/1 | | | 0/1 | 2/2 | N/A | 1/2 | |
| h. | Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency | 71% 5/7 | | 2/2 | | | 1/1 | 0/2 | N/A | 2/2 | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | consistent with the individual's status and the presenting problem with documentation of resolution of acute illness. | | | | | | | | | | |

Comments: a. For seven of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 13 acute illnesses addressed at the Center, including the following with dates of occurrence: Individual #311 (stoma infection on 11/3/16, and peripheral vascular disease on 2/2/17), Individual #191 (cough on 10/14/16, and fall with injury on 12/14/16), Individual #239 (redness of arms on 9/26/16, and hypoxia on 11/14/16), Individual #162 [clostridium difficile (C-Diff) on 11/29/16, and fever on 2/3/17], Individual #122 (break in skin integrity with drainage in the area of the elbow on 9/14/16, and hypoxia on 9/28/16), Individual #70 (fracture on 1/26/17), and Individual #333 (weight loss on 9/13/16, and boil on 10/31/16).

The acute illnesses for which documentation was present to show that medical providers assessed the individuals according to accepted clinical practice were for Individual #162 (fever on 2/3/17), and Individual #70 (fracture on 1/26/17). For many of the remaining acute illnesses treated at the Center that the Monitoring Team reviewed, medical providers did not cite the source of the information (e.g., nursing, activities/workshop staff, PT, OT, etc.) in assessing them. For Individual #333 (weight loss on 9/13/16, and boil on 10/31/16), reviews of the history of the problem were not documented, and assessment of the boil was not timely.

b. Some concerns noted included:

- For Individual #333 (weight loss on 9/13/16), the PCP ordered Megace, and blood work. However, no follow-up was found from the PCP.
- Individual #333 (boil on 10/31/16) had recurrent boils. However, although notes indicated the PCP ordered an antibiotic and was awaiting cultures, no PCP follow-up was found.

c. For five of the nine individuals reviewed, the Monitoring Team reviewed eight acute illnesses requiring hospital admission, Infirmary admission, or ED visit, including the following with dates of occurrence: Individual #311 (G-tube out on 10/24/16, and flu on 2/8/17), Individual #241 (pneumonia on 1/27/17), Individual #162 (fever on 11/12/16, and fever with lung infiltrate on 1/21/17), Individual #122 (rapid breathing on 1/6/17), and Individual #70 (emesis on 12/9/16, and pneumonia on 12/24/16).

For Individual #162 (fever with lung infiltrate on 1/21/17), and Individual #122 (rapid breathing beginning on 1/6/17), PCP IPNs were not completed on the next business day.

d. Of significant concern, on 1/10/17, Individual #122's PCP did not conduct and/or document a quality assessment upon her admission to the Infirmary. In the days preceding this admission, nursing staff documented numerous concerns regarding her respiratory status, and according to the PCP note, dated 1/10/17, she was admitted to the Infirmary for respiratory distress. However, the PCP did not address the respiratory distress in the note, and she was not transferred to the hospital until later that day, when an on-call PCP ordered the transfer. In the days preceding this event, the PCP's repeated exams did not address respiratory distress, foul smelling secretions, ongoing hypoxia, and/or ongoing fever. The PCP appeared to interpret all these symptoms as related to a urinary tract infection (UTI), even though the antibiotic prescribed to treat the UTI did not appear to have a clinical effect. In addition, the PCP did not appear to review nursing notes. On 1/13/17, Individual #122 died in the hospital.

e. At the time of the last review, the Center had sustained high scores with Indicator e, so it was moved to the category requiring less oversight. However, as noted above, based on the Monitoring Team's review of hospitalization documentation for Individual #122, significant concerns were noted with regard to her treatment leading up to the hospitalization on 1/10/17 for rapid breathing. On

1/13/17, she died in the hospital. This indicator will move back to active monitoring.

f. Although at the time of the last review Indicator f moved to the category requiring less oversight, in two of seven instances during this review, documentation was not found showing that the nurse or PCP communicated information to the ED or hospital staff. The Center should ensure this occurs consistently. At the time of the next review, if problems continue to be noted, this indicator will be moved back into active monitoring.

g. Examples of problems included:

- On 2/9/17, Individual #241's team met, and at his mother's recommendation created a SAP to teach him to tell staff when he is ill. However, the IDT did not discuss the cause of his pneumonia or make needed changes to his current IHCPs to prevent recurrence to the extent possible.
- Individual #70's ISPA provided no review of his recovery needs for his 12/10/16 hospitalization.

h. Given Individual #162's medical complexities, it was concerning to see that the PCP had conducted little to no follow-up after her acute illnesses. For the fever on 11/12/16, an x-ray showed right lower lobe infiltrate with moderate congestive heart failure. She was transferred to the hospital. On 11/23/16, she returned from the hospital with a diagnosis of pneumonia, but the PCP's first documented follow-up was not until 11/28/16. On 1/21/17, Individual #162 had a fever with lung infiltrate, and she was transferred to the hospital after hours. The PCP's post-hospital IPN, dated 2/1/17, provided little information or review of her hospital course and next steps.

| Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: These indicators will remain in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement. | Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight. | | | | | | | | | |
| b. | PCP completes review within five business days, or sooner if clinically indicated. | 65% 11/17 | 1/1 | 2/2 | 0/2 | 1/2 | 1/2 | 1/2 | 2/2 | 2/2 | 1/2 |
| c. | The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT. | 59% 10/17 | 1/1 | 0/2 | 0/2 | 1/2 | 2/2 | 2/2 | 2/2 | 2/2 | 0/2 |
| d. | If PCP agrees with consultation recommendation(s), there is evidence it was ordered. | 85% 11/13 | 0/1 | 2/2 | 1/1 | N/A | 2/2 | 1/1 | 2/2 | 2/2 | 1/2 |
| e. | As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans. | 14% 1/7 | N/A | N/A | N/A | 0/1 | 0/2 | 0/1 | N/A | 1/1 | 0/2 |
| Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 17 consultations. The consultations reviewed | | | | | | | | | | | |

included those for Individual #216 for ophthalmology on 11/8/16; Individual #311 for vascular surgery on 2/14/17, and urology on 1/12/17; Individual #191 for pulmonary on 9/23/16, and neurology on 11/16/16; Individual #239 for cardiology on 10/19/16, and neurology on 2/15/17; Individual #241 for neurology on 12/14/16, and neurology on 2/15/17; Individual #162 for pulmonary on 9/23/16, and neurology on 12/14/16; Individual #122 for ear, nose, and throat (ENT) on 10/4/16, and ophthalmology on 11/30/16; Individual #70 for ophthalmology on 9/2/16, and neurology on 3/22/17; and Individual #333 for neurology on 11/17/16, and neurology on 3/23/17.

b. The reviews that did not occur timely were those for: Individual #191 for pulmonary on 9/23/16, and neurology on 11/16/16; Individual #239 for neurology on 2/15/17; Individual #241 for neurology on 12/14/16; Individual #162 for neurology on 12/14/16; and Individual #333 for neurology on 11/17/16.

c. The IPNs written in relation to the following consultations did not provide the required information: Individual #311 for vascular surgery on 2/14/17, and urology on 1/12/17; and Individual #333 for neurology on 11/17/16, and neurology on 3/23/17. For the following consultations, no IPNs were submitted: Individual #191 for pulmonary on 9/23/16, and neurology on 11/16/16; and Individual #239 for neurology on 2/15/17.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, with the exceptions of the following: Individual #216 for ophthalmology on 11/8/16 (i.e., eye glass prescription), and Individual #333 for neurology on 3/23/17 (i.e., increase in Vimpat).

e. For a number of consultations, PCPs had not indicated in IPNs whether or not referral to the IDT was necessary.

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

| Summary: Additional work is needed to ensure individuals with chronic or at-risk conditions 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. This indicator will remain in active oversight. | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| 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. | 56% 10/18 | 1/2 | 0/2 | 1/2 | 2/2 | 1/2 | 2/2 | 0/2 | 2/2 | 1/2 |

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #216 – weight, and falls; Individual #311 – aspiration, and GI problems; Individual #191 – respiratory compromise, and falls; Individual #239 – aspiration, and GI problems; Individual #241 – weight, and cardiac disease; Individual #162 – aspiration, and osteoporosis; Individual #122 – respiratory compromise, and osteoporosis; Individual #70 – fractures, and aspiration; and Individual #333 – weight, and osteoporosis).

a. For the following individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #216 – weight; Individual #191 – respiratory compromise; Individual #239 – aspiration, and GI problems; Individual #241 – weight; Individual #162 – aspiration, and osteoporosis; Individual #70 – fractures, and aspiration; and Individual #333 – weight.

The following provides a few examples of concerns noted:

- Individual #122 had a long history of respiratory compromise that was due to infections (pneumonia), as well as congestive heart failure. Diagnoses included gastroesophageal reflux disease (GERD), and chronic respiratory failure. She had a gastrostomy-tube (G-tube) placement as well as tracheostomy. In April 2016, May 2016, and August 2016, she was hospitalized for respiratory distress and pneumonia. In May 2016, she developed E coli pneumonia and sepsis, and also had influenza. Of note, her osteoporosis was treated with Prolia, which could increase the risk of infections. On 1/6/17, she was noted to have a fever, and the PCP ordered lab testing. On 1/7/17, nursing IPNs indicated she had bilateral rales, a temperature of 103.0, with a respiratory rate of 28, and bilateral upper lobe crackles. Oxygen saturation was maintained by increasing the oxygen to five liters per minute. On 1/8/17, the PCP ordered Macrobid for a urinary tract infection (UTI). On 1/9/17, the nursing IPN noted sour milk on the trach gauze, and the nurse later called the PCP, reporting bronchospasm, congestion, and a temperature of 100.4, rectally. Despite the information reported in the nursing IPNs, the PCP IPN, dated 1/9/17, stated that there were no acute events overnight. On 1/10/17, nursing IPNs reported the individual had a fever of 101.6, labored breathing, cough, and foul-smelling secretions. The on-call MD was notified, and she was transferred to the Infirmary. A PCP IPN later on 1/10/17 did not address the respiratory distress, or foul secretions. That evening her respiratory rate was 28 to 30 and a chest x-ray was ordered. Oxygenation was unable to be maintained at 10 liters per minute, and she was subsequently transferred to the ED. On 1/13/17, Individual #122 died at the hospital.

  The PCP did not appear to have knowledge of the signs and symptoms that she experienced during her last days at CCSSLC. The cough, fever, repeated respiratory distress and congestion, increased respiratory rate, and foul-smelling secretions at the trach site were all ominous signs that were not addressed. The PCP remained focused on treating the results of a urinalysis, despite the history of repeated pneumonias. Moreover, in the submitted documents, there was no information to indicate that gastroparesis had been considered, nor whether GERD had worsened, and/or additional medical/surgical steps taken to minimize the complications of severe GERD.

- Individual #333 had a history of osteoporosis. In 2006, he had a femur and tibia fracture, and required insertion of rods in his right leg. On 3/21/14, the history indicated he fell during a transfer in the bathroom and sustained a right femoral neck and head fracture. On 5/28/14, a baseline DEXA was done and the report indicated a T-score of -4.0. He was placed on Fosamax, but this was replaced with Prolia on 6/3/15. The 9/21/15 IRRF indicated that he was having a positive response to aqua-therapy, with the ability to move his legs. At that time, he was noted to be able to take a few steps and complete a stand/pivot transfer. A follow-up DEXA on 10/21/15 indicated a T-score of -2.1. Starting on 12/15/15, Reclast was administered. On 1/26/17, he demonstrated the ability to ambulate 100 feet using the platform walker. An ISPA, dated 1/30/17, reviewed his orthopedic notes, and it was determined that he should continue to ambulate during a direct therapy program, using a platform walker. His muscle tone was considered tight and a muscle relaxer was added. On 3/2/17, his ambulation program was

resumed after temporarily being stopped until an ankle foot orthosis was fitted. On 2/28/17, the PT requested assistance from Behavioral Health Services due to Individual #333's challenging behaviors during the walking program. He continued to be prescribed Vitamin D and calcium. On 2/13/17, his Vitamin D level was 53. He had several risks for osteoporosis at a young age, including immobility, and many seizure medications. Additionally, the 9/21/15 IRRF indicated that he had "decreased testosterone levels," but there was no information in the AMA concerning a diagnosis of hypogonadism or treatment. This needs further evaluation to determine if he is hypo-gonadal, and documentation of the decision-process for the best treatment option in context of his behaviors. At this time, he has made some initial progress with ambulation, which should improve bone health. However, he needs further medical evaluation/review to determine his medical treatment, as well as evidence of implemented behavioral supports focusing on the goal of improved cooperation with his ambulation program.

- Over the last year, Individual #191 had experienced a number of falls, which indicated the need for further interdisciplinary review. For example, the role of his many medications in contributing to falls was not discussed in submitted documentation. The Pharmacy Department as well as the PCP should assist the IDT in reviewing his drug regimen. Other areas not discussed included vestibular pathology (i.e., he has a complex history of mastoidectomy, as well as placing foreign objects in his ears), orthostatic hypotension, and neurological evaluation. He has a diagnosis of intermittent explosive disorder, and behavioral services should provide insight into his impulsiveness and distractibility.

- Upon admission, Individual #241 had metabolic syndrome. According to the QDRR, he had three risk indicators, but a fourth might have been present (abdominal girth), but this was not recorded in the initial AMA or other documents. He was currently treated for hypertension and elevated triglycerides, and had low high-density lipoprotein (HDL). Currently, his hypertension was considered to be controlled. He was prescribed Clozapine, which adds to the risk for metabolic syndrome. He reportedly had two mini-strokes, one in May 2012, and one in 2016. He developed pneumonia after each mini-stroke. Additionally, after the second one, he was found to have diabetes mellitus. He continued to smoke. He was prescribed Metformin for diabetes mellitus (hemoglobin A1C 6.7 in December 2016). He had thrombocytopenia, and the IRRF stated he had a splenectomy. The thrombocytopenia was verified repeatedly in lab tests, but the history of splenectomy could not be verified elsewhere in submitted documentation. Due to the apparent discrepancy or lack of information, this needs further clarification. He was also prescribed valproic acid, which may cause thrombocytopenia. If he continues to lose weight, several of his risk indicators for metabolic syndrome might regress, which would have positive impact on his cardiac health. A formal exercise program would assist in weight reduction, as well as improvement in his HDL. A cardiology consult was ordered and the appointment was set for 5/8/17. It would be helpful to obtain the records of his prior strokes, given that these occurred in the recent past. Such information might uncover other aspects of his health that need monitoring. The AMA and IHCP did not provide sufficient clarity as to action steps to be taken in the next year to improve his health in this area.

| Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely. | |
|---|---|
| Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. However, documentation generally was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs/ISPs. This indicator will remain in active oversight until full sets of medical | Individuals: |

| action steps are included in IHCPs, and PCPs implement them. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions. | 80% 4/5 | 0/1 | N/A | 2/2 | N/A | N/A | 2/2 | N/A | N/A | N/A |
| Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed generally were implemented. | | | | | | | | | | | |

**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: N/R | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and | N/R | | | | | | | | | |
| b. | If an intervention is necessary, the pharmacy notifies the prescribing practitioner. | N/R | | | | | | | | | |
| 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: It was good to see improvement with regard to the timeliness as well as the quality of the QDRRs. In addition, when prescribers indicated agreement with recommendations, they implemented them. However, it was concerning that prescribers had not consistently reviewed QDRRs timely, and documented agreement or provided a clinical justification for lack of agreement with Pharmacy's recommendations. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | QDRRs are completed quarterly by the pharmacist. | 100% 18/18 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 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; | 89% 16/18 | 1/2 | 2/2 | 2/2 | 1/2 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 |
| | ii. Benzodiazepine use; | 100% 9/9 | 2/2 | 1/1 | N/A | 2/2 | 2/2 | 2/2 | N/A | N/A | N/A |
| | iii. Medication polypharmacy; | 90% 9/10 | 2/2 | N/A | 1/2 | N/A | 2/2 | N/A | N/A | 2/2 | 2/2 |
| | iv. New generation antipsychotic use; and | 75% 6/8 | 2/2 | 1/2 | 2/2 | N/A | 1/2 | N/A | N/A | N/A | N/A |
| | v. Anticholinergic burden. | 100% 14/14 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | N/A | N/A |
| 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. | 50% 9/18 | 1/2 | 1/2 | 2/2 | 1/2 | 1/2 | 1/2 | 0/2 | 1/2 | 1/2 |
| | ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need. | 63% 5/8 | 1/2 | 1/2 | 2/2 | N/A | 1/2 | N/A | N/A | N/A | N/A |
| d. | Records document that prescribers implement the recommendations agreed upon from QDRRs. | 100% 9/9 | 2/2 | N/A | 2/2 | 1/1 | 2/2 | N/A | N/A | 1/1 | 1/1 |
| 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. | N/R | | | | | | | | | |

Comments: a. It was positive that for the individuals reviewed, the Clinical Pharmacist completed timely QDRRs.

b. Overall, since the last review, the quality of the QDRRs improved. Some of the concerns noted included: labs for which more recent information was found, lack of identification of risk for metabolic syndrome, lack of information about waist circumference, and lack of identification of document showing justification for polypharmacy.

c. For the individuals reviewed, it was concerning that prescribers had not consistently reviewed QDRRs timely, and documented agreement or provided a clinical justification for lack of agreement with Pharmacy's recommendations.

d. When prescribers agreed to recommendations for the individuals reviewed, documentation was presented to show they implemented them.

## 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 generally did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions; | 14% 1/7 | 0/1 | N/A | 0/1 | N/A | 0/1 | 1/1 | 0/1 | 0/1 | 0/1 |
| b. | Individual has a measurable goal(s)/objective(s), including timeframes for completion; | 14% 1/7 | 0/1 | | 0/1 | | 0/1 | 1/1 | 0/1 | 0/1 | 0/1 |
| c. | Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s); | 0% 0/7 | 0/1 | | 0/1 | | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| d. | Individual has made progress on his/her dental goal(s)/objective(s); and | 0% 0/7 | 0/1 | | 0/1 | | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| e. | When there is a lack of progress, the IDT takes necessary action. | 0% 0/7 | 0/1 | | 0/1 | | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

Comments: a. and b. Individual #311 was edentulous, but was part of the core group, so a full review was conducted. Individual #239 was at low risk for dental issues and was part of the outcome group, so a limited review was conducted. Although Individual #122's IDT rated her at low risk, she was described as having incipient periodontitis, was resistant to dental treatment, and had 28 missing teeth. Her IDT should have rated her as having at least medium risk.

Individual #162's goal/objective related to staff brushing her teeth daily for two to three minutes for the next year was clinically relevant and measurable.

c. through e. It was positive that in some instances, QIDPs had included data related to individuals' dental goals/objectives in the integrated monthly reviews. However, without clinically relevant and measurable goals/objectives, and a lack of analysis of the 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.

| Outcome 4 – Individuals maintain optimal oral hygiene. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: The Monitoring Team will continue to review these indicators. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | Individuals have no diagnosed or untreated dental caries. | 100% 8/8 | 1/1 | N/A | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 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. | 75% 3/4 | 1/1 | N/A | 0/1 | 1/1 | N/A | N/A | N/A | N/A | 1/1 |
| | ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen. | 67% 2/3 | N/A | N/A | N/A | N/A | N/A | 1/1 | 1/1 | 0/1 | N/A |
| c. | Since the last exam, the individual's fair or good oral hygiene score was maintained or improved. | N/R | | | | | | | | | |
| Comments: Individual #311 was edentulous.<br><br>c. As indicated in the dental audit tool, this indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will be marked "N/R." At the time of the review, State Office had not yet developed a process to ensure inter-rater reliability with the Centers. | | | | | | | | | | | |

| Outcome 5 – Individuals receive necessary dental treatment. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Given that over the last two review periods and during this review, individuals generally received prophylactic care at least twice a year, or more frequently based on their needs (Round 10 – 100%, Round 11 – 89%, and Round 12 - 100%), Indicator a will move to the category requiring less oversight. Indicators d and e will remain in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| 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. | 100% 8/8 | 1/1 | N/A | 1/1 | 1/1 | 1/1 | 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. | Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight. | | | | | | | | | |
| c. | Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has | | | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | been provided for not conducting x-rays. | | | | | | | | | | |
| d. | If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year. | 100% 3/3 | 1/1 | N/A | 1/1 | N/A | 1/1 | N/A | N/A | N/A | N/A |
| e. | If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented. | 33% 1/3 | N/A | N/A | N/A | N/A | N/A | 1/1 | 0/1 | 0/1 | N/A |
| f. | If the individual has need for restorative work, it is completed in a timely manner. | Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight. | | | | | | | | | |
| g. | If the individual requires an extraction, it is done only when restorative options are exhausted. | | | | | | | | | | |
| Comments: d. Individual #311 was edentulous. It was good to see that individuals who needed it received two topical fluoride applications per year.<br><br>e. Individual #122's ISP did not include a plan to address "incipient periodontitis." Individual #70 had a plan, but it was not fully implemented. Based on documentation, his behavior was a barrier to the completion of the plan, but it did not appear that Behavioral Health Services staff were working with other members of the IDT to develop and implement a program that would increase the likelihood of his compliance with tooth brushing. | | | | | | | | | | | |

| Outcome 7 – Individuals receive timely, complete emergency dental care. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: N/A | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary. | Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight. | | | | | | | | | |
| b. | If the dental emergency requires dental treatment, the treatment is provided. | | | | | | | | | | |
| c. | In the case of a dental emergency, the individual receives pain management consistent with her/his needs. | | | | | | | | | | |
| Comments: None. | | | | | | | | | | | |

| Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: The Monitoring Team will continue to review all of these indicators. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of | 50% 1/2 | N/A | N/A | N/A | N/A | N/A | 1/1 | 0/1 | N/A | N/A |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | suction tooth brushing. | | | | | | | | | | |
| b. | The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP. | 0%<br>0/2 | | | | | | 0/1 | 0/1 | | |
| c. | If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique. | 0%<br>0/2 | | | | | | 0/1 | 0/1 | | |
| d. | At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing. | 0%<br>0/2 | | | | | | 0/1 | 0/1 | | |
| Comments: b. Although some information was provided on Medication Administration Records (MARs), it was not complete.<br><br>c. Based on documentation provided, the Dental Department was revising its monitoring procedures for suction tooth brushing to address the quality, as well as the safety of staff's implementation of the technique. | | | | | | | | | | | |

| Outcome 9 – Individuals who need them have dentures. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: N/A | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s). | Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight. | | | | | | | | | |
| 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: Based on interview with the Chief Nurse Executive (CNE), nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected. These indicators will remain in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | If the individual displays signs and symptoms of an acute illness | 0% | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| | and/or acute occurrence, nursing assessments (physical assessments) are performed. | | | | | | | | | | |
| b. | For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions. | 0% | | | | | | | | | |
| c. | For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments. | 0% | | | | | | | | | |
| d. | For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments. | 0% | | | | | | | | | |
| e. | The individual has an acute care plan that meets his/her needs. | 0% | | | | | | | | | |
| f. | The individual's acute care plan is implemented. | 0% | | | | | | | | | |

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

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

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

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

| # | Indicator | Overall Score | Individuals: 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| b. | Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| c. | Integrated ISP progress reports include specific data reflective of the measurable goal/objective. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| d. | Individual has made progress on his/her goal/objective. | 0% | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 0/18 | | | | | | | | | |
| 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 #216 – dental, and weight; Individual #311 – respiratory compromise, and skin integrity; Individual #191 – infections, and falls; Individual #239 – fractures, and skin integrity; Individual #241 – GI problems, and weight; Individual #162 – fractures, and skin integrity; Individual #122 – fractures, and cardiac disease; Individual #70 – falls, and skin integrity; and Individual #333 – constipation/bowel obstruction, and osteoporosis).

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.

| # | Indicator | Overall Score | Individuals: 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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% 0/15 | 0/2 | 0/2 | 0/2 | 0/2 | 0/1 | 0/1 | 0/2 | 0/1 | 0/2 |
| c. | The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets). | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |

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

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

| Outcome 6 – Individuals receive medications prescribed in a safe manner. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Since the last review, the efforts and training the Nursing Educators and nursing staff undertook was evident in the exceptional medication administration sessions observed for all eight individuals. For the two previous reviews, as well as this review, the Center did well with the indicators related to nurses administering medications in accordance with the nine rights (Indicator c), following individuals' PNMPs (f, formerly e), and adhering to infection control procedures while administering medications (g, and formerly f). However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will remain in active oversight as well. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | Individual receives prescribed medications in accordance with applicable standards of care. | N/R | | | | | | | N/A | | |
| b. | Medications that are not administered or the individual does not accept are explained. | N/R | | | | | | | | | |
| c. | The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation). | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | | 1/1 | 1/1 |
| d. | In order to ensure nurses administer medications safely: | | | | | | | | | | |
| | i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs. | 25% 1/4 | N/A | N/A | 0/1 | 0/1 | N/A | 1/1 | | N/A | 0/1 |
| | 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 | 20% 2/10 | N/A | 0/2 | 0/2 | 0/2 | N/A | 2/2 | | 0/1 | 0/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 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. | | | | | | | | | | |
| e. | If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response. | N/R | | | | | | | | | |
| f. | Individual's PNMP plan is followed during medication administration. | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | | 1/1 | 1/1 |
| g. | Infection Control Practices are followed before, during, and after the administration of the individual's medications. | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | | 1/1 | 1/1 |
| h. | Instructions are provided to the individual and staff regarding new orders or when orders change. | N/R | | | | | | | | | |
| i. | When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions. | N/R | | | | | | | | | |
| j. | If an ADR occurs, the individual's reactions are reported in the IPNs. | N/R | | | | | | | | | |
| k. | If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician. | N/R | | | | | | | | | |
| l. | If the individual is subject to a medication variance, there is proper reporting of the variance. | N/R | | | | | | | | | |
| m. | If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician. | N/R | | | | | | | | | |

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of eight individuals, including Individual #216, Individual #311, Individual #191, Individual #239, Individual #241, Individual #162, Individual #70, and Individual #333.

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

d. The CNE reported that nursing staff completed training regarding lung sounds during medication administration in alignment with the indicators. It was extremely positive that during observations, medication nurses completed lung sounds for applicable individuals. However, because the IHCPs did not define these assessments, the Center did not meet criteria for this indicator. Nursing staff are

encouraged to continue this practice during medication passes, and RN Case Managers should ensure that individuals' IHCPs and/or acute care plans define the assessments individuals need.

f. It was positive that for individuals observed, the nurses followed their PNMPs during medication administration.

g. For the individuals observed, nursing staff followed infection control practices, which was good to see.

## Physical and Nutritional Management

| Outcome 1 – Individuals' at-risk conditions are minimized. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Overall, 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 | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress: | | | | | | | | | | |
| | i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions; | 0% 0/9 | 0/1 | 0/2 | N/A | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| | ii. Individual has a measurable goal/objective, including timeframes for completion; | 0% 0/9 | 0/1 | 0/2 | | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| | iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective; | 0% 0/9 | 0/1 | 0/2 | | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| | iv. Individual has made progress on his/her goal/objective; and | 0% 0/9 | 0/1 | 0/2 | | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| | v. When there is a lack of progress, the IDT takes necessary action. | 0% 0/9 | 0/1 | 0/2 | | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| b. | Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress: | | | | | | | | | | |
| | i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate; | 67% 6/9 | 0/1 | N/A | 2/2 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 |
| | ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of | 0% 0/9 | 0/1 | | 0/2 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | interventions; | | | | | | | | | |
| | iii. | Individual has a measurable goal/objective, including timeframes for completion; | 0%<br>0/9 | 0/1 | | 0/2 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| | iv. | Integrated ISP progress reports include specific data reflective of the measurable goal/objective; | 0%<br>0/9 | 0/1 | | 0/2 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| | v. | Individual has made progress on his/her goal/objective; and | 0%<br>0/9 | 0/1 | | 0/2 | 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%<br>0/9 | 0/1 | | 0/2 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

Comments: The Monitoring Team reviewed nine goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: choking for Individual #216; aspiration, and GI problems for Individual #311; skin integrity for Individual #239; GI problems for Individual #241; skin integrity for Individual #162; skin integrity for Individual #122; fractures for Individual #70; and aspiration for Individual #333.

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

b.i. The Monitoring Team reviewed nine areas of need for eight individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goals/objectives were included. These areas of need included: weight for Individual #216; weight, and aspiration for Individual #191; aspiration for Individual #239; aspiration for Individual #241; aspiration for Individual #162; aspiration for Individual #122; aspiration for Individual #70; and weight for Individual #333.

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

- Individual #216's RN Case Manager and the nutritionist expressed concerns about her continued weight loss. The nursing quarterly review, for the period from July 2016 to October 2016, stated that no further weight loss was needed, but Individual #216 lost another 11 pounds the following quarter. The PNMT should have at least made a self-referral, conducted a review, and assisted the IDT in determining the cause and potential response.
- For Individual #239, the goal/objective that the IDT developed related to reducing the number of aspiration triggers to less than 15. When this goal/objective was not met and Individual #239 experienced 20 aspiration triggers, the IDT should have sought the assistance of the PNMT for at least a review. However, they did not, and the PNMT only reviewed him in December 2016, after he had a pneumonia diagnosis in November 2016.
- For Individual #333, the PNMT did not define individualized re-referral criteria. This was important due to Individual #333's significant history of weight loss and the difficulty he had regaining the weight once he lost it. A more individualized and proactive approach was needed that would have triggered a PNMT review or assessment earlier than the six-month weight loss mark.

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

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of measurable goals/objectives, progress reports, including data and analysis of the data, were generally 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: It was good to see that individuals' IDTs and the PNMT often were taking action when individuals' PNM risks increased or there was a change in status. It also was good to see improvement with regard to the PNMT discharge process. Focus is needed to improve PNM action plans in IHCPs and then to ensure they are implemented. These indicators will remain in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| 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. | 17% 3/18 | 0/2 | 0/2 | 0/2 | 1/2 | 0/2 | 2/2 | 0/2 | 0/2 | 0/2 |
| b. | When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action. | 69% 9/13 | 0/2 | N/A | 2/2 | 0/1 | 1/1 | 2/2 | 2/2 | 2/2 | 0/1 |
| c. | If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT. | 75% 3/4 | N/A | N/A | 2/2 | N/A | 0/1 | 1/1 | N/A | N/A | N/A |
| Comments: a. As noted above, none of the IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, the IHCPs for which documentation was found to confirm the implementation of the PNM action steps that were included were for skin integrity for Individual #239, and skin integrity, and aspiration for Individual #162.<br><br>c. For Individual #241, no ISPA meeting notes were found discussing the PNMT's findings. | | | | | | | | | | | |

| Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately. | | | |
|---|---|---|---|
| Summary: N/A | | | |
| # | Indicator | Overall Score | |
| a. | Individuals' PNMPs are implemented as written. | N/R | |

| | | |
|---|---|---|
| b. | Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP. | N/R |
| | Comments: Due to unexpected circumstances, the Monitoring Team member was unable to conduct observations to determine if staff implemented PNMPs as written. During the week of 6/12/17, the Monitoring Team member will return to the Center to conduct observations, and provide Center staff with feedback. | |

**Individuals that Are Enterally Nourished**

| Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: This indicator will remain in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| 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. | 0% 0/1 | | N/A | | N/A | | N/A | N/A | N/A | 0/1 |
| | Comments: a. Although staff were working with Individual #133 to increase the frequency of his oral intake, the IDT had not fully assessed the underlying cause of his food refusals, or developed measurable strategies and action plans to address such issues. | | | | | | | | | | |

**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: It was good to see that some OT/PT goals/objectives developed for individuals reviewed were clinically relevant. However, IDTs overall did not have a way to measure outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions. | 43% 3/7 | 0/1 | 0/1 | 0/1 | 0/1 | N/A | 1/1 | N/A | 1/1 | 1/1 |
| b. | Individual has a measurable goal(s)/objective(s), including timeframes for completion. | 14% 1/7 | 0/1 | 0/1 | 0/1 | 0/1 | N/A | 0/1 | N/A | 0/1 | 1/1 |
| c. | Integrated ISP progress reports include specific data reflective of the measurable goal. | 0% 0/7 | 0/1 | 0/1 | 0/1 | 0/1 | N/A | 0/1 | N/A | 0/1 | 0/1 |
| d. | Individual has made progress on his/her OT/PT goal. | 0% | 0/1 | 0/1 | 0/1 | 0/1 | N/A | 0/1 | N/A | 0/1 | 0/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 0/7 | | | | | | | | | |
| e. | When there is a lack of progress or criteria have been achieved, the IDT takes necessary action. | 14%<br>0/7 | 0/1 | 0/1 | 0/1 | 0/1 | N/A | 0/1 | N/A | 0/1 | 1/1 |

Comments: a. and b. Individual #241 had functional activities of daily living skills (ADLs), and did not have any other OT/PT needs. He was part of the outcome group, so further review was not conducted.

The goals/objectives that were clinically relevant and achievable, but not measurable were Individual #162's goal/objective related to finding a relaxation technique she likes, and Individual #122's goal/objective related to putting on his shirt.

The goal/objective that was clinically relevant and achievable, as well as measurable was Individual #333's goal/objective to ambulate 150 feet. It was very positive that the IDT, with the involvement of the PT, developed a direct therapy ambulation program for Individual #333.

c. through e. Overall, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. The Monitoring Team conducted full reviews for eight of the nine individuals.

On a positive note, for Individual #333, the IDT had taken some actions to address a lack of progress. On 1/30/17, the IDT agreed to start a formal direct therapy walking program using a platform walker. An ISPA, dated 3/2/17, noted this program had been discontinued due to the need for replacement of his ankle-foot orthosis (AFO), as well as the need for support from Behavioral Health Services (BHS) staff. Once the new AFO was obtained, therapy was reinitiated. The AFOs seemed to be having a positive impact. Based on a 3/21/17 ISPA, it also appeared that the PT had worked with BHS staff, who had conducted some observations. These were positive developments, and the Monitoring Team looks forward to learning about progress during upcoming reviews.

| Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: The Monitoring Team will continue to review these indicators. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented. | 29%<br>2/7 | 0/1 | 0/1 | 0/1 | 0/1 | N/R | 0/1 | N/A | 1/1 | 1/1 |
| b. | When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change. | 50%<br>1/2 | N/A | N/A | N/A | N/A | | N/A | N/A | 0/1 | 1/1 |

| |
|---|
| Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that OT/PT supports were implemented.<br><br>b. On 2/6/17, the PT recommended in a consultation report that the three-person transfers be discontinued. No ISPA meeting appeared to have been held to discuss this recommendation. |

| Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: N/A | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | | |
| a. | Assistive/adaptive equipment identified in the individual's PNMP is clean. | N/R | | | | | | | | | | |
| b. | Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition. | Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight. | | | | | | | | | | |
| c. | Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual. | N/R | | | | | | | | | | |
| Comments: Due to unexpected circumstances, the Monitoring Team member was unable to conduct observations to determine if adaptive equipment was clean and appeared to fit the individual. During the week of 6/12/17, the Monitoring Team member will return to the Center to conduct observations, and provide Center staff with feedback. | | | | | | | | | | | | |

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

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition. At the last review, none of the indicators were moved to the category of requiring less oversight. At this review, two indicators in skill acquisition will be moved to this category.

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.

ISP implementation and data are required if the set of indicators in Outcome 2 for ISPs is to be determined.

Attending to SAP content, implementation, data collection, and actions if SAPs are, or are not, progressing is an area of general focus for Corpus Christi SSLC. The Monitoring Team was aware of efforts being put forth by State Office to support Center staff to that end.

Corpus Christi regularly measured engagement and had set a goal for each treatment site. The Center recently changed its self-scoring method for engagement, which will likely result in scores that more closely approximate those of the Monitoring Team.

The Center did not have a way to measure clinically relevant communication outcomes 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: One goal met criteria with indicator 3. Implementation and data are required if this set of indicators is to be determined. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 311 | 275 | 123 | 216 | 162 | 333 | | | |
| 4 | The individual met, or is making progress towards achieving his/her overall personal goals. | 0%<br>0/6 | 0/6 | 0/6 | 0/6 | 0/6 | 1/6 | 0/6 | | | |
| 5 | If personal goals were met, the IDT updated or made new personal goals. | 0%<br>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 | 0%<br>0/6 | 0/6 | 0/6 | 0/6 | 0/6 | 0/6 | 0/6 | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | were made. | | | | | | | | | | |
| 7 | Activity and/or revisions to supports were implemented. | 0%<br>0/6 | 0/6 | 0/6 | 0/6 | 0/6 | 1/6 | 0/6 | | | |

Comments: As Corpus Christi SSLC further develops individualized personal goals, it should focus on developing actions plans that clearly support the achievement of those personal goals and, thus, the facility can achieve compliance with this outcome and its indicators. Examples of how this might be accomplished are provided above.

4-7. A personal goal that meets criterion for outcomes 1 through 3 is a pre-requisite for evaluating whether progress has been made. One of the personal goals met criterion for Indicators 1 through 3 as described above. This was the living options goal for Individual #162. While this personal goal was not met, progress was being made and activity implemented. There was no basis for assessing progress for the other goals because the IDTs failed to develop personal goals that were also measurable. The Monitoring Team found the lack of implementation, monitoring, and reliable and valid data to be significant concerns.

| Outcome 8 – ISPs are implemented correctly and as often as required. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 311 | 275 | 123 | 216 | 162 | 333 | | | |
| 39 | Staff exhibited a level of competence to ensure implementation of the ISP. | 0%<br>0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |
| 40 | Action steps in the ISP were consistently implemented. | 0%<br>0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |

Comments:

39. It was positive that most staff knew the preferences of individuals, but staff knowledge regarding individuals' ISPs was insufficient to ensure its implementation, based on observations, interviews, and lack of consistent implementation. For example:

- For Individual #333, the Behavioral Health Assistant could not describe the replacement behavior in the new PBSP and did not know whether the PBSP included any positive reinforcement strategies for refusals.
- Just prior to the monitoring visit, Individual #162's pulse oximeter was missing over a weekend and staff did not promptly recognize/take action to make sure this critical support was in place.
- A DSP interviewed was aware of the SAPs contained in Individual #123's ISP, but SAP implementation was observed and was not done correctly.
- Individual #311's DSP stated he didn't walk at all, but his PNMP indicated he could walk with one to two staff at his discretion and per physician order. The DSP also stated he did not have risks for choking and aspiration, but both were rated high risk.

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

**Skill Acquisition and Engagement**

| Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: All four indicators showed some decrease in performance. Attending to SAP implementation, data collection, and actions if SAPs are, or are not, progressing is an area of general focus for Corpus Christi SSLC. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
| 6 | The individual is progressing on his/her SAPS | 0% 0/24 | 0/3 | 0/3 | 0/2 | 0/3 | 0/3 | 0/3 | 0/3 | 0/1 | 0/3 |
| 7 | If the goal/objective was met, a new or updated goal/objective was introduced. | 0% 0/1 | N/A | N/A | N/A | N/A | 0/1 | N/A | N/A | N/A | N/A |
| 8 | If the individual was not making progress, actions were taken. | 6% 1/17 | 0/3 | 0/1 | 0/2 | 0/3 | 0/1 | 1/3 | 0/2 | N/A | 0/2 |
| 9 | Decisions to continue, discontinue, or modify SAPs were data based. | 69% 18/26 | 1/3 | 2/3 | 2/3 | 3/3 | 3/3 | 0/3 | 3/3 | 2/2 | 2/3 |

Comments:

6. Although graphs or monthly reviews suggested the individual was making progress on seven of the 24 SAPs for which data were provided (Individual #311 - hand sanitizing and phone skills, Individual #46 - exercise and SAMS, Individual #227 - computer use, Individual #216 - healthy snack, Individual #135 - money management), all were rated as not progressing due to the lack of reliable data.

7. Documents provided suggested that Individual #46 had mastered his exercise SAP. There was no evidence that a new or updated goal had been introduced.

8. There was evidence that action was to be taken for only one of the SAPs in which progress was not suggested. Staff were to be re-trained in data collection on the street crossing SAP for Individual #123.

9. Data were reviewed in at least one monthly review for 18 of 26 SAPs. One SAP was not included in this measure because it had been discontinued (Individual #216 - keyboard).

| Outcome 4- All individuals have SAPs that contain the required components. | |
|---|---|
| Summary: At the last review, some promising positive improvements were noted. They did not, however, result in improved performance. More attention to the content of SAPs is needed. The Monitoring Team was aware of efforts being put forth by state office to support facility staff to the end. This indicator will remain in | Individuals: |

| active monitoring. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
| 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. None of the 27 SAPs were considered complete. Major areas of concern included the following:
    - behavioral objectives that did not identify the conditions under which the behavior was to occur and/or indicate the level of independence;
    - teaching schedules that were quite limited and did not include the number of trials to be limited; and
    - reinforcing consequences for responses that were exhibited only after more intrusive prompting was provided.

| Outcome 5- SAPs are implemented with integrity. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Both indicators showed a decrease in performance compared with the last review and both will remain in active monitoring. Correct implementation of SAPs is an area of focus for Corpus Christi SSLC. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
| 14 | SAPs are implemented as written. | 25% 2/8 | 0/1 | 0/1 | 1/1 | 0/1 | N/A | 0/1 | 0/1 | 1/1 | 0/1 |
| 15 | A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved. | 7% 2/27 | 1/3 | 1/3 | 0/3 | 0/3 | 0/3 | 0/3 | 0/3 | 0/3 | 0/3 |

Comments:

14. A specific SAP training session was observed for eight of the nine individuals. The exception was Individual #46 who reported to his staff that he did not want the Monitoring Team present during his training. For Individual #275 and Individual #216, the SAP was implemented as written. For all others, the primary concern was that reinforcement was not delivered contingent upon correct responding, even if the individual was asked what he or she would like to access.

15. Assessment of integrity was to occur on every SAP at a minimum of once every six months. It was expected that a score of 80% or better would be achieved. Of the 27 SAPs reviewed, there was evidence of an integrity assessment for two (Individual #186 - money management, Individual #311 - hand sanitizing). The director of education and training indicated that there were problems associated with integrity checks and explained that a new system was to be introduced in the near future.

During observations by the Monitoring Team, Program Coordinators provided supportive feedback and training when conducting integrity checks on SAP implementation.

| Outcome 6 - SAP data are reviewed monthly, and data are graphed. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: The occurrence of regularly occurring monthly reviews of SAPs had decreased since the last review. Graphing continued to occur, however, they were not of good quality. These two indicators will remain in active monitoring. | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
| 16 | There is evidence that SAPs are reviewed monthly. | 0% 0/27 | 0/3 | 0/3 | 0/3 | 0/3 | 0/3 | 0/3 | 0/3 | 0/3 | 0/3 |
| 17 | SAP outcomes are graphed. | 93% 25/27 | 3/3 | 3/3 | 2/3 | 3/3 | 3/3 | 3/3 | 3/3 | 2/3 | 3/3 |

Comments:

16. QIDP Monthly Reviews were requested for the months of October 2016 through March 2017. None of the nine individuals had reviews for the first two months of this six-month period. In the subsequent reviews, a data-based review was provided for all three of Individual #46's and Individual #227's SAPs, and for two of the three SAPs for Individual #311, Individual #275, Individual #197, Individual #216, and Individual #135. The monthly reports for Individual #186 and Individual #123 did not provide data-based reviews of any of their identified SAPs.

17. Graphs were provided for 25 of the 27 SAPs. These graphs depicted the frequency of successful trials. When zero trials were recorded, one data path was present. However, when one or more trials were recorded, there were two data paths. It was not possible to understand what these different paths represented because they were not labeled. The director of education and training explained that a new graphing system was to be introduced. No graphs were provided for the applying lipstick SAP for Individual #275 or the exploitation SAP for Individual #216.

| Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: The facility regularly measured engagement and had set a goal for each treatment site. This has been the case for some time and, therefore, these two indicators (19 and 20) will be moved to the category of requiring less oversight. The facility recently change its self-scoring method for engagement, which will likely result in scores that more closely approximate those of the Monitoring Team's. Indicators 18 and 21 will remain in active monitoring. | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
| 18 | The individual is meaningfully engaged in residential and treatment sites. | 56% 5/9 | 0/1 | 0/1 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 |
| 19 | The facility regularly measures engagement in all of the individual's treatment sites. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 20 | The day and treatment sites of the individual have goal engagement level scores. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 21 | The facility's goal levels of engagement in the individual's day and treatment sites are achieved. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |

Comments:

18. Five of the nine individuals were meaningfully engaged. Individual #275 was often engaged when observed in her classes; Individual #46, Individual #123, and Individual #216 were engaged when observed at their job; and Individual #227 was observed engaged in leisure activities on his home and when out on campus. All others were not observed engaged in scheduled, structured activities. It should be noted that information provided by the facility indicated that eight individuals who were enrolled in vocational services worked between one (Individual #227) and 15 hours per week (Individual #46). (It should be noted that Individual #46's hours were reduced at his recent ISP meeting.) This resulted in an average of six hours per week per individual. It is suggested that more emphasis should be placed on finding meaningful employment for the individuals who are served by the facility.

19-20. The facility had established a policy of assessing engagement three times per week in each home and day program site. Engagement levels were established for each residential unit (Atlantic - 75%; Pacific - 65%; and Coral Sea - 50%) and for classroom and work sites (90%). For three of these four, the Monitoring Team was in agreement. Given the complex medical and physical status of the individuals at Coral Sea, the 50% goal was reasonable. On the other hand, the goal for Pacific should be re-assessed and likely be set slightly higher.

21. Data presented for the six-month period from September 2016 through February 2017 indicated that these goals had been achieved. Up until very recently (i.e., March 2017, one month prior to the onsite review), the staff were using an engagement observation tool that required observation for five one-minute intervals, likely inflating their scores. The new tool required the conduct of a snapshot observation of the area with the total observation taking approximately 30 seconds. This more approximated the method of assessing engagement used by the Monitoring Team, is a more valid measure of engagement, and should provide the facility with more useful data.

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

Summary: Indicators 22 and 23 showed nice improvement from 0% scores at the last review. With goals/expectations set, IDTs can now move toward addressing barriers as they arise (indicator 24). These three indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 186 | 311 | 275 | 197 | 46 | 123 | 227 | 216 | 135 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 22 | For the individual, goal frequencies of community recreational activities are established and achieved. | 78% 7/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 0/1 |
| 23 | For the individual, goal frequencies of SAP training in the community are established and achieved. | 22% 2/9 | 0/1 | 1/1 | 1/1 | 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%<br>0/7 | 0/1 | N/A | N/A | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

Comments:
22. None of the ISPs identified goal frequencies for community recreational activities. Rather, the director of education and training explained that the facility's expectation was for individuals living in the Atlantic unit to get out a minimum of twice per week, those in Pacific to get out twice per month, and those in Coral Sea to get out once per month. Exceptions were made when a physician indicated that community outings were not advised. For seven of the individuals reviewed, the minimum expectation was met or exceeded. The exceptions were Individual #227 and Individual #135.

23. As noted above, community based training was not identified in the individual's ISP, rather there was a facility-wide expectation based on residence. For those individuals residing in the Atlantic unit, the expectation was one community-based training per week. None of the seven individuals residing in this unit (Individual #186, Individual #197, Individual #46, Individual #123, Individual #227, Individual #216, Individual #135) met this goal. Only Individual #311 and Individual #275 met their community-based training goal of twice per month.

24. There was no evidence that the IDT met to determine barriers or develop corrective action plans for the seven individuals whose community recreational activities and/or community-based training goals were not achieved.

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 receiving educational services. Individual #135, however, was receiving educational services as per his ISP from August 2016, but he dropped out and failed to get his diploma or pursue a GED certificate. 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. At the time of the onsite visit, none of the individuals attended school.

Note, however, that part of Individual #135's vision identified at his ISP meeting in August 2016 was to graduate from high school or obtain his GED. When the Monitoring Team requested action plans taken to address this vision, the facility indicated there were no actions taken. Later in the day, follow-up information was provided. The monthly review from March 2017 indicated enrollment in another school was not possible due to zoning/location and Individual #135 refused to go back to school or explore obtaining a GED. This issue should have been addressed in a more timely manner.

**Dental**

| Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: N/A | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions; | N/A | | | | | | | | | |
| b. | Individual has a measurable goal(s)/objective(s), including timeframes for completion; | N/A | | | | | | | | | |
| c. | Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s); | N/A | | | | | | | | | |
| d. | Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and | N/A | | | | | | | | | |
| e. | When there is a lack of progress, the IDT takes necessary action. | N/A | | | | | | | | | |
| Comments: None of the individuals reviewed had refused dental services. | | | | | | | | | | | |

**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 did not have a way to measure clinically relevant communication outcomes for the individuals reviewed. These indicators will remain under active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions. | 22% 2/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 1/2 | N/A | 0/1 | 1/1 |
| b. | Individual has a measurable goal(s)/objective(s), including timeframes for completion | 11% 1/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 1/2 | N/A | 0/1 | 0/1 |
| c. | Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s). | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/2 | N/A | 0/1 | 0/1 |
| d. | Individual has made progress on his/her communication | 0% | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/2 | N/A | 0/1 | 0/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | goal(s)/objective(s). | 0/9 | | | | | | | | | |
| e. | When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action. | 0%<br>0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/2 | N/A | 0/1 | 0/1 |

Comments: a. and b. The goal/objective that was clinically relevant, as well as measurable was Individual #162's direct therapy goal/objective related to accessing nine icons on her AAC device. Individual #333's goal/objective to activate a switch to hear his mother's voice was clinically relevant, but not measurable.

c. The Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, as well as a lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives.

| Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: These indicators will remain in active oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 216 | 311 | 191 | 239 | 241 | 162 | 122 | 70 | 333 |
| a. | There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented. | 0%<br>0/6 | 0/1 | 0/1 | N/A | 0/1 | N/A | 0/2 | N/A | N/A | 0/1 |
| b. | When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination. | N/A | | | | | | | | | |

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

- In October 2016, the SLP recommended a program for Individual #333 to activate a recording of his mother, but it was not implemented until March 2017. The reasoning was that his mother travelled a lot, but attempts to obtain a recording of his mother over the phone were not documented. The IDT might want to consider changing the recording monthly or at least quarterly to keep the program fresh and meaningful.
- Individual #216's ISP indicated that a trial of direct therapy would be conducted, but no ISPA was found to show that it occurred and/or the results.
- Evidence generally was not found to show that individuals were using communication devices regularly, or that other communication strategies were implemented.

| Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: N/A | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual. | N/R | | | | | | | | | | |
| b. | Individual is noted to be using the device or language-based support in a functional manner in each observed setting. | N/R | | | | | | | | | | |
| c. | Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times. | N/R | | | | | | | | | | |
| Comments: Due to unexpected circumstances, the Monitoring Team member was unable to conduct observations of individuals with AAC devices. During the week of 6/12/17, the Monitoring Team member will return to the Center to conduct observations, and provide Center staff with feedback. | | | | | | | | | | | | |

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

This Domain contains five outcomes and 20 underlying indicators. At this time, none will be moved to the category requiring less oversight. This is only the second round of reviews in which the Monitoring Team reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. In addition, early in 2016, the Center began additional post-move monitoring responsibilities, and had begun to follow individuals in the community for a year as opposed to 90 days.

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

More work was needed to make supports in the CLDPs measurable. In addition, a number of essential supports were missing from the CLDPs reviewed, and this should be a focus for Center staff.

It was positive that the Post-Move Monitor conducted timely monitoring for the individuals reviewed, and provided documentation to substantiate findings. IDTs also generally followed up in a timely and thorough manner when the PMM noted problems with the provision of supports. It will be important for CLDPs to include measurable supports and define evidence in a way that helps to ensure that reliable and valid data are available to the PMM.

Neither individual experienced a negative event during the transition process.

Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of transition assessments. This was an area on which Admissions Placement Department staff were actively working with IDTs and there were beginning to be some positive results, which was good to see. Although Center staff provided training to community provider staff, the CLDPs did not define the training well, and the training did not appear to meet the individual's needs. These indicators will remain in active oversight.

| 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: More work was needed to make supports in the CLDPs measurable. In addition, a number of essential supports were missing from the CLDPs reviewed, and this should continue to be a focus for Center staff. These indicators will remain in active oversight. | Individuals: |

| # | Indicator | Overall Score | 148 | 348 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | The individual's CLDP contains supports that are measurable. | 0%<br>0/2 | 0/1 | 0/1 | | | | | | | |
| 2 | The supports are based upon the individual's ISP, assessments, preferences, and needs. | 0%<br>0/2 | 0/1 | 0/1 | | | | | | | |

Comments: 1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how needs and preferences must be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make adjustments as needed. For these two CLDPs, supports were not consistently measurable and did not provide the Post Move Monitor with measurable criteria or indicators that could be used to ensure supports were being provided as needed. At the time of the last monitoring visit, the Monitoring Team noted that the CLDPs did not contain all necessary pre-move requirements, and specifically that pre-move supports did not define any required provider training. This continued to be of concern during this visit.

- The IDT developed seven pre-move supports and 22 post-move supports for Individual #148: The CLDP did not include any specific pre-move supports for training of provider staff or call for any testing of staff knowledge. Pre-move supports primarily focused on exchange of information, but did not provide any means by which to measure whether provider staff had the necessary knowledge.
    - Three of Individual #148's supports called for providing Special Needs Instructions to include: verbal prompts to take small bites while dining; instructions to de-bone all meats; and, to make staff aware of his history of jumping out of a moving vehicle and related prevention precautions. These supports did not include any descriptions of how staff training would be carried out or any competency demonstration criteria. The only evidence required was the special needs forms.
    - Another three supports called for the provision of materials to the provider. These included MRSA protocols, his communication dictionary, and a communication booklet. None of these had any requirement for staff training or demonstration of staff knowledge or competence. Again, the only evidence specified was the presence of the documents. The presence of documents would not provide sufficient evidence that provider staff were knowledgeable of Individual #148's needs or how to meet them.
- Post-move supports for Individual #148 had similar issues related to measurability. None required any verification of staff knowledge or competence. Of the 22 post-move supports, 19 required only review of some form of documentation. For example:
    - Post-move supports called for dining and vehicle safety instructions, as in the pre-move supports described above, but again required only that the PMM observe the presence of the instruction forms. The CLDP supports did not require the PMM to observe for implementation or confirm that staff were knowledgeable of the instructions.
    - Similarly, several supports called for continued use of Individual #148's small bowl spoon, high-sided plate and dycem mat for dining, but the only evidence required was for the PMM to view the equipment was present. The CLDP did not require the PMM to observe for implementation or confirm that staff were knowledgeable of these supports.
    - A support to continue with his Positive Behavior Support Plan (PBSP) until his initial appointment with a psychologist required review of data sheets only. It did not require any confirmation of staff knowledge of his various behavioral needs or interventions.

- The IDT developed three pre-move supports and 30 post-move supports for Individual #348:
    - Individual #348's pre-move supports included that signed doctor's orders would include new diet orders; that the provider would create two special needs sheets, including one with information about diet (no added salt, no lactose, moisten dry foods and breads to be cut into dime-sized pieces) and one for bowel movement tracking. The evidence required was observation of the documents. Like Individual #148' CLDP, Individual #348's did not include any specific pre-move supports for training of provider staff or call for any testing of staff knowledge. The mere presence of the specified documents would not provide sufficient evidence that provider staff were knowledgeable of Individual #348's needs in these areas or how to meet them, but also did not require evidence of staff knowledge of many other needs.
    - Some of Individual #348's post-move supports were measurable, providing specific criteria. For example, a support called for administration of Keppra for seizures to be discontinued by 12/22/16 as evidenced by a review of the medication administration record sheets (MARS.) Another called for her to have an initial appointment with a neurologist for seizure management by 7/13/17, to be evidenced by a consult or visit summary.
    - Other supports were overly broad and did not provide specific criteria the PMM could use to determine if they were present. For example:
        - A support called for the provider to monitor Individual #348's intake. It did not describe what the provider should monitor for or what actions might be needed based on the results.
        - Another support stated the provider would monitor ounces of fluid consumed daily. It did not indicate how many ounces she should be offered or consume.

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. The Center had identified many supports for these two individuals and it was positive they had made a diligent effort to address their needs. Despite these efforts, neither of these CLDPs comprehensively addressed support needs and did not meet criterion, as described below:

a. Past history, and recent and current behavioral and psychiatric problems: Supports did not sufficiently reflect the individual's past history, and recent and current behavioral and psychiatric problems in a consistent manner. Examples included:
    - For Individual #148, supports in this area included providing special instructions to make staff aware of his history of jumping out of vehicles, including ensuring safety with either safety locks or seating positioning, and continuing his PBSP until his initial appointment with a psychologist. It was concerning supports did not specifically spell out his other behavioral needs, including target behaviors and interventions. For example, the IDT did not provide any specific supports for the following needs:
        - Individual #148 had an extensive history of significant behavioral issues in community homes. This included a history of aggression toward housemates, self- injurious behaviors and public incidents of inappropriate sexual behaviors as recently as 2013, as well as multiple psychiatric hospitalizations occurring during the period June 2014 to October 2014. One assessment noted he assaulted and injured an elderly male peer in December 2012. He also had a history of unauthorized departures in community settings. The CLDP did not include any support for provider staff to be knowledgeable of these behaviors.
        - Individual #148 had a PBSP that targeted property destruction and theft, which the ISP indicated were barriers to community placement. He also had a replacement behavior to ask for items rather than taking

them. The CLDP did not include any support for provider staff to be knowledgeable of these specific behaviors.
    - Individual #148 had been provided with various communication devices, which he often would break. The behavioral health assessment recommended consideration of a behavioral contract that provided him with positive reinforcement when he took care of his personal belongings. CLDP supports did not address this behavior or recommendation.
- Individual #348 had five supports related to her behavioral needs. These included having an initial appointment with a Community Behavior Therapist to review behavioral tracking sheets and to assess and determine behavioral health supports needed. Several other supports called for the provider to use and track preventions and interventions per the PBSP, and track challenging and replacement behaviors until the initial Community Behavior Therapist assessment. Most of the supports did not provide specific details and none of them defined or required demonstration of staff competence.
- During Individual #348's community exploration, the IDT indicated she "has a thing about scissors" and other sharp objects, such as knives and forks. Providers were asked to put all such objects away during tours and to make sure they knew that Individual #348 could open safety locks on cabinets. The CLDP did not include any specific supports for staff to be aware of this behavior or related environmental needs.

b. Safety, medical, healthcare, therapeutic, risk, and supervision needs:
- For Individual #148, the CLDP included many supports related to his safety, medical, and healthcare needs. These included completing lab work; receiving an annual EKG and flu shot; and, establishment of dental, neurology and ophthalmology care. Support needs that were not thoroughly addressed included:
    - The CLDP did not include a specific support that described his required supervision level in the community setting. The CLDP narrative indicated his level of supervision was routine and that this consisted of staff having knowledge of his whereabouts at all times, and that, in turn, he was responsible for letting staff know where he goes before he leaves home. This supervision was specific to living at the Center and did not clearly represent what might be needed in the community, particularly given his history of unauthorized departure, theft, aggression toward peers, and inappropriate sexual behavior.
    - He had a seizure disorder diagnosis. The medical assessment documented he had no seizures for the last five years, but remained on Depakote for behavioral needs. Per the nursing assessment, his last seizure reported was in 2014. The IRRF noted action plans for follow-up with a neurologist for seizures and to train the direct support professionals to record any seizure activity on a seizure record and report to a nurse. The CLDP included a support for follow-up with a neurologist, but did not call for any provider staff training on how to recognize seizure activity or reporting requirements.
    - The CLDP included conflicting information about the status of his diagnosis of Hepatitis B. The medical assessment stated this diagnosis was incorrect and had been removed from the diagnosis list. Neither the medical assessment nor the nursing assessment discussed whether he had carrier status or called for any related lab work, but the CLDP narrative indicated he needed lab work every six months to assess his viral load. The narrative further stated the physician answered questions during the CLDP meeting about what carrier status meant for provider staff regarding transmission, but no details were provided nor any support developed.

- Individual #148 had received substantial speech and language therapy while at the Center. Per his speech assessment, he could express himself well with gestures, pictures, a communication book, voice-output devices, and facial expression. He also attempted to imitate word approximations and could use pictures to make himself understood if gestures/vocalizations were not effective. At his shredding job, he used a voice output aid to call for help and a personal communication board. He received direct speech therapy four to eight times per month from May 2015 to July 1, 2016. Prior to transition, he was engaged in a trial with a Conversa device to see how he would do with a more technologically complex device, with the support of a PBSP that targeted proper use and care of the device. This was discontinued the month prior to transition due to poor attendance in therapy and plans to transition to community. The latter rationale was concerning. The speech assessment recommended SLP consultation as needed to ensure current supports are effective and functional. The CLDP supports for communication were limited to providing his communication dictionary and a communication booklet. It did not include any supports for augmentative communication or for any SLP consultation, and did not include any supports for specific staff training or staff knowledge regarding his communication needs.

- Individual #348's CLDP did not include a support for supervision, although the narrative did indicate she would need 24/7 awake staff close enough to prevent wandering at night, and to provide verbal prompting and redirection as needed. It did not address the need to be closely supervised regarding sharp instruments as indicated above. She also had some other specific needs for supervision and assistance that were not referenced. For example, the Functional Skills Assessment (FSA) indicated an area of need for toileting, including that she occasionally had accidents and needed assistance or prompting, particularly with closing the door for privacy and using toilet tissue.
- The CLDP supports did not include staff knowledge or competence regarding some of Individual #348's adaptive equipment.
    - A support did state the wall mat would be placed on the wall if Individual #348's bed was against the wall, while another called for a wheelchair to be made available as needed. A third stated a divided plate would be used for scooping and keeping food separated. Other equipment, including a pressure relief mat and a padded headboard and footboard for her bed, was referenced in the section following the supports, indicating that the physical therapist had been designated to ensure these items were provided on the day of transition. Of some concern, these latter items were apparently not included as supports because the provider stated Individual #348 did not have these for her overnight stay and did not seem to need them. The habilitation therapies assessment indicated the pressure relief mattress was needed for joint comfort due to extensive right hip joint osteoarthritis, so it was not clear how the provider made an assessment that she did not need it.
- Because of her osteoarthritis and other orthopedic issues, Individual #348 sometimes had significant pain that could affect her daily functioning and was treated with pain medication. The CLDP did not include any support related to her pain. She had been issued a wheelchair for long distances, doctor appointments, or when she was sedated, unsteady or not able to walk, or when she was in pain. The CLDP support indicated only that she had a wheelchair to be used "as needed." It did not include any details for staff as to what those needs might be. The wheelchair support did not specify the chair should have a removable seat, armrests and footrests, and rear anti-tippers.
- In addition, the medical assessment indicated Individual #348 should not be given ibuprofen because of her diagnosis of stage three renal disease, but this was not included as a support. The CLDP did not address any staff knowledge

supports regarding this diagnosis.

- Individual #348 was supposed to have a low sodium diet due to hypertension, which was couched as no added salt. The CLDP did include this instruction in the Special Needs Sheet to be developed by the provider. The provider indicated they did not use menus, but did log what individuals ate. It may have been prudent for the Center to provide more specific information about the need for controlling sodium. Per the post-move monitoring (PMM) reports, Individual #348's favorite food since transitioning were high sodium processed meats, such as wieners and bologna.
- The CLDP did not make recommendations or develop supports for needed lab work or some health care consultations. It did include supports for initial appointments with a neurologist, psychiatrist, and dentist, but deferred any recommendations for other needs to the community primary care provider (PCP). This included, for example, a determination as to her need to see a nephrologist to monitor her stage III renal disease. The psychiatry assessment recommended annual monitoring for prolactin level, but this was not even included in the list of needs to be considered by the community PCP.
- Individual #348's last modified barium swallow study (MBSS) was completed on 1/24/13. It indicated mild oral dysphagia. She had dining plan instructions including the following: to sit in a regular dining room chair; to replenish her fluids in smaller amounts to prevent gulping; to assist her if she refused to eat; and, verbal cues for her not to spit out her foods, which she frequently did. Additionally, staff were to encourage Individual #348 to take small sips of fluids to keep her from gulping her fluids. She also refused meals and would throw food when she was finished or did not want to eat. The CLDP did not include any of these instructions or require staff training/competence.

c. What was important to the individual:
   - For Individual #148, the CLDP listed important personal preferences, including various activities he enjoyed, but did not include any narrative regarding outcomes important to him and related personal goals. The ISP personal goals included having a friend, working in the community, and playing a sport on a team in the community. CLDP supports included obtaining employment, but did not otherwise address his specific preferences, leisure activities, having a friend, or participating in a team sport.
   - For Individual #348, the CLDP did not identify important outcomes or personal goals that should be continued. It noted personal goals from her ISP, including operating her radio independently via adaptive equipment, increasing her pay from work, and identifying currency, but all were discontinued.

d. Need/desire for employment, and/or other meaningful day activities in integrated community settings:
   - For Individual #148, the CLDP called for him to be employed within 30 days of his transition date. The support did not provide any additional detail about his employment strengths and preferences. Supports did not include any other reference to meaningful day activities in integrated community settings.
   - For Individual #348, the CLDP stated it was the consensus at the meeting that she would not work when she moved. This determination was based on her having low attendance at work and no real interest in making purchases. This conflicted with her ISP vision which included living in a quiet group home in Austin where she would listen to her music purchased with the larger sum of money she would earn from her supported workplace. The final CLDP recommendation was only for her to attend day habilitation. Post-move supports stated she would have opportunities to listen to music for at least 30 minutes and to walk daily at the day habilitation program. The CLDP did not include any other supports that addressed meaningful day activities in integrated community settings.

e. Positive reinforcement, incentives, and/or other motivating components to an individual's success:

- For Individual #148, the CLDP called for him to continue with his PBSP until his initial appointment with a psychologist. The support did not require any staff knowledge of his specific replacement behavior for requesting items. The CLDP also did not address the behavioral health assessment recommendation for consideration of a behavioral contract to provide him with positive reinforcement when he took care of his personal belongings.
- For Individual #348, the CLDP included supports for a sensory bin with her preferred string to be available and for tracking her replacement behavior of requesting items, at least until the Community Behavior Therapist's initial assessment. As noted above, a support for having the opportunity to listen to music at the home and day habilitation program was also defined. This CLDP met criterion for this sub-indicator.

f. Teaching, maintenance, participation, and acquisition of specific skills: The respective IDTs developed some supports related to teaching, maintenance, participation, and acquisition of specific skills, but did not address these needs in a comprehensive fashion.
   - The CLDP for Individual #148 included training objectives for Community Safety (crossing the street) and Personal Safety. This was positive. The narrative and assessments also noted Individual #148 required gestural through physical assistance in many areas, including hygiene, grooming, coin identification, telephone skills, and leisure skills. He also needed assistance and prompting from staff for oral hygiene. The CLDP did not include any related supports for these needs.
   - For Individual #348, the CLDP included one support related to teaching, maintenance, participation, and acquisition of specific skills. This support called for the provider to use one- to two-step instructions to prompt Individual #348 to brush her teeth on both sides with a soft toothbrush three times per day. On the other hand, the IDT decided not to include training to use a radio with an adaptive switch, as recommended by the SLP and residential assessments. The narrative indicated the SLP agreed in discussion that having the opportunity to listen to music "would suffice," but provided no rationale.

g. All recommendations from assessments are included, or if not, there is a rationale provided: Overall, the Center implemented a good process for reviewing CLDP assessments and for making and documenting team decisions about recommendations. Still, there were recommendations that were either not addressed or did not have an adequate rationale provided for not being included. Sometimes clinicians imbedded recommendations in their assessment narratives, but did not carry them through to the recommendations section. This resulted in important recommendations not being carried over to the CLDP discussion and or included in CLDP supports. Examples included:
   - For Individual #148, as described above, the behavioral health assessment recommended consideration of a behavioral contract that provided him with positive reinforcement when he took care of his personal belongings. CLDP supports did not address this recommendation or indicate a rationale for not including it.
   - For Individual #348, the behavioral health assessment recommended she should have a visual schedule, utilizing a "first, then" approach. The CLDP did not include these supports or provide a reasonable justification.

| Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive. | |
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| Summary: It was positive that the Post-Move Monitor conducted timely monitoring for the individuals reviewed, and provided documentation to substantiate findings. IDTs also generally followed up in a timely and thorough manner when the PMM noted problems | Individuals: |

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| with the provision of supports. It will be important for CLDPs to include measurable supports and define evidence in a way that helps to ensure that reliable and valid data are available to the PMM. This is only the second round of reviews in which the Monitoring Team reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. These indicators will remain in active oversight. | | | | | | | | | | | | |
| # | Indicator | Overall Score | 148 | 348 | | | | | | | | |
| 3 | Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date | 100% 2/2 | 1/1 | 1/1 | | | | | | | | |
| 4 | Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports. | 0% 0/2 | 0/1 | 0/1 | | | | | | | | |
| 5 | Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary. | 0% 0/2 | 0/1 | 0/1 | | | | | | | | |
| 6 | The PMM's assessment is correct based on the evidence. | 100% 2/2 | 1/1 | 1/1 | | | | | | | | |
| 7 | If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner. | 50% 1/2 | 1/1 | 0/1 | | | | | | | | |
| 8 | Every problem was followed through to resolution. | 50% 1/2 | 1/1 | 0/1 | | | | | | | | |
| 9 | Based upon observation, the PMM did a thorough and complete job of post-move monitoring. | N/A | N/A | N/A | | | | | | | | |
| 10 | The PMM's report was an accurate reflection of the post-move monitoring visit. | N/A | N/A | N/A | | | | | | | | |

Comments: 3. Post-move monitoring was completed at required intervals for both individuals. 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.

4. In many cases, the PMM Checklists provided reliable and valid data that reported/summarized the status regarding receipt of supports. For both individuals, it was not always possible to ascertain whether reliable and valid data were present, due in part to a lack of specificity and measurability of some supports as described in Indicator #1.

5. Based on information the Post Move Monitor collected, neither of the individuals had consistently received supports as listed and/or described in the CLDP, as detailed below:

- Individual #148 did not consistently receive supports as listed and/or described in the CLDP. Examples at the time of the 45-Day PMM visit included:
    - He did not have his Ophthalmologist appointment on 9/20/16 as scheduled. It had been rescheduled for 12/8/16.
    - He did not receive his Flu shot in September.
    - His special needs form did not have the instructions to "take small bites;" rather, it stated food will be cut into small bites. This was corrected on site and staff were re-in-serviced on this need and the special needs form, which was positive.
    - Individual #148 was not employed within 30 days of transition.
    - Individual #148's SAP for Personal Safety was not being completed.
- Individual #348 was not consistently receiving supports as listed and/or described in the CLDP. Examples included:
    - At the time of the Seven-Day PMM visit, the PMM documented that behavioral data sheets were not being completed at the day habilitation program as required.
    - At the time of the 45-Day PMM visit, the PMM documented the following supports were not in place:
        - January weights were not available for review.
        - Care had not yet been established with a community PCP.
        - Behavioral data sheets from the day habilitation program were missing.
    - At the time of the 90-Day PMM meeting, the community PCP had not yet determined any treatment plans regarding labs, DEXA scan, EKG and consultations, including the orthopedic surgeon, nephrologist, dietitian, audiology or any other specialist and/or exams.

6. Overall, the Post-Move Monitor's scoring was correct, based on the supports defined in the CLDP.

7-8. The IDT/Facility generally implemented corrective actions in a timely manner for the many supports that were not being provided as needed. It was positive the IDT met to review the PMM Checklists and make recommendations about any unmet supports. The Post Move Monitor was diligent in her efforts to address all unmet needs and made it a practice to document the resolution for each issue. At the time of the monitoring visit, only Individual #348 had an outstanding issue that was pending resolution that had not been followed up as needed. The CLDP included a support for her to have an initial PCP visit by 1/13/17, to include determining protocol labs and making recommendations for numerous exams and medical follow-up. By the time of the 90-Day PMM visit on 3/1/17, this had not yet been completed. The PMM documented provider staff would make another appointment to complete this support. The PMM Checklist indicated the due date for resolution was 3/30/17, but no resolution was documented. While a PMM may frequently observe for resolution at the time of the next PMM visit, this is not always a sufficient practice. For Individual #348, for example, the next monitoring visit would be 90 days later, which would not be reasonably timely given the nature of the support. In any event, the PMM should have a process in place to evaluate and document resolution by the date agreed upon (in this case 3/30/17) rather than waiting for the next PMM visit.

9.-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 negative events following transition into the community. | | | | | | | | | | | | |
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| Summary: Neither individual experienced a negative event during the transition process. This indicator will remain in active oversight. | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | 148 | 348 | | | | | | | | |
| 11 | Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring. | 100% 2/2 | 1/1 | 1/1 | | | | | | | | |
| Comments: 11. Neither individual had experienced a negative event during the transition process. | | | | | | | | | | | | |

| 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. | | | | | | | | | | | | |
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| Summary: Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of transition assessments. This was an area on which Admissions Placement Department staff were actively working with IDTs and there were beginning to be some positive results, which was good to see. Although Center staff provided training to community provider staff, the CLDPs did not define the training well, and the training did not appear to meet the individual's needs. These indicators will remain in active oversight. | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | 148 | 348 | | | | | | | | |
| 12 | Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. | 0% 0/2 | 0/1 | 0/1 | | | | | | | | |
| 13 | The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting. | 100% 2/2 | 1/1 | 1/1 | | | | | | | | |
| 14 | Facility staff provide training of community provider staff that meets the | 0% 0/2 | 0/1 | 0/1 | | | | | | | | |

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

Comments: 12. While assessments did not consistently meet criterion for this indicator, it was positive transition staff had provided training for discipline leads about what needed to be included in discharge assessments, giving very specific examples as to what needed to be modified in recent assessments. Their focus had been on improving the detail provided about individuals' histories, including recommendations that addressed community living needs, and the content and measurability of recommendations overall. The assessments reviewed, while still needing improvement, showed progress in these areas. Transition staff also reported they were beginning to focus on the development of recommendations at the time of the 14-Day Referral meeting, which was another positive development. These initiatives should assist the Center to make progress in each of the four sub-indicators considered when evaluating compliance. Examples of findings for this review included:

- Assessments updated within 45 Days of transition: The Center did not review or update the Integrated Risk Rating Form (IRRF) for either of the individuals, but should have, or should have indicated that the IRRF was reviewed and no updates were required. The IRRF section of the ISP typically contains a great amount of information. On a positive note, the Admissions Placement Coordinator (APC) indicated the Center had recently begun to ensure the IDTs reviewed the status of the IRRF as part of the transition assessment process. Other timeliness concerns included:
  - For Individual #148, the Center did not provide an updated pharmacy assessment. The medical assessment was dated 3/2/16, but the signature date was 8/17/16. The habilitation therapies assessment was dated well before the 45-day requirement on 4/8/16. The signature lines indicated a 7/6/16 date, but there were no signatures, and the content did not seem to be updated or reflect community needs.
  - For Individual #348, the Center did not provide an updated pharmacy assessment. The nursing assessment did not contain updated recommendations.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Assessments that were not available or updated had a negative impact on the scoring of this indicator for both individuals. In addition:
  - For Individual #148, the nursing and medical assessments did not clearly describe his Hepatitis B status and related needs.
  - For Individual #348, her behavioral health assessment did not include any information about her fascination with scissors and other sharp objects. The social assessment did not provide a detailed summary of relevant facts of

Individual #348's stay at the facility.

- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments did not consistently meet criterion for this indicator. Again, missing assessments factored into this determination. Other issues included:
  - For Individual #148, the nursing and medical assessments did not clearly describe his Hepatitis B status and related needs. The CLDP narrative indicated the physician provided an overview of his Hepatitis B carrier status and answered questions about what this meant regarding transmission, but none of this was covered in the assessments.
  - For Individual #348, per the CLDP narrative, the RN Case Manager noted that the recommendations available at that time were not accurate or up-to-date and should, therefore, not be considered.
- Assessments specifically address/focus on the new community home and day/work settings:
  - For Individual #148, the habilitation therapies assessment content was not clearly updated to reflect community needs. For example, it referenced a plan to increase attendance at bike-riding therapy, which was not included in CLDP supports.
  - On a positive note, for Individual #348, the FSA included several recommendations for community living, including recommending that she continue to use an adaptive switch to turn on her radio, as this was a good way to give her control of her environment. Another was that she be assisted to call her Corpus Christi SSLC home to hear familiar staff while she adjusted to her new home.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator, including the following: 1) There was documentation to show IDT members actively participated in the transition planning process; 2) the CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed; 3) the CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting. Both CLDPs met criterion.

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: Although the CLDPs did not include staff training supports, pre-move training was provided. The Monitoring Team requested and reviewed the training documentation, including the training and testing materials. The testing materials did not clearly demonstrate staff had the knowledge or competence to meet either individuals' needs. Transition staff indicated they were aware of the need to create more rigorous competency tests as well as ensure they were reviewed and scored consistently. They reported recent transitions had more emphasis on competency-based training, including updated training methodologies, such as a video demonstrating food textures. These were positive developments. Overall, the Center needed to ensure the CLDP specified the competencies staff needed to have to meet the specific health and safety needs of every individual and define how competency was to be demonstrated. The IDTs then needed to develop more thorough competency testing. The materials reviewed did not include all the essential health and safety needs or thoroughly test for competency in all areas. For example:

- The training materials for Individual #348's dining plan included dining instructions to provide verbal prompts not to gulp her food, to replenish fluids in smaller amounts to prevent gulping, to verbally cue her not to spit out her food, to assist with eating if she refuses to feed herself, to use Suplena or lactose free milk to soften desserts, and to provide au jus at all meals to moisten cubed breads and dry meats as needed. Competence quizzes did not address all dining instructions. For example, dining instructions related to the need to moisten her breads and desserts and to have no milk or milk products were not included in

any quiz. Other dining needs were addressed, but only in a superficial manner. For example, a quiz asked for a True or False answer regarding whether she needed verbal prompts for dining, but did not ask for knowledge of the specific issues for which she needed prompting.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The CLDP should provide a specific statement documenting the team's consideration of the need for any such collaboration, and include corresponding supports, as appropriate. Neither of these CLDPs did so.

- For Individual #148, the CLDP narrative discussion of the psychiatric assessment indicated both treating psychiatrists felt very strongly the specific combination of atypical antipsychotics, antidepressant, anxiolytic, and alpha 2 agonists should be continued for his transition to be successful. The APC suggested that one of the psychiatrists would do well to place a phone call to the community psychiatrist once identified to explain their reasoning. It was positive this discussion occurred, but the IDT needed to make a determination as to the need for its implementation and include a support if one was needed.

- For Individual #348, the CLDP defined a support for the QIDP and provider counterpart to establish contact on a schedule for the first three months to address any concerns or issues that might arise. This was positive. The CLDP did not otherwise indicate whether any collaboration of clinicians was needed. Based on her many health care needs, the IDT should have documented such consideration.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results. The CLDPs did not document a statement regarding the need for any setting assessment and did not meet criterion.

17. The CLDP should provide a specific statement about the types and level of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences. Examples include provider direct support staff spending time at the Facility, Facility direct support staff spending time with the individual in the community, and Facility and provider direct support staff meeting to discuss the individual's needs. Neither of these CLDPs met criterion.

18. The LIDDA participated in both CLDPs. For Individual #148, the CLDP documented the LIDDA's concern about the wisdom of the transition due to previous failed placements, but the LIDDA staff still assisted with paperwork and other needs.

19. The Pre-Move Site Reviews (PMSRs) for both individuals were completed in a timely manner and each indicated all supports were in place. Due to the lack of supports for staff training, knowledge and competence, the PMSRs for both individuals failed to document that provider staff had knowledge of important health and safety needs that should have been clearly in place at the time of transition.

| Outcome 5 – Individuals have timely transition planning and implementation. | | | | | | | | | | | | |
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| Summary: This indicator will remain in active oversight. | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | 148 | 348 | | | | | | | | |
| | Individuals referred for community transition move to a community setting | 100% | 1/1 | 1/1 | | | | | | | | |

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| | within 180 days of being referred, or reasonable justification is provided. | 2/2 | | | | | | | | | |
| Comments: 20. Individual #148 was referred on 5/23/16, and transitioned on 8/24/16, within 180 days. Individual #348 was referred on 12/14/15, and transitioned on 12/13/16. The Transition Logs documented regular and ongoing activity by the Corpus Christi SSLC Transition Specialist and IDT to locate, visit, and consider community living options for Individual #348. | | | | | | | | | | | |

## 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 |