United States v. State of Texas

Monitoring Team Report

Corpus Christi State Supported Living Center

Dates of Onsite Review: January 22nd to 26th, 2018

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Background

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

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

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

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

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

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

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

Methodology

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

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

Organization of Report

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

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

Executive Summary

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

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at 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. Fifteen of these, in incident management and restraint, were moved to, or were already in, 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 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.

Restraint

Corpus Christi SSLC changed to a straight frequency count of restraints beginning in May 2017. Before that time, episodes were counted. Therefore, long-term trends could no longer be determined. But, since May 2017, restraint occurrences were not declining. Overall, the Center was about in the middle when comparing the last few months of census-adjusted frequency rates to the other SSLCs.

Some other important aspects of restraint management, however, showed good performance, such as number of individuals who had a crisis intervention chemical or mechanical restraint, use of protective mechanical restraint for self-injurious behavior, and average duration of a crisis intervention physical restraint. The consultation and review documentation by the psychiatrist and pharmacist were completed within the allotted time frame. Staff, when interviewed, were knowledgeable about restraint practices and correctly answered all of the Monitoring Team's questions. Restraint Reduction Committee was active.

Some documentation corrections were needed regarding the monitoring of individuals during and after restraint. Other documentation did not correctly specify the date and time of restraint reviews (at least not in the printouts from the electronic

record). There continued to be a need for the Center to track, trend, and graph usages of non-chemical restraint for medical and dental procedures, pretreatment sedation for medical and for dental, and TIVA.

Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: monitoring individuals for potential side effects of chemical restraints; providing follow-up for abnormalities in vital signs; conducting complete assessments of injuries; and documenting whether or not injuries were the result of restraint, or if this is unknown, stating so.

Abuse, Neglect, and Incident Management

Direct support professional knowledge regarding basic abuse and neglect policy and reporting responsibilities and timeframes, when interviewed, was very good. The Center was following DFPS policy and SSLC policy regarding individuals identified for streamlined investigations. Most Corpus Christi SSLC investigations included recommendations for disciplinary or programmatic actions. These actions were taken in a timely manner.

There remained some important areas for improvement in order for Corpus Christi SSLC to have a solid abuse/neglect prevention and detection and incident management system. For instance, there were some issues with timely reporting. The Center, in examining how reporting occurred, needs to look more in depth at the nature of the incident and whether or not someone should have seen, or heard, anything that should have been reported earlier than the actual recorded date and time of reporting. Timely and proper reporting is one of the cornerstones of a solid abuse/neglect prevention and detection system.

For both DFPS and Facility-only investigations, content, consideration of evidence, and conclusions were, for the most part, very good. For one investigation, an inconclusive finding by DFPS, there was sufficient evidence available for the finding to be questioned and/or changed at the Center level. The Center chose not to do this. In this case, the reporter received disciplinary action for not intervening in the alleged abusive act, but no disciplinary or administrative action was taken for the alleged abuser.

Non-serious injury investigations were not always done when required. The Center acknowledged that this needed to be improved and had initiated a four-step action plan to do so. The analysis of trends needs improvement; this is outcome 10, which includes indicators 19 to 23. These QA data need to be delineated into more discrete data sets to set the occasion for analysis leading to more targeted action plans for systemic issues.

Other

The Center has recently (December 2017) formed a committee to look at how desensitization and other strategies might be developed to reduce future need for pretreatment sedation and/or TIVA.

Since the last review, improvement was noted with regard to the completion of DUEs, as well as necessary follow-up activities.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.												
Summary: Corpus Christi SSLC changed to a straight frequency count of restraints beginning in May 2017. Before that time, episodes were counted. Therefore, long-term trends could no longer be determined. But, since May 2017, restraint occurrences were not declining. Some other important aspects of restraint management, however, showed good performance, such as number of individuals who had a crisis intervention restraint, use of protective mechanical restraint for self-injurious behavior, and average duration of a crisis intervention physical restraint. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	177	218	267	97	304	40	363	135	149
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	67% 8/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	80% 8/10	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (March 2017 through November 2017) were reviewed. In May 2017 (part-way through the nine-month review period), the Center changed its count of restraints from episodes to frequency. This made it impossible to look longitudinally at the trend in the frequency of crisis intervention restraints. However, when looking at the frequency for the seven-month period since May 2017, a decrease was not evident and the census-adjusted rate was in the middle when compared to the other Centers. It is important for every restraint to be counted. In addition, although not requested by the Monitoring Team, the Center might want to also graph episodes per month because this might be helpful to have as part of their own analysis of restraint. Some of the other Centers are already doing this. The Monitoring Team would be open to receiving this information in future reviews and learning about the Center's analysis of those data, too.

The number of crisis intervention physical restraints paralleled the frequency of all crisis intervention restraints because most crisis intervention restraints were crisis intervention physical restraints. The average duration of a crisis intervention physical restraint decreased since the last review, but that would be expected given the change to frequency from episodes. Even so, the duration since May 2017 was under three minutes, one of the lowest averages in the state. Frequency of crisis intervention chemical restraint was low, though there was as spike in August 2017 directly related to the Hurricane Harvey evacuation and temporary resettlement at the San Antonio SSLC. There were no occurrences of crisis intervention mechanical restraint. One individual had protective mechanical restraint for self-injurious behavior (PMR-SIB). He had this support in place for many years and the Center was making continual progress in increasing his time out of the PMR-SIB (Individual #9, mittens). No instances were found of any protective/supportive device (e.g., helmet) being used to treat a behavior disorder. Fewer individuals received crisis intervention restraint each month compared with the last review. There were few injuries during restraint reported by the behavioral health services department.

Graphs were not provided for data sets 9-12. However, from the data spreadsheets and onsite interview, the Monitoring Team was able to determine that there were no usages of non-chemical restraint for medical or dental procedures, and no use of pretreatment sedation for dental procedures. Without graphic presentations, the Monitoring Team was unable to determine a trend for usage of pretreatment sedation for medical procedures and for the usage of TIVA. In the last report, the Monitoring Team also pointed to the need for the Center to track, trend, and graph usages of non-chemical restraint for medical and dental procedures, pretreatment sedation for medical and for dental, and TIVA.

Thus, facility data showed low/zero usage and/or decreases in eight of these 12 facility-wide measures (duration of crisis intervention physical restraint, use of crisis intervention chemical and mechanical restraint, restraint-related injuries, number of individuals who had crisis intervention restraint, use of PMR-SIB, use of non-chemical restraints for medical and for dental procedures, and pretreatment sedation for dental procedures).

The Monitoring Team attended the restraint reduction committee, called Restrictive Practices Committee, and also reviewed minutes from two recent meetings. The committee looks at individual occurrences of crisis intervention restraint as well as Center-wide data (though that didn't occur during the meeting observed by the Monitoring Team). Various restraint trainers, nursing staff, and others attend the meeting from time to time. The Monitoring Team suggested that the committee develop some policy or procedure to set the scope and responsibility of the group, and also to include the medical and dental related restraint and pretreatment sedation numbers.

2. Five of the individuals reviewed by the Monitoring Team were subject to restraint. In addition, a restraint for one other individual was included. Of these six individuals, all six received crisis intervention physical restraints (Individual #177, Individual #218, Individual #40, Individual #135, Individual #149, Individual #123) and one also received crisis intervention chemical restraint (Individual #123). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for four of the six (Individual #177, Individual #218, Individual #135, Individual #149). The other three 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: Restraint requirements continued to be met, for the most part. The six indicators in the category of requiring less oversight will remain in that category. In addition, indicator 10 will be moved to this category due to sustained high performance for all restraints for this review and for the previous three reviews, too (with one exception in each of the last two reviews). Indicators 9 and 11 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	218	40	135	149	123			
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the									

4	The restraint was a method approved in facility policy.	category of requiring less oversight.									
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.	50% 1/2	Not rated	Not rated	0/1	Not rated	Not rated	1/1			
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 8/8	1/1	1/1	2/2	2/2	1/1	1/1			
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	88% 7/8	1/1	0/1	2/2	2/2	1/1	1/1			

Comments:
The Monitoring Team chose to review eight restraint incidents that occurred for six different individuals (Individual #177, Individual #218, Individual #40, Individual #135, Individual #149, Individual #123). Of these, seven were crisis intervention physical restraints, and one was a crisis intervention chemical restraint. 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. The Center had improved performance again (see comments from last report). For indicator 7, however, two restraints did not contain the nurse's notation that an injury check occurred. Ultimately, the Monitoring Team found documentation that these checks did occur. In the future, the Center should make sure that the nurse's check is documented on the restraint documentation, too.

9. Because criterion for indicator #2 was met for four of the individuals, this indicator was not scored for them. For this indicator, the Monitoring Team looks at eight different sub-indicators. For Individual #123, all criteria were met for all sub-indicators. For Individual #40, the Monitoring Team found his participation and engagement in activities, including day activities, to be low.

11. Individual #218's IRRF did not include the proper information.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.	
Summary: Staff, when interviewed, were knowledgeable about restraint practices and correctly answered all of the questions of the Monitoring Team. Due to sustained high performance over this and the previous two reviews, this indicator	Individuals:

will be moved to the category of requiring less oversight.											
#	Indicator	Overall Score	177	218	40	135	149	123			
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 4/4	Not rated	1/1	1/1	Not rated	1/1	1/1			
Comments:											

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.											
Summary: Some documentation corrections are needed in order for indicator 13 to return to higher performance. The Center reported, during onsite meetings, that some additional staff training was going to occur. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	218	40	135	149	123			
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	50% 4/8	1/1	1/1	1/2	1/2	0/1	0/1			
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Comments: 13. For Individual #40 11/1/17, the restraint monitor arrived 28 minutes after initiation of restraint. For Individual #135 11/10/17, there was no information on the presence of the restraint monitor. For Individual #149 11/17/17 and Individual #123 11/30/17, due to no nursing entries, the direct consequences of the restraint could not be determined.											

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
Summary: Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: monitoring individuals for potential side effects of chemical restraints; providing follow-up for abnormalities in vital signs; conducting complete assessments of injuries; and documenting whether or not injuries were the result of restraint, or if this is unknown, stating so. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	177	218	40	135	149	123			

		Score									
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	13% 1/8	0/1	0/1	1/2	0/2	0/1	0/1			
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	50% 4/8	0/1	1/1	1/2	1/2	0/1	1/1			
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	13% 1/8	0/1	0/1	1/2	0/2	0/1	0/1			

Comments: The crisis intervention restraints reviewed included those for: Individual #177 on 8/8/17 at 2:06 p.m.; Individual #218 on 8/31/17 at 8:25 pm; Individual #40 on 11/1/17 at 7:51 p.m., and 10/5/17 at 6:47 p.m.; Individual #135 on 8/11/17 at 5:58 p.m. (chemical), and 11/10/17 at 6:25 a.m.; Individual #149 on 11/17/17 at 7:31 p.m.; and Individual #123 on 11/30/17 at 3:41 p.m.

a. through c. Individual #40's restraint on 10/5/17 at 6:47 p.m. met criteria for all three indicators.

a. For five of the eight crisis intervention restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint. The exceptions were for Individual #40 on 10/5/17 at 6:47 p.m., Individual #135 on 11/10/17 at 6:25 a.m., and Individual #123 on 11/30/17 at 3:41 p.m.

The following provide examples of other concerns noted:

- At times, individuals' vital signs were elevated, but nurses did not re-take them. For example:
  - On 8/11/17, nursing staff administered two chemical restraints to Individual #135, including Ativan 2 milligrams (mg) intramuscular (IM) at 5:49 p.m., and Zyprexa 5 mg IM at 5:58 p.m. The IPN did not indicate the exact location the injections were administered (i.e., only noted buttocks for both). The Center did not provide a Medication Administration Record (MAR). Vitals signs were initially timely taken. However, the IPN indicated that his blood pressure was 92/51, after the chemical restraints. The IPN also indicated that the individual was "able to hold head up but keeps slouching in chair and able to bear weight but unsteady balance requiring assistance from staff." IView documentation provided did not reflect that vitals were taken every 15 minutes, which was especially concerning given that the individual had a low blood pressure following two chemical restraints that were administered only 10 minutes apart.
  - According to IView documentation, at 2:19 p.m., Individual #177's pulse was 102 and his blood pressure was 127/90 (i.e., both values elevated). Aside from the nurse taking the individual's respirations at 2:45 p.m., and 3:07 p.m., a full set of vitals were not taken again until 4:00 p.m. at which time, the individual's pulse was still elevated at 96, and his blood pressure was 121/79. No additional follow-up vital signs were found in the documentation provided.
  - At 8:35 p.m., Individual #218's initial vital signs were: pulse 102 and blood pressure 138/88 (i.e., both values elevated). Documentation was not found to show vital signs were retaken. In addition, the nurse provided no indication in the IPN, dated 8/31/17, at 11:00 p.m., what behaviors the individual demonstrated that resulted in a restraint.
- In other instances, full vital signs were not documented. For example, on 10/5/17, the nurse did not complete an IPN and only documented a respiration value in IView.

b. For Individual #177, on 8/8/17, an IPN indicated that he had "erythema noted to the left side of his scalp, the left cheek, and some spots noted to the right side of his head." The note indicated that an injury report was generated, but did not indicate if these injuries were from the restraint procedures. No nursing physical assessment was found related to these injuries. A document the Center provided (TX-CC-1801-1.50) indicated that there were no injuries from restraint or during restraints for 8/8/17.

For Individual #40's restraint on 10/5/17, the lack of documentation made it impossible to determine if any restraint-related injuries occurred. Similarly, for Individual #135's restraint on 11/10/17, no IPN was provided, and It was unclear if the injuries noted were due to the restraint process.

For Individual #149, nursing staff provided no description of the injury to the individual's lower chin in the brief IPN addressing two episodes of restraint at 7:30 p.m. and 7:31 p.m.

c. In addition to concerns identified above, on 11/10/17, documentation indicated that Individual #135 was banging the right side of his face and had a throbbing right eye. Nursing staff did not document an assessment of his vision or the completion of neurological checks. The Center did not submit a nursing IPN addressing this episode.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary: With sustained high performance over this and the last three reviews (with one exception at the last review), this indicator will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	177	218	40	135	149	123			
15	Restraint was documented in compliance with Appendix A.	100% 8/8	1/1	1/1	2/2	2/2	1/1	1/1			
Comments:												

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.												
Summary: Attention to documentation should result in improved scores for indicator 16. Both indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	177	218	40	135	149	123			
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	25% 2/8	1/1	0/1	0/2	1/2	0/1	0/1			
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	86% 6/7	N/A	0/1	2/2	2/2	1/1	1/1			
Comments:												

16. The primary problem with the restraint documentation that did not meet criteria was that the date and time of restraint reviews was not included in the electronic record reports. For one restraint, there was also an issue with timeliness of review (Individual #218 8/31/17).

17. For Individual #218 8/31/17, no information was provided regarding recommendations or a rationale for no 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: For the one crisis intervention chemical restraint that was chosen for review, the consultation and documentation met criteria. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	135								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 1/1	1/1								
48	Multiple medications were not used during chemical restraint.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
49	Psychiatry follow-up occurred following chemical restraint.										
Comments: 47. Individual #135 had an episode of chemical restraint during this review period. The consultation and review documentation by the psychiatrist and pharmacist was completed within the allotted time frame.											

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
Summary: Corpus Christi SSLC reduced the likelihood of incidents occurring by completing the required staff-related activities and by looking at trends and implementing supports for nine of the 11 investigations chosen for review. For the other two, some aspects of their support programs were not in place. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	218	267	97	40	363	135	149		
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	82% 9/11	2/2	1/1	1/1	2/2	1/2	1/1	1/2		
Comments: The Monitoring Team reviewed 11 investigations that occurred for seven individuals. Of these 11 investigations, nine were DFPS											

investigations of abuse-neglect allegations (three confirmed, four unconfirmed, one inconclusive, one unfounded). One of these nine was a streamlined investigation. The other two were for facility investigations of serious injuries. 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 #218, UIR 2017-455, DFPS 45352351, confirmed and inconclusive allegations of physical abuse, streamlined, 6/30/17
- Individual #218, UIR 2018-038, DFPS 45646388, unfounded allegation of physical abuse, streamlined, 10/16/17
- Individual #267, UIR 2017-520, DFPS 45414930, unconfirmed allegation of neglect, 8/10/17
- Individual #97, UIR 2018-034, DFPS 45600748, unconfirmed allegation of physical abuse or neglect, streamlined, 10/7/17
- Individual #40, UIR 2017-530, DFPS 45428294, confirmed allegation of physical abuse, 8/18/17
- Individual #40, UIR 2018-011, DFPS 45539248, unconfirmed allegation of neglect, 9/13/17
- Individual #363, UIR 2017-415, DFPS 45310128, unconfirmed allegation of physical abuse, 6/1/17
- Individual #363, UIR 2017-441, discovered fracture, ribs, 6/11/17
- Individual #135, UIR 2017-492, DFPS 45385209, confirmed and unfounded allegation of physical abuse, streamlined, 7/23/17
- Individual #149, UIR 2018-009, DFPS 45534515, inconclusive allegation of physical abuse, 9/12/17
- Individual #149, UIR 2017-486, witnessed cut to chin, self-injury, 7/18/17

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

For all investigations for all individuals, sub-indicator a was met. For nine of the investigations, the other three sub-indicators were met. For Individual #363 UIR 17-441, his risk for falls was addressed in his IRRF, however, the issues were not addressed in his PNMP. For Individual #149 UIR17-486, an interim version of a PBSP was developed, but not implemented at the time of this incident.

Fifteen individuals were designated by DFPS for streamlined investigations (reduced from 22 in May 2017). Corpus Christi SSLC did not maintain an additional list of individuals who frequently made spurious allegations. At the last review, the Center was not following the required protocols from DFPS and from the SSLC State Office. At this time, however, the Center was doing so, such as communicating regularly with DFPS, making sure that individuals were reviewed quarterly by DFPS, including in the PBSP the behaviors that led to placement on the streamlined caller list, and reviewing those plans. To make this determination, the Monitoring Team looked at the submitted documentation and at the PBSPs for three of the individuals designated for streamlined investigations. PBSPs included information about making false allegations for two of the three (i.e., for Individual #218 and for Individual #97, but not for Individual #135).

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.											
Summary: Two incidents were reported correctly, but late. A third incident was reported after other protective practices (i.e., video review, restraint review) occurred. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	218	267	97	40	363	135	149		
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	73% 8/11	1/2	1/1	0/1	1/2	2/2	1/1	2/2		

Comments:

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

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

- Individual #218 UIR 17-455: the incident occurred at 10:00 pm and was reported at 12:39 am.
- Individual #97 UIR 18-034: the incident occurred at 11:55 pm and was reported to DFPS at 6:32 pm. The 11:55 entry as pm was probably an entry error because information in the UIR indicated the incident happened at lunchtime, thus, making this a late report.
- Individual #40 UIR 17-530: this incident occurred on 8/9/17 and was reported on 8/18/17. There was nothing in the UIR to offer a rationale for this late reporting or to attempt to construct any hypothesis on this. While onsite, the Monitoring Team learned that the facility reported this incident after the restraint was noted through routine video review, and later confirmed by a restraint review. It was good that this process ended up in reporting. Nevertheless, other staff that were part of, or monitoring, the restraint episode, should have suspected a "restraint gone bad" and reported that at the time it was observed.
- Individual #135 UIR 17-492: the UIR sufficiently identified the individual as the reporter, therefore, this was not considered to be a late report.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting.											
Summary: Corpus Christi SSLC staff correctly answered questions about this topic for this review and for the three previous reviews, too. As a result of this sustained high performance, this indicator will be moved to the category of requiring less oversight. Even so, the Center should continue to ensure that staff can state the proper reporting protocols because some examples of late reporting persisted (indicator 2).			Individuals:								
#	Indicator	Overall	218	267	97	40	363	135	149		

		Score									
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 2/2	Not rated	Not rated	Not rated	Not rated	1/1	Not rated	1/1		
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.										
Comments: 3. Because indicator #1 was met for five of the individuals, this indicator was not scored for them. For the other two, all staff correctly answered the Monitoring Team's questions about abuse, neglect, and incident reporting.											

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.											
Summary:			Individuals:								
#	Indicator	Overall Score									
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments:											

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

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
Summary: Performance steadily increased for all three indicators across the last three reviews, to 100% (or almost 100%) for all three. These indicators will remain in active oversight, but with sustained high performance one or more might be moved to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	218	267	97	40	363	135	149		

8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 11/11	2/2	1/1	1/1	2/2	2/2	1/1	2/2		
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 11/11	2/2	1/1	1/1	2/2	2/2	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)	91% 10/11	2/2	1/1	1/1	2/2	2/2	1/1	1/2		
Comments: 10. For Individual #149 UIR 18-009, an inconclusive finding was made even though the DFPS investigation noted that reports from clinical staff appeared to have no motivation for misrepresentation.											

Outcome 7– Investigations are conducted and reviewed as required.											
Summary: Corpus Christi SSLC showed good progress on indicator 13, improving scoring from 20% at the last review to 82% at this review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	218	267	97	40	363	135	149		
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.									
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.	82% 9/11	2/2	1/1	0/1	2/2	2/2	1/1	1/2		
Comments: 13. Two investigations did not meet 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. In other words, a score of zero regarding late reporting or interviewing of all involved staff does not result in an automatic zero score for this indicator. Identifying, correcting, and/or explaining errors and inconsistencies contributes to the scoring determination for this indicator. For Individual #97 UIR 18-034, supervisory review did not detect time of reporting discrepancy in DFPS report. For Individual #149, UIR 18-009, supervisory review did not question the inconclusive finding even though the report acknowledged											

the clinician's witness of the interview. Further, the Center took disciplinary action with the clinician for not immediately intervening, thus, seeming to find validity in the allegation. Facility consideration to changing the DFPS inconclusive finding to a confirmation did not occur.

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

Summary: Audits of serious injuries occurred for more individuals at this review than at the last review. Non-serious injury investigations, however, were not being conducted as required, a need for improvement already self-identified by the Center. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 218	267	97	40	363	135	149		
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	71% 5/7	1/1	1/1	1/1	1/1	0/1	0/1	1/1		
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	43% 3/7	0/1	1/1	1/1	0/1	1/1	0/1	0/1		

Comments:
14. For Individual #363 and Individual #135, the audits were not conducted to completion. That is, the actions to be taken section was left blank.

15. Four of the individuals had non-serious injuries that should have been subjected to non-serious injury investigations, but were not. The Center acknowledged the need to correct this and, at the time of the onsite visit, had developed a four-step plan to do so.

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

Summary: Most Corpus Christi SSLC investigations included recommendations for disciplinary or programmatic actions. These actions were taken in a timely manner (though see comment regarding indicator 17 below). Employment was not maintained for any alleged perpetrators confirmed for physical abuse category 2. These two indicators will remain in active monitoring. With sustained high performance, one or both might be moved to the category of requiring less oversight after the next review.

#	Indicator	Overall Score	Individuals: 218	267	97	40	363	135	149		
16	The investigation included recommendations for corrective action	100%	2/2	1/1	1/1	1/1	2/2	1/1	2/2		

	that were directly related to findings and addressed any concerns noted in the case.	10/10									
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 9/9	2/2	1/1	1/1	N/A	2/2	1/1	2/2		

Comments:
17. As noted in indicators 10 and 13 regarding Individual #149 UIR 18-009, no actions were taken with an alleged perpetrator who engaged in questionable interaction with the individual.

There were four cases in which an alleged perpetrator was confirmed for physical abuse category 2. In all four cases, the alleged perpetrators' employment was terminated.

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

Summary: This outcome consists of facility indicators. Criteria were not yet met. Assistance from State Office would be helpful to the incident management and facility management staff. 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. A variety of data were collected, but not yet sufficiently delineated in order to better understand what might be a contributing factor to the incident and to enable more focused remediation efforts. There were no formal corrective action plans, but informal actions were implemented in some cases, which was a start. Data needed attention regarding ensuring reliability and relationship to Monitoring Team scores. Involvement of facility management along with incident management department will likely be helpful in

moving Corpus Christi SSLC forward.

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	304	363	42	167	327	269	114	91	187
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	N/A	N/A	N/A	0/1	N/A	0/1	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. As discussed in the last report, the Center's policies with regard to criteria for the use of TIVA, as well as medical clearance for TIVA/general anesthesia need to be expanded and improved. For example, the Center's policy on the criteria for the use of TIVA were not consistent with the requirements included in the dental audit tool. In addition, the Center provided a document entitled "TIVA Criteria List," which was undated, but was attached to an email, dated 5/10/17. It provided information about conditions that prohibit the use of TIVA, for which certain criteria should be met prior to the use of TIVA, as well as which require certain perioperative assessment. However, this did not appear to be a policy or clinical guideline, and it did not provide references. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures. Given the risks involved with TIVA/general anesthesia, it is essential that such policies be developed and implemented.

For these two instances of the use of TIVA, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, an operative note defined the procedures and assessments completed, and post-operative vital sign flow sheets were completed according to the requirements of the 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: The Monitoring Team will continue to assess this indicator.			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	71% 17/24	N/A	7/11	N/A	N/A	N/A	5/8	5/5	N/A	N/A

Comments: a. The following individuals reviewed had pretreatment sedation for medical procedures:

- Individual #363 on 8/1/17 (no consent), 8/9/17 (no consent), 8/24/17 (no consent, and no vital signs found for time period of

evacuation), 8/31/17 (no consent), 9/12/17, 9/15/17, 9/21/17, 9/28/17, 10/2/17, 11/2/17, and 11/9/17.
- Individual #269 on 6/1/17 (no consent), 7/26/17 (no consent), 8/1/17 (no consent), 9/6/17, 9/29/17, 11/6/17, 11/9/17, and 11/10/17.
- Individual #114 on 7/7/17, 7/14/17, 7/17/17, 7/21/17, and 7/24/17.

Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.												
Summary: Monitoring of this outcome and its indicators is put on hold while the State develops instructions, guidelines, and protocols for meeting criteria with this outcome and its indicators.			Individuals:									
#	Indicator	Overall Score										
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.											
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.											
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.											
4	Action plans were implemented.											
5	If implemented, progress was monitored.											
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.											
Comments:												

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	340	161	130	114					

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.	100% 4/4	1/1	1/1	1/1	1/1					
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 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, four individuals died. The Monitoring Team reviewed all four deaths:

- On 3/19/17, Individual #340 died at the age of 50 of sepsis secondary to recurrent aspiration pneumonia from dysphagia;
- On 5/29/17, Individual #161 died at the age of 57 of multi-factorial syndrome, recurrent pneumonia, cellulitis, urinary tract infections, large diaphragmatic hernia, and spastic quadriparesis;
- On 7/26/17, Individual #130 died at the age of 51 of dysphagia; and
- On 9/14/17, Individual #114 died at the age of 36 of testicular cancer with metastases to the bone.

b. through d. Evidence was not submitted to show the Center conducted thorough reviews of medical and/or nursing care, or an analysis of medical/nursing reviews to determine additional steps that should be incorporated in the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews.

Some examples of problems noted included:

- The review of the circumstances leading to Individual #340's death should have triggered a refresher training on recurrent aspiration pneumonia, including the causes and treatments. It also would have been an appropriate time to review the monitoring of positioning of individuals with recurrent aspiration pneumonia, including positioning during and after meals, during check and change, during bathing, checking for residuals, etc. However, the Center's mortality reviews did not generate corresponding recommendations.
- Individual #114's death review should have triggered a refresher training on palliative/end-of-life care, including pain management, control of nausea and vomiting, oral care, etc., but did not.
- Nursing death reviews were often incomplete (e.g., 72-hours prior to death not described, reviews of nursing care left blank, etc.).

- At times, even when issues were identified, the mortality review committee did not address the findings. For example, for Individual #161, the nurse reviewer stated: "I also believe we need to further investigate if [Individual #161] was spending too much time in his wheelchair due to staffing issues and address if needed." Since the mortality review indicated that Individual #161 had developed significant skin issues, a recommendation should have been implemented to follow-up on the lack of changes in positioning that the nurse referenced, including steps to determine if other individuals were affected, and to develop a plan and monitoring system to ensure this issue was addressed. No follow-up documentation was provided to show that these issues were further reviewed and addressed.

e. The recommendations generally were not written in a way that ensured that Center practice had improved. For example, a recommendation that read: "Training for nurses on reading lab forms regarding ESBL [Extended-spectrum beta-lactamases] diagnoses…" Although training rosters were provided, there was no curriculum included in order to determine the quality of the content of the training. Also, no monitoring system was put in place to ensure that the training provided was effective. The recommendation should have been written in a manner that required monitoring to determine whether or not nursing staff were correctly interpreting the lab results.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: For the one ADR identified for the individuals reviewed, Center staff properly reported it, took the clinical actions necessary, and reviewed it in the Pharmacy and Therapeutics Committee. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
a.	ADRs are reported immediately.	100% 1/1	1/1	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.	N/A	N/A								
Comments: a. through d. On 1/10/17, Individual #304 was given Lorazepam 2 milligrams (mg) and Hydroxyzine 50 mg by mouth (PO) as a pretreatment chemical restraint. Upon return to campus, he was clinically unstable. He was transferred to the Infirmary, where four doses of an antidote were administered without effect. Individual #304 was transferred to the ED. On 3/22/17, the Pharmacy and Therapeutics Committee decided this was not a MedWatch reportable event.											

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: Since the last review, improvement was noted with regard to the completion of DUEs, as well as necessary follow-up activities. 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.	100% 2/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 3/3
Comments: a. and b. In the six months prior to the review, Corpus Christi SSLC completed the following DUEs: • A DUE on Prolia that was presented to the Pharmacy and Therapeutics (P&T) Committee on 6/29/17, for which a follow-up study was completed on 9/27/17; • A DUE on Clozapine that was presented to the P&T Committee on 9/27/17, for which no follow-up was needed; and • A follow-up to a prior DUE was completed on anticholinergic medications, and it was presented to the P&T Committee on 6/29/17.		

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. Nineteen of these indicators, in psychiatry, behavioral health, medical, dental, nursing, and skill acquisition, were moved to, or were already in, the category of requiring less oversight after the last review. For this review, five other indicators were moved to this category, in ISPs, psychology, medical, and physical and nutritional management. One indicator in OT/PT was 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.

There was a new Director of Behavioral Health Services, who had already initiated some positive changes. These included ensuring training of individual PBSPs to all staff in the homes, classrooms, and work sites; more timely completion of assessments; better assessment of the need for a PBSP versus a PSP; and pursuit of counseling services in the community.

<u>Assessments</u>
The IDTs considered what assessments were needed for all individuals. This was good to see. But then, the IDTs did not consistently arrange for and obtain these assessments prior to the IDT meeting for almost all of the individuals.

It was positive to see that QIDP monthly reviews were being completed on a more timely basis than in the past. Implementation and revision, however, were not occurring.

There were some incremental gains demonstrated by QIDPs related to knowledge of individuals' health and safety risks, as evidenced in onsite interviews. The Monitoring Team was particularly impressed with the overall fluency of one QIDP. Due to personnel adjustments across campus, several individuals had newly-assigned QIDPs, so this might have affected this outcome. These findings were consistent with the Center's own findings for its Corrective Action Plan in this area.

In psychiatry, continued progress was seen in timeliness and submission of annual updates for the ISP. In behavioral health, all of the individuals had a current behavioral health assessment, but two were considered complete. Less than half of the individuals had a current functional behavior assessment, and all but one were incomplete.

All of the individuals had current a Functional Skills Assessment (FSA), Preferences and Strengths Inventory (PSI), and vocational assessment.

For the individuals' risks reviewed, IDTs continued to struggle to effectively use supporting clinical data (including comparisons from year to year), use the risk guidelines when determining a risk level, and/or as appropriate, provide clinical justification for exceptions to the guidelines. 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.

On a positive note, for this review and the previous two reviews, Medical Department staff generally completed the medical assessments in a timely manner. As a result, the related indicator will be placed in the category requiring less oversight.

Although additional work was needed, the Center made progress with regard to the quality of medical assessments. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history, updated active problem lists, and plans of care for each active medical problem, when appropriate.

It was great to see that all nine dental exams and the eight annual dental summaries reviewed included the necessary components.

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

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. As a result of sustained performance in this area, the related indicator will move to less oversight. The Center should focus on improving the referral of all individuals that meet criteria for PNMT review, completion of PNMT comprehensive assessments for individuals needing them, and the quality of the PNMT reviews and comprehensive assessments.

The Center should focus on improving the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs. The quality of OT/PT assessments continues to need improvement.

In addition to ensuring individuals receive the right type of communication assessment (e.g., comprehensive assessment versus update, consultation, etc.), Center staff should make improvements to the quality of comprehensive assessments and updates.

It was good to see that all individuals had SAPs. Less than half of the SAPs, however, met criteria for being assessment-based, practical, functional, and meaningful. On the positive, however, reliable and valid data were available for a number of these SAPs that showed individual performance. This improvement was good to see.

Individualized Support Plans

Corpus Christi SSLC ISPs continued to contain some personal goals that were individualized, though somewhat less than at the last review. Similarly, fewer were written in measurable terminology, and for only one were there reliable data to indicate implementation and to be able to evaluate progress.

Some goals had no related action plans, while others were minimally or tangentially related to the achievement of the goal. None met criterion for supporting overall independence. The IDTs did not assertively address risk areas for some individuals. The IDTs did not consistently address barriers to achieving goals. ISPs were not consistently implemented on a timely basis. None of six individuals reviewed had an appropriately constituted IDT.

The Monitoring Team observed the ISP annual meeting for Individual #267 held during this visit. It was positive to see that the ISP facilitator took great care to include Individual #267 in the discussion and to use language that encouraged his participation.

Corpus Christi SSLC continued to move forward in creating psychiatry-related goals. The goals, however, need improvement so that they can be measurable and objectively monitored (i.e., the psychiatric indicators/symptoms need to be clearly specified and described/defined).

Corpus Christi SSLC was not ensuring that every individual who needed a PBSP had one. This is the third consecutive review during which the Monitoring Team has raised this concern. Some individuals had PSPs instead of PBSPs, whereas others did not have a PBSP even though they demonstrated the types of behaviors that would warrant a PBSP.

The PBSPs for less than half of the individuals were current. None were complete in terms of content, though many of the PBSPs contained many of the required components.

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: Corpus Christi SSLC ISPs continued to contain some personal goals that were individualized, though somewhat less than at the last review. Similarly, fewer were written in measurable terminology and for only one were there reliable data to indicate implementation and to be able to evaluate progress. Continued improvement in the creation of personal goals in each of the six ISP areas will require focused effort from the QIDP department. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	267	97	304	363	269	42			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	2/6	3/6	1/6	2/6	1/6	1/6			
2	The personal goals are measurable.	0% 0/6	0/6	1/6	0/6	0/6	0/6	1/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	1/6	0/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #267, Individual #97, Individual #304, Individual #363, Individual #269 and Individual #42. 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.

The IDTs continued to work toward developing personal, measurable goals. For this review period, none of the six ISPs contained individualized goals in all areas; therefore, none had a comprehensive set of goals that met criterion. While the Center did not make progress overall in developing personal goals since the previous visit, it was positive that one personal goal, the work goal for Individual #97, met criteria for Indicators 1-8.

1. During the last monitoring visit, the Monitoring Team found 16 personal goals met criterion for being individualized, reflective of the individual's preferences and strengths and based on input from the individual on what is important to him or her. During the current site visit, 10 personal goals met criterion. Findings included:

- The 10 personal goals that met criterion included leisure goals for Individual #269 and Individual #42, the relationship goal for Individual #267, work goals for Individual #97 and Individual #363, independence goals for Individual #267 and Individual #97, and living options goals for Individual #97, Individual #304 and Individual #363.
- It was positive that the IDTs had made attempts to develop personal goals that addressed individual preferences in some domains, such as leisure and living options. Overall, however, considerable work remained to be done in this area, especially for employment, relationships, and independence goals.
- The IDTs often did not develop relationship goals for individuals, because they asserted the individuals were content with their current situation. Four of six individuals (Individual #97, Individual #304, Individual #269, Individual #42) did not have relationships goals. Documentation indicated these individuals often had unmet needs in these areas, and it was hard to imagine there weren't opportunities for enriching their relationships.
- Of the remaining personal goals, many were not aspirational.

2. The Monitoring Team reviewed the 10 personal goals that met criterion for Indicator 1 and their underlying action plans to evaluate whether they also met criterion for measurability. Of these 10 personal goals, two met criterion for measurability. These were the work goal for Individual #97 and the leisure goal for Individual #42. Often, the IDT stated personal goals in broad terms without projecting a timeframe for, or a clear path toward, achievement. In such instances, the Monitoring Team also reviewed the action plans to assess whether these provided that needed measurability. Examples of personal goals that did not meet criterion for measurability are described below:

- Living options goals that did not meet criterion for measurability failed to describe the characteristics of the setting that would be important to the individual and/or to project a timeframe for expected achievement. For example, many individuals had the same living options goal for more than one year, but with no projected timeframe for that to be achieved, and had little to no implementation of community exploration or examination of the barriers that prevented such exploration.
- For Individual #267, the personal relationships goal to attend church in the community did not include any expectation of frequency or any action plans that described measurable outcomes regarding relationship needs. The IDT continued this goal at the annual ISP planning meeting observed onsite without addressing its lack of implementation throughout the previous year or how the barriers could be addressed.
- Individual #267's personal goal for independence, to learn to do his laundry, was too broad to be measurable as stated and the ISP did not define any action plan that specifically addressed laundry-related tasks or learning.
- Individual #97's leisure goal was to be a member of a bowling league and compete in competitions, but the ISP did not indicate any expectation for frequency. The sole related action plan indicated that she can go practice bowling with recreational department on Saturday's, but did not have a corresponding skill acquisition plan (SAP) or staff service objective (SSO). This action plan had not been implemented through the first three months following her ISP meeting in September 2017.

3. For the two personal goals that met criterion in indicator 1, Individual #97's work goal had reliable and valid data and again met criterion. For Individual #42, the Center's documentation in the SAP summary report did not include the leisure SAP and no related data were found there.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: The indicators in this outcome look at the entire set of action plans in the ISP. These quality characteristics of the set of actions, supports, and services comprise, in large part, a quality ISP. There were some positive examples for some individuals, but overall, performance decreased compared to the last review or remained at the same low score of 0%. Some important areas of safety and risk were not adequately addressed by the IDTs (see comments for indicator 12). These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	267	97	304	363	269	42			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	1/6	0/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for	0%	0/6	1/6	0/6	0/6	0/6	0/6			

	implementation, data collection, and review to occur.	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. For the most part, this group of individuals did not have personal goals that met criterion, as described under Indicator 1 above. The exception was the work goal for Individual #97, which met criterion as a measurable personal goal and had action plans that supported its achievement. IDTs needed to focus on laying out a clear path of assertive action plans to meet each goal. Some goals had no related action plans, while others were only minimally or tangentially related to the achievement of the goal. For example:

- Individual #267 had an independence goal to learn to do his laundry, but the related action plans did not reference any laundry tasks.
- Individual #97 had a living options goal to live in a small group home or apartment in the community, but the ISP did not include any related action plans.
- Individual #363 had a leisure goal to participate in Special Olympics, with an action plan to go bowling in the community twice a month. The ISP did not include any action plans that addressed how the IDT could get him involved with Special Olympics, or when that might occur.

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

- For Individual #97, it was positive that her ISP included opportunities for choice around work. Otherwise, many of her action plans that might have addressed preferences and provided opportunities for choice, such as volunteering in the community and being a member of a bowling league, did not have specific implementation plans and, in fact, had not been implemented.
- Individual #363's action plans addressed some preferences, such as to make coffee and to plan a visit with family. The IDT addressed the latter in a minimal manner with no specific implementation plan. His ISP also did not specify any action plans that offered opportunities for choice.
- Individual #42 had an action plan for planning a trip of her choice, which integrated both her preferences and opportunities for choice. This was positive, but it was the only action plan that offered opportunities for choice and it required only four such opportunities per month. To achieve compliance, the IDT should develop assertive action plans that specify opportunities for choice on a regular and ongoing basis.

10. One of six (for Individual #97) ISPs clearly addressed strengths, needs, and barriers related to informed decision-making. She had action plans for using a ledger to track her budget and for self-administration of medication using a lockbox, both of which were functional for her needs in the areas of financial and medical decision-making. This was a positive finding and represented progress from previous reviews. In other instances, the Monitoring Team found that the IDTs rarely developed such action plans. The IDT for Individual #42 did make an effort to develop some such action plans, but they did not rise to the level of being functional for the purposes of addressing informed decision making. For example:

- The ISP for Individual #42 indicated that she had skill acquisition plans (SAPs) for self-administration of medication (SAMs) and money management as action plans related to informed decision making, but neither of these clearly addressed needed

informed decision-making skills. For example, the IDT for Individual #42 indicated that she could manage $40 per week. The IDT further identified the barrier to full access to her funds was possible exploitation and loss of money. Logically, then, action plans should focus on recognizing and avoiding exploitation and how to keep her money secure. Instead, her SAP in this area called for her to point to a dollar bill, which would not address her identified needs for informed decision-making in this area.

11. None of six ISPs met criterion for supporting overall independence. Findings included:
    - The ability to communicate wants and needs is one of the most fundamental tools for enhancing independence. The ISPs for Individual #304, Individual #363 and Individual #269 did not assertively address their communication needs.
    - For Individual #269, the ISP did include an action plan for using an automatic door switch to open doors. This was positive to see, but it had never been implemented.
    - The ISP for Individual #42 indicated that she should receive an evaluation for use of a motorized wheelchair. She travelled around campus in her manual wheelchair, but a motorized chair would have allowed her to access all parts of the campus more readily and independently. The IDT did not develop an action plan or require a full assessment; instead they relied upon a 2016 habilitation assessment that stated she likely would not be able to use a motorized chair. No trials or a full assessment had been completed.

12. The IDTs did not assertively address risk areas in a consistent manner. The Monitoring Team was concerned about the ability of the IDTs to accurately identify and adequately address areas of risk.
    - The IDT for Individual #363 did not assertively address his repeated and ongoing falls. The Center did not have a consistent approach for tracking falls and data were not reliable, but the available information demonstrated a lengthy and recent history of falls with resulting injuries. For example, his Integrated Risk Rating Form (IRRF), dated 3/27/17, noted 13 falls for 2015-2016 and at least one required a CT to rule out head injury. From 4/13/17-8/29/17, various documents indicated that another nine falls had occurred. In June 2017, he sustained a broken rib and a broken finger related to falls. During the week prior to the monitoring visit, he stumbled in the bathroom and fell into the wall. Injury reports over the past 12 months indicated 12 of his 29 injuries were clearly related to falls. Still, the IDT had not made a referral to the Physical and Nutritional Management Team (PNMT). While the IDT had met on several occasions and proposed several strategies for addressing falls and his potential for injuries, they had not completed a thorough falls analysis or developed a plan for collecting the types of comprehensive data needed to determine and address the root causes. They had also implemented the proposed strategies haphazardly and made decisions about these with little to no reliable data. At a minimum, the IDT needed to make a referral to the PNMT and complete a longitudinal analysis of his falls, including where and when they occurred and other environmental factors, and compare those with data related to sleep patterns, medication changes and psychotropic drug blood levels, seizures, orthostatic hypotension and constipation. They also needed to complete a new functional behavioral assessment, as well as vocational and sensory assessments, to address other factors that may assist the IDT in the analysis of falls as well as to develop preventative strategies. The IDT should also consider additional clinical assessments that may be needed to rule out other potential factors.
    - Individual #304 had experienced significant decompensation in his health, weight, mobility, and functional status and the IDT had not taken assertive action in an overall manner. Just as in the previous example, the IDT had not developed a plan for collecting the types of comprehensive data needed to determine and address the root causes. The IDT had jumped to a conclusion that he had dementia and that this was likely to be the cause of his functional decline. Per the available

documentation, the IDT based this diagnosis on a screening completed by a member of the behavioral staff, but without further diagnostic testing or assessment. A screening tool is typically used to indicate whether additional assessment may be needed to rule out a diagnosis, rather than as its basis. In this instance, the completed tool was also only partially filled out and had large gaps. The IDT needed to undertake a more thorough and data-based assessment of the root causes of his decompensation and use those findings to develop an appropriate set of action plans for Individual #304 based on the identified needs. Even if the assessment confirms the dementia diagnosis, the action plans should focus on how to minimize its impact and maximize his independence and functional skills. As the Center may anticipate that the aging of its population will likely result in a higher incidence of dementia, it should ensure the IDTs meet to carefully examine both the diagnostic process as well as to develop assertive strategies to assist individuals to maintain their highest levels of independence.

- Individual #267 had a history of small bowel obstruction and currently had a diagnosis of diverticulosis, but had been asymptomatic. His last screening colonoscopy was in August 2007, which revealed a healthy colon and recommended a repeat in five to 10 years. The 2017 AMA noted it was due and to be scheduled. At the time of the 2018 ISP annual meeting observed onsite, the IDT did not have any discussion about this need. Per the QIDP interview, it had not yet been completed and she did not have any knowledge that it had been scheduled.

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:

- In the area of behavioral support needs, Individual #97 had an expired interim PBSP that had been in place since her re-admission in August 2017. It did not specifically address her swallowing of items as a target behavior, even though she had a long history of the behavior as well as a confirmed episode of swallowing a pair of earrings as recently as 11/9/17. While this behavior was infrequent, it had potentially severe consequences and needed to be addressed assertively.
- The IDT for Individual #269 had not obtained behavioral support to address her frequent refusals and combative behavior during personal care tasks. For example, she had a toothbrushing SSO, but the QIDP Monthly Reviews for September 2017 through November of 2017 indicated that staff had not been able to consistently implement this support because she was combative.

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

- Individual #267's 2017 ISP included an action plan to attend church in the community, but it was never implemented. Instead, he attended church on campus.
- Individual #97 had a personal goal to be a member of a bowling league and compete in competitions, which could have led to opportunity for community integration. The IDT did not develop assertive action plans to support this. The sole related action plan stated she can practice bowling with the recreational department on Saturdays. There was no SAP or staff service objective (SSO), and she had not yet gone bowling.
- Individual #363 also had a SAP for community bowling, but it had not been implemented. As written, it did not provide any strategies to promote community integration.

15. One of six ISPs (for Individual #97) considered opportunities for day programming in the most integrated setting consistent with

the individual's preferences and support needs. She was participating in a vocational apprentice program and had on-campus employment in her preferred area. She was very satisfied with the apprentice experience and excited about the opportunities it presented. Examples of those that did not meet criterion included:

- Individual #363's IDT stated recommendations for community work or training were not applicable because he had never worked. Further, the IDT stated he would need to be employed on campus first and build upon that before considering outside employment goals. The ISP did not describe a vision for employment or include any action plan that clearly laid out opportunities for on-campus employment,
- Individual #269 enjoyed talking about her children, participating in arts and craft activities, and outings to art venues. The IDT could have considered participation in a community senior center program as an opportunity for day programming.
- The IDT did not develop any personal goal or action plan for Individual #42 in this area. Per interview with her QIDP, the IDT determined she liked shredding and that was all she wanted to do. The IDT did not discuss any opportunities for related work in the community or a more integrated setting. Individual #42 continued to have a personal goal for community transition, so the IDT should have given some consideration to how her work preferences might be supported in a community setting as well.

16. None of six ISPs 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. Overall, the ISPs provided limited opportunities for learning and functional engagement. The IDTs did not place significant focus on skill acquisition. Many SAPs took place only four times per month. For most of the individuals whose ISPs were reviewed, more frequent opportunities were likely needed to result in learning and retention.

17. The IDT did not consistently address barriers to achieving goals. For example:

- IDTs did not effectively address barriers to community transition with individualized and measurable action plans as described below in Indicator 26.
- IDTs did not consistently address barriers to lack of implementation of the ISP. For example, Individual #267 had action plans to attend church in the community and for counseling. Neither had been implemented during the past ISP year, but the IDT continued them in the ISP observed onsite without discussing how the barriers that prevented their implementation could be addressed.
- Individual #363's ISP systematically identified potential barriers to each personal goal, which was positive to see, but did not then address these assertively. For example, for his goal to participate in Special Olympics, the IDT identified barriers, including that it may be difficult to get him to practice every week, he may not be able to focus on event, and he may not like Special Olympics. The only related action plan was a SAP for bowling in the community twice a month, but it did not address any of these barriers. The IDT discussed a trial of direct speech/occupational therapy for increasing attention to task, but did not develop a formal action plan. A trial of this intervention was attempted, but discontinued for lack of progress due to the many times he was asleep or not present when therapy was scheduled. The IDT did not review or discuss how to potentially improve participation before discontinuing.

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

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
Summary: Progress was seen for some individuals in some indicators. Two indicators showed sustained high performance. These were regarding there being a good description of the individual's community living preferences during ISP meetings observed by the Monitoring Team, and regarding the written ISP including a clear statement of the IDT's overall decision. Thus, indicators 20 and 22 will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	267	97	304	363	269	42			
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	1/1	1/1	0/1	0/1	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	1/1	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.	17% 1/6	0/1	0/1	1/1	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).	83% 5/6	1/1	0/1	1/1	1/1	1/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/5	0/1	0/1	0/1	0/1	N/A	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	0/1	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized-measurable plans to educate	0%	0/1	0/1	0/1	0/1	0/1	0/1			

	the individual/LAR about community living options.	0/6									
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A			

Comments:

19. Two of six ISPs (for Individual #267 and Individual #97) included a description of the individual's preference for where to live and how that was determined. Individual #269's IDT discussed her preferences and needs and how that would inform where she would like to live. Individual #269 needed more community exploration appropriate to her learning needs, but the discussion and conclusion met criterion for this indicator. Otherwise, the IDTs indicated the individuals' preferences were undetermined or unknown, generally based on lack of awareness of community living.

20. One of the six individuals (Individual #267) had an annual ISP meeting during this onsite visit, and the IDT clearly described his living options preference.

21. Overall, none of six ISPs fully included the opinions and recommendation of the IDT's staff members, but progress was noted. Examples of findings included:

- Assessments typically provided a statement of the opinion and recommendation of the respective team member. This was positive.
- ISPs did not yet consistently include independent recommendations from each staff member on the team that identified the most integrated setting appropriate to the individual's need. Those that did not meet criterion included:
    - For Individual #267, most IDT members made a recommendation based on his existing court commitment rather than on his preferences, skills, and needs
    - Five of six ISPs did not document the independent recommendation of the PCP.

22. This indicator met criterion. Six of six ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.

23. One of six individuals had a thorough examination of living options based upon their preferences, needs, and strengths. Individual #304's IDT discussed his reaction to a group home tour as well as how a smaller and quieter environment would both meet his needs and address his preferences. Otherwise, the ISPs did not reflect a robust discussion of available settings that might meet individuals' needs. Findings included:

- For Individual #267, the IDT was not prepared to have any discussion about availability of any homes or community resources that could serve his needs related to his court commitment as a sexual offender.
- Individual #269 did not appear to show interest in the community living videos shown to her, as evidenced by her keeping her head down while it played. The IDT did not document any discussion about whether video tours were appropriate to her learning needs.

24. Five of six ISPs met criterion and identified a thorough and comprehensive list of obstacles to referral in a manner that would allow for the development of relevant and measurable goals to address the obstacle. This was positive. The exception was for Individual #97, whose IDT identified LAR choice due to unsuccessful prior community placements as the sole barrier. It did not identify

psychiatric/behavioral needs or individual choice as barriers, even though both were included in the narrative as rationales provided by IDT members.

25. For Individual #267, whose ISP meeting was observed during this onsite visit, the IDT did not identify a full a list of obstacles to referral.

26. The IDT for Individual #269 recommended referral. None of remaining five individuals had individualized, measurable action plans, with learning objectives or outcomes, to address obstacles to referral.

27. During Individual #267's onsite annual ISP meeting observed on-site, the IDT did not discuss or develop meaningful or measurable action plans to address the barrier to his awareness of community living options as that related to the afore-mentioned legal barrier to group home tours.

28. None of six ISPs had individualized and measurable plans for education.

29. Five of six individuals had obstacles identified at the time of the ISP. The sixth individual, Individual #269, had been referred, although the referral had since been rescinded due to medical concerns.

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

Summary: Scoring for these four indicators decreased compared with the last review. Thus, attention from the QIDPs and IDTs is needed in order for improvement to occur. Even so, there were some positives, such as the efforts taken by the IDT for Individual #267 to participate in his annual ISP meeting. Another positive was the increase (somewhat) in the knowledge of the QIDPs regarding the individuals on their caseload. These four indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	267	97	304	363	269	42			
30	The ISP was revised at least annually.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	50% 1/2	N/A	1/1	N/A	N/A	N/A	0/1			
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).	50% 3/6	1/1	1/1	1/1	0/1	0/1	0/1			

34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

31. Individual #97 and Individual #42 had been recently re-admitted from community transition. The IDT for Individual #97 held her ISP on a timely basis and met criterion. The IDT for Individual #42 did not document a timely meeting to address her re-admission.

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

33. Three of six individuals participated in their ISP meetings.
- Per documentation, Individual #363 and Individual #42 refused to attend.
- Individual #269 was unable to attend her ISP meeting because her wheelchair was being serviced and she refused to get into a spare chair for transportation. The IDT did not document any planning for this barrier prior to the meeting or consideration of re-scheduling once the wheelchair repair was complete.

The Monitoring Team observed the ISP annual meeting for Individual #267 held during this visit. It was positive to see that the ISP facilitator took great care to include Individual #267 in the discussion and to use language that encouraged his participation. Individual #267 did not stay for the entire meeting, but did participate during the entirety of the personal goal discussion. This was commendable.

34. None of six individuals had an appropriately constituted IDT that participated in the planning process, based on their strengths, needs, and preferences. The following examples impacted this finding:
- All of these individuals, with the exception of Individual #97, had communication and/or habilitation needs. OT/PT staff did not participate in ISP annual meetings for Individual #267, Individual #363, Individual #269, or Individual #42, but should have based on their needs. Speech/Language staff did not participate in ISP annual meetings for Individual #267, Individual #304, Individual #363, or Individual #269, but should have based on their needs.

While there was significant room for improvement, there had been some incremental gains demonstrated by QIDPs related to knowledge of individuals' health and safety risks, as evidenced in onsite interviews. The Monitoring Team was particularly impressed with the overall fluency of one QIDP in this area. Due to personnel adjustments across campus, several individuals had newly-assigned QIDPs at the time of the monitoring visit, so this may have affected this outcome. These findings were consistent with the Center's own findings for its Corrective Action Plan in this area.

Outcome 6: ISP assessments are completed as per the individuals' needs.	
Summary: It was good to see that IDTs considered and identified what assessments were needed. With sustained high performance, this indicator (35) might be moved to the category of requiring less oversight after the next review. That being said, assessments were often not ultimately obtained. Both indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	267	97	304	363	269	42			
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.	100% 5/5	1/1	N/A	1/1	1/1	1/1	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting, for five of five individuals. (The ISP reviewed for Individual #97 was an initial plan, so the IDT did not hold an ISP Preparation meeting.)

36. IDTs did not consistently arrange for and obtain needed, relevant assessments prior to the IDT meeting. One of six (Individual #269) ISPs met criterion. Examples of those that did not included:

- The IDT for Individual #363 requested a vocational assessment, with a specific question about whether he would be appropriate for the Green Thumb or arts and crafts program. The IDT did not obtain the assessment. The documentation provided indicated an assessment was not due until 2018 and the most recent available was from 2015.
- Individual #267, Individual #97 and Individual #304 did not have current Functional Behavior Analyses.

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

Summary: It was positive to see that QIDP monthly reviews were being completed on a more timely basis than in the past. Implementation and revision, however, were not occurring. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	267	97	304	363	269	42			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

Overall, consistent implementation and monitoring of ISP action steps continued to be areas of significant concern.

37-38. IDTs did not revise the ISPs as needed, as evidenced throughout this section and others. This reflected negatively on the role of the QIDP to ensure individuals received required monitoring/review and revision of treatments, services, and supports.

- In one positive finding, QIDP Monthly Reviews had more often been completed on a timely basis, in a significant improvement

over the last visit. The QIDP Coordinator reported the Center had begun to stagger monthly reviews over the course of the month, so that they didn't all come due at one time.

- Monthly review provided minimal analysis regarding progress or outstanding needs. Follow-up to identified concerns was still generally haphazard or absent.
- For all individuals, most action plans for personal goals had been infrequently implemented, if at all. In some cases, these unimplemented plans had been continued from one ISP year to the next without identifying and addressing the barriers that prevented implementation.

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

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

#	Indicator	Overall Score	Individuals: 304	363	42	167	327	269	114	91	187
a.	The individual's risk rating is accurate.	28% 5/18	0/2	0/2	1/2	0/2	0/2	1/2	1/2	2/2	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.	28% 5/18	0/2	0/2	0/2	1/2	2/2	1/2	1/2	0/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #304 – choking, and infections; Individual #363 – falls, and constipation/bowel obstruction; Individual #42 – falls, and infections; Individual #167 – constipation/bowel obstruction, and choking; Individual #327 – constipation/bowel obstruction, and polypharmacy/medication side effects; Individual #269 – fractures, and urinary tract infections (UTIs); Individual #114 – falls, and choking; Individual #91 – skin integrity, and constipation/bowel obstruction; and Individual #187 – gastrointestinal (GI) problems, and weight].

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 #42 – infections, Individual #269 – fractures, Individual #114 – choking, and Individual #91 – skin integrity, and constipation/bowel obstruction.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, when Individual #42 returned from a failed community placement, the IDT did not update her IRRF, despite the fact that she had been hospitalized during her time in the community. In addition, 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 #167 – choking; Individual #327 – constipation/bowel obstruction, and polypharmacy/medication side effects; Individual #269 – UTIs; and Individual #114 – choking.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: It was good to see that Corpus Christi SSLC continued to move forward in creating psychiatry-related goals as per the various criteria in this set of indicators. The goals, however, need improvement so that they can be measurable and objectively monitored (i.e., the psychiatric indicators/symptoms need to be clearly specified and described/defined) and that they are derived from the psychiatric diagnosis. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	218	267	97	304	40	363	135	149
4	The individual has goals/objectives related to psychiatric status.	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
The Corpus Christi SSLC psychiatry department continued to make good progress in developing psychiatry-related goals for individuals. This outcome contains four indicators that each get at an important aspect of the goals. Each will be discussed in turn below.

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

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

In psychiatry, the focus is upon what have come to be called psychiatric indicators. These are the observable, measurable symptoms

chosen by the psychiatrist (with input from behavioral health services and IDT members) to determine the presence, level, and severity of the individual's psychiatric disorder. They are hypothesized to be, for the most part, due to the individual's psychiatric disorder. Psychiatric indicators can be psychometrically sound rating scales, and/or data collection recordings of symptoms directly observed by SSLC staff. Psychiatric indicators need to be directly related (derived from) the individual's diagnosis or diagnoses. Individuals should have psychiatric indicators (and goals) that are related to the reduction of psychiatric symptoms and goals/objectives related to the increase of positive/desirable behaviors.

Goals for behavioral health services typically appear in the functional assessment and/or the PBSP. Goals for psychiatry typically appear in the annual psychiatry update and/or quarterly psychiatry clinic review reports. Goals for behavioral health services and for psychiatry ultimately need to appear in the behavioral health risk section of the IHCP.

4. The Monitoring Team looks at the set of goals for each individual. Goals must include the focus of the goal (i.e., psychiatric indicators), address the reduction of symptoms and the increase of prosocial behaviors, and include criterion.

At Corpus Christi SSLC, goals for none of the individuals met all of the criteria, however, there was excellent progress as described in some detail below, along with specific feedback and suggestions from the Monitoring Team.

- All of the individuals had identified target behaviors that were related to their psychiatric disorder. The goals were developed in the annual Psychiatric Treatment Plan and appeared in the form of a grid.
- The grid contained the derivation of the monitored behaviors from the psychiatric diagnosis. However, the connection between the psychiatric indicator and the underlying diagnosis was tenuous for some individuals.
    - For example, for Individual #363, the link between the psychiatric indicator of aggression and the diagnoses of generalized anxiety disorder and personality change due to a general medical condition was not fully explained.
    - Likewise, for Individual #304 the indicator of putting inappropriate items in the trash did not seem to be an adequate proxy for the diagnosis of obsessive compulsive disorder.
- Prosocial psychiatry goals were identified for all of the individuals, except Individual #97 and Individual #149. A prosocial goal for many individuals was their attendance at work or outings, but again, the linkage of these goals to the underlying diagnosis was not explained.
- There were deficits related to the lack of objective criteria that could be empirically monitored. An example of this is the lack of clarity for the measurement of anxiety and disruptive behavior for Individual #149. There often seemed to be a lack of connection between the psychiatric indicator and the related behavioral health services targeted behavior data as they were reported in different sections of the quarterlies and the discussions were not integrated.
- The most important deficit was the lack of carryover of this information to the ISPs. During the review of this information with the treatment team, they indicated that although this information did not appear in the ISPs it did appear in the Integrated Health Plans. Accordingly, these documents were requested and reviewed. The information in these documents was formatted differently and did not contain a comparable amount of information when compared to that in the Annual Psychiatric Treatment Plans and Quarterly reviews. The lack of objective criteria also persisted. Also, there was a lack of follow through to the quarterly reviews. Goals need to appear in the IHCP section of the ISP. This was not yet the case.

5. Goals must be measurable. That is, the psychiatric indicators in each goal must be observable and measurable. They must be

designed so that their reliability can be determined.

- Some goals included some detail in the definition (operationalization) of the psychiatric indicator as noted above in indicator 4. In order for the goal to be measurable, the definition (operationalization) needs to more clearly describe exactly what it is that the person recording information needs to see. This is typically direct support professional staff, but sometimes might be behavioral health services staff or psychiatry staff (e.g., for rating scales). Those recorders need to know how to determine if a psychiatric indicator (symptom) is or is not occurring and if it should or should not be counted.
- The psychiatry documentation should include a specific operational, observable, measurable description of the psychiatric indicators included in the goals.

6. Goals (and their psychiatric indicators) must be related to the individual's assessment and diagnosis.

- The Monitoring Team does not require that there be a separate goal for reduction and a separate goal for increase for every diagnosis.
- Corpus Christi SSLC performed periodic thorough assessments in the form of the PTPs as well as the annual updates to the CPEs. The negative psychiatric indicators were based on these assessments, but as described above, the psychiatric indicators themselves did not constitute measurable goals.

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

- Data were being collected for PBSP target behaviors, some of which were also designated as psychiatric indicators. The behavioral data that were generated at Corpus Christi SSLC were not found to be reliable.
- There was no system to adequately collect or assess the reliability of the data on psychiatric indicators (that were not also target behaviors in the PBSP).
- Ensuring reliable data is an area of focus for the psychiatry department. Likely, accomplishing this will require collaborative work between psychiatry, behavioral health, residential services, day/vocational services, and the Center's ADOP.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: Corpus Christi SSLC showed continued progress on both indicators. With sustained high performance, indicator 15 might be moved to the category of requiring less oversight after the next review. Indicator 16 has shown an increase in performance from review to review over the last three reviews. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	218	267	97	304	40	363	135	149
12	The individual has a CPE.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B										
14	CPE content is comprehensive.										

15	If admitted within two years prior to the onsite review, and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	100% 2/2	N/A	1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A
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.	63% 5/8	0/1	1/1	N/A	0/1	1/1	0/1	1/1	1/1	1/1

Comments:

15. Individual #218 and Individual #97 had been admitted to the facility within the last two years. 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 five of the eight individuals. The psychiatric diagnoses in the records of Individual #177 and Individual #40 were consistent in the psychiatric and behavioral health sections of the record, but the diagnoses in the annual medical assessment were different. For Individual #97, the diagnoses in the psychiatric and medical sections were consistent, but a psychiatric diagnosis could not be found in the behavioral health assessment or PBSP, and there was no functional assessment.

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

Summary: Continued progress was seen in timeliness and submission of annual updates for the ISP. Thus, with sustained high performance, indicator 18 might be moved to the category of requiring less oversight after the next review. It was good to see that about half of the ISPs contained the relevant and required content regarding psychiatry department participation in the ISP meeting. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 177	218	267	97	304	40	363	135	149
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% 8/8	1/1	1/1	N/A	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.	50% 4/8	1/1	1/1	N/A	1/1	0/1	0/1	0/1	1/1	0/1

Comments:
21. The documentation in the ISPs was found to contain the essential elements for half of the individuals (not for Individual #40, Individual #304, Individual #363, and Individual #149). The discussion of the side effects was detailed in all of the ISPs. The deficits in these four 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. The fundamental problem was the lack of behavioral data that would make it possible to determine that the prescribed medications had a significant enough impact on the monitored negative behaviors to conclude the benefits outweighed the risks and, thus, represent the least intrusive most effective interventions.

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

Summary: PSPs continued to have proper content, and this indicator will remain in less oversight. However, two individuals in the review group should have had a PBSP rather than a PSP based upon their behavioral presentation and the requirements of the Settlement Agreement for a PBSP. In order to maintain the less oversight designation for this indicator, Corpus Christi SSLC should review all PSPs to ensure that every individual who should have a PBSP does indeed have one.

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. Two individuals, Individual #177 and Individual #304, had a PSP that met the content requirements. However, the Monitoring Team concluded that, although the PSPs met the content requirements, the behavioral aspects of the individuals' presentations were too significant to be appropriately addressed by a PSP and that a PBSP was necessary.

Corpus Christi SSLC should review all PSPs to ensure that individuals do not need a PBSP instead. At this time, 35 of the 101 individuals (35%) who were currently prescribed psychotropic medication had a PSP instead of a PBSP. This compared to 33% at the time of the prior review.

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

Summary: With sustained high performance, one or both indicators might be moved to the category of requiring less oversight after the next review.

Individuals:

#	Indicator	Overall Score	177	218	267	97	304	40	363	135	149

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.	100% 8/8	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	100% 8/8	1/1	1/1	N/A	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. At the time of the prior review, there were two individuals whose consents were found to be inadequate because there was no consideration of the cumulative side effects of multiple psychiatric medications. During the current review, it was noted that the facility had added a section to the side effects discussion of the consent, which specifically addressed this issue.

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: Corpus Christi SSLC was not ensuring that every individual who needed a PBSP had one. This is the third consecutive review during which this concern has been raised by the Monitoring Team. Some individuals had PSPs instead of PBSPs, whereas others did not have a PBSP even though they demonstrated the types of behaviors described in indicator 1. And not all those who had PBSPs had goals/objectives for all targeted behaviors (indicator 2, which will remain in the category of requiring less oversight, however, in order to remain in that category will require some attention from the behavioral health services department). That being said, when goals/objectives were written, they were done in measurable terminology for all individuals, for all goals, for this review, and for the previous three reviews, with one exception for one individual in July 2016. Therefore, indicator 3 will be moved to the category of requiring less oversight. There remained a need for data that were reliable for ultimately determining progress and making treatment decisions. Indicators 1, 4, and 5 will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	177	218	267	97	304	40	363	135	149
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.	42% 5/12	0/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
3	The psychological/behavioral goals/objectives are measurable.	100% 6/6	N/A	1/1	1/1	N/A	N/A	1/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	83% 5/6	N/A	1/1	1/1	N/A	N/A	1/1	1/1	1/1	0/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

1. Of the 15 individuals in the review groups for both Monitoring Teams, five of the individuals (Individual #218, Individual #267, Individual #40, Individual #363, Individual #135) reviewed by the behavioral health monitoring team had a Positive Behavior Support Plan (PBSP), and none of the individuals reviewed by the physical health monitoring team had a PBSP. This was appropriate for Individual #327, Individual #91, and Individual #187 (based on document review). For the other seven individuals, there were concerns raised after reviewing documents, meeting the individual, and/or speaking with staff. In each case, a functional behavior assessment had not been done, but is recommended, with consideration for the development of a PBSP. Specific comments are below.

- Individual #177 had a Psychiatric Support Plan (PSP) that targeted physical aggression and property destruction, and had experienced more than three restraints in a rolling 30-day period in the past six months.
- Individual #97 was still being supported with an Interim PBSP. This expired at the end of November 2017.
- Individual #304 had a PSP, but his behavioral health assessment noted a history of aggression and self-injurious behavior, and his PNMP noted that he will scream when angry.
- Individual #149 also had an Interim PBSP that had expired. He displayed significant self-injurious behavior that often resulted in injury to his chin requiring sutures.
- Individual #167's ISP indicated that she had a PSP. However, other documents indicated that she displayed disruptive behavior, including throwing materials, verbal aggression, and had injured herself after hitting objects (e.g., plexiglass windows). Her IRRF also indicated that her PSP would be replaced with a PBSP.
- Individual #269's staff reported that she displayed aggression towards others (e.g., punching, pinching, hair pulling, kicking), will swear in Spanish, and will refuse to eat or get out of bed.
- Individual #42 had a PBSP that targeted aggression and self-injurious behavior when she transitioned to the community from the facility. When she returned four months later, a PSP was introduced.

2. For five of the seven individuals who had either a PBSP or an interim PBSP, they had goals/objectives related to psychological/behavioral services. The exceptions were Individual #97 for whom objectives had not been developed and Individual #363 for whom objectives had been developed for two of the four behaviors targeted for reduction.

3. The objectives that had been developed were measurable.

4. For five of the six individuals who had goals/objectives, these were based on assessments. The exception was Individual #149 who did not have a functional behavior assessment.

5. In every case, the data used to evaluate the individual's progress was determined to be unreliable. Data timeliness was not addressed and inter-observer agreement measures were either not regularly assessed or were solely completed when no target behaviors occurred. One individual, Individual #149, was observed engaging in food foraging behavior. When his data were reviewed for the specific date and time, these events had not been recorded

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

Summary: Performance remained about the same as at the last review. More attention needs to be paid to these important assessments that set the occasion for proper behavioral treatment planning. These indicators will remain in active monitoring. Note, however, that all criteria for all indicators were met for one individual (Individual #218), indicating that Corpus Christi SSLC has the capability to do so.

#	Indicator	Overall Score	Individuals: 177	218	267	97	304	40	363	135	149
10	The individual has a current, and complete annual behavioral health update.	22% 2/9	0/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
11	The functional assessment is current (within the past 12 months).	44% 4/9	0/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1	0/1
12	The functional assessment is complete.	20% 1/5	N/A	1/1	0/1	N/A	N/A	0/1	0/1	0/1	N/A

Comments:

10. All of the individuals had a current behavioral health assessment, but two were considered complete (Individual #218, Individual #40). For the other seven individuals, there was no review of their physical health over the previous 12 months. Further, the assessments for Individual #267, Individual #97, and Individual #363 did not include an assessment of their cognitive abilities.

11. Four of the nine individuals (Individual #218, Individual #40, Individual #363, Individual #135) had a current functional behavior assessment. Individual #177 and Individual #304 did not have an assessment presumably because they had Psychiatric Support Plans

instead of Positive Behavior Support Plans. Individual #97 and Individual #149 were still being supported with expired interim PBSPs. Although FBAs had been recommended, these had not yet been completed. Lastly, Individual #267's FBA was a 2016 review of an assessment completed in 2014.

12. Individual #218's FBA was considered complete. In three cases (Individual #267, Individual #40, Individual #363), no identified problem behaviors were observed during the observations. The need for additional observations was not addressed in the report. Additionally, for Individual #267, all observations took place in the living room of his home where antecedent conditions were unlikely. The indirect assessments completed for Individual #135 addressed aggression and property destruction, but omitted self-injury, verbal threats, and theft. Lastly, clear summary statements were not included in the reports for Individual #267, Individual #363, and Individual #135.

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

Summary: Performance remained about the same as at the last review. In addition to attending to the more logistical requirements of indicators 13 and 14, many important quality aspects of PBSPs needed attention as detailed in the comments below for indicator 15. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 177	218	267	97	304	40	363	135	149
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	71% 5/7	N/A	1/1	0/1	1/1	N/A	1/1	1/1	1/1	0/1
14	The PBSP was current (within the past 12 months).	57% 4/7	N/A	1/1	0/1	0/1	N/A	1/1	1/1	1/1	0/1
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/7	N/A	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1

Comments:

13. Five of the seven PBSPs were implemented within 14 days of required consents. The exceptions were the plans for Individual #267 and Individual #149, whose plans were implemented prior to consent.

14. The PBSPs for four individuals (Individual #218, Individual #40, Individual #363, Individual #135) were current. Individual #267's plan was implemented in 2016. As his goals were to be achieved by the end of the same month as implementation, it appeared that this was a plan from the previous year. As noted earlier, both Individual #97 and Individual #149 were being supported with interim PBSPs, both of which had expired.

15. Although none of the PBSPs were considered complete, several indicators were met in five or more of the plans. These included operational definitions of functionally equivalent replacement behaviors, guidelines for training/reinforcing replacement behaviors, and treatment objectives.

Elements that were missing included the use of positive reinforcement in a manner likely to affect behavior change, sufficient

opportunities for replacement behavior to be reinforced, and clear interventions for all targeted and monitored behaviors.

Several individual specific comments are outlined below.

- In the PBSPs for both Individual #267 and Individual #40, staff are advised to document targeted behaviors on data sheets; the plans had not been updated to reference Care Tracker.
- Monitored behaviors were not always operationally defined (e.g., Individual #218 - leaving work early), nor were there guidelines for staff to follow when the behaviors occurred (e.g., Individual #218 - work refusals; Individual #40 - property destruction).
- One possible consequence for rectal digging was to offer Individual #363 a shower. Because showering was an identified preference, this may reinforce the unwanted behavior.
- Similarly, Individual #218 was to receive 1:1 attention as soon as he stopped displaying aggression. Because attention was an identified preference, this intervention may reinforce the unwanted behavior.
- Individual #40's plan included his attending weekly counseling, but he was not enrolled in this service.
- Similarly, Individual #97 has a contract that included reinforcement for attending counseling. She was not receiving this support.
- Instructions were needed to advise staff not to laugh at Individual #40 when he engages in verbal threats. This should be standard procedure when working with all individuals.
- Staff working with Individual #40 were advised to document disruptive behavior (not addressed in his plan). Further, self-injury was identified as a monitored behavior when in fact it was one of his targeted behaviors.
- Individual #363's PBSP referenced the use of a helmet, but there was no indication that this was approved by the Human Rights Committee. Further, when a request was made for the plan to teach him to wear a helmet, the facility could not provide one.
- Individual #135 was noted to engage in self-injury, verbal threats, and theft of materials, but these were not addressed in his plan.

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

Summary: Both indicators will remain in active monitoring. The new director of behavioral health services was aware of the need to find a way to provide counseling services to those individuals who were in need of it.

Individuals:

#	Indicator	Overall Score	177	218	267	97	304	40	363	135	149
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	0% 0/3	N/A	N/A	N/A	0/1		0/1	N/A	0/1	N/A
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A

Comments:

24. The IDTs for two individuals, Individual #97 and Individual #40, had recommended a referral to counseling. When information regarding the referrals was requested, the facility indicated this was not applicable. Documents for Individual #135 indicated that he

was enrolled in counseling. However, at the time of the onsite visit, none of these individuals were receiving this service. It was positive, however, that the Director of Behavioral Health Services was exploring the recruitment of community-based counselors to provide this service.

25. While onsite, a request was submitted for the counseling plan that had been in place for Individual #135. The facility provided a plan from July 2016 with goals to be achieved in 12 months. Although a data sheet and generalization plan were referenced, neither were provided. Similarly, although progress notes were requested, two documents entitled Final Reports were provided. These consisted of brief narratives that did not review his progress towards identified goals/objectives. No data were provided.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.

Summary: Given that over the last two review periods and during this review, individuals reviewed generally have had timely annual medical assessments (Round 11 – 89%, Round 12 – 100%, and Round 13 - 88%), Indicator b will move to the category requiring less oversight. Center staff should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. The remaining indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
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.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	88% 7/8	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	0/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." 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 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: Although additional work was needed, the Center made progress with regard to the quality of medical assessments. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
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, childhood illnesses, past medical histories, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history, updated active problem lists, and plans of care for each active medical problem, when appropriate.

b. Two individuals had diagnoses of "dementia" that were not justified within the submitted documentation. Forms of dementia are often clarified and defined by excluding other diagnoses, as well as accurate trend data indicating functional decline in activities of daily living as well as changes in behaviors. These require both medical evaluations and accurate and consistent data collection on the part of direct support professionals, nursing, and behavioral health staff. Additionally, other diagnoses that might contribute to decline in cognition or cause such decline should be aggressively evaluated and ruled out, to ensure that signs and symptoms of decline are not automatically assumed to be due to dementia when they actually are due to other treatable causes. Evaluations of dementia should be reflected in the AMA and brought forward year to year to provide evidence of this evaluation process. For Individual #304 and Individual #269, evidence was not found to show that such data was collected or analyzed prior to the individual being diagnosed with "dementia," and it was unclear that other potential causes for the dementia-like symptoms were thoroughly ruled out. It is recommended that the Center provide additional training to medical staff as well as IDTs on the current standards for evaluating dementia-like symptoms. Given the additional challenges that having an intellectual disability has on the diagnosis process, one helpful resource might be the National Task Group on Intellectual Disabilities and Dementia Practices: https://aadmd.org/ntg.

c. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [Individual #304 – seizures, and weight; Individual #363 – osteoporosis, and falls; Individual #42 – osteoporosis, and falls; Individual #167 – gastrointestinal (GI) problems, and constipation/bowel obstruction; Individual #327 – respiratory compromise, and GI problems; Individual #269 – seizures, and GI problems; Individual #114 – cardiac disease, and other: cancer; Individual #91 – urinary tract infections (UTIs), and seizures; and Individual #187 – diabetes, and skin integrity].

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.

Of note, although some interim reviews were completed, many were of poor quality. For example, several stated that the individual had "no chronic problems," despite the individual having numerous ongoing medical issues (e.g., Individual #187, Individual #91, Individual #269, and Individual #304). Others did not mention significant events that impacted individuals' health and/or at-risk conditions [e.g., Individual #304's weight loss, Individual #363's osteopenia and falls, Individual #42's most recent falls, and Individual #327's gastrostomy-tube (G-tube) dislodgements]. On a positive note, the updates for Individual #114, dated 2/22/17, and 5/31/17, provided extensive updates on his testicular cancer, as well as his cardiac disease; the review for Individual #187, dated 11/10/17, provided an extensive update on her diabetes mellitus; Individual #167's reviews provided the necessary information about his GI issues, and constipation; and Individual #327's reviews addressed her pneumonia.

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

Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 304	363	42	167	327	269	114	91	187
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	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.	0% 0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #304 – seizures, and weight; Individual #363 – osteoporosis, and falls; Individual #42 – osteoporosis, and falls; Individual #167 – GI problems, and constipation/bowel obstruction; Individual #327 – respiratory compromise, and GI problems; Individual #269 – seizures, and GI problems; Individual #114 – cardiac disease, and other: cancer; Individual #91 – UTIs, and seizures; and Individual #187 – diabetes, and skin integrity). Individual #114's IHCP on other: cancer sufficiently addressed the condition in accordance with applicable medical guidelines.

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

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: It was great to see high quality annual dental exam and dental summary documentation for the individuals reviewed. Over this review and the last one, the dental summaries reviewed generally included the necessary components. If the Center sustains this progress, Indicator c might move to the category requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
a.	Individual receives timely dental examination and summary:	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.										
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.										
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.										
b.	Individual receives a comprehensive dental examination.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	100% 8/8	1/1	1/1	1/1	1/1	Not rated (N/R)	1/1	1/1	1/1	1/1
Comments: b. and c. Individual #327 was at low risk for dental issues (i.e., she was edentulous), and was part of the outcome group, so a limited review was conducted for her. It was great to see that all nine dental exams and the eight annual dental summaries reviewed included the necessary components.											

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.	
Summary: Full physical assessments were not documented for a number of individuals (i.e., missing were fall assessments, weight graphs, reproductive assessments, and Braden scores). The remaining indicators require continued focus	Individuals:

to ensure nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice. All of these indicators will remain in active oversight.											
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
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	0/1	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	13% 1/8	0/1	0/1	N/A	1/1	0/1	0/1	0/1	0/1	0/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	11% 1/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	27% 3/11	0/1	1/1	1/2	N/A	0/1	0/1	0/1	0/2	1/2

Comments: a. Full physical assessments were not documented for a number of individuals. For eight of the individuals, problems were noted with regard to completion of complete physical assessments, including weight graphs, fall assessments, Braden scores, and assessments of reproductive systems.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #304 – choking, and infections; Individual #363 – falls, and constipation/bowel obstruction; Individual #42 – falls, and infections; Individual #167 – constipation/bowel obstruction, and choking; Individual #327 – constipation/bowel obstruction, and polypharmacy/medication side effects; Individual #269 – fractures, and urinary tract infections; Individual #114 – falls, and choking; Individual #91 – skin integrity, and constipation/bowel obstruction; and Individual #187 – GI problems, and weight).

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

extent possible. For a few individuals (i.e., Individual #167 – constipation/bowel obstruction, and choking; Individual #269 – fractures; Individual #114 – choking; and Individual #91 – constipation/bowel obstruction), the assessments contained status updates of the individuals' risks, which was good to see, but then the RN Case Manager did not use this information to conduct an analysis.

c. On a positive note, nurses conducted assessments according to relevant guidelines for a possible fall for Individual #363 on 8/23/17, a fall that Individual #42 reported after staff noted bruising on 7/17/17, and of emesis, a seizure, and lethargy for Individual #187 on 11/22/17.

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

- No nursing assessment was found of Individual #304, when he stopped independently feeding himself, and staff needed to begin feeding him his meals.
- An IPN, dated 10/5/17, noted that Individual #42 was unable to transfer herself, had frequent urination, was unable to bear weight, had a rapid pulse (i.e., 120), and a reddened peri-area. The nurse made no mention of the individual's current fluid intake, how frequent she was urinating and the amount of urine, any swelling to her joints, her mental status, a skin assessment, and/or whether or not the individual experienced incontinence, and/or pain on urination, or if the PCP was notified of a change in status.
- An IPN, dated 9/27/17, indicated that staff reported that the individual had not had a bowel movement (BM) since 9/21/17. Given that the standard nursing guidelines requires that a nurse completes an assessment and notified the PCP when an individual has no BM in three days, this was very concerning. In addition, this individual was at high risk due to her chronic constipation, so nursing staff should have routinely assessed her and reviewed the Bowel Log daily. In the IPN, the nurse did not document any assessment of bowel sounds, fluid intake, abdominal circumference measurement, or palpation of the abdomen prior to administering an enema.
- An IPN, dated 10/27/17, first noted a purple bruise to the center of Individual # 269's chest. Nursing staff did not complete a physical assessment at the time this bruise was found, which when x-rayed was identified as a fractured right clavicle.
- On 9/3/17, Individual #114 fell from his bed. The nursing IPN did not include any description of pain medications he had recently received (i.e., the individual was on hospice) or an assessment of dizziness, sedation, lethargy, or confusion, and the nurse made no mention that the PCP was notified.
- The first IPN found noting skin issues to Individual #91's buttocks was on 7/28/17, at 9:15 a.m. The IPN described no specific assessment of the area, but stated: "Excoriation to buttocks with a small, 1 mm area that wants to start opening." Although the note indicated that the nurse notified the PCP and Habilitation Therapy staff, there was no plan or indication that the nurse provided direct support professional staff any instructions regarding this issue. On 7/28/17, at 2:57 p.m., an IPN from Habilitation Therapies staff indicated: "noted to have a moderate amount of denude tissue and presenting with multiple superficial irregularly-shaped open areas of varying sizes in the bilateral gluteal areas." The note went on to say: "Denuded tissue is a result of increased moisture in the affected areas primarily from incontinent episodes."
- On 8/4/17, and IPN indicated that Individual 91's last BM was on 8/2/17. The nurse stated in the note: "order obtained for bowel protocol – no BM x 2 days-administered at 0723." The nurse did not specify in the note what was administered, the dose, the route, and/or the individual's response, if there were abnormal assessment findings, or the status of his fluid intake.
- An ISPA, dated 7/13/17, noted that Individual #187 had lost 26 pounds in less than one month. No nursing assessment was

found in the IPNs to address this significant weight loss.

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 five 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	304	363	42	167	327	269	114	91	187
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.	6% 1/18	0/2	0/2	0/2	0/2	1/2	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.	11% 2/18	1/2	0/2	0/2	0/2	1/2	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).	11% 2/18	1/2	0/2	0/2	0/2	1/2	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).	11% 2/18	1/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	17% 3/18	1/2	0/2	1/2	0/2	1/2	0/2	0/2	0/2	0/2
Comments: a. through f. Individual #304's IHCP for choking included a number of the necessary elements. For example, it included a nursing intervention to check lung sounds twice a day before and after morning and evening medication administration. The IHCP defined the frequency for this intervention. However, not all nursing interventions in this plan were measurable. Individual #327's IHCP for polypharmacy/medication side effects included an intervention for nursing staff to complete MOSES evaluations every six months.											

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	Individuals:

Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results. This has been a consistent finding for this review and the previous two (Round 11 – 100%, Round 12 - 100%, and Round 13 – 100%). As a result, Indicator e will move to the category of less oversight. The Center should focus on improving the referral of all individuals that meet criteria for PNMT review, completion of PNMT comprehensive assessments for individuals needing them, and the quality of the PNMT reviews and comprehensive assessments. The remaining indicators will continue in active oversight.											
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	50% 4/8	0/1	0/1	N/A	1/1	1/1	0/1	1/1	0/1	1/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	50% 4/8	1/1	0/1		1/1	1/1	0/1	1/1	0/1	0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	50% 2/4	1/1	0/1		1/1	N/A	N/A	N/A	N/A	0/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	63% 5/8	1/1	0/1		1/1	1/1	0/1	1/1	1/1	0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 4/4	1/1	N/A		1/1	N/A	N/A	N/A	1/1	1/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	75% 6/8	1/1	0/1		1/1	1/1	0/1	1/1	1/1	1/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/4	N/A	N/A		N/A	0/1	0/1	0/1	0/1	N/A
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4	0/1	0/1		0/1	N/A	N/A	N/A	N/A	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:

- While Individual #304 did not meet the criteria for weight loss of three pounds per month for three consecutive months, he essentially lost in excess of two pounds per month between October 2016 and September 2017. While the weight loss was initially intended, it became undesirable as Individual #304 fell into his estimated desired weight range (EDWR), but continued to lose weight. The PNMT should have become involved before he fell through the bottom range of the EDWR. By the time the PNMT conducted a review, Individual #304's weight had decreased from 146 pounds in October 2016 to 113 pounds in September 2017. Once Individual #304 was referred, the PNMT conducted a timely review, and appropriately determined that the type of review needed was a comprehensive assessment, which the PNMT completed in a timely manner.
- Significant issues were noted with regard to the Center's data related to falls, making it difficult to determine how many times Individual #363 had fallen. However, he had ongoing issues with falls (i.e., approximately 20 falls during the 2016-2017 ISP year, and an additional nine falls since his ISP meeting in April 2017). He also had a history of serious injuries related to falls, and according to his QIDP, in the previous nine months, he had 29 injuries, 12 of which were related to falls. The IDT should have referred him to the PNMT, but did not.
- For Individual #167, the IDT made a timely referral to the PNMT in relation to emesis. The PNMT conducted a timely review, and timely comprehensive assessment. Comments with regard to the quality of the comprehensive review are provided below.
- On 6/27/17, the PNMT conducted a review of Individual #327 for pneumonia. The PNMT identified multiple concerns, but provided little detail with regard to how these issues would be rectified. For example, during the observations, poor positioning was noted during bathing, and while the individual was in bed. Additionally, the PNMT noted issues with transfers and difficulties during oral care. Although the review stated the PNMT addressed the concerns, it was unclear how the PNMT addressed them beyond immediate correction. For example, no plan for retraining of staff was noted. Based on the documentation in the review, the PNMT treated these issues as isolated events and not potentially as a more systemic problem. Discrepancies also were noted between the PNMP and the positioning pictures. In addition, the head-of bed elevation (HOBE) review only stated that it remained optimal and provided no data to justify the statement. Regarding recommendations, the PNMT made no recommendations to provide home staff with training, to reassess bathing supports, and/or to address oral care. When the PNMT conducted a review on 8/2/17, the same issues were noted with bed positioning, and the discrepancies between the positioning photos and the PNMP. It was unclear why these issues were not addressed between the reviews. For both reviews, the PNMT also stated that a medication observation was pending completion, but no evidence was presented to show it was completed, or the rationale for not completing it.
- On 11/2/17, Individual #269 suffered a fracture of her clavicular head. The clavicle is a long bone, and, therefore, this fracture should have triggered at least a PNMT review. Such a fracture has the potential to impact multiple PNM systems (e.g., eating, respiration, positioning).
- On 6/5/17, the PNMT completed a review of Individual #114 in relation to a choking event that occurred on 5/26/17, during which the individual choked on a pork chop. The PMT review did not clearly identify the potential root cause(s) of the choking event. Staff training on dining strategies was an issue that the PNMT addressed. A modified barium swallow study (MBSS) was conducted that recommended no changes. However, except to ensure staff were nearby, the PNMT did not formulate a plan to improve oral motor functioning and safe dining.
- On 7/24/17, Individual #91 returned from the hospital with diagnoses of a dislocated left shoulder status post open reduction and internal fixation (ORIF). His IDT did not refer him to the PNMT until 8/1/17, and the PNMT did not conduct a review until 8/15/17. The review identified that Individual #91 showed a decrease in the ability to feed himself, but offered no more

assessment of the issue. More specifically, staff stated that he was refusing to feed himself since returning from hospital, but the PNMT did not offer potential interventions or a plan to further assess the situation.

- For Individual #187, a PNMT review for progression of chronic kidney disease to end stage renal disease was originally scheduled for 6/20/17, but the PNMT did not complete the review until 8/3/17. It was noted that this was due to the unavailability of the IDT. During this time that the IDT was unavailable, Individual #187 developed pressure sores. The PNMT review and notes all stated that she had experienced an overall decline in health, so it was unclear why the PNMT did not conduct a comprehensive assessment, given that virtually all areas of daily living had been impacted (e.g., dining, mobility, independence). In November 2016, the PNMT conducted an assessment, but due to the overall decline, this assessment was no longer a valid representation of the individual's status.

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

h. As noted above, two individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #363, and Individual #187). The following summarizes some of the concerns noted with the two assessments that the PNMT completed:

- With regard to the assessment the PNMT completed for Individual #304, medications potentially impacting weight loss were listed, but not analyzed. The PNMT included a statement that the individual had been prescribed the medications for an extended period of time, but the PNMT did not recommend a review of the medications to address the potential impact that the current dosages might have due to his decreased weight, as well as the potential long-term impacts the medications might cause. The PNMT noted that bathing required further assessment, but no evidence of this additional assessment was noted. At times, the assessment included conflicting statements. For example, it stated Individual #304 was independent in mobility in the home, but then mentioned that he required the use of a gait belt. The PNMT assessment identified changes in his gait pattern, but provided no further assessment and stated one was not needed due to Individual #304 not experiencing falls. The assessment also mentioned that Individual #304 was on nectar-thick liquids, but the PNMP listed regular liquids. Therapists attempted a HOBE evaluation once, but did not complete it due to the individual's refusal. No second attempt was documented. The PNMT's rationale was that he had no overt signs of gastroesophageal reflux disease (GERD), but GERD might not have overt symptoms, and many times, it might impact intake, and, therefore, weight stability. The PNMT should have made additional attempts to complete a HOBE.
- For Individual #167, the PNMT had not identified the underlying cause of her emesis. Although they had taken steps in that direction, their analysis was incomplete. For example, they identified that when her abdominal girth was increased, she was likely constipated, and that led to emesis. If the data supported this theory, then, the next step for the PNMT would have been to identify the potential cause(s) of her constipation. In other words, the next "why" would have been: "Why is she constipated?" Pursuing the underlying cause further might have led to the development of clinically relevant goals on which Individual #167 could work (e.g., more exercise, more fiber in her diet, more fluid intake, changes to medications, etc.). In addition, the PNMT assessment stated that the individual's head-of-bed elevation promoted the optimal positioning, but it included no evidence of an assessment or review of data to support this statement. The PNMT review stated that the Pharmacist identified multiple drugs that could result in emesis or vomiting, but provided no further information. Under the discussion of effectiveness of supports, the PNMT noted that the individual required constant verbal prompts to complete bathing, whereas the PNMP stated she was independent. No further exploration or assessment was noted regarding this issue.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: No improvement was seen with regard to these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
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).	6% 1/18	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	0% 0/11	0/1	0/1	0/2	0/1	0/2	0/1	0/1	0/1	0/1
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/18	2/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: choking, and weight for Individual #304; choking, and falls for Individual #363; aspiration, and choking for Individual #42; choking, and gastrointestinal (GI) problems for Individual #167; respiratory compromise, and weight for Individual #327; choking, and fractures for Individual #269; GI problems, and choking for Individual #114; aspiration, and fractures for Individual #91; and choking, and skin integrity for Individual #187.

a. and b. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP (i.e., the exception was the IHCP for choking for Individual #42), and/or include preventative physical and nutritional management interventions to minimize the individuals' risks.

c. All individuals reviewed had PNMPs and/or Dining Plans, and problems with them varied. For example:

- When the PNMT reviewed Individual #327 on 6/27/17 and 8/2/17, discrepancies were identified between the PNMP and the positioning pictures. These errors should have been corrected immediately.
- Although the PNMPs reviewed stated the risk categories, none of them included the risk levels (i.e., medium or high).

- For approximately half of the individuals reviewed, the triggers in the PNMPs were not consistent with those in the IHCPs.
- Two individuals' PNMPs did not have pictures of the person using the gait belt.
- Individual #187's IHCP stated that foot of her bed should be elevated 15 degrees to help with edema and that this would be marked by a chain. In the PNMP, the picture of the bed positioning appeared to have elevation, but the instructions did not note the need to elevate the foot of the bed 15 degrees, and the picture did not clearly show that it was marked on a chain.
- With regard to mobility instructions, the PNMP for Individual #304 provided conflicting information. It stated that he was independent, but then stated that he required staff assistance with a gait belt to walk to and from the dining room.
- With regard to bathing instructions, Individual #363's PNMP did not describe the level of assistance needed. Individual #167's PNMP said she was independent in bathing, which was in contradiction to the observations the PNMP Coordinator conducted on 9/26/17. On 8/2/17, the PNMT stated as part of its review of Individual #327 that supports during bathing were not effective, yet no changes were noted to the PNMP.
- For two individuals (i.e., Individual #363, and Individual #42), the PNMPs did not specify the level of assistance the individuals required with toileting and personal assistance.
- With regard to mealtime instructions:
    - Individual #304's PNMP stated that staff should feed him once he stopped feeding himself. Whereas, the IHCP stated that staff should feed him throughout the meal. The IHCP stated that staff should offer him fluids at end of the meal, but the PNMP stated staff should offer them at the end of the meal, if he refused them during the meal.
    - Individual #167's PNMP did not match her Dining Plan. The PNMP did not include instructions for cubed breads, no rice, and no peanut butter and jelly.

On a positive note, all of the PNMPs reviewed:

- Described the individuals' assistive/adaptive equipment;
- Provided instructions for transfers;
- Stated handling precautions or moving techniques;
- Included instructions for medication administration;
- Provided oral hygiene instructions, including positioning and brushing instructions; and
- Described communication strategies.

e. The IHCP reviewed that identified the necessary clinical indicators was for GI problems for Individual #167.

g. Often, the IHCPs reviewed did not include the frequency of PNMP monitoring. The exceptions were the IHCPs for choking, and weight for Individual #304.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall	304	363	42	167	327	269	114	91	187

		Score									
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.	100% 2/2	N/A	N/A	N/A	N/A	1/1	1/1	N/A	N/A	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	N/A					N/A	N/A			
Comments: a. and b. It was good to see that Individual #327 and Individual #269's IDTs had justified the continued use of the enteral nutrition and/or medication administration. Individual #269 ate orally, and only used the tube for medication administration.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied. The quality of OT/PT assessments continues to be an area on which Center staff should focus. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	33% 3/9	0/1	0/1	0/1	1/1	0/1	1/1	1/1	0/1	0/1
b.	Individual receives the type of assessment in accordance with her/his	44%	0/1	0/1	0/1	1/1	1/1	1/1	1/1	0/1	0/1

	individual OT/PT-related needs.	4/9									
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/3	0/1	0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/6	N/A	N/A	N/A	0/1	0/1	0/1	0/1	0/1	0/1

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

- On 4/26/17, Individual #42 was readmitted to the Center after a failed community transition. However, the OT/PT did not complete an update until 8/17/17. In addition, no evidence was found that Individual #42 had a comprehensive OT/PT assessment within the last three years, nor was justification found for not completing one. Also of concern, on 10/17/17, her IDT requested an assessment of lower extremity weakness. The PT focused on modifications to her mattress, but did not address lower extremity weakness, stating she could be weaker due to a urinary tract infection (UTI).
- An Integrated Progress Note (IPN), dated 9/15/17, stated that the OT/PT would further assess Individual #304 for direct therapy. However, it was not until 10/6/17 that further assessment was noted (i.e., the Tinetti balance test was submitted), and then again on 11/29/17. It was unclear why the delay occurred. In addition, since the last annual assessment, Individual #304 experienced significant declines in areas such as activities of daily living, and ambulation. Therefore, a comprehensive assessment was warranted, but the OT/PT only completed an update.
- Individual #363's IDT requested an assessment of balance, but the Center did not submit evidence of a formal balance test. On 4/20/17, a note stated that the individual's balance reactions were appropriate, but provided no data to support the statement. One trial of a rolling walker occurred, and it did not include multiple trials in varying environments. The OT/PT made recommendations for consideration of hockey-style helmet, but no evidence was submitted of an actual trial. On 1/27/17, 3/13/17, 3/23/17, 3/28/17, 4/13/17, 4/19/17, 5/3/17, 5/5/17, 6/11/17, 6/15/17, 7/28/17, and 8/29/17, Individual #363

fell. No comprehensive falls analysis was completed.

- On 10/17/17, Individual #327's IDT sent a request for a consult to the PT to address bathing, positioning, and changing. The PT only addressed bed positioning in the consult. In its comments on the draft report, the State indicated this was due to the fact that on 10/13/17, the PT responded to an injury, and thought that the issues were due to bed positioning. According to the State, when the consult request from the IDT came in "…due to their previous determination that the issue was most likely with bed positioning, they continued with the plan to trial different pillows or devices for her hands." While the PT might have felt that the bed positioning was most likely the issue, assessment of the other areas would be necessary to be sure. On 11/8/17, the IDT sent another consult request to the PT regarding bathing, positioning, and changing, and again, bathing was not addressed. In its comments on the draft report, the State clarified that the OT "initiated a summary of the observations," and so what appeared to be a second consultation request was a continuation of the first. This was not clear from the documentation provided. On 11/8/17, the IDT's request also asked for retraining of staff, but the PT did not address this request in the consult. Moreover, during an observation on 6/22/17, the PT noted the need for further wheelchair assessment due to the individual's weight gain and poor position. It was not until 7/12/17 that Individual #327 was seen for the wheelchair assessment. At that time, the recommendation was to modify the seat, but no timeframe for completion was noted, and evidence of its completion was not noted in an ISPA, in the OT/PT update that occurred a week later, or in the ISP, dated 8/10/17.
- On 7/24/17, Individual #91's IDT requested a consult from the OT related to eating/feeding. No evidence was submitted of an assessment, except for a note stating that staff were having to feed him since his fracture.
- On 12/28/17, Individual #187's PCP noted a gastric emptying delay. No evidence was found that the OT/PT completed a HOBE review or a new assessment. In addition, the IDT sent a request for a consult to the PT to determine if Individual #187's standing program could be increased. The PT completed a consult, but did not complete trials to address the question of increasing the standing program. The current program was scheduled to run two to three times per week, and the consultation recommendation was three times per week. In its comments on the draft report, the State disputed this finding. Specifically, the State indicated: "In response to the consult, PT observed client during her indirect therapy session, and stated that she was not a candidate for additional mobility training based on her current physical and cognitive status, but he continued her standing program 3x per week (increased from 2-3x per week) per the IDT request. Review of her PNMP Coordinator Program Data Sheets for the months of Oct-Dec 2017 reveal that attempts were made to provide standing program 3x per week." As indicated in the Monitoring Team's original findings, without trials (i.e., data) to support the decision, the PT could not reasonably respond to the IDT's request.

d. As noted above, Individual #304, and Individual #42 should have had comprehensive assessments, but did not. The following summarizes some of the problems noted for Individual #363's comprehensive assessment:

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: The assessment indicated that some prescribed medications might impact balance, but offered no further analysis;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings: Effectiveness statements were not backed by data;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services: The assessment identified OT and/or PT needs for which supports or services were not recommended, but clinical justification was not offered for not making such recommendations. Individual #363 had 29 injuries during the past nine months, with 12 resulting from

falls, but the assessors did not recommend therapy or services, and did not justify this approach; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need: As noted above, recommendations that should have been made to address the individual's needs were not.

On a positive note, Individual #363's assessment included:
- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths were used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living;
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments; and
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale).

e. The following summarizes some examples of concerns noted with regard to the required components of OT/PT updates:
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: For four of the six individuals, the updates provided limited discussion of the impact of medications on OT/PT supports, and/or failed to identify whether or not the individual experienced potential side effects;
- 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): As discussed above, during an observation on 6/22/17, the PT noted the need for further wheelchair assessment due to Individual #327's weight gain and poor position. It was not until 7/12/17 that Individual #327 was seen for the wheelchair assessment. At that time, the recommendation was to modify the seat, but no timeframe for completion was noted, and evidence of its completion was not noted in an ISPA, in the OT/PT update that occurred a week later, or in the ISP, dated 8/10/17;
- 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: For two individuals, the comparative analyses were incomplete and/or provided information that conflicted with other documentation;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: Analysis of effectiveness was not based on data, including findings from monitoring/assessments conducted throughout the year;
- 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: For five individuals reviewed, justification was not provided for not developing OT/PT supports to address identified needs; 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: As noted above, five updates did not include recommendations to address strategies, interventions, and programs necessary to meet individuals' needs.

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;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports; and
- 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.

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: Due to the fact that most ISPs reviewed did not provide descriptions of how the individual functioned from an OT/PT perspective, Indicator a will return to active oversight. The Monitoring Team will continue to review the remaining indicators as well.

#	Indicator	Overall Score	Individuals: 304	363	42	167	327	269	114	91	187
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	Due to the Center's sustained performance with this indicator, at the time of the last review, it moved to the category requiring less oversight. However, based on the Monitoring Team's review of ISPs for other indicators, most ISPs did not include a description of how the individual functions from an OT/PT perspective. Therefore, this indicator will return to active oversight.									
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	70% 7/10	1/2	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	43% 3/7	0/2	0/1	0/1	N/A	N/A	1/1	N/A	1/1	1/1

Comments: a. Most ISPs reviewed did not clearly describe the individuals' status related to ambulation, as well as their ability to complete activities of daily living.

b. Simply including a stock statement such as "Team reviewed and approved PNMP" did not provide evidence of what the IDT reviewed, revised, and/or approved.

c. and d. Examples of concerns noted included:

- For Individual #304, the update, dated 5/7/17, recommended therapy interventions, but they did not appear to begin until September 2017. No ISPAs were found to show IDT discussion and/or approval of the direct OT or PT programs.
- The assessment for Individual #363 recommended the possibility of him using a bathrobe when leaving the shower and then allowing him to dress in his bedroom so that he had extra time to focus on dressing and fastening his buttons (i.e., so as to not lose the skill). There was no evidence this was implemented. In addition, evidence was not found to show implementation of a helmet-wearing program, which if implemented would have required authorization as a restrictive measure. The assessment noted the need for a trial regarding knee pads, but no evidence was found to show whether or not the trial was completed or if it was, the result, and/or why the knee pads are no longer utilized.
- For Individual #42, evidence was not found that the ambulation program was initiated and implemented, except for the OT/PT assessment, which stated participation fluctuated, but offered no specific data.
- For Individual #363, no ISPA was found showing IDT discussion of the balance assessment.
- For Individual #42, no ISPA was found to discuss the PT's consult related to lower extremity weakness.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: In addition to ensuring individuals receive the right type of communication assessment (e.g., comprehensive assessment versus update, consultation, etc.), Center staff should make improvements to the quality of comprehensive assessments and updates. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
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.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	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.	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	56% 5/9	0/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1	0/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/6	0/1	0/1	0/1	0/1	N/A	0/1	N/A	N/A	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/2	N/A	N/A	N/A	N/A	0/1	N/A	N/A	0/1	N/A

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

- On 4/26/17, Individual #42 was readmitted to the Center, but the speech language pathologist (SLP) did not complete a screening or assessment until 9/1/17.
- Based on review of the PNMT assessment and QIDP notes, Individual #304 experienced a decline in cognitive skills and staff believed he was at the beginning stages of dementia. However, the SLP did not complete any additional assessment or consult that focused on this issue and/or identified methods to address dementia and its related effects.
- Reportedly, Individual #269 had a decline in expressive and receptive cognitive functioning. As a result, she should have had a comprehensive assessment, but only had an update.
- On 10/16/17, a PT consultation noted that Individual #187's dementia was worsening, and she was no longer able to perform one-step instructions. However, the SLP did not provide a consultation.

d. As discussed above, Individual #304 and Individual #269 should have had comprehensive assessments, but did not. The following

describe some of the concerns with the four assessments reviewed:

- The individual's preferences and strengths are used in the development of communication supports and services: Some assessments did not incorporate individuals' strengths into next steps to expand their communication skills. In other cases, preferences were not clearly connected to recommendations for communication supports;
- 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: The SLP concluded that Individual #187 had limited potential to expand her communication skills without providing sufficient data to support this finding. In Individual #167's assessment, the SLP relied on grids within the assessment to provide a description of her communication skills, resulting in a vague description, and limited connection to functional communication skills;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services: Assessments showed few trials of limited options for AAC and EC. Such trials did not consistently occur in functional environments, and/or were not linked to individuals' preferences;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated: For Individual #363, the assessment indicated that on 3/17/17, the SLP met face-to-face with the Behavior Support Specialist regarding the replacement behavior, and the need to switch over to use of a sign for coffee versus a symbol. However, the assessment did not provide a description of the result of that meeting; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Given that assessments of individuals' communication were incomplete, it was unclear whether or not the assessments included a full set of recommendations to address individuals' strengths, preferences, and needs. In addition, although assessments included recommendations for communication strategies, they did not offer recommendations for integrating them into other goals or programs.

On a positive note, all four assessments provided:

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

e. The following provide examples of concerns noted with regard to the required components for the two updates reviewed:

- The individual's preferences and strengths are used in the development of communication supports and services: Although specific strengths and preferences were identified that could have been used to expand the individuals' communication skills, the updates did not incorporate them;
- 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, they lacked discussion of whether such side effects had been noted for the individual being assessed;

- The effectiveness of current supports, including monitoring findings: The assessments did not include monitoring findings, and/or include input from direct support professionals on the effectiveness of the individuals' communication dictionaries;
- Assessment of communication needs (including AAC, 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: Assessments showed few trials of limited options for AAC and EC. Such trials did not consistently occur in functional environments, and/or were not linked to individuals' preferences, including preferred staff; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Given that assessments of individuals' communication were incomplete, it was unclear whether or not the assessments included a full set of recommendations to address individuals' strengths, preferences, and needs. In addition, although assessments included recommendations for communication strategies, they did not offer recommendations for integrating them into other goals or programs.

On a positive note, the updates did sufficiently address:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication; and
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills.

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: For most individuals reviewed, ISPs described how they communicate and how others should communicate with them. It was positive that ISPs/ISPAs reviewed included the strategies, interventions, and programs that communication assessments recommended. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 304	363	42	167	327	269	114	91	187
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.	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/5	0/1	0/1	N/A	N/A	0/1	0/1	N/A	0/1	N/A
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs)	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	recommended in the assessment.										
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: a. Individual #363's ISP was not updated when she returned from a failed community transition.

c. It was positive that ISPs/ISPAs reviewed included the strategies, interventions, and programs that communication assessments recommended.

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: It was good to see that all individuals had SAPs. Less than half of the SAPs, however, met criteria for being assessment-based, practical, functional, and meaningful. This was about the same percentage as at the last review. On the positive, however, reliable and valid data were available for a number of these SAPs that showed individual performance. This improvement was good to see. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 177	218	267	97	304	40	363	135	149
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.	44% 12/27	0/3	3/3	0/3	1/3	3/3	0/3	1/3	1/3	3/3
4	SAPs are practical, functional, and meaningful.	30% 8/27	0/3	1/3	0/3	2/3	0/3	0/3	2/3	1/3	2/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	44% 12/27	3/3	1/3	0/3	2/3	0/3	1/3	0/3	2/3	3/3

Comments:

1. All of the individuals had Skill Acquisition Plans (SAPs). Three SAPs were reviewed for each individual for a total of 27 SAPs.

2. All of the SAPs that were reviewed were measurable.

3. Twelve of the 27 SAPs were based on assessment results. These included all of the SAPs for Individual #218, Individual #304, and Individual #149, and one SAP each for Individual #97, Individual #363, and Individual #135 for which baseline had been assessed.

In all other cases, either the Functional Skills Assessment indicated that the individual could perform the basic components of the skill independently or at the level of prompting identified in the objective (e.g., Individual #177 - all three SAPs; Individual #267 - money management and model car building; Individual #97 - use of a locked box and a ledger; Individual #40 - computer and vending machine use), or baseline was not assessed prior to introducing the SAP. SAPs developed more recently tended to include baseline assessment.

4. Eight of the 27 SAPs were considered practical, functional, or meaningful. These were the following:
   - Individual #218 learning to make a fishing leader because fishing was an identified preference.
   - Although she had the basic components for completing these skills, Individual #97's learning all about her medications and learning to track her money (even though assessment suggested she had the basic components to allow for quick skill acquisition).
   - Individual #363 learning to make coffee and being introduced to work by learning to pot plants.
   - Individual #135 learning about his medication; and Individual #149 learning to gather his work materials and play a DVD.

All others were considered impractical, nonfunctional, or meaningless for the following reasons:
   - Assessments indicated the individual already could perform the task independently or with the identified level of prompting.
   - The SAP was based on behavior from the past that may no longer be applicable (Individual #267 - STOP).
   - The SAP did not teach new skills and would be better addressed in counseling (Individual #40 and Individual #135 - anger management; Individual #135 - borrowing versus stealing).
   - The SAP addressed prerequisite skills that are typically acquired in elementary school and are not the end goal for the adult (Individual #177 - coin value).
   - The SAP involved developing an inside leisure skill when the individual clearly preferred being outside (Individual #363-bowling).
   - The SAP involved such a delay in reinforcement that motivation to participate would likely be difficult to maintain (Individual #149 - planning a community outing).

5. There was evidence that data reliability had been assessed at least once in the past six months for 12 of the 27 SAPs.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.

Summary: The three assessments were current and in place for individuals and with sustained high performance, indicator 10 might be moved to the category of requiring less oversight after the next review. Some attention should be paid to the singular requirement for indicator 12. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 177	218	267	97	304	40	363	135	149
10	The individual has a current FSA, PSI, and vocational assessment.	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

		9/9									
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	56% 5/9	0/1	0/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	44% 4/9	1/1	0/1	0/1	0/1	1/1	1/1	0/1	1/1	0/1

Comments:
10. All of the individuals had current a Functional Skills Assessment (FSA), Preferences and Strengths Inventory (PSI), and vocational assessment.

11. As indicated by the QIDP tracking data and the dates on the documents, these assessments were available to the IDT at least 10 days prior to the ISP meetings for Individual #267, Individual #304, Individual #40, Individual #135, and Individual #149.

12. Both the FSA and vocational assessment completed for Individual #177, Individual #304, Individual #40, and Individual #135 included at least one SAP recommendation. For four of the remaining five individuals, recommendations were not provided in the vocational assessment. In Individual #267's case, no SAP recommendations were provided.

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

This domain contains 40 outcomes and 176 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Twenty-five of these indicators, in restraints, psychiatry, medical, dental, and OT/PT, were moved to, or were already in, the category of requiring less oversight after the last review. For this review, five other indicators were added to this category, in psychiatry, pharmacy, and dental. In medical, however, two indicators were 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, integrated progress reports with data and analysis of the data often were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

The individual's psychiatric clinic, as observed, included the standard components.

In behavioral health services, PBSPs were now being written by staff with proper credentials and training. The progress notes for most individuals commented on the individual's progress. The graphs were not considered useful for data-based decisions for any of the individuals.

Acute Illnesses/Occurrences

Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected.

It was positive that at the time individuals were admitted to the Infirmary or prior to hospitalizations, providers generally conducted thorough assessments, and provided needed care. However, particularly for acute illnesses/occurrences treated at the Center, concerns were identified with regard to a lack of PCP follow-up, and/or documentation of basic follow-up. Based on the review of hospitalization and ED visit documentation for other indicators, providers and/or nurses did not consistently document contact with the hospital staff to provide relevant clinical information. This regression also was discussed in the previous report. As a result, the related indicator will return to active oversight.

The quality of the content of the reviews that occurred after more than three restraints in any rolling 30-day period were not yet at criteria, especially regarding the content requirements of indicators 20 to 23 (regarding a review of different variables that might be playing a role in the need for such frequent usage).

In psychiatry, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals with one exception at this review.

Implementation of Plans

In behavioral health services, without data that are trusted and reliable, a true determination of progress cannot be determined. Even so, based on the data that were available, when many individuals were not making progress, no modifications were made to their programs.

Corpus Christi SSLC was not ensuring that staff (regular and float) were trained in PBSPs or that staff had all of the proper information regarding PBSPs. The new Director of Behavioral Health Services, however, had a plan to ensure that this would be corrected.

The Center had not yet addressed timely documentation of data, therefore, the data collection systems were considered inadequate for measuring individuals' target or replacement behaviors.

As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs for nursing supports due to 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.

On a positive note, based on medication observations, 1) nurses administered medications according to the nine rights; 2) nurses followed individuals' PNMPs during medication pass; and 3) nurses adhered to infection control procedures while administering medications. It also was positive that some individuals who were at high risk for aspiration pneumonia or respiratory issues had IHCPs that defined the need to assess lung sounds on an individualized frequency and that data showed nurses completed these assessments

For a number of individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were not completed, and/or the PCP had not identified the necessary treatment(s), interventions, and strategies, as appropriate.

Based on the review of consultation documentation for other indicators, PCPs did not consistently document agreement or not with the recommendations in consultation reports. As a result, the related indicator will return to active oversight. The Center needs to focus on ensuring PCPs complete timely reviews of consultation reports, write complete IPNs for consultation reports, and refer consultation recommendations to IDTs, when appropriate, and that IDTs review the recommendations and document their decisions and plans in ISPAs.

It was good to see that for individuals reviewed with medium or high dental caries risk, the Dental Department provided them with at least two fluoride applications per year. For the previous two reviews, this was a consistent finding, so the related indicator will move to the category of less oversight. This results in the entire outcome related to the provision of routine dental treatment moving to less oversight.

Based on the individuals reviewed, the Clinical Pharmacist's Quarterly Drug Regimen Reviews (QDRRs) were timely. Because this has been a consistent finding for a few reviews, the related indicator will be placed in the category requiring less oversight. The Center should continue its efforts to improve the quality of the QDRRs. Since the last review, improvement was noted with regard to the prescribers' timely review of QDRRs. Prescribers also followed through on agreed-upon recommendations, which was good to see.

Adaptive equipment was generally clean, and improvement was noted with regard to proper fit.

Based on observations, there were still numerous instances (40% of 35 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. Of note, though, based on past performance, significant improvement was noted in staff's adherence to PNMPs and Dining Plans. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should continue to determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
Summary: The quality of the content of the reviews that occurred after more than three restraints in any rolling 30-day period were not yet at criteria, especially regarding the content requirements of indicators 20-23. Overall, some indicators showed a slight increase, some a slight decrease, but performance for this outcome had not improved. This set of indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	177	40	135	149					

		Score									
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	75% 3/4	1/1	0/1	1/1	1/1					
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 4/4	1/1	1/1	1/1	1/1					
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	25% 1/4	1/1	0/1	0/1	0/1					
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	50% 2/4	1/1	0/1	1/1	0/1					
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	0% 0/4	0/1	0/1	0/1	0/1					
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	0% 0/4	0/1	0/1	0/1	0/1					
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	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).	67% 2/3	N/A	1/1	1/1	0/1					
26	The PBSP was complete.	N/A	N/A	N/A	N/A	N/A					
27	The crisis intervention plan was complete.	100% 3/3	N/A	1/1	1/1	1/1					
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity	0% 0/3	N/A	0/1	0/1	0/1					

	data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.										
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.	33% 1/3	N/A	0/1	1/1	0/1					

Comments:

18-19. Between the beginning of June 2017 and the end of November 2017, four individuals were restrained more than three times in any rolling 30-day period. This occurred once for Individual #177, twice for Individual #40, three times for Individual #135, and four times for Individual #149. There was evidence that the IDTs met a sufficient number of times to address restraint, timely (i.e., within 10 days) review of more than three restraints in a rolling 30-day period occurred for Individual #177, Individual #135, and Individual #149.

20-23. Structured review of all of the potential variables contributing to repeated restraint did not occur for the individuals. Specific feedback for each individual is provided below.

- Individual #177: The IDT reviewed his psychiatric diagnosis resulting in medication adjustments. Biological issues were also reviewed which led to the completion of lab tests. When elevated temperatures, both inside and outside the home were identified, efforts were made to reduce the inside temperatures with portable air conditioning units.
- Individual #40: Restraints applied in July 2017 and August 2017 were reviewed at an ISPA meeting in September 2017. Several recommendations were made including the following: ensure that only the minimum number of necessary staff are present during restraint; due to the reported ineffectiveness of PMAB techniques, consider requesting modifications; teach him to use de-escalation techniques and self-management skills to use when waiting; complete a scatterplot to analyze times of day when aggression and resulting restraint occur; and complete a Root Cause Analysis. There was no evidence that these recommendations had been implemented. Additionally, he had a communication book due to his poor communication skills, but this was not being used. There were no plans to address this issue. Further, he often became upset when he wanted back an item that he had traded. There were no plans to address this matter.
- Individual #135: His psychiatric diagnosis was reviewed and medications were adjusted. Additionally, the team made changes to his daily schedule based upon his expressed preference. Areas of concern included difficulties with a female peer and recognition of his history of trauma. Neither of these matters were addressed. Further, his PBSP did not address self-injurious behavior, although a crisis as defined in his CIP included the possibility of him causing harm to himself. Finally, the counseling that had been provided was not formalized. At the time of the on-site visit, he was not participating in this service.
- Individual #149: When reviewing ISPA minutes, variables that were identified as potentially resulting in restraint included the following: his autism diagnosis, his poor communication skills, his heightened activity levels following a visit with family, and his change in behavior during rain storms. There were no clear plans to address any of these variables other than a mention that habilitation therapies was involved and he would be allowed to sit on the patio during rainstorms. There was limited involvement of behavioral health services. Although repeated restraint occurred as early as June 2017 and continued until November 2017, no functional behavior assessment had been completed by the time of the on-site visit by the monitoring team. He was still being supported by an expired interim PBSP. This plan did not include enhanced communication strategies, directions for staff to get acquainted with him when taking over his level of supervision, or his spending time on the patio during rainstorms. Further, it was noted in November 2017 that due to repeated self-injurious behavior, he had developed

significant scar tissue on his chin due to repeated application of sutures. As there were concerns that this medical intervention would become increasingly difficult to perform, a helmet was recommended. Again, this was suggested prior to the completion of a thorough functional behavior assessment, without a plan for implementation, and prior to obtaining necessary consents.

24. Individual #40 and Individual #135 had a current PBSP. Individual #177 had a Psychiatric Support Plan and Individual #149 had an interim PBSP that had expired by the last occurrence of more than three restraints in a rolling 30-day period.

25. Similarly, Individual #40 and Individual #135 had a CIP that was in place at the time of their repeated restraints. Individual #177's team had considered developing a CIP, but determined that this was not needed due to the limited use of restraint. Although first recommended in July 2017, Individual #149's CIP was not implemented until December 2017.

26. PBSPs are reviewed in detail in the Psychology/Behavioral Health sections of this report.

27. The three CIPs were considered complete. Staff are advised to ensure that a crisis is clearly defined to ensure that staff recognize the difference between a situation that requires PBSP intervention versus that which requires a restraint. Staff are also advised to review and possibly update the CIP for Individual #40 because this was first developed in 2012. Lastly, consideration should be given to adding self-injury to Individual #135's PBSP because this is described as a potential crisis in his CIP.

28. Treatment integrity had not been regularly assessed per facility policy for any of the individuals who had a PBSP.

29. There was evidence that the IDT had reviewed and revised the PBSP for Individual #135.

Note: Two additional points should be made regarding restraint. First, the staff are commended for their continued efforts to fade the protective mechanical restraint (mittens) that were being used with Individual #9. The graph that was provided reflected an ascending trend for time without mittens. As reported at the IMRT meeting held during the onsite visit, the mittens had been faded completely. Second, one document requested prior to the onsite visit was a list of individuals for whom restraint has been eliminated over the previous nine months. The facility provided a list of five individuals. However, when reviewing all documents, it became evident that Individual #191 was restrained twice in June 2017, Individual #199 was restrained once in July 2017, and daily use of a protective mechanical restraint for self-injurious behavior continued for Individual #9.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
Summary: Reiss screens were done for all individuals who needed them for this review and for the previous three reviews, too, with one exception. As a result of this sustained high performance, these three indicators will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall	267	327	269	91	187				

		Score									
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.	100% 1/1	N/A	N/A	N/A	N/A	1/1				
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	100% 1/1	N/A	N/A	N/A	N/A	1/1				

Comments:
1. Of the 16 individuals in the combined review groups, five were not followed by the psychiatric team. All of these individuals had undergone screening with the Reiss and four received a score that was below the clinical cutoff.

2-3. One of the five, Individual #187, had a Reiss score of 15 dated 7/15/17 and a CPE dated 7/27/17 was performed in response to this. The clinical record noted that the Reiss was performed as part of a psychiatric consult that had been requested in response to a change in status. Specifically, she had been noted to be crying more often as well as related behavioral changes.

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

Summary: The Monitoring Team acknowledges that, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals (with one exception at this review). These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 177	218	267	97	304	40	363	135	149
8	The individual is making progress and/or maintaining stability.	0% 0/8	0/1	0/1	N/A	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% 0/8	0/1	0/1	N/A	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.	86% 6/7	1/1	1/1	N/A	N/A	0/1	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 6/6	1/1	1/1	N/A	N/A	N/A	1/1	1/1	1/1	1/1

Comments:
8. It was not possible to determine if the individual was making progress because the existing goals 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 were not available, the review of the records indicated that when an individual's clinical status was deteriorating, emergency/interim consults would be made 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 #177, Individual #218, Individual #40, Individual #363, Individual #135, and Individual #149.

The clinical record for Individual #304 did not indicate any recognition of the problems that were identified during the onsite Monitoring Teams' review regarding dementia. Discussion of this issue with the psychiatric team during the onsite review indicated that they were not made aware of many of these issues. Mechanisms should be in place to ensure that the psychiatric team is aware of all relevant changes in an individual's status.

11. The records of the six individuals identified above also indicated that the recommendations to change 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: Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	218	267	97	304	40	363	135	149
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.	88% 7/8	1/1	1/1	N/A	0/1	1/1	1/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	75% 6/8	1/1	1/1	N/A		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 #97 for whom there was insufficient discussion of this topic in both the Behavioral Health Assessment and the Functional Assessment.

24. Previously the PBSP contained a reference to the discussion between the psychiatrist and the behavioral specialist concerning the development of the PBSP, including the date of the discussion, which usually occurred in context of a psychiatric clinical review. The format for this documentation changed in June 2017 and, thus, was not available for Individual #218 and Individual #40. In order to compensate for this, the psychiatric team began to have a member of the team attend the meeting of the Behavioral Support Committee (BSC) during which the PBSP is reviewed and approved. The attendance sheets for the meetings during which the PBSP plans for Individual #218 and Individual #40 were reviewed and did contain the signature of the psychiatric assistant, but this individual is not a licensed clinician. Individual #177 and Individual #304 had PSPs rather than PBSPs and thus this observation was not relevant for them. The psychiatrist's signature was present on the PSPs.

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: 25-27. The psychiatry department monitored the neurological status of the individuals they followed who were also prescribed anticonvulsant medications by the neurologist, even though those medications were not for dual use. In the interval since the prior review, they also started a joint Neuro-Psychiatry review committee to routinely discuss the individuals who were prescribed anticonvulsant medications in addition to psychotropic medication.											

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: With sustained high performance, indicator 35 might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	218	267	97	304	40	363	135	149
33	Quarterly reviews were completed quarterly.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
34	Quarterly reviews contained required content.										
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
Comments: 35. During the onsite review, the Monitoring Team observed the psychiatric clinic for Individual #304 on 1/23/18. 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/AIMS was completed as required based upon the	Due to the Center's sustained performance, this indicator was moved to the									

	medication received.	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 needed.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?										
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?										
Comments:											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary:			Individuals:								
#	Indicator	Overall Score	177	218	267	97	304	40	363	135	149
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 8/8	1/1	1/1	N/A	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% 8/8	1/1	1/1	N/A	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.	75% 6/8	1/1	1/1	N/A	0/1	1/1	1/1	1/1	1/1	0/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:

40. There were three individuals that were prescribed psychotropic medications that were above the usually accepted FDA range. These individuals were Individual #177 (Zyprexa 30 mg/day), Individual #363 (Zyprexa 40mg/day), and Individual #135 (Tenex 6 mg/day). An onsite document request indicated that there were 14 individuals at Corpus Christi SSLC that were prescribed psychotropic medications in dosages above the usually accepted FDA range.

41. Although these three individuals were prescribed psychotropic medications that were above the usually accepted range, there was no indication that the intent was to produce sedation, nor any indication that they were sedated. The higher dosage range was

referenced and discussed in the quarterly review documentation for each individual.

42. There was a treatment program in the record of six individuals. Individual #97 and Individual #149 had interim PBSPs, which had expired.

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: Without data that are trusted and reliable, a true determination of progress cannot be determined (indicator 6). Even so, based on the data that were available, one of the individuals met one objective, but it was never updated. Another four individuals were not making progress, but no modifications were made to their programs (or rationale as to why not). These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	218	267	97	304	40	363	135	149
6	The individual is making expected progress	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A

8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	0% 0/4	N/A	N/A	N/A	N/A	N/A	0/1	0/1	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:

6. Although the graphs included in the behavioral health progress notes for Individual #177, Individual #218, Individual #267, Individual #97, and Individual #304 indicated stable or descending trends for targeted problem behaviors, this indicator was rated as zero for all nine individuals due to the lack of reliable data (see indicator 5).

7. Based on the data provided, Individual #267 had met his objective for inappropriate sexual behavior. The objective remained the same from one year to the next.

8-9. Graphs indicated that Individual #40, Individual #363, Individual #135, and Individual #149 were not making progress on their PSBPs. There was no evidence that corrective actions had been identified or implemented for these individuals.

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

Summary: Corpus Christi SSLC was not ensuring that staff were trained in PBSPs or that staff had all of the proper information regarding PBSPs. The new director of behavioral health services, however, had a plan to ensure this was corrected. Float (substitute) staff summaries had incorrect information, further compounding the already difficult position that float staff find themselves in when working with individuals whom they do not know very well. On the positive, PBSPs were now being written by individuals with proper credentials and training. With sustained high performance, this indicator (18) might be moved to the category of requiring less oversight after the next review. These three indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	177	218	267	97	304	40	363	135	149
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.	14% 1/7	N/A	0/1	0/1	0/1	N/A	1/1	0/1	0/1	0/1
17	There was a PBSP summary for float staff.	29% 2/7	N/A	1/1	0/1	0/1	N/A	1/1	0/1	0/1	0/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1

Comments:

16. Documentation provided by the facility indicated that there was one individual, Individual #40, for whom over 80% of his assigned staff had been trained on his PBSP. There was no evidence that training had occurred across home, workplace, and classroom

environments. The new Director of Behavioral Health Services indicated that one of her goals was to ensure training of 80% or better of staff in all environments prior to PBSP implementation.

17. Two of the seven individuals (Individual #218, Individual #40) had PBSP summaries that matched their PBSPs. Individual #267, Individual #97, and Individual #149 did not have plan summaries. While summaries had been developed for Individual #363 and Individual #135, these did not match their PBSPs. Specifically, Individual #363's summary did not include his target behavior of self-injury or interventions outlined in his plan. Individual #135's summary did not identify his problem behaviors and noted that he should be offered preferred activities if he refuses class; the PBSP indicated he should be given a choice of tasks following refusals. Staff are advised to date all PBSP summaries to ensure these are current.

18. All functional assessments and PBSPs were written by a BCBA or a behavioral health specialist who was enrolled or had completed coursework.

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

Summary: Three of the five indicators scored better than at the last review (19, 21, 22). Attention to the quality, and thereby usefulness, of the graphic summaries of targeted and replacement behaviors is needed. Peer reviews were occurring, but not quite at the required frequency. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 177	218	267	97	304	40	363	135	149
19	The individual's progress note comments on the progress of the individual.	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1
20	The graphs are useful for making data based treatment decisions.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	67% 2/3	1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	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. The progress notes for seven of the nine individuals commented on the individual's progress. The exceptions were Individual #97 and Individual #363. Individual #97's progress notes did not report on her interim PBSP, rather these referenced a PSP. Individual

#363's progress notes did not address two of his behaviors targeted for reduction (elopement and rectal digging). For Individual #97 and Individual #149, progress notes were consistently completed within the identified time frame (i.e., 30 days).

20. The graphs were not considered useful for data-based decisions for any of the individuals. While all of the graphs were simple and easy to interpret, there were problems with the use of phase change lines and/or appropriate labels. For Individual #177, Individual #218, Individual #267, Individual #40, Individual #135, and Individual #149, there were no phase change lines indicating introduction of the individual's PSP or PBSP. All of the graphs were labeled frequency, although for several individuals (Individual #177, Individual #218, Individual #135), operational definitions of target behaviors indicated data were collected on episodes.

21. An observation was conducted at the psychiatric clinic for one individual, Individual #304. The behavior health specialist reviewed data, including measures for the month in which the clinic was held.

22. For two of three individuals (Individual #177, Individual #40) reviewed by the internal and/or external peer review committees, there was evidence of follow-up to the recommendations made. The exception was Individual #149. The minutes from a meeting of the internal peer review committee indicated his interim PBSP was extended pending consent from his guardian. As documents provided by the facility indicated that consent had been obtained in June 2017, this did not appear to be relevant. Further, this was not a valid reason for delaying the completion of a functional behavior assessment resulting in a new PBSP.

23. The facility reported that over a six-month period, the internal peer review committee met three times each month in five of six months and the external peer review committee met monthly in five of six months. That is, both were slightly below criteria for this indicator.

Outcome 8 – Data are collected correctly and reliably.											
Summary: Various aspects of data collection were not being addressed, competing with the Center's ability to assess progress and make treatment decisions (e.g., indicators 5, 19, 20).			Individuals:								
#	Indicator	Overall Score	177	218	267	97	304	40	363	135	149
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	0% 0/7	N/A	0/1	0/1	0/1	N/A	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.	0% 0/7	N/A	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/7	N/A	0/1	0/1	0/1	N/A	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).	0% 0/7	N/A	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0%	N/A	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1

		0/7									

Comments:
26-27. The facility had not yet addressed timely documentation of data, therefore, the data collection systems were considered inadequate for measuring individuals' target or replacement behaviors. Additional concerns were raised for individuals whose target behaviors were defined as episodes, separated by two to five minutes without problem behavior, but whose progress referenced behavior frequency.

28-29. As noted above, at the time of the onsite visit, there was no established system for assessing data timeliness. Measures of IOA and treatment integrity were expected to be completed at a minimum of once monthly for PBSPs and once every three months for PSPs. Expected levels were 80% or better. Currently, treatment integrity can be assessed via staff interview. As discussed with the Director of Behavioral Health Services, observation of staff working or interacting with the individual is the preferred method for assessing the fidelity of plan implementation.

30. Due to the identified problems with assessment of data timeliness, this indicator was not met for any of the individuals. It should be noted that monthly IOA and treatment integrity measures were reported for both Individual #267 and Individual #363, however, in six and three months respectively, no target behaviors were observed.

Medical

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

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

#	Indicator	Overall Score	Individuals: 304	363	42	167	327	269	114	91	187
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	6% 1/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #304 –

seizures, and weight; Individual #363 – osteoporosis, and falls; Individual #42 – osteoporosis, and falls; Individual #167 – GI problems, and constipation/bowel obstruction; Individual #327 – respiratory compromise, and GI problems; Individual #269 – seizures, and GI problems; Individual #114 – cardiac disease, and other: cancer; Individual #91 – UTIs, and seizures; and Individual #187 – diabetes, and skin integrity).

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #269 – seizures.

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

Outcome 4 – Individuals receive preventative care.

Summary: With regard to preventative care, the overall scores for this review generally showed improvement in comparison with last two reviews. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators until the Center's quality assurance/ improvement mechanisms related to preventative care can be assessed, and are deemed to meet the requirements of the Settlement Agreement.

Individuals:

#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
a.	Individual receives timely preventative care:										
	i. Immunizations	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
	iii. Breast cancer screening	100% 5/5	N/A	N/A	1/1	1/1	1/1	1/1	N/A	N/A	1/1
	iv. Vision screen	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
	v. Hearing screen	67% 6/9	1/1	1/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1
	vi. Osteoporosis	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	vii. Cervical cancer screening	80% 4/5	N/A	N/A	1/1	1/1	0/1	1/1	N/A	N/A	1/1
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.	67% 2/3	N/A	N/A	0/1	1/1	1/1	N/A	N/A	N/A	N/A

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

- For Individual #42, the Center submitted a statement indicating: "unable to locate a hearing screening."
- Documentation submitted for Individual #327 indicated that the Center was unable to locate an ophthalmology report, audiology report, and pap smear report.
- For Individual #114, the Center submitted a statement indicating: "unable to locate a hearing screening."

b. On a positive note, Individual #167's PCP reviewed and addressed concerns related to polypharmacy, and made changes to considerably reduce the anticholinergic burden.

In response to a recommendation from the Pharmacist, Individual #42's PCP ordered monitoring of metabolic syndrome and antipsychotic use, which was good to see. However, one recommendation, from the 7/26/17 QDRR, related to measuring the abdominal circumference. It was completed on 8/8/17, but then was not listed in the AMA as part of the PCP review of the QDRR contents. Also, the AMA, dated 9/5/17, did not address the anticholinergic burden mentioned in the QDRR.

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.

#	Indicator	Overall Score	Individuals: 304	363	42	167	327	269	114	91	187
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.	33% 1/3	N/A	N/A	N/A	N/A	0/1	N/A	1/1	N/A	0/1

Comments: a. Based on the documentation provided, neither Individual #327 nor Individual #187 had a qualifying condition for a DNR Order that the Center could execute according to State Office policy. In its comments on the draft report, the State disputed these findings, and indicated that the individuals met the State Office policy. The Monitor has not changed the original findings, and provides the additional information to clarify, as well as a request that State Office review all DNR Orders at the Center:

- On 2/9/11, the Ethics Committee met and based Individual #327's DNR status on diagnoses current at the time: fever, dehydration, and respiratory failure with pneumonia. At some point, these issues resolved, However, based on the documentation provided, the qualifying condition for DNR has not been revisited in seven years. The State referenced an ISPA meeting, held on 12/14/17, but although this was in the date range of the documents requested, no ISPA with that date was

included in the records submitted.

- For Individual #187, the Center stated "not applicable" in response to the Monitoring Team's request for: "Clinical justification for Do Not Resuscitate Order, if applicable, including, as applicable, the DNR form, and any relevant documentation of discussions with State Office, including the legal department." However, based on the Monitoring Team's review of other documentation, although Individual #187 had several significant diagnoses, and was clinically complex, she appeared to have stabilized in many areas of her health. She had made progress in healing of skin issues. She remained on dialysis. Habilitation therapy staff continued to work with her. With progress in these areas and continuing recovery, it was difficult to align a qualifying diagnosis for DNR status consistent with State Office requirements. In its comments, the State indicated the qualifying condition was a progressive neuro-cognitive decline. Given the often prolonged downhill course of many neurological conditions, State Office should work with the Centers to determine at what point on the spectrum of decline an individual would qualify for terminal status to ensure that the decisions are consistent with State Office guidelines.

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

Summary: Particularly for acute illnesses/occurrences treated at the Center, concerns were identified with regard to a lack of PCP follow-up, and/or documentation of follow-up. Based on the review of hospitalization and ED visit documentation for other indicators, providers and/or nurses did not consistently document contact with the hospital staff to provide relevant clinical information. This regression also was discussed in the previous report. As a result, Indicator f will return to active oversight. The Monitoring Team will continue to review the remaining indicators.

#	Indicator	Overall Score	Individuals: 304	363	42	167	327	269	114	91	187
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.	23% 3/13	0/2	0/2	N/A	N/A	0/2	1/2	0/2	0/1	2/2
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	50% 6/12	0/2	1/2			1/2	1/2	1/2	N/A	2/2
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	100% 7/7	1/1	N/A	1/1	N/A	1/1	1/1	N/A	1/1	2/2

	disposition.										
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	83% 5/6	N/A		1/1		1/1	1/1		1/1	1/2
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.	100% 4/4	1/1		N/A		N/A	N/A		1/1	2/2
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	Due to the Center's sustained performance with this indicator, it was moved to the category requiring less oversight. However, concerns were noted during the previous review, and the Center was told that if such issues were not corrected by the next review, this indicator would return to active oversight. Problems were again noted during this review. Therefore, this indicator will return to active oversight.									
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	100% 3/3	N/A		N/A		N/A	N/A		1/1	2/2
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	100% 6/6	1/1		1/1		1/1	N/A		1/1	2/2

Comments: a. For seven of the nine individuals reviewed, the Monitoring Team reviewed 13 acute illnesses addressed at the Center, including: Individual #304 (abrasion to the arm on 6/9/17, and hypoxia on 7/18/17), Individual #363 (fracture of left index finger on 7/21/17, and fall with rib fracture on 6/17/17), Individual #327 (fever on 6/8/17, and pneumonia on 7/24/17), Individual #269 (hypertension and meal refusal on 8/10/17, and bruising of chest on 10/31/17), Individual #114 (chest pain on 7/5/17, and ulcer to right forearm on 8/21/17), Individual #91 (cough on 11/3/17), and Individual #187 (agitation on 7/1/17, and cloudy urine on 9/9/17).

PCPs assessed the following acute issues according to accepted clinical practice: Individual #269 (bruising of chest on 10/31/17), and Individual #187 (agitation on 7/1/17, and cloudy urine on 9/9/17). For the remainder, what was missing was the source of the information.

b. For the following acute illnesses/occurrences, the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized: Individual #363 (fall with rib fracture on 6/17/17), Individual #327 (pneumonia on 7/24/17), Individual #269 (bruising of chest on 10/31/17), Individual #114 (ulcer to right forearm on 8/21/17), and Individual #187 (agitation on 7/1/17, and cloudy urine on 9/9/17).

The following provide examples of concerns noted:

- For Individual #304, on 6/7/17 and 6/8/17, nursing IPNs noted abrasions to his arms. On 6/9/17, the PCP saw him, ordered trimming of his nails, and indicated follow-up would occur in a week. On 6/25/17, the abrasions remained on Individual #304's arm, but the PCP had not conducted follow-up in a week, or at all.

- On 7/18/17, Individual #304 had an episode of hypoxia. The PCP saw him, and noted a little cough, but no respiratory distress or fever. The PCP ordered a chest x-ray, a complete blood count (CBC), and comprehensive metabolic panel (CMP). On 7/20/17, the PCP saw Individual #304, noted the hypoxia was resolved, but ordered an electrocardiogram (EKG) due to intermittent tachycardia. Based on the documentation submitted, the PCP did not review the EKG or lab results.

- On 7/21/17, Individual #363's PCP diagnosed a left index finger fracture with moderate swelling, warm skin intact, and decreased motion. The plan was to continue Tylenol, monitor closely, and apply a topical antibiotic ointment. On 7/27/17, a follow-up x-ray of left index finger showed "increased displacement of fragments." Individual #363 was scheduled for an appointment with the orthopedist on 8/1/17. The nurse attempted to apply a splint with a tongue depressor, but the individual tore it off as soon as it was placed. After attempting to apply an aluminum bivalve finger splint and Coban wrap, Habilitation Therapy staff decided to leave it alone, with the reasoning that he could hurt himself more with a splint. No additional PCP notes were found related to this acute occurrence.

- On 6/7/17 at 11:04 p.m., nursing staff wrote an IPN and referred Individual #327 to the PCP. Based on an IPN on 6/8/17 at 10:02 a.m., the PCP made no findings upon the exam of the individual. The PCP ordered a CBC, a CMP, and a chest x-ray. The PCP noted that the individual was prescribed daily nitrofurantoin for recurrent urinary tract infections (UTIs). On 6/9/17 at 7:51 p.m., nursing staff notified the PCP that the individual had an elevated temperature. The PCP gave no new orders. Nursing staff, gave the individual extra fluids through the G-tube. On 6/9/17 at 9:38 p.m., the PCP ordered Zithromax and Ceftin as follow-up to pneumonia. However, the submitted documentation did not include a follow-up PCP IPN to document review of the lab tests and ordered chest x-ray, to explain the reason for the antibiotics, etc.

- Although no nursing notes were found addressing Individual #269's hypertension on 8/10/17, the PCP wrote a note that included blood pressure readings. The plan was to add Lisinopril daily, to speak to the IDT and Registered Dietician (RD), and to monitor the individual's blood pressure weekly. As of 9/13/17, no PCP follow-up was found.

- On 7/5/17 at 7:45 a.m., a nursing IPN indicated that Individual #114 complained of chest pain. On 7/5/17 at 9:57 a.m., a PCP IPN indicated that the PCP ordered a chest x-ray for tenderness to the ribs on the right lower chest. The x-ray showed a mildly patchy density in the right lower lobe compatible with pneumonia. The PCP concluded that the individual had a non-cardiac right sided chest tenderness mostly due to smoking. The PCP stated: "Though x-ray is suggestive of pneumonia, he is afebrile, walking around. I will not start antibiotics as clinically I do not think it is required at this time… will follow up." However, the PCP documented no follow-up related to this issue to ensure it had resolved.

c. For six of the nine individuals reviewed, the Monitoring Team reviewed seven acute illnesses/occurrences that required Infirmary

admission, hospitalization, or an ED visit, including those for Individual #304 (ED visit for unresponsiveness on 6/27/17), Individual #42 (Infirmary admission for UTI on 10/6/17), Individual #327 (Infirmary admission for fever and thick sputum on 8/19/17), Individual #269 (Infirmary admission for refusal to eat and get out of bed), Individual #91 (hospitalization for dislocated left shoulder on 7/21/17), and Individual #187 (hospitalization for sepsis on 6/5/17, and hospitalization for renal failure/hyperkalemia).

d. The PCP for Individual #187 did not write a note indicating the reason for the transfer to the hospital for sepsis on 6/5/17.

f. Although this indicator previously moved to less oversight, based on review of these acute events for the other indicators, for two of the four transfers out of the Center that the Monitoring Team reviewed, no documentation was found to show that a provider or nurse contacted the hospital and provided necessary clinical information about the individual. Those for which this did not occur were for Individual #304 (ED visit for unresponsiveness on 6/27/17), and Individual #187 (hospitalization for sepsis on 6/5/17). In the last report, the Monitoring Team notified the Center that if it did not correct these deficiencies, this indicator would return to active oversight. Due to the continuing issues noted during this review, Indicator f will return to active oversight.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.

Summary: Based on the review of consultation documentation for other indicators, PCPs did not consistently document agreement or not with the recommendations in consultation reports. As a result, Indicator a will return to active oversight. The Center needs to focus on ensuring PCPs complete timely reviews of consultation reports, write complete IPNs for consultation reports, and refer consultation recommendations to IDTs, when appropriate, and that IDTs review the recommendations and document their decisions and plans in ISPAs. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 304	363	42	167	327	269	114	91	187
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, after Round 11, it moved to the category requiring less oversight. However, based on the Monitoring Team's review of consultation documentation for other indicators, the Center regressed in its performance on this indicator. Therefore, it will move back to active oversight.									
b.	PCP completes review within five business days, or sooner if clinically indicated.	63% 10/16	1/2	2/2	1/1	1/2	1/2	2/2	0/1	1/2	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	50% 8/16	0/2	1/2	1/1	2/2	0/2	1/2	0/1	1/2	2/2

	the IDT.										
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	90% 9/10	1/2	1/1	1/1	N/A	N/A	2/2	1/1	2/2	1/1
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/6	0/2	N/A	N/A	N/A	0/1	0/1	0/1	0/1	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 16 consultations. The consultations reviewed included those for Individual #304 for pulmonology on 8/10/17, and neurology on 7/20/17; Individual #363 for ear, nose, and throat (ENT) on 11/29/17, and orthopedics on 8/1/17; Individual #42 for ophthalmology on 8/21/17; Individual #167 for cardiology on 6/6/17, and neurology on 8/16/17; Individual #327 for gastroenterology (GI) on 9/6/17, and pulmonary on 6/16/17; Individual #269 for hematology on 11/10/17, and neurology on 5/18/17; Individual #114 for oncology on 7/5/17; Individual #91 for neurology on 8/18/17, and urology on 8/17/17; and Individual #187 for ENT on 10/31/17, and urology on 10/5/17.

a. The consultation reports for which PCPs did not indicate agreement or disagreement with the recommendations were for Individual #304 for pulmonology on 8/10/17, and neurology on 7/20/17; Individual #327 for pulmonary on 6/16/17; Individual #269 for neurology on 5/18/17; Individual #114 for oncology on 7/5/17; and Individual #91 for urology on 8/17/17.

b. The reviews that did not occur timely were for: Individual #304 for pulmonology on 8/10/17, Individual #167 for neurology on 8/16/17, Individual #327 for pulmonary on 6/16/17, Individual #114 for oncology on 7/5/17, Individual #91 for neurology on 8/18/17, and Individual #187 for urology on 10/5/17.

c. Half of the PCP IPNs related to the consultations reviewed included all of the components State Office policy requires. The exceptions were for Individual #304 for pulmonology on 8/10/17, and neurology on 7/20/17; Individual #363 for orthopedics on 8/1/17; Individual #327 for GI on 9/6/17, and pulmonary on 6/16/17; Individual #269 for neurology on 5/18/17; Individual #114 for oncology on 7/5/17; and Individual #91 for urology on 8/17/17.

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 exception of a nebulizer treatment for Individual #304 recommended on 8/10/17. However, because PCPs did not consistently indicate agreement or disagreement, it was unclear for some recommendations whether or not orders were needed.

e. For the consultations that scored negatively, PCPs did not indicate in their IPNs whether or not IDT referral was needed.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.	
Summary: For a number of individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were not completed, and/or the PCP had not identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.	Individuals:

#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	33% 6/18	0/2	0/2	0/2	2/2	0/2	0/2	2/2	0/2	2/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., .e., Individual #304 – seizures, and weight; Individual #363 – osteoporosis, and falls; Individual #42 – osteoporosis, and falls; Individual #167 – GI problems, and constipation/bowel obstruction; Individual #327 – respiratory compromise, and GI problems; Individual #269 – seizures, and GI problems; Individual #114 – cardiac disease, and other: cancer; Individual #91 – UTIs, and seizures; and Individual #187 – diabetes, and skin integrity).

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 #167 – GI problems, and constipation/bowel obstruction; Individual #114 – cardiac disease, and other: cancer; and Individual #187 – diabetes, and skin integrity. The following provide examples of concerns noted:

- Over the last one to two years, Individual #304 experienced a neurological decline, although the submitted documentation did not clarify the date of onset. On 4/11/16, he was hospitalized for hypoxia and altered mental status due to seizures, and required intubation at that time. On 7/25/16, he had a cluster of three seizures. On 11/17/16, the neurologist indicated he had been seizure free for several months. On 1/9/17, he developed severe hypotension due to the administration of pre-sedation (i.e., Ativan and Vistaril) and was hospitalized for treatment and observation. Cardiology followed him at intervals, but as of 2/10/17, his cardiovascular status was considered stable, and there was no change in cardiovascular medication, which included medication to treat hypertension. His lipid levels were considered normal at that time. He was prescribed sodium chloride (NaCl) tabs for hyponatremia, although the etiology of the hyponatremia was not stated in the AMA.

  On 2/16/17, the PCP ordered tests to rule out the more common treatable causes of dementia, such as B12 deficiency, and thyroid abnormalities. He was started on Aricept at that time. On 5/19/17, cardiology saw him, with no change in cardiovascular medication.

  On 6/7/17, an OT's note indicated that Individual #304 had regressed in self-care and mobility. The OT began direct therapy to address and resolve this regression. On 6/27/17, he was seen in the ED for seizures, and Vimpat was increased. On 7/16/17, he had a cluster of seizures, for which he received two doses of Ativan. On 7/18/17, the neurologist saw him and reduced his Vimpat due to possible worsening of hypoxia. Keppra was maintained and Zonisamide was added. The neurologist noted signs consistent with dementia or other neurological decline, with a shuffling gait and slowed ambulatory pace, as well as decreased facial expression. On 7/30/17, a nursing IPN indicated that he needed verbal reminders in order to successfully navigate to the dining room in his home, which was a change for him. A 9/13/17 Habilitation Therapies IPN indicated that Individual #304 needed increased assistance with bathing and dressing. His gait was described as dragging his right foot and walking sideways with left foot leading. He would stop during ambulation and had difficulty initiating movements. His eyes closed intermittently, and at times, would roll back. The PNMP was modified with instructions for staff to assist him with a gait belt and use of a wheelchair for transport, as needed.

On 9/18/17, as part of his evaluation for his neurological decline, a computed tomography (CT) of the head was completed, which indicated cerebral atrophy with no acute abnormalities. A 10/9/17 Habilitation Therapies IPN indicated that his protective reactions for imbalance were delayed and he would stagger and then recover. His gait would freeze intermittently. On 10/24/17, Behavioral Health Services staff conducted a dementia screening test, and interpreted the results as indicative of beginning dementia. However, the staff conducting the screening bypassed a number of sections, which suggested an incomplete review.

The submitted documentation did not include a timeline of Individual #304's decline in various measurable functions, such as dressing, bathing, eating, as well as getting lost, medications used during that time, or sleep data to determine impact of sleep hygiene or disrupted sleep. A consistent downhill course over time would be consistent with Alzheimer's dementia, but the data was not available to confirm this diagnosis. Neither was there any data to confirm a multi-infarct component to the dementia, when the pace of decline might rapidly worsen at intervals in a step wise fashion. Measuring the pace of decline would provide a prognosis of his neurological degeneration and potentially provide evidence of dementia. Marked variations in functional decline were not ruled out, which would indicate delirium or other comorbid conditions, as well as potentially contributing factors such as side effects of medication. The lack of information did not provide the affirmation needed that dementia was the only etiology of his decline. In addition, the IDT was not collecting data to determine the impact of the dementia medication prescribed in plateauing the decline for any length of time. By assuming dementia was the etiology of all aspects of decline, the PCP and IDT were potentially overlooking alternative or additional diagnoses.

- Over the prior year, Individual #304 had significant weight loss. In January 2017, he weighed 140.8 pounds, but by July 2017, he weighed 126.6 pounds. On 7/18/17, an MBSS indicated oral and pharyngeal dysphagia, but no penetration or aspiration. On 8/1/17, Habilitation Therapies staff observed him and noted he and ate drank 100% of the offered meal with no triggers. Oxygenation was 99%. On 8/4/17, the therapists updated the PNMP to allow him to ambulate to the dining room and to eat by himself. When he became tired, staff were to assist him to complete eating his meal. He also was allowed to eat in his home if he refused to eat in the dining room. However, on 9/20/17, when Habilitation Therapy staff monitored the home, the PNMP available to staff had not been updated.

  By 8/20/17, his weight had declined to 120 pounds. On 9/27/17, weight clinic notes indicated that staff had been assisting for the first half of the meal, but then Individual #304 was to be offered the spoon to complete the meal. At that point, he ate only a few bites, then appeared to forget to finish eating. It was assumed the decline in mentation was the cause of the decrease in caloric intake and weight loss. Because of this finding, staff were then to assist with the remainder of the meal. These interventions did appear to improve his weight. On 9/29/17, he reached his lowest weight at 112.4 pounds, and since then, had weighed 119 to 120 pounds, but had not increased further according to submitted information. Based on the documentation, nutritional services saw him nine times since March 2017.

  It is unclear if there are additional factors associated with his weight loss, as his weight has not recovered to the weight of a year ago, but plateaued according to submitted data. The identification of weight loss appeared to occur late in his clinical decline. As recently as the 6/25/17, the ISP goal was to continue to lose one pound per month. The IDT might have used

outdated information in addressing this risk factor. It was not until July 2017, when his weight had decreased by 14 pounds, that his IDT and the PCP began to focus on determining causes. This type of weight loss is compatible with the clinical course of dementia, but other causes of weight loss needed to be considered and ruled out. If a weight loss medical evaluation had been completed, it was not included in the quarterly medical reviews during 2017.

- Individual #363 ambulated with a rapid pace. On 9/15/17, he completed a DEXA scan, and the T-score was -1.8, indicating osteopenia. He had been treated with Alendronate, but on 11/9/17, it was discontinued due to a lack of osteoporosis. The Pharmacist also calculated a FRAX score (but not include it in the QDRR), and the risk of a fracture was below the threshold for treatment. According to the nutritional assessment, he received 1521 milligrams (mg) of calcium in his daily diet, and was prescribed supplemental calcium as well. The nutritionist indicated he received approximately 267 international units (IU) of Vitamin D in his diet, and received supplemental Vitamin D as well. On 9/21/17, his last Vitamin D level was 43. At that time, his prolactin level was 19.4 and thyroid stimulating hormone (TSH) was 1.46. He also was reported to have a prior low testosterone level of 61 (physiologic range 292 to 867), but there was no follow-up in the submitted documentation, except a PCP comment "to monitor, may refer to urology." There was no information as to how the individual would be monitored, and no submitted urology consult focused on potential hypogonadism. However, hormonal replacement would need to be discussed in the context of its effect on his behaviors. A referral to endocrinology for the potential of hypogonadism as well as osteopenia in an active adult male was not discussed in submitted documentation.

- Individual #363 had a history of falls with injury. The most recent AMA, dated 3/8/17, indicated he fell 13 times in the year prior to the AMA. He had bilateral cataracts, as well as dry eyes for which he received artificial tears. His last ophthalmology visit was on 2/13/17. He had diagnoses of generalized anxiety disorder, primary insomnia, and self-injurious behavior (SIB). He had mild hearing loss.

  In January 2006, he fell and sustained a fracture of his left 3rd finger. In April 2014, he fell and developed a concussion. A CT of the brain showed no acute abnormalities. In July 2014, he fractured his 2nd metacarpal. On 3/28/16, he fell and sustained a head injury. He had a seizure at that time. A CT of the head was negative. The 3/13/17 IRRF documented that as soon staff placed a helmet on his head, he would remove it and throw it at others. On 4/16/17, Keppra was discontinued.

  On 5/10/17, the IDT met to discuss his falls. He had fallen over a wheelchair in his room. The Home Supervisor was to provide an in-service on where to park/store the wheelchair when it was not being used. Speech therapy and occupational therapy attempted to provide direct therapy to improve attention to task, but this was not successful. Staff were to carry his helmet and offer it at intervals. During his recent falls, Individual #363 sustained some injuries, but the IDT did not determine an etiology(ies) of the falls, because they were unwitnessed. This made tracking falls with injuries difficult. For example, he had a habit of placing his head in a corner of the room and swaying his head side to side. This behavior was also associated with injuries. Following the IDT meeting of 6/1/17, he was placed on one-to-one level of supervision. On 6/11/17, he was found on the floor face down. He had a hematoma of his right eye, and a small laceration. Staff witnessed him having a seizure when he fell. He was subsequently diagnosed with a fracture of the left 9th rib. A 6/14/17 Habilitation Therapies note provided details of his difficult behaviors associated with impulsivity and agitation. On 6/15/17, he was running in a hallway and fell on his hands. He hit the bridge of his nose, sustaining a small cut. He injured his left hand and wrist. On 6/27/17, a floor mat was

provided next to his bed, as well as a wall mat. The IDT reported that he attempted to escape environments that had too many people or that were noisy.

At an ISPA meeting on 6/27/17, the IDT discussed several action steps, including steps to assist with his compliance in wearing a hat and subsequently a helmet, but this plan was never implemented. Several other actions were to be implemented according to the ISPA, with the benefit of data collection. However, the submitted documentation did not provide evidence of this information. On 7/13/17, the psychiatrist increased his Tenex and continued his Ativan and Zyprexa. On 7/20/17, a door was shut on his left index finger, and he sustained a fracture. On 7/25/17, he fell against a corner of the wall, hitting his shoulder and back, but there were no injuries. On 8/26/17, he fell and sustained an elbow laceration, which subsequently developed cellulitis. At the time of the onsite review, he remained agile and ambulated quickly.

Although Individual #363's IDT had developed some creative plans to determine the cause of the falls as well as steps to prevent falls, evidence was not found to show that implementation occurred. Additionally, the known fact of environmental noise and crowded conditions aggravating his behavior did not subsequently result in a plan to provide a calm, supportive environment.

- On 6/13/14, Individual #42 had a DEXA scan showing a T-score of -3.1, which indicated a diagnosis of osteoporosis. On 3/31/15, Reclast was discontinued. The plan was to start Prolia, but the dental clearance did not occur. The AMA, dated 9/5/17, indicated she was not being treated with Prolia, because clearance from the Dental Department was pending. In October 2016, she had another DEXA scan showing a T-score of -2.5 at the femoral neck, which continued to indicate a diagnosis of osteoporosis. According to the PCP, in November 2017, she finally received a Prolia injection. According to the AMA, the plan was to receive Prolia every six months. However, the Medication Patient Profile did not mention Prolia, nor did the last six months of physician orders, nor the most recent two QDRRs.

- Individual #42 recently fell three times, including one fall with an injury. There was no information submitted concerning a formal exercise program, or PT and OT involvement in strengthening and ongoing balance therapy. In the AMA, the PCP commented that she spends most of her time in a wheelchair due to falling. Action steps are needed to prevent deconditioning, which will increase her risk of falling in the future. The lack of an ISPA reflecting ongoing IDT monitoring with documentation regarding action steps was problematic.

- For Individual #327, some documents indicated that she had a G-tube and other documents stated she had a jejunostomy-tube (J-tube). On site, the PCP clarified she had a G-tube. She had a nothing-by-mouth (NPO) status and received all nutrition, fluids, and medications through her G-tube. In recent months, she had a number of G-tube dislodgements (i.e., April 2017 - specific date not available, 6/15/17, 7/30/17, 9/16/17, 11/9/17, and 11/17/17). The submitted documentation did not indicate that these frequent dislodgements had been addressed. The PCP and IDT had not conducted a root cause analysis or used another investigative approach to prevent these occurrences.

- Individual #327 had a tracheostomy, a history of chronic obstructive pulmonary disease (COPD), and received Xopenex and Pulmicort nebulizer treatments routinely. In recent years, she had a number of pneumonias (i.e., 1/17/15, 1/20/16, 5/19/16,

8/8/16, 6/12/17, and 7/25/17), as well as bronchitis/exacerbation of her COPD on 8/18/17. A pulmonologist followed her. On 11/17/17, she had an episode of hypoxia, associated with thick yellow tracheal secretion mixed with gastric bile. Individual #327 was noted to have bilateral wheezing and labored breathing. Oxygenation was 88 to 93% on room air. She improved on frequent nebulizer treatments. This scenario suggested severe reflux with aspiration. A prior pneumonia, on 8/8/16, was also associated with bile in her tracheostomy and mouth. Reportedly, she tolerated her enteral feedings with no elevated residuals recorded. However, historically, she had volume intolerance and required continuous feedings. Of concern, despite the gastric bile being found in the tracheal secretions, her PCP had pursued no further evaluation for severe gastric reflux, development of gastroparesis, or an anatomic anomaly, such as a trachea-esophageal fistula. Her current gastroesophageal reflux disease (GERD) treatment included a proton pump inhibitor and Carafate. Positioning instructions required head-of-bed elevation at 25 to 30 degrees. Further medical and or surgical treatment might be indicated.

- Individual #269 had a diagnosis of dementia. The submitted documentation did not describe the criteria she met or the decision tree used to reach this diagnosis. The evaluation might have occurred prior to the time period of the submitted documents, but a summary would have been expected in the interval or past history section of the AMA. On 3/11/16, she was started on Aricept. She also had been prescribed Memantine XR twice daily for the dementia. On 4/24/17, the Aricept dosage was increased. In a PCP IPN, dated 10/16/17, it was noted she was uncooperative, refusing to get out of bed until late in the day, and not allowing staff to transfer her to a wheelchair. Aricept was increased at that time, and the plan was "to keep monitoring," although no description was provided of any monitoring process, including specific indicators. Her behaviors included refusing meals, and aggression. On 11/20/17, the psychiatrist saw her, and started Depakote to control her agitation. At that time, lamotrigine was decreased due to the potential effect of Depakote on lamotrigine blood levels. On 11/28/17, Aricept was decreased.

  As previously mentioned, the submitted information did not include medical, functional, and behavioral evaluations leading to the diagnosis of dementia, nor ongoing data collection and analysis, which might confirm the continued decline in functional abilities. Other potential comorbidities and clinical information were not discussed, such as quality of sleep, presence of depression, whether subclinical seizure activity existed, and whether there were functional abilities that fluctuated throughout the day or week suggesting other etiologies (e.g., medication side effects, environmental factors, etc.). Additional data collection would confirm the diagnosis of dementia or uncover other comorbid conditions explaining her neurological decline. Lab values, such as a B12 level or other screening tests, if completed in the past, were not carried forward in the AMA.

- In June 2013, Individual #269 had a G-tube placed to be used when the individual ate less than 50% of her meals. In the six-month window of submitted documentation, her G-tube was dislodged several times: 6/7/17, 6/22/17, 7/25/17, 8/30/17, and 10/6/17. Additionally, on 10/23/17, the G-tube became clogged and had to be replaced. There was no discussion in submitted documents as to a review of these dislodgements nor proactive steps to prevent recurrence of the dislodgments. Although she was on a regular ground diet with pureed breads and desserts, as well as thin liquids, she continued to receive formula supplementation if she refused meals. She regularly received bedtime feedings due to refusing breakfast, indicating the need for a consistently functioning G-tube for ready administration of supplementation. There appeared to be no interdisciplinary evaluation and subsequent treatment with resolution of this problem.

- Individual #91 had a history of UTIs, benign prostatic hypertrophy, bilateral kidney stones, urinary retention, and urinary incontinence. At medication pass, he was offered 350 milliliters (ml) of fluid with the goal of 1000 cubic centimeters (cc) daily independent of fluids consumed during mealtimes. On 6/18/15, he underwent a TURP for acute urinary retention due to benign prostatic hypertrophy. On 3/24/16, a urology consult recommended continuation of his urologic medication, which included finasteride and trimethoprim for suppression of UTIs. A follow-up urology consultation report, dated 9/23/16, indicated that at that office visit, he did not have a UTI, had 435 cc of post-void residual, and a renal scan reported non-obstructive bilateral renal stones. The report noted consideration of Extra-Corporeal Shock Wave Lithotripsy in the future, and he was to continue his same urologic medication. On 11/17/16, his PSA was 0.4. On 2/13/17, his blood urea nitrogen (BUN) was 7, creatinine 0.90, and albumin was 3.8. On 7/21/17, he was hospitalized for an open reduction of a left shoulder dislocation, and during the hospitalization developed post-surgical urinary retention and hematuria. On 7/25/17, a bladder scan showed 438 ml urine in the bladder, and a straight catheterization obtained 475 ml. On 7/26/17, the bladder scan showed 450 ml, and a straight catheterization obtained 500 ml. The urine was cloudy with clots, and foul smelling, and a urinalysis and culture were obtained. On 7/31/17, a bladder scan showed 634 ml of urine. On 8/17/17, urology was consulted for the hematuria. A CT scan of the abdomen and pelvis was negative. There were no stones or source of hematuria at that time. He was to recheck with urology in six months. On 8/22/17, a PSA was 0.1 ml and the urinalysis was interpreted as normal. He continued on Finasteride and Trimethoprim, as well as UTI Stat that the Dietary Department provided.

  During the onsite review, the physician on the Monitoring Team asked the PCP about the details of Individual #91's urologic history, and to provide the background information for the presence of kidney stones in September 2016, but the absence of the stone on the more recent scan of 8/17/17. The individual also had hematuria, and the PCP was asked the clinical steps taken in the past and to be taken in the future concerning evaluation and treatment of the hematuria. The Monitoring Team member reviewed the Pharmacy QDRR with the PCP, including the statement of a "notable potential adverse reaction topiramate increases the risk for renal stones (He has apparently had renal calculi in 2011), should be monitored closely for presence of stones." The PCP was asked about the continued prescribing of topiramate, and whether there had been discussion with neurology about alternative medication. The PCP was not able to provide background medical information or describe the clinical decision-making process related to evaluation of the individual's ongoing hematuria, or provide an explanation of the non-agreement in the results of the recent scans concerning the presence or absence of kidney stones. The PCP also did not provide information concerning discussion with the neurologist, and had no information that metabolic acidosis had been ruled out as a side effect of topiramate and as a potential cause/contributing factor for the stones.

- Individual #91 also had a recent history of cluster seizures. IPNs indicated he refused medications at least once at the time of a cluster of seizures. The reason for the refusal was unclear. However, given the refusal of medication followed by a cluster of seizures, the IDT would have been expected to hold an ISPA meeting to discuss ways to improve compliance, with the PCP or Behavioral Health Services staff leading the discussion. However, no information was submitted as to root cause analysis findings or action steps to address his behavior.

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 often 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 action steps are included in IHCPs, and PCPs implement them.			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	70% 7/10	0/1	0/2	2/2	2/2	N/A	2/2	N/A	1/1	N/A
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed often were implemented. The following provide examples of interventions not completed: • One of the action steps for Individual #304 was for the PCP to order a consult for the completion of a dementia evaluation. At the time of the review, this action step was incomplete. • For Individual #363, the PCP had not further evaluated hypogonadism. • For Individual #363, the PCP had not followed up on low testosterone levels.											

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: It was good to see that the Pharmacy Department reviewed the new orders selected for review, and notified the prescribing practitioner when an intervention was necessary. This is the first time the Monitoring Team has reviewed these indicators at CCSSLC. They will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	100% 2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	100% 4/4	N/A	1/1	N/A	N/A	N/A	1/1	1/1	N/A	1/1
Comments: a. and b. The Monitoring Team selected two new medications for each individual reviewed, including synthroid on 8/10/17,											

and zonisamide on 9/20/17 for Individual #304; clindamycin on 9/26/17, and triazolam and hydroxyzine on 11/29/17 for Individual #363; clozapine on 4/26/17, and milk of magnesia on 10/12/17 for Individual #42; doxycycline on 12/1/17, and lubiprostone on 9/16/17 for Individual #167; Prolia on 11/10/17, and azithromycin on 8/23/17 for Individual #327; lamotrigine on 11/21/17, and Prolia on 9/27/17 for Individual #269; omega 3 capsules on 6/9/17, and divalproex on 8/17/17 for Individual #114; calcium carbonate on 11/16/17, and multivitamin on 11/2/17 for Individual #91; and lidocaine patch on 6/26/17, and meropenem on 12/10/17 for Individual #187.

It was good to see that the Pharmacy Department reviewed these new orders, and notified the prescribing practitioner when an intervention was necessary.

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: Given that QDRRs for the individuals reviewed were generally timely during this review and the past two reviews (Round 11 – 89%, Round 12 – 100%, and Round 13 - 100%), Indicator a will be placed in the category requiring less oversight. The Center should continue its efforts to improve the quality of the QDRRs. Since the last review, improvement was noted with regard to the prescribers' timely review of QDRRs. Prescribers also followed through on agreed-upon recommendations, which was good to see. The remaining indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 304	363	42	167	327	269	114	91	187
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;	72% 13/18	1/2	2/2	1/2	1/2	1/2	2/2	2/2	1/2	2/2
	ii. Benzodiazepine use;	92% 11/12	2/2	2/2	N/A	2/2	N/A	2/2	1/2	2/2	N/A
	iii. Medication polypharmacy;	92% 11/12	2/2	2/2	N/A	1/2	N/A	2/2	2/2	2/2	N/A
	iv. New generation antipsychotic use; and	90% 9/10	2/2	2/2	2/2	2/2	N/A	N/A	1/2	N/A	N/A
	v. Anticholinergic burden.	89%	2/2	2/2	2/2	2/2	2/2	1/2	1/2	2/2	2/2

		16/18									
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.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 10/10	2/2	2/2	2/2	2/2	N/A	N/A	2/2	N/A	N/A
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	100% 6/6	N/A	1/1	2/2	N/A	1/1	1/1	N/A	1/1	N/A
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.	100% 4/4	N/A	1/1	N/A	N/A	N/A	1/1	1/1	N/A	1/1

Comments: b. For a number of individuals, the most recent lab data available had not been incorporated into the QDRR reports.

Individual #114's 8/31/17 QDRR stated he had no benzodiazepine use, but then listed lorazepam for pain.

Individual #167's 6/12/17 QDRR did not identify the polypharmacy for constipation.

Individual #114's 5/22/17 QDDR did not list his waist circumference.

One or more medications with anticholinergic effects were missing from the lists included in the QDRRs for Individual #269 (10/11/17), and Individual #114 (5/22/17).

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

d. and e. 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 did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.	Individuals:

#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	N/A	0/1	0/1	0/1	N/A	0/1	0/1	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/6		0/1	0/1	0/1		0/1	0/1		0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/6		0/1	0/1	0/1		0/1	0/1		0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/6		0/1	0/1	0/1		0/1	0/1		0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/6		0/1	0/1	0/1		0/1	0/1		0/1

Comments: a. and b. Individual #304 and Individual #91 were edentulous, but were part of the core group, so full reviews were conducted. Individual #327 was edentulous, but was part of the outcome group, so a limited review was conducted for her. The Monitoring Team reviewed six individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, integrated progress reports on existing goals, including data and analysis of the data, often were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

Outcome 4 – Individuals maintain optimal oral hygiene.

Summary: N/A

Individuals:

#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	N/R	N/A	N/R	N/R	N/R	N/A	N/R	N/R	N/A	N/R

Comments: Individual #304, Individual #327, and Individual #91 were edentulous.

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 reviewed with medium or high caries risk received fluoride applications at least twice a year (Round 11 – 100%, Round 12 – 100%, and Round 13 - 100%), Indicator d will move to the category requiring less oversight. This will result in the entire outcome moving to less oversight.			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.										
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.										
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	100% 3/3	N/A	N/A	N/A	1/1	N/A	1/1	1/1	N/A	N/A
e.	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.									
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.										
Comments: d. It was good to see that for individuals reviewed with medium or high dental caries risk, the Dental Department provided them with at least two fluoride applications per year.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
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: a. through c. None.

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	N/A									
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	N/A									
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	N/A									
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	N/A									
Comments: a. through d. None of the individuals reviewed required suction tooth brushing.											

Outcome 9 – Individuals who need them have dentures.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
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 the Center's response to the Monitoring Team's document	Individuals:

request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected. These indicators will remain in active oversight.											
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0%									
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	0%									
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0%									
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0%									
e.	The individual has an acute care plan that meets his/her needs.	0%									
f.	The individual's acute care plan is implemented.	0%									
Comments: a. through f. Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. At least in part, the conversion to the IRIS system complicated entry of acute care plans into the system. However, this is a substantial deviation from standard practice and needs to be corrected. The Monitoring Team has discussed this issue with State Office. Given that Center staff acknowledged that acute care plans have not been consistently developed and entered into the system, it was decided that the Monitoring Team would not search for needed acute care plans that might not exist. However, as a result of this systems issue, these indicators do not meet criteria. Center staff should continue to work with State Office to correct this issue.											

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall	304	363	42	167	327	269	114	91	187

		Score									
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% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #304 – choking, and infections; Individual #363 – falls, and constipation/bowel obstruction; Individual #42 – falls, and infections; Individual #167 – constipation/bowel obstruction, and choking; Individual #327 – constipation/bowel obstruction, and polypharmacy/medication side effects; Individual #269 – fractures, and urinary tract infections; Individual #114 – falls, and choking; Individual #91 – skin integrity, and constipation/bowel obstruction; and Individual #187 – GI problems, and weight).

None of the goals/objectives reviewed were clinically relevant, achievable, and/or measurable.

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

Outcome 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 five 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	304	363	42	167	327	269	114	91	187
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	11% 2/18	2/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/11	0/1	0/1	0/2	0/1	N/A	0/1	0/1	0/2	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).	11% 2/18	2/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

a. and b. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, or that nursing interventions were implemented thoroughly. The exceptions were the interventions for Individual #304 for choking and infections, for which nursing staff completed the interventions for lung sounds, as well as quarterly skin assessments and Braden scores, respectively.

b. The following provide examples of where IDTs did not take immediate action in response to risk:

- ISPAs, dated 7/14/17, 9/7/17, and 9/19/17, indicated that Individual #304 was experiencing a "decline in his general health status." His weight decreased from 140.8 pounds in January 2017 to 119.6 pounds in October 2017. He went from independently eating to having staff feed him his meals (i.e., per the Nursing Quarterly for 7/1/17 to 10/1/17). The ISPA, dated 9/7/17, indicated that: "there are not enough staff to assist [Individual #304] during dining and he may not be getting enough nutrients." He also had recurrent ileus/constipation; episodes of hypoxia on 4/11/17, 1/9/17 (related to a pre-treatment sedation of Ativan 2 mg and Vistaril 50 mg), and 5/15/17; difficulty walking requiring a wheelchair to go to work; lethargy and lost interest in going to work (i.e., per the ISPA, dated 7/14/17), two falls (i.e., on 5/10/17, and 9/29/17); three episodes of dyspnea (dates not provided in IRRF); urinary incontinence and urethra stricture; past UTIs; abdominal distention; hypertension with episodes of hypotension; as well as other diagnoses. In reviewing the ISPAs, although the IDT clearly recognized Individual #304's decline, the IDT had not collected and/or analyzed relevant data to determine trends or patterns, such as data related to orthostatic blood pressures, vital signs and oxygen saturations, fluid intake, urinary output, medication changes, caloric intake, lab values, etc.

  As discussed in the medical section of this report, the submitted documentation did not include a timeline of Individual #304's decline in various measurable functions, such as dressing, bathing, eating, as well as getting lost, medications used during that time, or sleep data to determine any impact of sleep hygiene or disrupted sleep. A consistent downhill course over time would be consistent with Alzheimer's dementia, but the data were not available to confirm this diagnosis. Neither was there any data to confirm a multi-infarct component to the dementia, when the pace of decline might rapidly worsen at intervals in a step wise fashion. Measuring the pace of decline would provide a prognosis of his neurological degeneration and potentially provide evidence of dementia. Marked variations in functional decline were not ruled out, which would indicate delirium or other comorbid conditions, as well as potentially contributing factors such as side effects of medication. The lack of information did not provide the affirmation needed that dementia was the only etiology of his decline. In addition, the IDT was not collecting data to determine the impact of the dementia medication prescribed in plateauing the decline for any length of time. By assuming dementia was the etiology of all aspects of decline, the PCP and IDT were potentially overlooking alternative or additional diagnoses.

- No ISPAs were found to show that the IDT was assessing and analyzing Individual #42's increase in falls, despite her diagnosis of osteoporosis (i.e., a T-score of -3.1 from 6/13/14), fracture of her left distal fibula on 9/29/10, three falls during the previous ISP year according to the recent IRRF, bilateral cataracts, and falls noted on the episode tracker on 7/17/17, 9/30/17 (neither of these falls were included in Document Request TX-CC-1801-IV.1-20), and 10/14/17, in addition to at least one fall while at the group home. Her PNMP indicated that she had a "history of falls due to lack of safety precautions." However, the IDT had not yet assessed the cause(s) of her falls or implemented interventions to prevent them.
- Based on the information the Center provided for Document Request TX-CC-1801-IV.1-20, from 6/7/17 through 1/19/18, Individual #167 had 41 episodes of constipation. The ISPAs, dated 6/20/17 and 7/17/17, noted that she was "currently being followed in the PNMT due to emesis as well as weight loss" and "the root cause has not been identified as of yet." Neither of these ISPAs nor any of the ISPAs provided through 12/11/17 mentioned her significant episodes of constipation or the potential association with her psychotropic medication regimen, episodes of emesis, and/or weight loss. The IHCP addressing constipation did not include assessments of her bowel status that were consistent with relevant nursing guidelines or monitoring of her fluid intake. Based on submitted documents, the IDT did not conduct any analysis of her constipation despite the fact that the plan in place was ineffective. It was alarming that her IDT either was not aware of the significant use of pro re nata (PRN, or “as needed”) bowel medications, or was aware of the issue, but did not recognize the need to meet.
- Although Individual #114 fell four times (i.e., 7/10/17, 9/3/17, 9/7/17, and 9/9/17), including three times shortly prior to his death on 9/14/17, no ISPAs were found to show that the IDT addressed his safety while he was taking multiple pain medications for his cancer while on hospice. Depending on which data sets one reviewed, he had either two or three falls from his three-wheeled bike. However, in spite of his osteoporosis and the hip pain noted in the IPNs, the IDT did not document any plans to prevent falls for this individual. During September 2017, IPNs indicated that he was weak, pale, crying often, and taking pain medications. Due to his significant change in status, after a fall on 9/3/17 from his bed, the IDT should have met to modify his plan to focus on preventing falls, especially since his PCP noted a decline in his health after an evacuation for a hurricane. After 9/3/17, he experienced two additional falls with no indication that the IDT met.
- From the documentation in IView, Individual #91's Braden Score at his annual ISP was 17. The nursing quarterly assessments for March through June 2017, and June through September 2017 reported decreased Braden Scores of 15, and 14, respectively (i.e., the lower the score the higher the risk). At the time of the skin breakdown to his buttocks on 7/28/17, there was no indication that the IDT was aware of his increasing risk for skin issues or the open areas found on his skin. From the documentation provided, the IDT did not call an ISPA meeting to address his skin issues and develop a plan to ensure that strategies were in place to track the healing of his open areas and prevent any further skin issues. The IHCP addressing his skin integrity did not include the interventions to meet his needs.

  In addition, after Individual #91’s left shoulder was dislocated on 7/21/17, and he had surgery on 7/24/17, the ISPA, dated 10/5/17 (two months later), noted that the root cause of his dislocation was unknown. However, the IDT noted: "improper mechanical forces as a result of his tone issues, manner by which he transfers (stand pivot transfer with staff assist), or history of stiffening up and resisting when being assisted are all factors that could have contributed to the shoulder dislocation." Although some valid possibilities of the cause of the dislocation were identified, the IDT did not develop supports to address these possibilities and to potentially prevent additional injuries.
- The nursing annual assessment noted that Individual #91 had not needed additional medications for constipation during the prior ISP year. However, from the documentation provided, he had experienced an increase in episodes of constipation on

4/24/17, 8/5/17, and 8/11/17 (this information was not included in Document Request TX-CC-1801-IV. 1-20). Based on the ISPAs provided, the IDT did not meet to address the issue.

- Although the ISPAs indicated that the IDT followed Individual #187 regarding a number of her health issues (e.g., fracture of L5, five UTIs, decrease in function from ambulating to using the wheelchair, new onset of seizures, skin breakdown to buttocks and left heel, and increase in dialysis), the ISPAs did not include information regarding her episodes of emesis (i.e., 11/4/17 x3, 11/19/17, 11/22/17 x2, 12/3/17, and 1/15/18) or her weight loss issues. As a result, these health issues had not been analyzed or aggregated with other health data to determine the cause in order to put preventative measures in place. In addition, the IHCPs and IRRFs did not reflect these health issues, nor were they included in the Document Request TX-CC-1801-IV.1-20.

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

Summary: For the two previous reviews, as well as this review, the Center did well with the indicators related to: 1) nurses administering medications according to the nine rights; 2) nurses following individuals' PNMPs during medication pass; and 3) nurses adhering to infection control procedures while administering medications. However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will remain in active oversight as well.

#	Indicator	Overall Score	Individuals: 304	363	42	167	327	269	114	91	187
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% 7/7	N/R	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	100% 2/2	N/A	N/A	N/A	N/A	1/1	1/1		N/A	N/A

	includes lung sounds in IView or the IPNs.										
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	50% 1/2	N/A	N/A	N/A	N/A	1/1	0/1		N/A	N/A
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	100% 7/7		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% 7/7		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 seven individuals, including Individual #363, Individual #42, Individual #167, Individual #327, Individual #269, Individual #91, and Individual #187.

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

d. It was positive that some individuals who were at high risk for aspiration pneumonia or respiratory issues had IHCPs that defined the need to assess lung sounds on an individualized frequency and that data showed nurses completed these assessments (i.e., Individual #327, and Individual #269).

The following concern was noted:

- Based on observations, Individual #269 had a seizure during medication administration. The Center's nurse observer had to prompt the medication nurse to listen to the individual's lung sounds after medications were administered.

f. For the individuals observed, it was positive that medication nurses followed their PNMPs.

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 clinically relevant and measurable outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
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% 0/11	0/1	0/1	0/2	0/1	0/2	0/1	0/1	0/1	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	36% 4/11	1/1	1/1	1/2	1/1	0/2	0/1	0/1	0/1	0/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/11	0/1	0/1	0/2	0/1	0/2	0/1	0/1	0/1	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/11	0/1	0/1	0/2	0/1	0/2	0/1	0/1	0/1	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/11	0/1	0/1	0/2	0/1	0/2	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;	57% 4/7	0/1	0/1	N/A	1/1	N/A	0/1	1/1	1/1	1/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7	0/1	0/1		0/1		0/1	0/1	0/1	0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/7	0/1	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% 0/7	0/1	0/1		0/1		0/1	0/1	0/1	0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/7	0/1	0/1		0/1		0/1	0/1	0/1	0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/7	0/1	0/1		0/1		0/1	0/1	0/1	0/1

Comments: The Monitoring Team reviewed 11 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: choking for Individual #304; choking for Individual #363; aspiration, and choking for Individual #42; choking for Individual #167; respiratory compromise, and weight for Individual #327; choking for Individual #269; GI problems for Individual #114; aspiration for Individual #91; and choking for Individual #187.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: choking for Individual #304, choking for Individual #363, choking for Individual #42, and choking for Individual #167.

b.i. The Monitoring Team reviewed seven areas of need for seven individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: weight for Individual #304, falls for Individual #363, GI problems for Individual #167, fractures for Individual #269, choking for Individual #114, fractures for Individual #91, and skin integrity for Individual #187.

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

- While Individual #304 did not meet the criteria for weight loss of three pounds per month for three consecutive months, he essentially lost in excess of two pounds per month between October 2016 and September 2017. While the weight loss was initially intended, it became undesirable as Individual #304 fell into his estimated desired weight range (EDWR), but continued to lose weight. The PNMT should have become involved before he fell through the bottom range of the EDWR. By the time the PNMT conducted a review, Individual #304's weight had decreased from 146 pounds in October 2016 to 113 pounds in September 2017.
- Significant issues were noted with regard to the Center's data related to falls, making it difficult to determine how many times

Individual #363 had fallen. However, he had ongoing issues with falls (i.e., approximately 20 falls during the 2016-2017 ISP year, and an additional nine falls since his ISP meeting in April 2017). He also had a history of serious injuries related to falls, and according to his QIDP, in the previous nine months, he had 29 injuries, 12 of which were related to falls. The IDT should have referred him to the PNMT, but did not.

- On 11/2/17, Individual #269 suffered a fracture of her clavicular head. The clavicle is a long bone, and, therefore, this fracture should have triggered at least a PNMT review.

b.ii. and b.iii. None of these goals/objectives were clinically relevant, achievable, and measurable.

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of measurable goals/objectives, integrated progress reports with data and analysis of the data were generally not available to IDTs. For example, the QIDP integrated reviews did not summarize or analyze the data for Individual #167's GI problem goal, but the PNMT minutes and notes did. 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 and the lack of inclusion of information in the QIDP reports for Individual #167, the Monitoring Team conducted full reviews of all nine individuals' PNM supports.

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
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.	13% 2/16	0/2	0/2	0/2	2/2	0/2	0/2	N/A	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.	18% 2/11	0/1	1/1	N/A	1/1	0/2	0/1	0/1	0/2	0/2
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	100% 3/3	N/A	N/A	N/A	1/1	N/A	N/A	1/1	1/1	N/A
Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, the IHCPs for which documentation was found to confirm the implementation of the PNM action steps that were included was for choking and GI issues for Individual #167.											

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: Although during numerous observations, staff failed to implement individuals' PNMPs as written, the Center had significantly improved its performance in this regard (i.e., Round 9 – 25%, and Round 11 – 40%). PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should continue to determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	60% 21/35	
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.	50% 1/2	
Comments a. The Monitoring Team conducted 35 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 12 out of 20 observations (60%). Staff followed individuals' dining plans during nine out of 14 mealtime observations (64%). Staff completed transfers correctly during zero out of one observation (0%).			

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A					N/A	N/A			
Comments: a. None.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.

Summary: Overall, for the individuals reviewed, IDTs did not have a way to measure clinically relevant and measurable outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	22% 2/9	1/2	0/1	0/1	0/1	0/1	0/1	N/A	0/1	1/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	22% 2/9	1/2	0/1	0/1	0/1	0/1	0/1		0/1	1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/9	0/2	0/1	0/1	0/1	0/1	0/1		0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/9	0/2	0/1	0/1	0/1	0/1	0/1		0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/9	0/2	0/1	0/1	0/1	0/1	0/1		0/1	0/1

Comments: a. and b. Individual #114 was independent with activities of daily living until the progression of his cancer resulted in decreased function, at which time supports were put in place. He was part of the core group, so a full review was conducted for him.

The goals/objectives that were clinically relevant and achievable, as well as measurable were those for Individual #304 (i.e., standing with rolling walker), and Individual #187 (i.e., weight bearing and gait training).

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, integrated progress reports with data and analysis of the data generally were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. The Monitoring Team conducted full reviews for all nine individuals.

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	304	363	42	167	327	269	114	91	187
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	20% 2/10	1/2	0/1	0/1	0/1	0/1	0/1	0/1	0/1	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	33% 1/3	0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1

	change.										
Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that supports were implemented.											

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: It was good to see that most adaptive equipment observed was clean. If the Center sustains it performance, at the time of the next review, Indicator a might move to the category of less oversight. Although improvement was noted during this review, given the importance of the proper fit of adaptive equipment to the health and safety of individuals, Indicator c will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	35	200	333	210	98	297	132	283	137
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	87% 20/23	1/1	2/2	1/1	1/2	2/2	1/1	2/2	2/2	1/1
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.	91% 21/23	1/1	2/2	1/1	1/2	2/2	1/1	2/2	2/2	1/1
		Individuals:									
#	Indicator		67	287	379	65	372	367	58	291	269
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
Comments: a. The Monitoring Team conducted observations of 23 pieces of adaptive equipment. Individual #201's hand splints were not present. The individuals the Monitoring Team observed generally had clean adaptive equipment, which was good to see. The exceptions were Individual #287's wheelchair, and Individual #58's wheelchair. c. As noted above, Individual #201's hand splints were not present. Based on observation of Individual #372 in her wheelchair, the outcome was that she was not positioned correctly. It appeared that the wheelchair was too narrow. It is the Center's responsibility to determine whether or not this issue was due to the equipment, or staff not positioning the individual correctly, or other factors.											

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. Previously, two of the indicators were moved to, or were already in, the category of requiring less oversight. At this review, no additional indicators 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.

For the annual ISPs, one goal met criteria and the individual was progressing, which was good to see. For the most part, however, action steps were not consistently implemented for any individuals.

A small number of SAPs were progressing (and had data to support that progress). For many SAPs, however, progress was not occurring, but no actions were taken to make changes to the SAPs.

Many SAPs contained some of the required components, but no SAPs contained all of the required components. Moreover, poor, conflicting, and/or confusing instruction procedures within many SAPs would likely compete with the likelihood of progress occurring.

SAP implementation integrity had improved slightly and the Center had implemented protocols to assess SAP integrity more so than in the past. Many SAPs were again being reviewed monthly; an improvement from the last review. All SAPs were graphed.

Flu on campus and homes on isolation precautions competed with the Monitoring Team's ability to do multiple engagement observations for all individuals. Engagement scores for the past six months that the Center provided indicated that levels were not achieved in both their home and day program sites. However, for individuals who participated in some form of employment, engagement levels were consistently met in their work environments.

For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals.

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

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Given that all but one of the goals did not meet criterion with all three ISP indicators 1-3 (individualized, measurable, and data available), the indicators of this outcome also did not meet criteria. The one goal that met criteria with these indicators was progressing, which was good to see. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	267	97	304	363	269	42			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	1/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/5	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/5	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	1/6	0/6	0/6	0/6	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.

4-7. A personal goal that meets criterion for outcomes 1 through 3 is a pre-requisite for evaluating whether progress has been made. Generally, there was no basis for assessing progress as the IDTs failed to develop many personal goals that were also measurable.

The Monitoring Team found the continued lack of implementation, monitoring and reliable and valid data to be significant concerns.

In a positive finding, however, one of the personal goals did meet criterion for Indicators 4 through 7, and overall for Indicators 1 through 8. This was the work goal for Individual #97. While her other goals did not meet criterion, resulting in an overall finding of noncompliance, it was good to see she was making progress toward her work goal.

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	267	97	304	363	269	42			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
39. It was positive that many staff knew the preferences of individuals and demonstrated improvement in their ability to describe some of the key elements of each individual's ISP, however, overall staff knowledge regarding individuals' ISPs was insufficient to ensure its implementation, based on observations, interviews, and lack of consistent implementation.

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: It was good to see at least a small number of SAPs were progressing (and had data to support that progress [indicator 5]). For many SAPs, progress was not occurring, but no actions were taken to make changes to the SAPs. These indicators will remain in active monitoring.

			Individuals:								
#	Indicator	Overall Score	177	218	267	97	304	40	363	135	149
6	The individual is progressing on his/her SAPS	13% 3/24	0/3	0/3	0/3	N/A	0/3	1/3	0/3	1/3	1/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	0% 0/15	0/3	0/2	0/2	N/A	0/2	0/1	0/2	0/1	0/2
9	Decisions to continue, discontinue, or modify SAPs were data based.	100% 27/27	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3

Comments:
6. Three SAPs had data that suggested progress and that had been assessed for reliability. These were the following: Individual #40-anger management; Individual #135 - borrowing versus stealing; and Individual #149 - gathering work materials. Based on a review of data, 15 SAPs were not progressing. Another six were rated as not progressing because the data were not reliable. All three of Individual #97's SAPs were excluded from this analysis because there were insufficient data to determine progress or the lack thereof.

7. The identified goal was not met in any of the 27 SAPs.

8. There was no evidence that actions had been taken to address the lack of progress in the 15 identified SAPs. One example of a lack of attention to limited progress was for Individual #363 learning to bowl. For six consecutive months, it was indicated that the IDT would

meet to discuss his lack of progress. This did not occur.

9. A data review did occur for all 27 SAPs.

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

Summary: Many SAPs contained some of the required components, and no SAPs contained all of the required components. Moreover, poor, conflicting, and/or confusing instruction procedures within many SAPs would likely compete with the likelihood of progress occurring. This SAP will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 177	218	267	97	304	40	363	135	149
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. Most (80%) included a task analysis when appropriate, operational definitions of the targeted skill (often embedded in the task analysis), and plans for maintenance and generalization. About two-thirds of the SAPs also included behavioral objectives, relevant discriminative stimuli, specific consequences for correct and incorrect responding, and documentation methodology.

The weakest areas were specific instructions for teaching the skill and teaching schedules that included the number of trials. In fact, 15 of the 27 SAPs were scheduled to occur only once per week. Such limited training will most likely impede acquisition of new skills. None of the SAPs indicated the number of trials to be implemented. Some specific feedback is provided below.

- Several objectives identified a level of prompting that was the same as what was needed during baseline assessment. Examples included Individual #218's bowling and health choices SAPs and Individual #304's SAMs and vocational SAPs.
- Some of the SAPs included guidelines following incorrect responding that involved prompts not relevant to the skill. Examples included Individual #267's money management and STOP SAPs and Individual #97's use of a locked box that involved reporting information related to her medications. This was usually seen when gestural or more intrusive prompts were recommended for SAPs that required a verbal response.
- At least two of Individual #363's SAPs (bowling, coffee making) included objectives that noted he would perform the skill independently, yet staff were to score a correct response if he required partial physical prompting. Similar confusion was found in Individual #135's SAP to learn the difference between borrowing and stealing. The objective indicated he would perform the skill independently with verbal prompts.
- Individual #149's vocational SAP did not specify the materials he was expected to gather. Further, if he hit himself or ran away, staff were to tell him that it was okay and he could do the SAP later. Caution is advised because this may reinforce these undesirable behaviors.

Outcome 5- SAPs are implemented with integrity.											
Summary: Both indicators scored higher than ever before. Both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	218	267	97	304	40	363	135	149
14	SAPs are implemented as written.	60% 3/5	0/1	Not available	Not available	1/1	Not available	0/1	Not available	1/1	1/1
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.	52% 14/27	3/3	1/3	1/3	2/3	1/3	1/3	0/3	2/3	3/3

Comments:

14. SAP observations were arranged for all nine individuals during the onsite week. Individual #267, Individual #304, and Individual #363 were not present and/or were engaged in other activities at the scheduled times, and Individual #218 refused to transition from his home to participate in his SAP. Feedback for the five remaining individuals is provided below.

- Staff followed the SAP as written for three individuals: Individual #97, Individual #135, and Individual #149. This was good to see.
- Exceptions were Individual #177 and Individual #40. Individual #177 was clearly able to identify the four coins that were displayed. He was not required to sit down to work on this SAP and the television remained on throughout the observation. The staff member working with him did not appear to understand the difference between the discriminative stimulus and a verbal prompt and, therefore, recording was inaccurate. The staff present were advised to consider the practicality and functionality of teaching Individual #177 to indicate the number of pennies required to make up other coins. As the goal is to teach him to make purchases, there are more functional ways of teaching this skill. Individual #40 entered the computer lab and immediately opened the computer with very little assistance from staff. There was no evidence of staff referencing the SAP or ensuring that guidelines were followed.
- Individual #97 (medication), Individual #40 (computer use), Individual #135 (borrowing versus stealing), and Individual #149 (play DVD) all completed their SAPs without difficulty. As discussed with the staff who were present, it would be advisable to probe the terminal behavior to assess whether the individual can consistently perform the identified skill. If this is found to be true, the SAP should be revised to provide for more advanced skill development or it should be replaced with an alternative skill.

15. The guidelines for SAP integrity indicated that measures should be collected at least once every six months for each SAP. If scores fell below 80%, retraining of staff was to occur. During SAP observations, staff addressed retraining for any problems identified in implementation as well as data recording. There was evidence that at least one integrity measure had been collected over a six-month period for all three SAPs for Individual #177 and Individual #149, two SAPs for Individual #97 and Individual #135, and one SAP each for Individual #218, Individual #267, Individual #304, and Individual #40.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.												
Summary: Many SAPs were again being reviewed monthly; an improvement from the last review. All SAPs were graphed. With sustained high performance, this latter indicator (17) might be moved to the category of requiring less oversight after the next review. Both will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	177	218	267	97	304	40	363	135	149
16	There is evidence that SAPs are reviewed monthly.	44% 12/27	3/3	3/3	1/3	0/3	1/3	1/3	1/3	0/3	2/3
17	SAP outcomes are graphed.	100% 27/27	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3

Comments:
16. Six consecutive QIDP monthly reports were reviewed for eight of the nine individuals. The exception was Individual #97 who had been re-admitted in August, 2017 and for whom two monthly reports were available. These documents revealed that 12 of the 27 SAPs were reviewed each month. These were the following: all three of Individual #177's and Individual #218's SAPs; the model car SAP for Individual #267; the medication SAP for Individual #304; the community money SAP for Individual #40; the pot a plant SAP for Individual #363; and the gather work materials and community calendar SAPs for Individual #149.

17. For all 27 SAPs, monthly data were presented in graphic format.

Based on the information provided, 11 of the 27 SAPs were implemented greater than four times in a month. These limited learning trials will likely lead to poor rates of skills acquisition.

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	218	267	97	304	40	363	135	149
18	The individual is meaningfully engaged in residential and treatment sites.	22% 2/9	1/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	The day and treatment sites of the individual have goal engagement level scores.										
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

18. Due to an outbreak of flu during the onsite visit, it was difficult to conduct repeated observations of all nine individuals in their home and day program sites. As a result, engagement was assessed based upon work and class attendance over the past three months. Documentation provided by the facility indicated that two of the nine individuals (Individual #177, Individual #267) had attended both their scheduled work and classroom programs more than 50% of the time.

21. Engagement scores for the past six months provided by the facility indicated that levels for the nine individuals were not achieved in both their home and day program sites. However, for the eight individuals who participated in some form of employment, engagement levels were consistently met in their work environments. Engagement levels were consistently met in the classroom settings for Individual #304 and Individual #363. Engagement levels were consistently met in the home environments for Individual #177, Individual #97, and Individual #149. It should be noted that this information did not provide engagement measures for specific individuals, but rather by setting.

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

Summary: Progress shown at the last review was not maintained. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 177	218	267	97	304	40	363	135	149
22	For the individual, goal frequencies of community recreational activities are established and achieved.	22% 2/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

22. Individual #97 and Individual #149 had goal frequencies for community recreational activities that were achieved. While Individual #177, Individual #218, and Individual #40 all participated in multiple trips to the community, their ISPs did not include established frequency goals. Individual #363 and Individual #135 did not meet their established goal frequencies. Lastly, Individual #267 and Individual #304 did not have established goal frequencies and did not participate in regular monthly outings.

23. Although dates of community training were provided for Individual #218, Individual #267, Individual #40, and Individual #149, either the SAP was not identified or there were no data indicating whether the goal had been met. In Individual #363's case, there were dates provided indicating the goal had not been met, but his QIDP monthly reports indicated no trials of this particular SAP (bowling) in a six-month period.

24. For none of the nine individuals was there evidence that barriers had been identified with resulting recommendations for correcting these problems.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.												
Summary: There were no individuals at Corpus Christi SSLC who were of school age and entitled to public school educational services. This indicator will remain in active monitoring for possible review at the next onsite visit.			Individuals:									
#	Indicator	Overall Score										
25	The student receives educational services that are integrated with the ISP.	N/A										
Comments:												

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/2	N/A	0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/2		0/1					0/1		
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/2		0/1					0/1		
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/2		0/1					0/1		
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/2		0/1					0/1		
Comments: a. through e. For Individual #363, an ISPA, dated 3/13/17, reviewed his refusal to attend a dental appointment on 3/6/17. The documentation stated: "[Individual #363] currently has a desensitization program that is assisting with appointment attendance. The IDT will collect data for 90 days and review for efficacy. It is the IDT's belief that if the desensitization plan does not show any progress within the 90 days, the team will reconvene and consider sedation for dental appts. [appointments] be added to his PTCR." According to Dental Department staff, no desensitization program was implemented. For Individual #114, the Center did not submit an ISPA that discussed his refusals and/or plans to improve this outcome, and no Dental											

Progress Notes referred to an ISPA or plan to improve this outcome.

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: Overall, IDTs did not have a way to measure clinically relevant, achievable, and measurable outcomes related to individuals' formal communication services and supports. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	304	363	42	167	327	269	114	91	187
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	25% 2/8	1/1	1/1	0/1	0/1	0/1	0/1		0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	25% 2/8	1/1	1/1	0/1	0/1	0/1	0/1		0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1		0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1		0/1	0/1

Comments: a. and b. Individual #114 had functional expressive and receptive communication skills.

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 #304 (pushing VOCA for medication administration, for which the assessment did not provide a rationale, and no baseline was established), and Individual #362 (attention to making a puzzle, for which it was unclear how this activity related to his desire to participate in Special Olympics).

c. through e. QIDP reviews included analysis of data for Individual #304 (pushing VOCA for medication administration), and Individual #362 (attention to making a puzzle). Although these individuals had made little to no progress on their goals/objectives, their IDTs did not review and modify them, as appropriate.

As noted above, Individual #114 had functional communication skills. He was part of the core group, so a full review was conducted for him. For the remaining eight individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals.

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	304	363	42	167	327	269	114	91	187
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	13% 1/8	1/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	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.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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

- Often, no evidence was found to show that recommended strategies were implemented.
- For Individual #363, therapy was only provided three times during the month of April 2017, and twice in May 2017. The IDT did not meet to address issues with completing therapy and methods to potentially improve the individual's availability and participation.

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
Summary: The Center should focus on ensuring individuals have their AAC devices with them, and that staff prompt individuals to use them in a functional manner. These indicators will remain in active monitoring. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "Overall Score."]			Individuals:								
#	Indicator	Overall Score	137	67	321	182	372	97	367	91	136
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	27% 3/11	1/1	0/1	0/1	0/1	1/2	0/1	0/1	0/1	0/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	0% 0/11	0/1	0/1	0/1	0/1	0/2	0/1	0/1	0/1	0/1
			Individuals:								
#	Indicator		40								
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		1/1								
b.	Individual is noted to be using the device or language-based support		0/1								

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

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

This Domain contains five outcomes and 20 underlying indicators. At this time, one will move to the category requiring less oversight.

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

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

For this review and the previous two reviews, post-move monitoring was completed at the required intervals. As a result, the related indicator will move to the category requiring less oversight. Some of the areas in which further efforts were needed related to the Post-Move Monitor basing decisions about supports on reliable and valid data using measurable criteria, and the PMM accurately rating the presence or absence of supports.

One of the two individuals reviewed had experienced multiple PDCT events, including a return to the Center. It was positive that for one of these events, the IDT and Admissions Placement staff identified actions that potentially would have reduced the likeliness of its occurrence. However, for the other negative events, the IDT did not develop a full list of necessary supports to reduce the likelihood of them recurring.

Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of transition assessments. Fortunately, transition staff at CCSSLC had self-identified the quality of assessments, as well as pre-move training as areas in need of improvement. Improvements also are needed with regard to, as needed, collaboration between Center and community clinicians, clinicians' completion of settings assessments, development and implementation of individualized transition activities, and improved documentation of the evidence to confirm the completion of pre-move supports. It was positive that IDTs showed good participation in the transition planning process, the CLDPs reviewed clearly defined who was responsible for action steps and the timeframes for completion, and IDTs reviewed the CLDPs with the individual and/or LAR. Similarly, ongoing collaboration was noted between LIDDA and APC staff during and after individuals' transitions.

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

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.											
Summary: Although some progress had occurred, more work was needed to make supports in the CLDPs measurable. In addition, a number of essential supports were missing from the CLDPs reviewed, and this should continue to be a focus for Center staff. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	86	97							
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1							
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1							

Comments: Since the last review, three individuals transitioned from the Center to the community. Two were included in this review (Individual #86, and Individual #97). Individual #86 transitioned to a group home that Corpus Christi SSLC operates, while Individual #97 originally transitioned to the home of her mother/Legally Authorized Representative (LAR) with provider host home supports. The Monitoring Team reviewed these two transitions, and while onsite, discussed them in detail with the Corpus Christi SSLC Admissions and Placement staff.

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 individuals' needs and preferences will be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. To move toward compliance, the IDTs should continue to focus on identifying the measurable criteria upon which the Post-Move Monitor (PMM) can accurately judge implementation of each support. Examples of supports that both met and did not meet criterion are described below:

- Pre-move supports: The respective IDTs developed four pre-move supports for Individual #86, and 18 pre-move supports for Individual #97.
  - For Individual #86, pre-move supports included the availability of several pieces of needed equipment, including a bath chair, a shower trolley and a G-tube pump. The CLDP also included a support for Individual #86 to attend an appointment with the community PCP prior to the move. These supports were measurable in terms of quantifying the presence of these very limited pre-move expectations, but they failed to consistently describe other important and related requirements. For example, the CLDP did not prescribe any pre-move training or evidence of staff competence even for the equipment it indicated needed to be in place. Overall, it was concerning the IDT did not require any staff training or evidence of staff competence to meet his needs.
  - For Individual #97, the IDT developed some measurable supports, such as for completion of lab work prior to the move. Other supports also described some pre-move training for provider staff and did have a level of measurability. The training supports addressed medication, diagnoses, risk factors, labs, appointments, testing, and reading blood sugar; what a hypoglycemic episode looked like and how to react; C-Pap use and maintenance; how to place wedges and bolster for positioning; psychiatric indicators; likes and dislikes; strengths; and, what was important to her. To

meet criterion, pre-move training supports should address the content of provider staff training, as well as describe the staff to be trained, the training methodologies to be used, and the competency criteria. The supports for Individual #97 met some, but not all of these criteria. More specifically, pre-move training supports that were included did not clearly indicate if the prescribed content also represented the specific competency criteria needed to confirm essential staff knowledge.

- It was positive these supports typically described staff to be trained, the training method and the training materials to be used. It was also positive the IDT sometimes described training methodology other than simply didactic training. For example, the CLDP specified that training for C-Pap use and placement of wedges/bolsters would be modeling
- To continue to move toward compliance, the CLDP should specify the competency criteria for these pre-move training supports. While it was positive the IDT made reference to how competency would be determined for these supports, they did not consistently specify the competency criteria that would be used for making that determination.

- Post-Move: The respective IDTs developed 30 post-move supports for Individual #86, and 20 post-move supports for Individual #97.
  - Overall, the IDT for Individual #86 developed supports that met criterion for measurability. This was commendable. The CLDP did, however, include one post-move support that was overly broad, calling for his Physical Nutritional Management Plan (PNMP) to be followed at all times or until the community habilitation therapists instructed otherwise. The support indicated this would include, but not be limited to, communication, medication administration, oral/dental care, transfers, mobility, positioning, dining plan, bathing, toileting, dressing, grooming, and usage of assistive equipment. The evidence to be reviewed included the PNMP, the equipment, and an interview with the provider nurse. This support did not specify any measurable criteria that could be used to demonstrate that supports to address his many needs in these areas were in place as needed. The presence of the PNMP document and the equipment would not be sufficient to demonstrate provider staff were knowledgeable of the needs or could competently implement them. The support did not describe what the interview with the provider nurse should cover for the purpose of ensuring his PNMP was implemented as required.
  - For Individual #97, the IDT also developed some measurable post-move supports, but did so with less consistency than the IDT for Individual #86. For example, the CLDP included post-move supports for provider training, but these did not consistently provide competency criteria. These supports called for only a signed roster and interviews as evidence. A signed roster only indicates that those being trained were present and does not confirm competence. Further, the support did not define who should be interviewed or define its expected content or outcome.

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

- Past history, and recent and current behavioral and psychiatric problems: The CLDPs did not include supports that comprehensively addressed past history, and recent and current behavioral and psychiatric problems. To meet criterion, the IDTs should continue their efforts to develop current and comprehensive supports. Findings included:

- For Individual #86, the IDT did not develop any supports for staff knowledge related to the individual's behavioral history. The quiz for the pre-move training the Center provided included a question that referenced a history of obsessive-compulsive disorder, self-injurious behaviors and rectal digging, and asked what staff should do if these were to recur. The training material, consisting of the behavioral health assessment (BHA,) did not provide any description of the behavioral topography related to his diagnosis of obsessive-compulsive disorder, and did not reference self-injurious behaviors or rectal digging at all.
- For Individual #97, the CLDP included a pre-move support calling for training for psychiatric indicators including mood instability and refusals; how to prevent and intervene with the psychiatric symptoms; historical behaviors and indicators (including sexual behavior and prostitution, theft, drug usage, self-injurious behavior, aggression) and what to do if they re-emerged; and how to fill out the data sheets. It was positive the pre-move training addressed psychiatric indicators and interventions and included a sample data sheet. Still, pre-move staff training did not address historical behaviors and indicators or how to address them if they re-emerged.
- The Monitoring Team was also concerned about the lack of clear supports for provider staff to be aware of Individual #97's history of swallowing inedible objects.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The respective IDTs developed supports in some areas related to safety, medical, healthcare, therapeutic and risk needs, such as for scheduling of health care appointments. To meet criteria, the IDTs still needed to develop clear and comprehensive supports in this area. For example:
  - For Individual #86, the IDT elected not to include many of his healthcare and therapeutic needs as formal supports; rather they indicated in the CLDP narrative that these requirements would be included in provider staff training and/or reflected in Special Instruction sheets. The CLDP also did not include formal supports for the indicated provider staff training.
  - For Individual #97, the CLDP did not address concerns about her weight with assertive supports. She was morbidly obese, had a diagnosis of diabetes, requiring daily medication, and had been gaining weight over the months preceding her transition. The CLDP did not include any specific supports related to her daily caloric needs. The nutrition discharge assessment stated she could not be expected to follow an exact calorie-controlled diet in the community, but did suggest several strategies such as taking "reasonable" portion sizes, avoiding fried foods, removing visible fat, and avoiding added salt and sugary foods. The IDT did not even include these in any formal supports.
  - The CLDP for Individual #97 did include a pre-move training support related to how to recognize and respond to a hypoglycemic event, but the Monitoring Team did not find evidence the training clearly addressed this issue. For example, the nutrition assessment indicated there should be regular jelly available to be given immediately in the event of a hypoglycemic event, to be followed up with a sandwich or meal. This would have been important staff knowledge. Neither the support nor the pre-move training included this strategy.
- What was important to the individual: Neither of the CLDPs met criterion. The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. Neither CLDP assertively addressed these outcomes. Findings included:
  - For Individual #86, the CLDP listed four ISP personal goals as important outcomes. The CLDP included a support for one of four outcomes, for using the library. It also identified living in the community as a personal goal and this was satisfied by the transition. The IDT indicated supports would not be developed for employment and the use of an

adaptive switch.
    - The CLDP for Individual #97 identified two goals from her ISP as having importance to her, but did not include formal supports to address either of these. One of these goals was to have a friend in the community, but the CLDP did not have any specific supports to facilitate attaining this outcome. The IDT also identified her ISP goal to take her medications independently as important, but indicated Individual #97's mother would be administering the medications for at least the first six months. The narrative suggested this goal might be pursued at some point in the future, but the IDT did not develop any formal expectation in this regard. As detailed below, the IDT also did not assertively address Individual #97's desire for employment, which her ISP and assessments documented as an important personal outcome.
- Need/desire for employment, and/or other meaningful day activities: Neither CLDP met criterion, as described below:
    - Individual #86 had been working in paper shredding while residing at the Center, earning $7.30 an hour. The vocational assessment recommended the provider allow for weekly exposure to different types of day activities to see what might capture his interest, since he lacked awareness of possible work or day activity in the community. This recommendation was not addressed. The CLDP narrative indicated only that he would be participating in shredding after he transitioned, but did not include any formal support in this area. Per interview with transition staff, Individual #86 actually had been able to continue working at the Center. It was positive the Center made this opportunity available, but it should have been reflected in the CLDP.
    - For Individual #97, work and earning money were important. While living at the Center, she was working in a janitorial position and earning minimum wage. Per the vocational assessment, she needed a job coach and transportation to support employment. The IDT did not develop assertive supports in this area. The CLDP included only one post-move support that called for an application to be completed and this was not due until 11/8/17, or six months after transition. The support did not reflect any actual employment outcome for Individual #97.
- Positive reinforcement, incentives, and/or other motivating components to an individual's success. For both individuals, the IDTs defined supports that included some elements of positive reinforcement and other motivating components.
    - For Individual #86, these supports were limited to two supports that addressed opportunities to listen to music for two hours each day. This did not meet criterion.
    - On the other hand, for Individual #97, the CLDP included a support for pre-move training that described in detail how to encourage, reinforce, and motivate her. This met criterion.
- Teaching, maintenance, participation, and acquisition of specific skills: The respective IDTs did not develop supports related to teaching, maintenance, participation, and acquisition of specific skills.
    - For Individual #86, the functional skills assessment (FSA) indicated he could use switches with assistance and understood cause and effect. It further indicated he could wash his face, independently take off his pants and underwear completely, as well as remove pull-over garments. The CLDP did not contain any supports to address maintenance of these skills or any other skill acquisition.
    - Individual #97 had skill acquisition programs at the Center for diabetes knowledge, budgeting using a ledger, bus usage, anger management, and self-administration of medication using a lock box. The IDT did not yet develop any supports for skill acquisition or maintenance.
- All recommendations from assessments are included, or if not, there is a rationale provided: Overall, Corpus Christi SSLC had a process in place for documenting discussion of assessments and recommendations, including the IDT's rationale for any

changes to, or additional, recommendations. As described in examples above, the IDT did not consistently address recommendations with supports or otherwise provide a justification.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.												
Summary: Given that over the last two review periods and during this review, the post-move monitoring was completed at the required intervals (Round 11 – 100%, Round 12 – 100%, and Round 13 - 100%), Indicator 3 will move to the category requiring less oversight. Some of the areas in which further efforts were needed related to the PMM basing decisions about supports on reliable and valid data, and the PMM accurately rating the presence or absence of supports. The remaining indicators will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	86	97								
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.	0% 0/2	0/1	0/1								
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	0% 0/2	0/1	0/1								
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1								
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A	N/A	N/A								
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A	N/A	N/A								
Comments: 3. Post-move monitoring was completed at required intervals for both individuals. Each of these post-move monitoring visits were within the required timeframes, were done in the proper format, and occurred at all locations where the individual lived or worked.												

4. The PMM Checklists did not yet consistently provide valid and reliable data. To continue to move toward compliance, the Center should work toward improving overall clarity and measurability of supports to provide guidance to the PMM as to what criteria would constitute the presence of various supports. In some supports, the language was broad and vague as described above in relation to Indicator #1. For example, for Individual #86, a support indicated his PNMP would continue to be followed at all times or until a community habilitation therapist instructed otherwise. The support listed the broad categories addressed in the PNMP (e.g. communication, mobility, positioning, dining plan, bathing, etc.), but it did not provide any specific criteria by which the PMM could confirm provider staff were implementing these as required. As evidence, the CLDP required the presence of the PNMP and needed equipment and an interview with the provider nurse. The CLDP did not include a training support for these many PNMP strategies or require any evidence that provider staff were knowledgeable and competent to implement them. The PMM only documented reviewing a copy of the current PNMP and interviewing provider supervisory and/or nursing staff who indicated staff continued to use the PNMP and that no changes had been made. She did not interview direct support staff or document the presence of all equipment.

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

- At the time of the seven-day PMM visit for Individual #86, the PMM appropriately determined the evidence indicated two supports were not in place as required. Provider staff had not consistently documented completing oral care or flushing of the G-tube. It was positive, though, that the PMM documented she took the necessary follow-up steps with the provider, notified the IDT, and obtained their input and approval. This was a good practice
- Since the date of transition on 5/8/17 through 7/6/17, Individual #97 had gained almost 30 pounds. Per the CLDP, the provider should have obtained a dietitian assessment within 60 days. Per the 90-day PMM documentation, the PMM reviewed a referral intake form, dated 6/20/17, indicating the assessment was still pending and had not yet occurred.

6. Based on the supports defined in the CLDP, the Post-Move Monitor's scoring was frequently correct, but this was not yet consistent. Examples included:

- The CLDP for Individual #86 included a support to be given the opportunity to check out at least one library book a month, beginning on 11/30/17. The IDT indicated the required evidence would be the library slip/receipt, the library books, observation of him obtaining the books, and observation notes. The PMM documented meeting with the provider Program Manager who reported Individual #86 had checked out a book. Based on that report, the PMM marked the support as in place. She did not document reviewing the library slip/receipt or independently verifying the presence of the library book, but should have. In general, the PMM should not rely solely on the verbal report of the provider, but should obtain some additional form of evidence that confirms that report.
- The CLDP for Individual #86 included a support to clean his stoma site daily with soap and water, pat the area dry and apply cream. The evidence required, per the support, included a review of the medication administration record (MAR) and an interview with the provider nurse. At the time of the 45-day PMM visit, the MAR did not document this cleansing process. The PMM interviewed the provider nurse, who stated this was nursing protocol, but she agreed to add it to the MAR. The PMM indicated follow-up would consist of review of the MAR at the next PMM visit. At the time of the 90-day PMM visit, the PMM found the provider had not made the agreed-upon change. When the PMM addressed this with the provider nurse, she stated

she had not added it because it was standard nursing protocol. The PMM marked the support as present at both intervals, but did not have the required evidence that would confirm this. The PMM should have marked the support as not in place based on the required evidence and brought this to the attention of the Center IDT to obtain guidance as to whether the provider's approach was acceptable.

- At the time of the 90-day PMM visit for Individual #97, the PMM marked the support for a dietitian assessment within 60 days as not applicable, but should have scored it as not in place. As described above, the evidence indicated the assessment was still pending and had not been completed.

7. and 8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed up through to resolution. Whether follow-up is completed as needed relies heavily on the accuracy of the PMM's assessment of whether supports were, or were not, in place. As described with regard to the previous indicators, the PMM immediately took needed follow-up when she accurately identified a support was not in place, such as for Individual #86's oral care and G-tube flushing supports. At other times, such as for Individual #97's dietary assessment, the PMM did not take needed follow-up because the support was not accurately identified as missing.

9. and 10. The Monitoring Team did not participate in post move monitoring 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.

Summary: One of the two individuals reviewed had experienced multiple PDCT events, including a return to the Center. It was positive that for one of these events, the IDT and Admissions Placement staff identified actions that potentially would have reduced the likeliness of its occurrence. However, for the other negative events, the IDT did not develop a full list of necessary supports to reduce the likelihood of them recurring. This indicator will remain in active oversight.

Individuals:

#	Indicator	Overall Score	86	97							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	50% 1/2	1/1	0/1							

Comments: 11. Individual #86 had not experienced a PDCT event. Individual #97 had experienced four PDCTs including a return to the Center. The first event occurred on 7/17/17, when she was hospitalized for an abscess and treated with intravenous antibiotics. On 7/27/17, she moved from her mother's host home to a group home. On 8/11/17, she experienced a psychiatric hospitalization, and on 8/17/17, she left the psychiatric setting and could not be located for a period of time. She finally returned to Corpus Christi SSLC on

8/23/17.

The IDT acknowledged it could have developed more comprehensive and assertive supports that may have reduced the likelihood of these negative events, and the Monitoring Team agreed with this assessment. It was positive the IDT identified specific areas for process improvement. It also identified some remedial actions, but did not consistently ensure these were completed. Findings included:

- The IDT met on a timely basis to review the first PDCT that occurred on 7/17/17. It accurately identified the event as potentially preventable and listed some additional actions the IDT should have taken, including developing a support for staff to monitor and ensure Individual #97 completed needed hygiene on a regular basis. The IDT identified she would have benefited from more complete supports about her dietary needs and diabetes diagnosis. The IDT noted it had developed a support for a dietary assessment to be completed within 60 days of transition, but that it had not yet occurred. One of the IDT recommendations was to complete that assessment as soon as possible. It was concerning that at the time of the 90-day PMM visit on 7/20/17, the PMM reviewed a referral intake form, dated 6/20/17, indicating an appointment was pending. The support was marked as not applicable. As described above, this support should have been scored as not in place. Given the circumstances, the PMM should have taken assertive action to find out when the appointment was to occur.
- The IDT met on 8/21/17 to review the move from the host home, the psychiatric hospitalization and the period in which Individual #97 could not be located. During that meeting, the IDT made the determination that she should return to Corpus Christi SSLC. Per the discussion, the IDT identified all three of the events leading up to the return to the Center had not been anticipated. However, they may have been preventable if the IDT had taken certain actions in the development of CLDP supports, particularly those that pertained to Individual #97's behavioral and psychiatric history and history of interpersonal conflict with her mother.

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.	
Summary: Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of transition assessments. Fortunately, transition staff at CCSSLC had self-identified the quality of assessments, as well as pre-move training as areas in need of improvement. Improvements also are needed with regard to, as needed, collaboration between Center and community clinicians, clinicians' completion of settings assessments, development and implementation of individualized transition activities, and improved documentation of the evidence to confirm the completion of pre-move supports. For this review and the previous one, IDTs showed good participation in the transition planning process, the CLDPs reviewed clearly defined who was responsible for action steps and the timeframes for completion, and IDTs reviewed the CLDPs with the individual and/or LAR. If the Center sustains this progress, Indicator 13 might move to less oversight after the next review. Similarly, Indicator 18 might move to less oversight after the next	Individuals:

review, because of the ongoing collaboration between LIDDA and APC staff during and after individuals' transitions. Currently, all of these indicators will remain in active oversight.											
#	Indicator	Overall Score	86	97							
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 needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/2	0/1	0/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/1	0/1							
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	100% 2/2	1/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							
Comments: 12. Assessments did not consistently meet criterion for this indicator. It was positive transition staff had been working with several disciplines on the quality of transition assessments and recommendations, and some improvement was observed. This remained an area of need, however. The Monitoring Team considers the following four sub-indicators when evaluating compliance: • Assessments updated within 45 Days of transition: Assessments provided for review consistently met criterion for timeliness,											

but the Center did not provide the following updated assessments:
    - The Center did not update the IRRF or pharmacy assessment/QDRR for either individual.
    - Otherwise, for Individual #86, the Center provided updated assessments in a timely manner.
    - For Individual #97, the Center indicated a medical assessment update had not been received for the CLDP.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Assessments did not consistently meet criterion. For example, for Individual #86, the BHA indicated he had a history of Obsessive Compulsive Disorder (OCD), although the Center had no knowledge of the related symptoms. It did not reference any other behavioral history, yet the pre-move testing materials asked staff what to do in the event he engaged in OCD, rectal digging, and/or SIB.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments that had been updated did not yet thoroughly provide recommendations to support transition. For example, the nutrition assessment for Individual #97 did not include specific dietary recommendations about caloric intake and/or how to achieve needed weight maintenance or reduction.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not fully address/focus on the new community home and day/work settings. Per interview, transition staff identified this as an area of focus and described an initiative they had undertaken to work with several disciplines toward improving the quality of these recommendations. Currently, assessments did not consistently meet criterion in this area. For example, the psychiatric assessment for Individual #97 made only a vague statement that additional medical follow-up might be necessary in order to ensure appropriate monitoring and to reduce the risk of side effects associated with medications.

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 for this indicator. Section IV of the CLDP document, entitled Community Living, provided a summary of transition activities that described the involvement of the individual and LAR/ family, the LIDDA, and Center staff. These summaries were helpful in understanding how the Center's transition processes ensured necessary participation.

14. Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required: Training provided to community provider staff did not yet meet criterion for these two individuals. Per interview, transition staff also self-identified pre-move training as an area for improvement. This was positive. The Monitoring Team requested and reviewed the materials, rosters, and competency testing for all training provided related to these transitions. Findings included:

- It was particularly concerning the IDT for Individual #86 did not identify any pre-move training or competencies for provider staff. The CLDP narrative did include some discussion about pre-move provider training, but the lack of supports and needed competencies did not provide the PMM with any expectation for assessing whether supports were being provided as needed, or any indicators by which to make that assessment.
- Neither IDT consistently identified the expected provider staff knowledge or competencies that needed to be demonstrated. Neither the supports nor the training materials clearly defined criteria that would demonstrate provider staff were competent

to provide for the individuals' health and safety.

- It was positive that for Individual #97, the IDT frequently described the type of training needed for provider staff and sometimes required provider staff to demonstrate competence, such as for the use and maintenance of her C-Pap machine.
- It was positive the Center made an effort, albeit still in a limited fashion, to define how provider staff competency would be confirmed that went beyond a written exam. To continue to move towards compliance, the Center should ensure its written exams are constructed to cover all essential knowledge. The testing materials the Monitoring Team reviewed fell short of this mark. Competency testing did not clearly document provider staff had knowledge of all essential supports based on each individual's needs.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The IDT should include in the CLDP a specific statement as whether any collaboration was needed, and if any completed, summarize findings and outcomes. The CLDP should evidence the IDT's specific consideration as to the need for such collaboration as well as the results of any collaboration that might have taken place, but did not.

16. SSLC clinicians (e.g., OT/PT) complete assessments of settings as dictated by the individual's needs: The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. Neither of the CLDPs provided evidence the IDT made such a consideration.

17. Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual: The CLDP should include a specific statement of IDT considerations of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results. Examples include provider direct support staff spending time at the Center, Center direct support staff spending time with the individual in the community, and Center and provider direct support staff meeting to discuss the individual's needs. The CLDPs for Individual #86 and Individual #97 did not provide evidence of this consideration.

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

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

- Neither PMSR provided any evidentiary documentation to confirm pre-move supports were in place. Each requirement was checked off as in place, but did not describe how that was determined. Just as with the PMM Checklists, the PMM should provide a succinct comment about the evidence relied upon to verify the support was in place.
- For Individual #86, the CLDP did not specify any staff competencies that needed to be in place on the first day of transition, so the PMSR did not address whether staff were prepared to meet his health and safety needs.
- While the CLDP for Individual #97 included numerous pre-move supports for pre-move training, these did not meet criterion for ensuring that provider staff were competent, as described above.

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary: For this review, and the last two, it was positive that individuals often transitioned to the community within 180 days, and that when they did not, documentation showed adequate justification. Given the importance of this indicator, it will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	86	97								
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	100% 2/2	1/1	1/1								

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

- Individual #86 was referred on 3/1/16, and transitioned on 9/13/17. This exceeded 180 days, but documentation provided adequate justification. During this period of time, Individual #86 experienced several medical issues that delayed his transition, including but not limited to bouts of pneumonia, skin integrity issues, and surgery in the groin area. These medical issues served as primary factors in the ultimate choice of provider, as it provided 24-hour nursing care.
- Individual #97 was referred on 12/5/16, and transitioned on 5/8/17. This was within 180 days and met criterion.

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