United States v. State of Texas

Monitoring Team Report

Corpus Christi State Supported Living Center

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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 Center Director supported the work of the Monitoring Teams, and was available and responsive to all questions and concerns. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

Status of Compliance with the Settlement Agreement

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

This domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, mortality review, and quality assurance. Nineteen of these were moved to, or were already in, the category requiring less oversight after the last review. During this review four other indicators in restraint, and incident management had sustained high performance scores and will be moved to the category requiring less oversight. One indicator in incident management will return to active oversight.

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

Restraint:
Overall, usage of crisis intervention restraint showed a decreasing trend over the review period. The census-adjusted rate now placed Corpus Christi SSLC at the fourth lowest in the state. PMR-SIB was eliminated for an individual for whom the restraints had been used for many years.

Note: Although the Monitor reports on the frequency and rate of crisis intervention restraint, crisis intervention restraint should be implemented when there is an imminently dangerous situation during which staff determine that a crisis intervention restraint is warranted.

Most (non-nursing) restraint documentation was in good order. Staff knowledge of restraint policy was good. Staff were very knowledgeable about the individual who was the subject of the interview.

A number of problems with the documentation the Center submitted with regard to nursing staff's role in restraints made the Monitoring Team's review difficult. Based on the documentation submitted, it was difficult to determine whether qualified nursing staff conducted the necessary assessments; what, if any concerns or injuries nursing staff identified; and whether nurses conducted necessary follow-up. For the chemical restraints reviewed, because nurses' documentation of the individuals' mental status at the time of the administration was not provided, the need for the chemical restraint was unclear. Nurses did not document the sites of the chemical restraint administrations.

There was sustained high performance regarding psychiatrists' involvement in crisis intervention chemical restraint applications.

Various problems with restraints were not picked up by the Center's restraint review process. The Restraint Review Committee process needs to be improved and be more robust. To be specific, there should be participation from CTD, and Unit staff (e.g., house manager, DSP). The Center had a difficult time producing documentation that post-restraint recommendations (from ISPA review) were completed.

In general, many of the issues regarding restraint management may be related to staff changes and adjustment periods as newer staff become accustomed to the restraint management requirements.

Abuse, Neglect, and Incident Management

In general, UIRs were well written, clear, and easy to follow. For the most part, investigation content was acceptable, as were findings and conclusions. There were, however, some exceptions. Audits of serious and non-serious injuries were well done. When investigations included recommendations, they were implemented.

More than half of the investigations did not meet criteria for the taking of immediate actions. In three cases, there was no immediate reassignment of the alleged perpetrators, in two cases, there was no immediate reassignment of the alleged perpetrators because the incident was reported late, and in two other cases, additional protections were not put into place.

There were several investigations that were delayed because of staff availability for interview. This may be an indication of lack of staff cooperation and should be explored.

There were instances where an HHSC PI investigation was not completed within 10 days. Some extension requests were deemed unacceptable when it was clear that the investigation process did not start in a timely manner (e.g., first staff interview on day 9, first staff interview on day 17).

In general, many of the issues identified during the review week in incident management may be related to incident management department staff vacancies, staff changes, and adjustment periods as newer staff become accustomed to the requirements.

Other

Teams were discussing pretreatment sedation; however, they were not implementing plans to possibly reduce future likelihood of usage (or providing a rationale as to why not).

It was positive that since the last review, Center staff completed quarterly Drug Utilization Reviews (DUEs), along with the necessary follow-up.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.												
Summary: The usage of crisis intervention restraint for imminently dangerous situations, and the usage of non-chemical and medication interventions for medical and dental procedures were occurring at low rates and/or at descending trends. This is reflected in the 100% scores for both indicators. PMR-SIB was eliminated for an individual for whom the restraints had been used for many years. These indicators remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	38	58	372	178	248	129	92	135	143
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	100% 12/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	100% 10/10	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (December 2017 through August 2018) were reviewed. Overall, there was a decreasing trend in the occurrence of crisis intervention restraint across the nine-month period, even taking into consideration a mid-period spike. Moreover, the census-adjusted rate was the lowest for the Center since the Monitoring Team began looking at this indicator, and the Center now had the fourth lowest rate in the state when compared with the other Centers. About half of the restraints occurred in consecutive time periods. The Center might consider, for their own usage, doing a supplemental graph to show the number of episodes per month.

The usage of crisis intervention physical restraint paralleled the trend in the overall usage of crisis intervention restraint because most crisis intervention restraints were crisis intervention physical restraints. Moreover, the average duration of a crisis intervention physical restraint was descending across the review period to now at about one minute, one of the lowest average durations in the state. There were few crisis intervention chemical restraints (four in the review period) and no crisis intervention mechanical restraints. There was no usage of protective mechanical restraint for self-injurious behavior (PMR-SIB). Since the last review, the Center had taken a thoughtful and systematic approach to fading the PMR-SIB that existed for one individual (Individual #9).

Similarly, the number of individuals who had one or more crisis intervention restraints each month showed a descending trend across the nine-month review period and when compared with the previous two nine-month review periods. The most recent month showed only two individuals (August 2018). The Center also reported few injuries as a result of restraint implementation, all deemed non-serious (however, see comments regarding nursing assessments of individuals after a restraint occurrence).

Regarding supports for medical and dental procedures: the Center reported no usages of non-chemical restraints, and no usages of pretreatment sedation for dental procedures. A table showed the total usage for this and the previous nine-month periods for pretreatment sedation for medical and for TIVA usage. Both showed less during the most recent nine-month period. For the next

review, the Center should put these data into a graph with a data point for each month so that trends during the nine-month period can be viewed.

Thus, Corpus Christi SSLC scored positively for all 12 of these sub-indicators.

2. Four of the individuals reviewed by the Monitoring Team were subject to restraint. In addition, a restraint for one other individual was included. Of these five individuals, four received crisis intervention physical restraints (Individual #248, Individual #129, Individual #135, Individual #7) and two received crisis intervention chemical restraint (Individual #135, Individual #143). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for all of the five individuals. The other five individuals reviewed by the behavioral health Monitoring Team had no occurrences of crisis intervention restraint and were scored positively for this indicator.

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

This topic was discussed during the onsite visit based upon direct observations of the Monitoring Team. In one example, Individual #100 sustained an injury to his head after displaying serious self-injurious behavior. No restraint was implemented. Another example was a review of a video recording in which Individual #129 made repeated attempts in a crowded dining room to injure others with chairs or other items. There was no evidence of a physical escort to guide Individual #129 to another area where the risk of injury could be reduced. While every effort should be made to reduce the use of crisis restraint, this should remain an option when dangerous conditions exist.

Additional comments:
PMR-SIB: A very positive outcome was the recent elimination of PMR-SIB for Individual #9. The use of mittens and a helmet were discontinued in early April 2018. He was now wearing elbow pads and a terry cloth wristband on his right wrist. His staff member reported that Individual #9 was doing well and that he occasionally pulled at or picked at the terry cloth band instead of his elbow pads. The Monitoring Team observed a positive interaction between Individual #9 and his staff during a lunchtime. The staff member placed a filled spoon in Individual #9's hand and he independently brought this to his mouth to feed himself. He did the same when offered a drink. That being said, the BHS staff are advised to increase observations because an increase in SIB was reported in his most recent progress note.

Video reviews: The director of BHS initiated a review of all video recordings of restraint. This is a commendable effort to ensure that restraint in employed correctly and only when necessary. During and after review of the video, however, staff speculated about the events that led to the restraint, even though verbal interactions could not be assessed due to a lack of sound or when the view of the individuals involved was occasionally obscured. This resulted in an incomplete and, perhaps, inaccurate assessment of the variables that resulted in restraint. Video review can be helpful as a training opportunity to determine whether the operational definition

requires greater clarity, to assess staff members' understanding of the operational definition and measurement system, and to provide re-training as needed.

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. Although indicator 9 was not rated, comments are provided below regarding supports being in place to reduce the likelihood of restraint in the future. In addition, there were problems in the documentation for both of the crisis intervention chemical restraints (indicator 10). The Monitor will leave this in less oversight, but the Center will need to correct the problem in order for it to stay in this category after the next review (see comments below). Indicator 11, with sustained high performance might be moved to the category of requiring less oversight after the next review. However, please see comments below regarding indicator 11 and the need for more detail in the IRRF. Indicators 9 and 11 will remain in active monitoring.		Individuals:									
#	Indicator	Overall Score	248	129	135	143	7				
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The restraint was a method approved in facility policy.										
5	The individual posed an immediate and serious risk of harm to him/herself or others.										
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.										
7	There was no injury to the individual as a result of implementation of the restraint.										
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.										
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated				
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 6/6	1/1	1/1	2/2	1/1	1/1				

Comments:
The Monitoring Team chose to review six restraint incidents that occurred for five different individuals (Individual #248, Individual #129, Individual #135, Individual #143, Individual #7). Of these, four were crisis intervention physical restraints, and two were crisis intervention chemical restraints. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

9. Because criterion for indicator #2 was met for all of the individuals, this indicator was not scored for them. For this indicator, the Monitoring Team looks at eight different sub-indicators. Even though not rated, the Monitoring Team found that individuals were missing some relevant assessments, full implementation of PBSPs, and engagement in activities. Nevertheless, the use of restraint was low for these indicators.

10. There were problems with the documentation for both of the crisis intervention chemical restraints. This was discussed with the restraint management staff during the onsite week who, said they will make corrections going forward. Given the past performance of the Center on this indicator, it will remain in less oversight, but needs to be corrected in order to continue to be.

11. There should be, but wasn't, some brief statement in the IRRF indicating that the team considered individualized possible contra-indications for the individual, that is, for example, that the team looked at the active problem list (e.g., how osteoporosis might affect the usage or prohibition of restraint).

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.												
Summary:			Individuals:									
#	Indicator	Overall Score										
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
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: Overall, performance was good for indicator 13, with one exception. 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	248	129	135	143	7				
13	A complete face-to-face assessment was conducted by a staff member	83%	0/1	1/1	2/2	1/1	1/1				

	designated by the facility as a restraint monitor.	5/6									
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				

Comments:
13. For Individual #248 7/12/18, the IRIS document showed "no" in response to query, "assess immediate consequences." The Center provided some additional explanation, but no additional supporting documentation.

Note: The Center's use of "Textual Results" on the IRIS forms was useful in understanding what happened (i.e., circumstances surrounding the restraint incident). These notes were also used to correct errors on the IRIS form. For example, for Individual #135 7/17/18, it noted "corrected from Bear Hug" with the name of the person making the entry and date/time of the entry. This was a good practice.

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.

Summary: A number of problems with the documentation the Center submitted with regard to restraints made the Monitoring Team's review difficult. Based on the documentation submitted, it was difficult to determine whether qualified nursing staff conducted the necessary assessments; what, if any concerns or injuries nursing staff identified; and whether nurses conducted necessary follow-up. For the chemical restraints reviewed, because nurses' documentation of the individuals' mental status at the time of the administration was not provided, the need for the chemical restraint was unclear. Nurses did not document the sites of the chemical restraint administrations. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	248	129	135	143	7				
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	17% 1/6	1/1	0/1	0/2	0/1	0/1				
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	33% 2/6	1/1	0/1	1/2	0/1	0/1				
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	17% 1/6	1/1	0/1	0/2	0/1	0/1				

Comments: The restraints reviewed included those for: Individual #248 on 7/12/18 at 6:09 p.m.; Individual #129 on 3/12/18 at 3:53 p.m.; Individual #135 on 4/11/18 at 6:08 p.m. (chemical), and 7/17/18 at 7:31 p.m.; Individual #143 on 6/29/18 at 11:57 p.m. (chemical); and Individual #7 on 3/7/18 at 1:04 p.m.

a. through c. For Individual #248's restraint on 7/12/18, the nurse performed physical assessments, documented whether there were any restraint-related injuries or other negative health effects, and took action, as needed to meet the needs of the individual.

For Individual #135's restraint on 7/17/18, the nurse documented whether or not the individual sustained restraint-related injuries or other negative health effects.

The following provide examples of problems noted:

- Overall, the Center did not provide IView documentation for the restraints reviewed. With only the Flowsheets, it was not possible to determine the names and titles of the staff conducting/ documenting the assessments. For the next review, Center staff should correct this issue.
- For Individual #129's restraint on 3/12/18, no nursing IView documentation was provided. The IPN, dated 3/12/18, at 8:25 p.m., did not include any details regarding why the restraint was conducted or the time the nurse attempted an assessment. In the IPN, the nurse made no mention of an assessment to determine whether or not the individual sustained injuries related to the restraint procedure.
- For Individual #135's chemical restraint on 4/11/18, the Monitoring Team requested the PCP's order for the chemical restraint. In response, the Center indicated: "Physician order not available in record." However, one was included with the Medication Administration Record (MAR) documentation request response. The nursing IPN, dated 4/11/18, at 10:15 p.m., did not include justification for the administration of a chemical restraint, and did not indicate whether or not the individual had to be restrained for the injection. In addition, the note indicated the nurse administered the injection in the individual's right arm. The appropriate site for an intramuscular injection would be the deltoid. In addition, it was not clear from the IPNs which nurse called and received the order for the Ativan 2 milligram (mg) IM chemical restraint. The MAR provided did not clearly indicate if the nurse listed took the verbal order, or if she was the one that administered the Ativan IM. The Center did not provide any IView documentation. The Flowsheets provided noted vital signs were taken/attempted, but no nurses' names were provided on the Flowsheets and assessment comments were cut off the sheets. The documentation made no mention of a nursing assessment to determine whether or not the individual sustained injuries related to the restraint procedure. In addition, it was unclear how the individual moved from the road back to the Center, and if he was cooperative during this time.
- For Individual #143, in the IPN, dated 6/30/18, at 12:30 a.m., the nurse did not indicate the site where the chemical restraint was administered. In the IPNs provided, nurses did not indicate when the PCP transmitted the order for the chemical restraint. The MAR provided did not clearly indicate if the nurse listed took the verbal order, or if she was the one that administered the Ativan IM. The Center provided no IView documentation. The documentation submitted made no mention of a nursing assessment to determine whether or not the individual sustained injuries related to the restraint procedure. In addition, based on the documentation submitted, staff did not document the circumstances that necessitated the police bringing the individual back to the Center from the Dollar Store.
- For Individual #7, the nursing IPN, dated 3/8/18, at 12:31 p.m., indicated that staff "attempted bear hug restraint" on 3/7/18, but the restraint was not reported until the next day. However, the Flowsheet provided indicated that at 1:25 p.m., on 3/7/18, a nurse was notified of the restraint. A note indicated that on 3/8/18, at 12:23 p.m., the PCP was notified. No IPN was found for 3/7/18, addressing the restraint episode. The Center's response to the Monitoring Team's request for the PCP order indicated: "Physician order not available in record." However, an order was included with the MAR documentation request

response, but it was dated 3/8/18. No IView documentation was provided.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.											
Summary:			Individuals:								
#	Indicator	Overall Score									
15	Restraint was documented in compliance with Appendix A.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments:											

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
Summary: Performance remained about the same as at the last review. Attention to documentation should result in improved scores for indicator 16. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	248	129	135	143	7				
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	33% 2/6	0/1	1/1	1/2	0/1	0/1				
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	75% 3/4	1/1	N/A	2/2	N/A	0/1				
Comments: 16. Various problems with restraints were not picked up by the restraint review process. This included consultation before using crisis intervention chemical restraint, and restraint reviewed by the IMRT. 17. For Individual #7 3/7/18, the Monitoring Team could not determine implementation of home restriction, in part, because it was not defined or operationalized or reviewed by human rights committee.											

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: Due to sustained high performance regarding psychiatrist involvement in crisis intervention chemical restraint, indicator 47 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	135	143							
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 2/2	1/1	1/1							

48	Multiple medications were not used during chemical restraint.	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. Two individuals received crisis intervention chemical restraint during this review period. Individual #135 had two administrations, on 4/11/18 and 5/7/11. Individual #143 had one administration, on 6/29/18. The post-chemical restraint clinical review form, for all of these incidents, was reviewed by the clinical pharmacist and the psychiatrist within the required 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 continued to reduce the likelihood of incidents occurring by completing the required staff-related activities and by looking at trends for all investigations chosen for review. For two, however, there was no indication that PBSPs were being implemented with integrity. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	58	372	178	248	129	92	135	143
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	83% 10/12	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
			9	300	91						
			1/1	1/1	0/1						

Comments:
The Monitoring Team reviewed 12 investigations that occurred for 12 individuals. Of these 12 investigations, 10 were HHSC PI investigations of abuse-neglect allegations (three confirmed, four unconfirmed, one inconclusive, one unfounded, one referred for administrative review). 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 #38 and others, UIR 18-219, HHSC PI 46854627, administrative referral of allegation of neglect, 4/14/18
- Individual #58 and another, UIR 18-330, HHSC PI unknown, pending allegation of neglect, 8/31/18
- Individual #372, UIR 18-235, HHSC PI 46977973, unconfirmed allegation of physical abuse, 5/18/18
- Individual #178, UIR 18-317, HHSC PI 47397403, unconfirmed allegation of physical and verbal abuse, 8/13/18
- Individual #248, UIR 18-282, HHSC PI 47299978, confirmed allegation of physical abuse, 7/21/18
- Individual #129, UIR 18-245, HHSC PI 47052871, unconfirmed allegation of neglect, abbreviated investigation, 5/31/18

- Individual #92 and another, UIR 18-247, HHSC PI 47054548, confirmed and unconfirmed allegations of neglect, 6/1/18
- Individual #135, UIR 18-189, injury, peer aggression, 4/6/18
- Individual #143 and others, UIR 18-229, HHSC PI 46910511, unfounded allegation of neglect, streamlined investigation, 5/9/18
- Individual #9, UIR 18-164, HHSC PI 46548653, inconclusive allegation of physical abuse, 3/6/18
- Individual #300, UIR 18-185, confirmed and inconclusive allegations of neglect and sexual abuse, 3/30/18
- Individual #91, UIR 18-280, discovered fracture, hip, 7/18/18

1. For all 12 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, criminal background checks and duty to report forms were completed and available for review. For nine of the 12, the investigation was regarding solely allegations of staff misconduct and, for each of these, there were no relevant individual-related trends to be reviewed. For the other three, trends were monitored and a plan was in place (Individual #129 UIR 18-245, Individual #135 UIR 18-189, Individual #91 UIR 18-280). But for the latter two of these, there was evidence of staff training, but no evidence of checks of staff integrity regarding PBSP implementation.

Three individuals in the review group were subject to streamlined investigations, depending on specific criteria regarding the allegation. HHSC PI protocols were being implemented by HHSC PI for maintaining and assessing continued placement on the list. Similarly, SSLC protocols were being implemented by the Center, specifically, regarding a plan to address the frequent calling (in these cases, within a PBSP).

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

Summary: Half of the investigations chosen for review included problems with meeting reporting requirements. Some were reported slightly beyond the one-hour time requirement. Others involved circumstances where staff were present, but did not report the allegation or injury. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	58	372	178	248	129	92	135	143
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	50% 6/12	0/1	0/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1
			9	300	91						
			0/1	0/1	1/1						

Comments:
2. The Monitoring Team rated six of the investigations as being reported correctly. The other six 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 #38 UIR 18-219: Per HHSC PI, the incident occurred on 4/14/18 and was reported on 5/1/18. Per the UIR, the incident was reported to a supervisor on 4/14/18. The UIR also reported that it was unknown why it was not also reported to DFPS Intake.
- Individual #58 UIR 18-330: The reports showed that whoever reported this incident to DFPS Intake at 9:30, did not also report it to facility director/designee. The UIR showed the reporter as unknown, but it seemed likely that it was staff (by the comments in the HHSC PI interviews) or perhaps by the Center's security video operator. Nothing in the UIR showed an attempt to identify the reporter (e.g., a staff member).
- Individual #248 UIR 18-282: Per the HHSC PI report, the incident occurred at 6:48 pm and DFPS Intake received the report at 7:52 pm, just beyond the one-hour time requirement. It was reported by the Center's video operator (a good practice), but presumably, there were other staff in the room who witnessed the excessive force/choking and should have reported it (this case was confirmed for physical abuse). During the onsite week, the Center provided a statement that "there was no information to suggest staff failed to intervene or report abuse." The Center has since re-opened the case. It is possible that there was at least one other staff in the room where this incident took place who should have reported and did not.
- Individual #135 UIR 18-189: The UIR stated that the incident occurred at 4:34 pm and was reported to facility director/designee at 8:14 pm with a notation "reported within one hour of incident." It turned out that it was reported to director/designee by staff who were at the emergency room, when sutures were applied. The nature of this injury (deep laceration to right side of lip) should have triggered staff to immediately report it to the director/designee.
- Individual #9 UIR 18-164: The investigation reports showed the reporter as unknown. It looked like whoever reported it to DFPS Intake did not also report it to the director/designee. The HHSCI PI report showed that the incident occurred at 6:25 pm and DFPS Intake received the report at 7:28 pm, just past the one-hour time requirement. Intake then notified director/designee at 7:47 pm. During the onsite week, the Center provided a statement that the time discrepancy could have been because the reporter was on hold with DFPS intake.
- Individual #300 UIR 18-185: The reporter was unknown. Per the UIR, the alleged incident occurred while on a van ride with more than one staff in the van. The HHSC PI report stated that the incident occurred on 3/6/18 and was reported on 3/30/18. Staff in the van presumably were aware of this transgression and should have immediately reported.

Note: During the onsite review, the incident management department staff reported that they would be addressing, with a plan, the problem of telephone wait times leading to late notification of the Center and the potential immediate implementation of protections for individuals.

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: For indicator 4, sub-indicator .2, regarding the IDT/ISP review and discussion about abuse, neglect, and injuries, for six of the 12 individuals, the ISP stated that injuries and/or allegations/investigations occurred, but gave no data, summary, or indication of the outcome of investigations. However, for one individual, Individual #129, the information was a particularly good example of a summary of this type of information.			Individuals:									
#	Indicator	Overall Score										
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.											
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:												

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.												
Summary: Seven of the 12 investigations did not meet criteria for the taking of immediate actions. In three cases, there was no immediate reassignment of the alleged perpetrators (Individual #372 UIR 18-235, Individual #178 UIR 18-317, Individual #92 UIR 18-247). In two cases, there was no immediate reassignment of the alleged perpetrators because the incident was reported late (Individual #58 UIR 18-330, Individual #300 UIR 18-185). In two cases, additional protections were not put into place (Individual #248 UIR 18-282, Individual #129 UIR 18-245). As a result, indicator 6 will be returned to active monitoring.			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: In three cases, extensions were requested because witnesses were not available. The UIRs did not, but should have, explained the circumstances around their unavailability (e.g., refusal to cooperate, out on medical leave). This indicator will remain in the category of requiring less oversight, but this aspect of investigation documentation needs to be corrected for this indicator to remain in this category. Further, understanding the reasons for staff unavailability may lead to certain actions being taken by the Center.			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: In general, UIRs were well written and the content was easy to follow. This was good to see. Given sustained high performance, indicators 8 and 9 will be moved to the category of requiring less oversight. That being said, the Center needs to attend to the investigative activity noted in indicators 4.2, 6, and 7 above. Indicator 10 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	58	372	178	248	129	92	135	143
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 12/12	1/1	1/1	1`/1	1/1	1/1	1/1	1/1	1/1	1/1
			9	300	91						
			1/1	1/1	1/1						
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 12/12	38	58	372	178	248	129	92	135	143
			1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
			9	300	91						
			1/1	1/1	1/1						

10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	92% 11/12	38	58	372	178	248	129	92	135	143
			1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
			9	300	91						
			1/1	1/1	1/1						

Comments:
10. For Individual #248 UIR 18-282, from the contents of the UIR, it appeared that the Center follow-up did not address actions/inactions of witnesses to the incident and any culpability they may have had for not intervening in the altercation and/or immediately reporting it.

Outcome 7– Investigations are conducted and reviewed as required.

Summary: Three investigations were not completed within the 10-day requirement. Further, first interviews were not conducted until one to two weeks after the report for these three investigations. This needs to improve in order for indicator 12 to remain in the category of less oversight and, moreover, to ensure the validity of investigations and, thus, protections for individuals. Indicator 13 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	58	372	178	248	129	92	135	143
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.	42% 5/12	1/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1	1/1
			9	300	91						
			0/1	0/1	1/1						

Comments:
12. Three investigations did not meet the 10-day requirement and, moreover, did not conduct a first interview until one to two weeks after the report.

13. The supervisory review did not detect the various problems identified in the investigations, such as late reporting, alleged perpetrator reassignment, and/or late completion of the investigation. The expectation is that the facility's supervisory review process will identify the same types of issues that are identified by the Monitoring Team. In other words, a score of zero regarding late reporting or interviewing of all involved staff does not result in an automatic zero score for this indicator. Identifying, correcting, and/or explaining errors and inconsistencies contributes to the scoring determination for this indicator.

That being said, incident management review team daily meetings were comprehensive and included lots of involvement, commentary, and direction from the Center Director. This was a good practice that should help to improve the incident/investigation review process.

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: Injury audits were well done. This was an improvement from previous reviews, was good to see, and is reflected in the positive/high scores for both indicators. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	58	372	178	248	129	92	135	143
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 12/12	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
			9	300	91						
			1/1	1/1	1/1						
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	83% 10/12	38	58	372	178	248	129	92	135	143
			1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
			9	300	91						
			1/1	0/1	1/1						

Comments:
15. For Individual #248 there was conflicting information as to whether a non-serious injury was or was not witnessed. For Individual #300, not enough information was provided to be able to determine if she did or did not have any non-serious injuries.

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

Summary: Some investigations that should have had recommendations, did not. When recommendations were made, however, the Center implemented them. This has been the case for this and for the previous three reviews too (with one exception). Thus, indicator 18 will be moved to the category of requiring less oversight. Indicator 16 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	58	372	178	248	129	92	135	143
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	73% 8/11	1/1	1/1	1/1	0/1	0/1	0/1	N/A	1/1	1/1
			9	300	91						
			1/1	1/1	1/1						
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% 5/5	38	58	372	178	248	129	92	135	143
			N/A	N/A	1/1	N/A	N/A	1/1	N/A	1/1	1/1
			9	300	91						
			N/A	N/A	1/1						

Comments:

16. Three investigations did not meet criteria.
    - For Individual #178 UIR 18-317, there should have been a recommendation addressing the lack of staff availability that ended up causing a delay in completion of the investigation by HHSC PI.
    - For Individual #248 UIR 18-282, there should have been a recommendation addressing the lack of staff intervention at the time of the altercation given five or so other staff were present.
    - For Individual #129 UIR 18-245, the UIR showed no recommendations. There should have been one calling for an IDT review (though this did occur). Incident management staff should not assume that the IDT will meet after an investigation, it should always be included as a UIR recommendation, and then tracked for completion.

17. There were two cases that included a confirmation of physical abuse category 2. In both cases, the employment of the confirmed staff member was not maintained.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.												
Summary: This outcome consists of facility indicators. 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. All but one of the required categories of data were being tracked and trended: outcomes of investigations were not tracked and trended. In addition, unlike the other Centers, the trend report did not include data on non-serious injuries. Trending of non-serious injuries can lead to identifying areas in need of improvement 21-23. There were some action plans, but they were written in general terms, such as "Continue to implement…" That is, they were not stated in a way that could lead to a measurable description of the problem, that states a series of specific actions to be taken, and a data based method to evaluate whether the actions actually improved the problem.												

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104

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	0/1	0/1	N/A	N/A	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. As discussed in the last report, the Center's policies with regard to criteria for the use of TIVA, as well as medical clearance for TIVA/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 procedures and assessment completed, and post-operative vital sign flow sheets were submitted with documentation showing nurses completed vital signs at the frequency the policy requires.

b. Based on the documentation provided, during the six months prior to the review, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation for dental procedures.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A

Comments: a. For Individual #268, who received oral pre-treatment sedation for an ophthalmology appointment on 8/8/18, staff followed proper procedures. It was good to see that although the individual refused vital signs, nurses recorded respiratory rates, which do not require the individual's cooperation.

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: Teams were discussing pretreatment sedation; however, they were not implementing plans to possibly reduce future likelihood of usage (or providing a rationale as to why not). These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	38	58							

		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.	100% 2/2	1/1	1/1							
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	100% 2/2	1/1	1/1							
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	0% 0/2	0/1	0/1							
4	Action plans were implemented.	N/A	N/A	N/A							
5	If implemented, progress was monitored.	N/A	N/A	N/A							
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A	N/A	N/A							

Comments:

1-2. Based upon the documentation provided, two of the nine individuals, Individual #38 and Individual #58, had experienced pretreatment sedation over the previous 12 months. Each of their ISPs included a description of their observed behavior if pretreatment sedation was not used for medical appointments. Restraint plans and/or ISPA meeting minutes included recommended supports (e.g., familiar staff for Individual #58 and familiar staff and a preferred object/snack for Individual #38), risk/benefit analysis of the use of pretreatment sedation, and informed consent from the facility director and Human Rights Committee. Another document provided by the facility indicated that Individual #38's LAR had also provided consent.

3. The restraint plan for Individual #38 noted that a desensitization assessment was completed in March 2018, but at that time a plan was not recommended. At a follow-up meeting held in September 2018, it was agreed that a service objective would be developed to train staff in strategies to support Individual #38 during medical appointments. This was not evident in her current ISP.

The IDT had developed a desensitization plan to try to improve Individual #58's cooperation with dental exams. Based upon the information provided in the restraint plan, revised in October 2017, the IDT had agreed to continue the plan due to slow progress. This was not identified in the ISP as an action plan nor was there a SAP or SO to ensure its completion.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	209	327	247	77					
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, five individuals died. The Monitoring Team reviewed four of the five deaths. Causes of death were listed as:

- On 1/20/18, Individual #209 died at the age of 60 with the causes of death listed as acute respiratory failure, and pneumonia.
- On 7/1/18, Individual #327 died at the age of 65 with the cause of death listed as chronic respiratory failure.
- On 7/2/18, Individual #247 died at the age of49 with the cause of death listed as dysphagia.
- On 9/6/18, Individual #77 died at the age of 60 with the cause(s) of death pending an autopsy.
- On 9/19/18, Individual #44 died at the age of 56 with the cause(s) of death pending.

b. through d. Although the death reviews identified a number of important recommendations, overall, evidence was not submitted to show the Center conducted thorough reviews of 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:

- As indicated in previous reports, overall, the nursing reviews of deaths were not sufficient to identify problems with nursing care that required remediation. For each death, the Center provided a Quality Improvement Death Review of Nursing Services.

It included a narrative of events occurring in the 72 hours prior to the individual's death. The reports did not reflect comprehensive reviews of essential areas, such as risk areas, the quality and implementation of IHCPs, ISPs, ISPAs, implementation of Acute Care Plans, nursing assessments and documentation, and the IDT's response to issues. Often, information and/or data were not included to support the recommendations included in the reviews.

- At times, the Mortality Review Committee deferred recommendations citing that the identified issue was not a problem, and, therefore, the recommendation was not needed. However, the Committee did not request additional data or information to confirm that the individuals' needs had been met.
- Individual #77's mortality review should have resulted in a recommendation for an in-service training on antibiotic stewardship, but it did not. PCPs should receive periodic training on the McGeer criteria on urinary tract infections (UTIs) and other infections. Such training should include when PCPs should order a urinalysis, and criteria for documentation in the IPN.

e. The recommendations generally were not written in a way that ensured that Center practice had improved. For example, a recommendation that read: "DSPs [direct support professionals] will be provided training on documenting in CareTracker and any additional tracking methods on voids/BMs [bowel movements]" identified in-service training rosters as the evidence of completion. This in no way ensured that concerning practices changed. The recommendation should have been written in a manner that required monitoring to determine whether or not DSPs consistently and accurately completed necessary documentation.

Some of the recommendations generated from the nursing review of Individual #209's death included the following:

- Doctors to discuss the possibility of having protocol and x-rays for elevated temperatures.
- Ribbonfish nurses to be re-trained on Hyperthermia guidelines and documentation.
- Ribbonfish nurses to be re-trained on what to notify the Doctor of when calling for orders and how to document that.
- Ribbonfish nurses to be re-trained on when to contact a Physician.

There was no documentation provided indicating that these recommendations were addressed.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
a.	ADRs are reported immediately.	N/A									
b.	Clinical follow-up action is completed, as necessary, with the individual.	N/A									
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A									
d.	Reportable ADRs are sent to MedWatch.	N/A									
Comments: a. through d. Center staff had not identified and/or reported adverse drug reactions for any of the individuals reviewed.											

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
Summary: It was positive that since the last review, Center staff completed quarterly DUEs, along with the necessary follow-up. If the Center sustains this performance, after the next review, these indicators might move to the category of less 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% 4/4
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 four DUEs, including:

- A DUE on statins and atherosclerotic cardiovascular disease (ASCVD) risk that was presented to the Pharmacy and Therapeutics (P&T) Committee on 6/21/18, for which follow-up was not needed;
- A DUE on acute seizure treatment that was presented to the P&T Committee on 6/21/18, for which follow-up was completed;
- A DUE on medications for acute seizures that was presented to the P&T Committee on 3/29/18, for which follow-up was completed; and
- A DUE on olanzapine that was presented to the P&T Committee on 3/29/18 (i.e., the original DUE was completed on 12/21/17), for which follow-up was completed.

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. Twenty-three of these indicators, in psychiatry, behavioral health, medical, dental, nursing, and skill acquisition, were moved to, or were already in, the category requiring less oversight after the last review. For this review, five other indicators were moved to this category, in psychiatry, and dental.

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

Assessments

The Center continued to serve an increasing number of individuals with a need for trauma-informed care as well as other mental health needs, but had few resources in place to address those needs. For example, many individuals needed counseling, but had been unable to access it.

For about half of the individuals, the IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP. But then, IDTs did not consistently arrange for and obtain those needed, relevant assessments prior to the IDT meeting.

In psychiatry, there was timely submission of annual updates for all individuals. Psychiatrists were attending ISP meetings. Some of the required content, however, was not in the finalized ISP document.

In behavioral health services, individuals who needed a PBSP, had a PBSP. Two individuals with PBSPs, however, did not have behavioral health goals. At the time of the document request, the Center stated that Behavioral Health Assessments were not available, for more than half of the individuals. These were provided when requested onsite. These contained most, but not all, components. One quarter of individuals had a current functional behavior assessment. None of the FBAs were considered complete in terms of content.

In skill acquisition, individuals had the required assessments. Not all of these assessments, however, were available to the IDT as required, and not all included recommendations for skill acquisitions.

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.

Center staff should continue to improve the quality of the medical assessments, with a particular focus on complete problem lists, and plans of care for each active medical problem, as appropriate.

Due to the Center's sustained good performance with regard to the completion of comprehensive annual dental summaries for individuals' ISP meetings, the related indicator will move to the category of less oversight. In order to improve dental exams, individuals with periodontitis need periodontal probing and charting, and if this is not possible, the Dentist needs to document challenges and decisions to recall the individual to complete the periodontal charting.

For seven out of nine individuals reviewed, nurses completed timely annual or new-admission nursing reviews and physical assessments. Problems were noted with regard to nurses' timely completion of quarterly nursing record reviews and/or physical assessments.

It was positive that for most individuals reviewed, nurses completed annual and quarterly physical assessments that addressed the necessary components. Work is needed to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to individuals' at-risk conditions. In addition, when individuals experience changes of status, nurses need to complete assessments in accordance with current standards of practice.

When individuals reviewed were referred to the PNMT, the PNMT completed timely reviews and/or assessments. However, at times, when individuals should have been referred to the PNMT, IDTs did not refer them, and the PNMT did not make self-referrals. Although additional work was needed, some progress was noted with regard to the quality of PNMT comprehensive assessments.

Since the last review, 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 improved. The quality of OT/PT assessments continues to be an area on which Center staff should focus, but some improvement was noted there too.

Significant work is needed to improve the quality of communication assessments and updates in order to ensure that SLPs provide IDTs with clear understandings of individuals' functional communication status; AAC options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of communication supports are objectively evaluated.

Individualized Support Plans

There was improvement in the ability of QIDPs to speak with some fluency about the health and safety needs of the individuals on their caseloads. This has been a focus of a Center CAP for the last couple of years. While additional improvement continued to be needed, this was a sign of progress.

The QIDP Coordinator continued to conceptualize, create, and implement quality management tools to improve the development and implementation of ISPs. These included an ISPA Quality Review Checklist, an Unusual Incident ISPA template, and Action Plan Checklist, and the QIDP Monthly Review Monitoring Tool.

There was little progress in the identification of meaningful and measurable personal goals for the ISPs. For example, almost all individuals did not have relationships goals, even though assessments and other documentation indicated significant needs and barriers in this area. Quality aspects of an ISP were not being met (outcome 2, indicators 8-18). The Center should take a systematic approach to improving the quality of its ISPs.

ISPs and action plans were not implemented timely. The Center had not made progress in the completion of timely QIDP monthly reviews. The QIDP Coordinator attributed this finding to significant staffing changes in the department, but reported that this had begun to stabilize.

Corpus Christi SSLC made good progress towards identifying and defining psychiatric indicators. The psychiatry team at the Center appeared to have a good understanding of this (i.e., psychiatric indicators, goals, documentation, data) and had a plan to continue to move forward. Consents for psychotropic medication met all content requirements.

In behavioral health services, the PBSP was current for less than half of the individuals. None of the PBSPs were considered complete in terms of content. Data were not shown to be reliable, either by the Center's own assessment of reliability or by the Monitoring Team's observation of behavior occurrences that were not recorded in the Center's data system.

The Center continued to work on obtaining counseling services for those who needed it. Given the complex needs of many of the individuals, counseling availability and provision should be addressed as soon as possible. Recommendations from ISPAs that were the responsibility of behavioral health services staff were not always completed (e.g., related to trauma-informed care for one individual, related to another individual's ingestion of batteries).

In skill acquisition, individuals continued to have SAPs. Many/some were based on assessment results, were meaningful, and had reliable data.

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.

Center staff continued to make improvements with regard to the inclusion of OT/PT strategies and interventions in individuals' ISPs. To move forward, QIDPs and OTs/PTs should work together to make sure IDTs discuss and include in ISPs information related to individuals' OT/PT functioning, and that IDTs review PNMPs and/or Positioning Schedules, and document the results in the ISPs.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.

Summary: Corpus Christi SSLC did not make progress in developing personal goals that met the various criteria and contained the various characteristics. In other words, about the same number of goals met criteria as during the last review and there were a number of examples of goals that were not aspirational or meaningful for the individuals. Further, even those that did meet criteria were not written in measurable terminology (indicator 2). These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	178	129	135	184	268			
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	2/6	1/6	2/6	2/6	3/6			
2	The personal goals are measurable.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #38, Individual #135, Individual #129, Individual #178, Individual #184 and Individual #268. 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 measurable personal goals. For this review period, none of the six ISPs contained individualized and measurable goals in all areas; therefore, none had a comprehensive set of goals that met criterion. The Monitoring Team found little progress since the previous monitoring visit in the identification of meaningful and measurable personal goals for the ISPs reviewed.

1. Twelve personal goals met criterion as aspirational statements of outcomes, based on an expectation that individuals will learn new skills and have opportunities to try new things that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. There was no significant change from the previous monitoring visit, when 13 goals met criterion. Findings included:

- Personal goals that met criterion were:
    - Leisure goals for Individual #129 and Individual #268.
    - Work/Day goals for Individual #38, Individual #135, Individual #178 and Individual #268.
    - Independence goals for Individual #178 and Individual #184.
    - Living options goals for Individual #38, Individual #135, Individual #184 and Individual #268.
- Five of six individuals (Individual #38, Individual #129, Individual #178, Individual #184, Individual #268) did not have relationships goals, even though assessments and other documentation indicated significant needs and barriers in this area.
- Two of six individuals (Individual #129, Individual #268) had leisure goals that met criterion with this indicator, based on their expressed interest in bike riding. Individual #135 did not have a leisure goal, but should have, based on his needs. The remaining four individuals had leisure goals, but they did not meet criterion.
    - For example, Individual #38 and Individual #184 had leisure goals that were not aspirational: the goal for Individual #38 was to operate her recliner and the goal for Individual #184 was to apply Chapstick twice a day. These may have served as action plans that supported a more assertive goal, but did not stand alone as personal goals that expanded opportunities to try new leisure activities or being part of and valued by the community.
    - The Monitoring Team did note that Individual #38's IDT had been working to increase her willingness to go on community outings, with good success, but they still needed to propose an assertive and meaningful leisure goal. At the time of her annual ISP meeting, which was held during the monitoring visit, the IDT discontinued the goal to operate the recliner and replaced it with a goal to use her wheelchair brakes while in the community. Again, this did not address helping Individual #38 to discover and/or learn new leisure interests, which was a significant need. Using her wheelchair brakes could have been a good action plan to support more independence during leisure activities.

2. To meet criterion for this indicator, personal goals should include a specific, observable outcome that is clearly defined with who/what/where/when/how ("W") components. It should also be stated in observable/measurable terms and action verbs rather than vague terminology, such as "participation" or "being an active member." Based in these expectations for measurability, none of the

12 goals identified in Indicator 1 met criterion.

3. None of the personal goals met criterion for both Indicators 1 and 2, so the Monitoring Team did not have a basis for evaluating whether reliable and valid data had been collected.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: Each of these 11 indicators was scored as 0%. That is, these quality aspects of an ISP were not being met for any individual. Given the low performance in outcome 1 (indicators 1-3) and in this outcome (indicators 8-18), the Center should take some systematic approach to improving the quality of its ISPs. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	178	129	135	184	268			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	1/6	1/6	1/6	1/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	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.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	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	0%	0/1	0/1	0/1	0/1	0/1	0/1			

	achieving goals.	0/6									
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
As Corpus Christi SSLC further develops more individualized personal goals, it is likely that action 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. Each personal goal must have measurable action plans, whether skill acquisition plans (SAPs), service objectives for participation or for staff tasks (SOs), or Integrated Health Care Plans (IHCPs), that list the necessary steps to meet the personal goal. The action plans to achieve the goal should address what is hoped to be accomplished over the next year to meet each personal goal. If there is not a clear link between the action plans and the personal goal, there should be evidence in the ISP explaining how the action plans relate to the expectations for what is to be accomplished within the year.

Action plans also need to be individualized based on the needs of the individual. As described under Indicator 1, it was positive this group of individuals had some personal goals that met criterion. It was, therefore, unfortunate that many of those goals did not have assertive action plans that met the criteria described above. Some goals did have related action plans, but these were only minimally or tangentially related to the achievement of the goal.

For example, the IDTs developed aspirational community vocational goals for Individual #135, Individual #178, and Individual #268, but did not describe specific and individualized action plans that focused on developing needed work skills. While it was positive that the IDTs for Individual #135 and Individual #268 did develop action plans to address behavioral barriers, these did not offer opportunities to engage in preferred work or related tasks. The IDTs needed to develop action plans with opportunities that allowed individuals to experience the aspirations embodied in the personal goals, in addition to addressing barriers. These experiences may need to be somewhat limited in the beginning, if, for example, significant behavioral barriers exist. Still, IDTs should keep in mind the reinforcing and motivational of being able to engage in preferred work activities and the likelihood these would have a positive impact on the behavioral barriers as well.

9. None of six ISPs contained a set of action plans that clearly integrated both preferences and opportunities for choice in an assertive manner. IDTs continued to demonstrate increased proficiency in developing action plans that integrated preferences, which was positive, but offered minimal, if any, opportunities for choice-making. For example:

- Individual #184 had an action plan for work that did not reflect his preferences and his ISP did not include any formal opportunities for choice. He did have a SAP for applying Chapstick of his choice, but the SAP steps did not include offering him a choice, instead focusing solely on application.
- The narrative in Individual #268's ISP cited opportunities for choice that included being able to choose between a puzzle or other activity in classroom and to participate in programming or not. These were not assertive.

10. None of six ISPs clearly addressed strengths, needs, and barriers related to informed decision-making. The IDTs had not developed such action plans for these six individuals. IDTs should consider that action plans that promote the ability to make choices, as referenced above, can serve as stepping stones toward informed decision-making.

11. None of six ISPs met criterion for supporting overall independence. The IDTs did identify some action plans to support independence, but often did not address identified needs in this area in an assertive manner. In addition, many of the related SAPs and SOs had either not been developed and implemented or had inconsistent implementation. Examples included, but were not limited to:

- The IDT for Individual #38 did not integrate communication strategies into her action plans as recommended.
- Both Individual #129 and Individual #178 had good potential for, at least, semi-independent living, but their respective IDTs had identified few opportunities for learning independent living skills. Both individuals had a money management SAP for using a ledger to budget, which was positive, but each of these offered just four training opportunities per month. Individual #178 had an action plan for a cooking class, but with little implementation thus far.
- The Center should consider exploring the opportunities for independent living skills training at the local Center for Independent Living (Coastal Bend Center for Independent Living at http://cbcil.org/programs/independent-living-services.) Available instruction may include personal care, coping, financial management, social skills, and household management, as well as education and training necessary for living in the community and participating in community activities. The CIL may also offer peer counseling, which might be of benefit to both women.

12. IDTs did not assertively address risk areas in a consistent manner. IDTs were sometimes slow to react to both ongoing and emerging risks and often did not take assertive action to assess and develop needed interventions. None of six ISPs met criterion. Examples of findings for this visit included:

- For Individual #268, the IDT failed to address significant unplanned weight loss over a period of many months. He had lost 30 pounds between December 2017 and September 2018, including at least two instances of losing more than five pounds in a single month without action by the IDT. The IDT finally made a referral to the dietitian in mid-September 2018 after Individual #268's legally authorized representative (LAR) expressed concern, but did not refer to the physical and nutritional management team (PNMT) despite having met criteria as defined in Center policy. IDT members, including the QIDP, nurse, and dietitian were unable to articulate the role of the PNMT in addressing such needs or the specific criteria by which a PNMT assessment would be triggered. The Center's episode tracker system, which is intended to provide another method of identifying risk trends, also failed to result in PNMT recognizing and acting on this issue.
- The Center continued to serve an increasing number of individuals with a need for trauma-informed care as well as other mental health needs, including Individual #135, Individual #129, and Individual #178, but had few resources in place to address those needs. For example, all three of these individuals needed counseling, but had been unable to access it for many months. There had been some recent positive movement in this area, but Individual #129 had still not been able to receive counseling, even though the IDT had documented the need repeatedly for at least a year.
- Also for Individual #129, the IDT had not assertively addressed ingestion of batteries, including a failure to accurately identify the full scope of this concern. The team met in mid-September 2018 to discuss this issue shortly after an episode of ingestion and documented that she had had two other episodes, one each in April 2018 and July 2018. It did not identify two other episodes that had occurred in May 2018. Per an ISPA at the end of May 2018, the IDT planned to refer for a root cause analysis related to this behavior. This had not occurred, even though she has had two more episodes in September 2018 and one during this October 2018 monitoring visit.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy,

dental), and any other adaptive needs were not well-integrated, as also described throughout this report. In addition to the examples provided in #12 above, the IDTs did not assertively address other needs such as the following:

- The IDTs had not addressed behavioral needs in an assertive manner. For example:
  - The IDT did not develop assertive behavioral strategies to prevent ingestion of batteries for Individual #129. Her current PBSP did not address ingestion of batteries. The IDT met after each episode of ingestion and specified a plan to fade one-to-one supervision, but per the documentation and staff interview, did not follow the plan as described.
  - Individual #135 had frequently exhibited dangerous physical aggression resulting in injury to staff and peers. The IDT held his annual ISP meeting in August 2018 without having obtained a current behavioral health assessment (BHA) or structural functional analysis (SFA). At the time of the document request for this monitoring visit, he still did not have available the needed BHA, SFA, a current positive behavior support plan (PBSP), or his needed crisis intervention plan (CIP).
- The IDTs for Individual #38, Individual #184 and Individual #268 did not assertively address their communication needs with effective strategies. For example:
  - The IDT had not integrated Individual #38's communication need and strengths, particularly her use of signs, throughout her daily schedule. It was positive that during the ISP annual planning meeting observed onsite, the IDT discussed a strategy for putting a poster of the signs she knows and/or uses in her room, but still needed to give more consideration for how to formally integrate their functional use within the action plans.
  - Individual #268's IDT included an action plan for an SO to use a picture schedule, but the IDT had not developed or implemented this strategy.
- The IDT did not assertively address Individual #184's mobility needs. He had been hospitalized for a lengthy period and returned in a weakened condition. The primary care practitioner (PCP) stated Individual #184 should keep actively attempting ambulation to prevent deterioration and the IDT determined that he was to be reassessed for a walking program and incentives to participate. A direct ambulation program by the physical therapist (PT) began upon his return, but was then discontinued in favor of an indirect plan implemented by direct support professionals (DSPs). This latter plan was not assertive: it was to take place two to three times per week times a week and did not specify how long or how far he should walk. There had been very little implementation since the indirect program was begun. He sometimes refused to participate even with his reinforcement of miniature cars and trucks. The behavioral health specialist (BHS) noted he likes water guns/toy guns and it was agreed to use these to encourage participation, but this was not included in the indirect program. The PT documented reviewing the minimal data available, but took no action to ensure implementation on an assertive basis.

14. Meaningful and substantial community integration action plans were largely absent from the ISPs for these six individuals. Findings included:

- It was positive the IDT for Individual #38 had implemented a desensitization SAP for getting on the van to facilitate going to community outings, but the ISP action plan for community participation consisted of only one visit to an amusement park.
- Individual #135 had one SAP to make a purchase while on outings, but otherwise no action plans for community participation or integration.
- Individual #178's ISP included several missed opportunities for community participation and integration. For example, she had a leisure goal for meditation that could have easily translated to a community yoga studio.
- Individual #268's ISP included one community action plan to attend a tractor show or visit a fire department. It lacked a formal

implementation strategy, such as an SO, and had not been implemented.

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

- Despite personal goals for community work, the ISPs lacked assertive action plans that provided a path to achievement or even exposed the individuals to specific and individualized community work exploration. This was the case for Individual #135, Individual #129, Individual #178, and Individual #268.
- Individual #178's ISP did include an action plan to be assessed for community work, but it lacked a formal implementation methodology and the QIDP Monthly reviews documented that no job introductions had been completed.

16. None of the six ISPs included action plans that laid out substantial opportunities for functional engagement with sufficient frequency, duration, and intensity throughout the day to meet individuals' personal goals and needs. ISPs often provided limited opportunities for learning and functional engagement and even those had often not been implemented. For example:

- Individual #178's action plans did not lay out substantial opportunities for functional engagement with sufficient frequency, duration, and intensity throughout the day to meet her personal goals and needs. Her sole action plan for leisure was to meditate once a week. She did not have a relationships goal or any action plans despite significant needs in that area. She was not enrolled in cooking class, as the ISP indicated, until August 2018 and no activity had been undertaken for attending college classes. She was working approximately five hours per week in an on-campus job, but the IDT had documented no effort toward identifying community employment opportunities to meet her preference.

17. The IDT did not consistently address barriers to achieving goals. Overall, IDTs did not effectively address barriers to community transition with individualized and measurable action plans as described below in Indicator 26 and did not consistently address barriers to lack of implementation of the ISP. Examples included:

- It was positive the IDT for Individual #38 did address her barrier to leaving the home with a desensitization plan, but had not acted to address community living awareness for her or for her LAR with action plans that were either assertive or measurable.
- The IDTs for Individual #129 and Individual #178 did not ensure their self-injurious behaviors, which were barriers to independence, were addressed in their current PBSPs.

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, such as adequate instructions for teaching skills. Data had not been demonstrated to be valid or reliable, as described elsewhere in this report. Living options action plans for increasing awareness for the individual and/or LAR did not have measurable outcomes.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.	
Summary: There were some good examples where criterion was met for some of the indicators for some of the individuals. But overall, Corpus Christi SSLC was not regularly meeting most of these indicators. These indicators will remain in active monitoring (except for 20 and 22).	Individuals:

#	Indicator	Overall Score	38	178	129	135	184	268			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	67% 4/6	1/1	1/1	0/1	1/1	1/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
21	The ISP included the opinions and recommendation of the IDT's staff members.	17% 1/6	0/1	0/1	1/1	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
23	The determination was based on a thorough examination of living options.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	33% 2/6	1/1	1/1	0/1	0/1	0/1	0/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	100% 1/1	1/1	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	N/A	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 1/1	0/1	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:

19. Four of six ISPs (Individual #38, Individual #135, Individual #178, Individual #184) included a description of the individual's preference for where to live and how that was determined. Those that did not meet criterion were:

- Per interview, Individual #129 indicated very clearly that she was interested in supported living as an option, but the IDT had not discussed this.
- The IDT was not able to reliably describe the preferences for Individual #268 due to his lack of exposure to and awareness of community living options.

20. For the ISP meeting observed, Individual #38's preference for where to live was described and this preference appeared to have been determined in an adequate manner.

21. One of six (Individual #129) ISPs fully included the opinions and recommendation of the IDT's staff members. Findings included:

- Assessments often provided a statement of the opinion and recommendation of the respective team member. However, some important assessments were not available at the time of the ISP to provide the required opinions and recommendations. This was the case for Individual #38 and Individual #135.
- While improvement was noted overall, 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. For example:
    - The communication screening for Individual #184 did not make the required statement and recommendation. In addition, his IDT made inconsistent statements and recommendations without evidence the IDT reconciled them. The medical statement and recommendation were both positive, while those from behavioral were both negative, but for medical reasons. The IDT needed to examine this discrepancy.
    - The behavioral health staff for Individual #268 based his discipline-specific recommendation on the LAR's preference.

22. Five of six ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR. Individual #178's IDT had not met since her re-admission to complete a new ISP or to review and revise the ISP in place prior to her unsuccessful community transition and so, had not made a current statement. She had been referred again at her request, but the IDT did not provide documentation that the entire IDT had weighed in on this decision.

23. One of six (Individual #38) individuals had a thorough examination of living options based upon their preferences, needs and strengths. Otherwise, these ISPs did not reflect a robust discussion of available settings that might meet individuals' needs. For example:

- Individual #135 had a history of failed community living due to behavioral issues. He stated he would like to live in a group home, but the IDT did not document any discussion about what he felt his needs in the group home would be or what supports he thought he would need for success in future transitions.
- The IDT for Individual #184 did not document any examination of possible living options that might have been available near his family.
- The IDT for Individual #268 documented some attempt to describe a community setting that would address his preferences and needs, which was positive, but no discussion about available options.

24. One individual (Individual #178) was currently referred for transition. One of the remaining five ISPs (Individual #38) 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. Examples of those that did not included:

- The IDT for Individual #129 indicated LAR choice as the barrier due to unsuccessful prior placements. It did not indicate behavioral/ psychiatric needs as a barrier, but should have because that was the specific rationale cited for the determination by the IDT professionals.
- The IDT for Individual #184 documented LAR choice as the barrier, but should also have listed medical needs because the IDT

indicated it did not recommend transition due to recent health issues. The IDT also documented his lack of individual awareness, so should have likewise identified this a barrier.

25. For the annual ISP meeting observed for Individual #38, the IDT identified a comprehensive list of obstacles to referral.

26. None of five individuals who had not been referred had individualized, measurable action plans, with learning objectives or outcomes to address obstacles to referral. IDTs did not specify learning or awareness outcomes or plan to collect data to evaluate awareness for any of the individuals for whom this was a barrier.

27. For the annual ISP meetings observed for Individual #38, the IDT did not develop assertive action plans to address/overcome the identified obstacles. The IDT did not acknowledge a sense of urgency in this matter. The IDT members frequently spoke about how important Individual #38's parents were to her; in fact, they were the only thing in her life she responded to in a consistently positive manner. Further, the IDT noted the parents were elderly and in poor health, which made it impossible for them to continue to visit her at the Center. The IDT's estimation that transition should be a long-term plan did not factor in the reality that she might have not have a long-term opportunity to be near her parents and spend time with them.

28. None of six ISPs had individualized and measurable plans for education, as described above in Indicator 26.

29. Six of six individuals had obstacles identified at the time of the ISP. Individual #178 had recently been re-referred for transition at her request. The Monitoring Team noted the IDT had not discussed obstacles, but needed to do so, particularly in light of the recent unsuccessful transition.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
Summary: ISPs were not implemented timely, accommodations were not made for individual participation, and some important IDT members were not present to participate in the ISP meeting. Indicators 31-34 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	178	129	135	184	268			
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.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	33% 2/6	0/1	0/1	1/1	0/1	0/1	1/1			

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

Comments:

31. Individual #178 was re-admitted to Corpus Christi SSLC on 5/16/18, after an unsuccessful community transition that began on 3/1/18. At the time of the document request for this monitoring visit, the Center indicated it had been instructed by state office to review and implement her previous ISP, dated 12/1/17, and implement it as applicable. The IDT did not document a timely or thorough meeting to address a review of the ISP as a whole and to make revisions based on needs that had changed during that time, including, but not limited to, her behavioral needs.

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

33. Two of six individuals (Individual #129, Individual #268) participated in their ISP meetings. The IDTs sometimes did not consider making needed accommodations to facilitate individuals' participation. For example:

- For Individual #135, the ISP documentation indicated he paced during the meeting, sat down next to the QIDP, and then said he was sorry and asked if they could continue the meeting later. He further said he was getting tired and didn't want to be there anymore. The IDT encouraged him to stay, but eventually he said he had to leave. The documentation indicated the ISP meeting continued without consideration for continuing the meeting at a later time as he originally requested.
- The ISP documentation for Individual #184 indicated he couldn't attend the ISP meeting because he was in the hospital. In such instances, the IDT could seek an extension. At least, the IDT should have held an addendum meeting after his return to review the goals and action plans with him, as well as to make revisions based on any changes in status, needs or preferences. As documented elsewhere in this section, for example, the ISP developed without his participation did not address his changed preferences for work or day program.

34. None of six ISPs met all criteria for this indicator, which considers whether all IDT members participate in the planning process, based on individual need, and are knowledgeable of the personal goals, preferences, strengths and needs articulated in the ISP. Examples included:

- Individual #129 was at high risk for weight and for medication side effects, but neither nutrition staff nor psychiatry participated in her ISP.
- For Individual #268, who had been experiencing significant unplanned weight loss, no nutrition staff participated. Similarly, habilitation staff did not participate despite his high risk for falls and use of protective devices, including helmet and kneepads.
- As described above, the IDT did not meet for the purpose of reviewing and revising Individual #178's ISP after her re-admission.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: Both indicators scored lower than at the last review, and both will remain in active monitoring.			Individuals:								
#	Indicator	Overall	38	178	129	135	184	268			

		Score									
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	50% 3/6	0/1	0/1	1/1	1/1	1/1	0/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting for three of six individuals (Individual #135, Individual #129, Individual #184). Examples of those that did not were:

- The ISP Preparation documentation for Individual #38 did not specify a requirement for a vocational or day program assessment, despite having informally attempted to encourage her to attend over the previous year. A good assessment may have offered the IDT some ideas for day programming that may have motivated her attendance.
- By time of Individual #268's ISP in February 2018, he had experienced significant unexplained weight loss; this should have prompted a PNMT referral for assessment, but did not.
- For Individual #178, the IDT did not indicate whether assessments should be updated when she returned from community transition. Some IDT members updated their assessments upon her re-admission while others did not, but this was not based upon an IDT determination of needs.

36. IDTs did not consistently arrange for and obtain needed, relevant assessments prior to the IDT meeting. None of six ISPs met criterion. For example:

- Individual #135 did not have a BHA or SFA available for his ISP meeting.
- For three individuals (Individual #129, Individual #184, Individual #268), the QIDP did not complete the individual capacity assessment (ICA) until after the ISP annual planning meeting was held.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
Summary: ISP action plans were not being implemented, reviewed, and/or revised. The QIDP Coordinator had numerous plans in place for future improvement. Turnover in staffing had negatively impacted performance. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	178	129	135	184	268			
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:
Note: The performance on these indicators remained of significant concern. There had been little progress in ensuring the implementation of ISP action plans, based on the review for these six individuals. The QIDP Coordinator continued to conceptualize, create, and implement quality management tools to improve the development, implementation, and monitoring of ISPs. These included:

- ISPA Quality Review Checklist.
- Unusual Incident ISPA template.
- Action Plan Checklist.
- QIDP Monthly Review Monitoring Tool.

The Monitoring Team commended this effort. As the QIDP workforce has begun to stabilize after a period of staff changes and shortages, these initiatives should result in some improvements in ISP outcomes.

37. IDTs did not revise the ISPs as needed, as evidenced throughout this section and others. For all individuals, many 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.

38. The finding above reflected negatively on the role of the QIDP to ensure individuals received required monitoring/review and revision of treatments, services, and supports. Further:

- The Center had not made progress in the completion of timely QIDP monthly reviews. One of six individuals had consistently timely reviews of monthly progress. The Monitoring Team, however, had identified timeliness of these reviews as a positive trend at the time of the previous review. The QIDP Coordinator attributed this regression to significant staffing changes in the department, but reported this had begun to stabilize.
- Monthly reviews provided minimal analysis regarding progress or outstanding needs. The Center had just begun to use the new Monthly Report format developed by State Office that prompted a summary analysis of progress for goals, which should lead to improvement in this area in the future. This will only be effective if timeliness also improves, as analysis of old data has minimal impact on the ability of the IDT to make revisions as needed.

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.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
a.	The individual's risk rating is accurate.	11% 2/18	0/2	0/2	0/2	0/2	0/2	1/2	1/2	0/2	0/2

b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	44% 8/18	0/2	1/2	1/2	2/2	0/2	2/2	1/2	1/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #129 – other: pain, and behavioral health; Individual #178 – weight, and osteoporosis; Individual #184 – falls, and constipation/bowel obstruction; Individual #303 – constipation/bowel obstruction, and skin integrity; Individual #268 – falls, and infections; Individual #307 – constipation/bowel obstruction, and urinary tract infections (UTIs); Individual #247 – skin integrity, and constipation/bowel obstruction; Individual #8 – circulatory, and osteoporosis; and Individual #104 – constipation/bowel obstruction, and choking].

a. The IDTs that effectively used supporting clinical data, and used the risk guidelines when determining a risk level were those for Individual #307 – UTIs, and Individual #247 – skin integrity.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs completed IRRFs within 30 days of admission and for the most part updated the IRRFs at least annually (i.e., the exception was for Individual #268, for whom the IDT did not complete the section of the IRRF for skin integrity/infections). However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #178 – osteoporosis; Individual #184 – constipation/ bowel obstruction; Individual #303 – constipation/bowel obstruction, and skin integrity; Individual #307 – constipation/bowel obstruction, and urinary tract infections (UTIs); Individual #247 – skin integrity; and Individual #8 – osteoporosis.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: Corpus Christi SSLC made good progress towards meeting the requirements of this set of indicators (and sub-indicators). This is evident in the 1/2 scores in many of the individual scoring boxes below (and one 2/2 score, for indicator 6). The psychiatry team at the Center appeared to have a good understanding of these indicators (i.e., psychiatric indicators, goals, documentation, data) and had a plan to continue to move forward. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	58	372	178	248	129	92	135	143
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	0% 0/9	1/2	1/2	1/2	0/2	0/2	1/2	1/2	1/2	0/2
5	The individual has goals related to psychiatric status.	0% 0/9	1/2	1/2	1/2	0/2	0/2	1/2	0/2	1/2	0/2
6	Psychiatry goals are documented correctly.	11%	0/2	1/2	0/2	0/2	1/2	1/2	1/2	2/2	0/2

		1/9									
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments:
The scoring in the above boxes have a denominator of 2, which is comprised of whether criteria were met for all sub-indicators for psychiatric indicators/goals for (1) reduction and for (2) increase.

Note that there are various sub-indicators. All sub-indicators must meet criterion for the indicator to be scored positively.

At Corpus Christi SSLC, there was much progress in many of the sub-indicators.

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

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

In psychiatry, the focus is upon what have come to be called psychiatric indicators. These are the observable, measurable symptoms chosen by the psychiatrist (with input from behavioral health services and IDT members) to determine the presence, level, and severity of the individual's psychiatric disorder. They are hypothesized to be, for the most part, due to the individual's psychiatric disorder.

Psychiatric indicators can be measured via recordings of occurrences of indicators directly observed by SSLC staff. Another way is to use psychometrically sound rating scales that are designed specifically for the psychiatric disorder.

The Monitoring Team looks for:

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

4a. One of the ways Corpus Christi SSLC made progress was that each individual had at least one psychiatric indicator for reduction at

least one indicator for increase. Thus, criteria were met for this sub-indicator for all individuals for both types of indicators.

4b. In the detailed discussions with the psychiatric team, they were able to describe a plausible link between the psychiatric diagnosis and the indicator(s) for reduction. The rationales that were discussed also appeared in the goal grids that were contained in the quarterlies as well as the APTP. Thus, criteria were met for this sub-indicator for all individuals for indicators for reduction.

All of the indicators for increase were related to either the individual's attendance at class or vocational program or their participation in outings. Various combinations of these activities were also used for some individuals. The linkage to each individual's diagnosis was a variation on the logic that if the symptoms of their psychiatric disorder were under better control, they will be more likely to participate in these activities. As a common-sense proposition that had some merit.

The problem, however, with utilizing this for every individual was that it did not take into account the factor of preference. The individual may not be attending the program because they do not find it stimulating. There was also no individualized evidence that supported an empirical correlation/connection between their attendance at the program and the severity of their psychiatric symptoms. In addition, the attendance data were routinely presented as absolute numbers rather than as a percentage of the number of times that the activity was offered to them. The duration of time they spent at the vocational program would also be important in determining the significance of this factor. Thus, criteria were not yet met for this sub-indicator for indicators for increase.

4c. The psychiatric team described the objective behaviors with sufficient detail that they should be able to be monitored for six of the individuals. For Individual #178, Individual #248, and Individual #143, there were behavioral criteria that were too subjective to be accurately monitored.

For indicators for increase, whether or not the individual attended an outing or vocational program would at first appear to be a yes/no issue that could be easily measured, but without the additional information described above in 4b, this information is of little value. These comments are not meant to imply that the attendance at program and participation in outings are not viable considerations with more specific refinements.

Thus, for indicators for reduction, all three sub-indicators were met for six individuals. For indicators for increase, all three sub-indicators were not met for any individuals. Therefore, for six individuals a score of 1/2 is shown in their scoring boxes above.

5. Psychiatric goals:
The Monitoring Team looks for:

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

5d. The psychiatric team wrote goals for the psychiatric indicators to decrease for each individual. Each individual had a goal written for psychiatric indicators to increase.

5e. There was an attempt to define the type of data and how they were to be collected for each of the individuals. The description of

these data for the goals for reduction, and how they were to be collected, was too subjective to be effective for Individual #178, Individual #248, Individual #92, and Individual #143. The goals for increase all referenced the attendance data, which is described above in indicator 4. As noted in that discussion, there were fundamental flaws in the lack of specify related to the collection of these data, which made the those measures inadequate for the purpose of assessing progress toward meeting the goals.

Thus, for indicators for reduction, both sub-indicators were met for five individuals. For indicators for increase, the two sub-indicators were not met for any individuals. Therefore, for five individuals a score of 1/2 is shown in their scoring boxes above.

6. Documentation:
The Monitoring Team looks for:

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

6f. The goals for reduction did not yet routinely appear in an IHCP in the ISPs. For Individual #135, the 8/1/18 ISP did list a goal to reduce the frequencies of aggression and property destruction over the next ISP year. Six of the individuals (all except Individual #178, Individual #372, and Individual #38) had goals related to their attendance at activities in the section of the ISP labeled Personal Outcome Goals. These all listed a target percentage for the next year (but again, there was no linkage to the psychiatric disorder).

6g. The psychiatric team had this year reached a point where they were developing goals that had the potential to be viable. Therefore, there were not goals from the prior year to be updated or modified. This would likely occur during the next ISP year.

Thus, for indicators for reduction, indicator 6f was met for one individual (Individual #135). For indicators for increase, indicator 6f was met for six individuals (one of which was Individual #135). For all individuals, 6g was rated as not applicable. Therefore, for Individual #135 a score of 2/2 is shown in the scoring box above. And, for five individuals, a score of 1/2 is shown in the scoring box above.

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

The review of the psychiatric indicator and behavioral health target behavior data (for reduction and for increase) performed by the Monitoring Team indicated that the behavioral data were not reliable and, thus, could not be used to assess an individual's progress on their psychiatric goals.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
Summary: Corpus Christi SSLC met criteria for indicator 15 regarding admissions activities for all individuals for this review and the previous two reviews, too. Therefore, indicator 15 will be moved to the category of requiring less oversight. Indicator 16 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	58	372	178	248	129	92	135	143
12	The individual has a CPE.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B										
14	CPE content is comprehensive.										
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					1/1		1/1		
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	67% 6/9	1/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1	1/1
Comments: 15. Individual #248 and Individual #92 had been admitted within the prior two years. The records of both individuals contained a CPE that had been done within 30 days of admission and an admission IPN, which was done on the day of admission. 16. The psychiatric diagnoses were consistent in the behavioral health and psychiatric sections of the record for all the individuals. These diagnoses were not consistent in the medical section of the records for Individual #129, Individual #92, and Individual #135.											

Outcome 5 – Individuals' status and treatment are reviewed annually.											
Summary: Corpus Christi SSLC met criteria for indicator 18 regarding timely submission of annual psychiatry updates for all individuals for this review and the previous two reviews, too. Therefore, indicator 18 will be moved to the category of requiring less oversight. Indicator 21 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	58	372	178	248	129	92	135	143
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	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	complete (e.g., annual psychiatry CPE update, PMTP).	9/9									
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.	56% 5/9	0/1	1/1	1/1	0/1	1/1	0/1	0/1	1/1	1/1

Comments:
18. The information contained is the APTPs was comprehensive and met the content requirements.

21. The ISPs for five of the individuals met the content requirements. Those for whom there were deficiencies in the documentation were Individual #92, Individual #129, Individual #178, and Individual #38. All of the ISPs contained a detailed description of the psychiatric medications including their side effects and indications, as well as documenting the participation of the psychiatric team member in the meeting. The deficits for the four individuals were in the areas of the integration between the psychiatric and behavioral aspects of the individual's presentation, the absence of adequate behavioral data, and an empirical justification that the medications represented the least intrusive/most positive interventions.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.											
Summary:			Individuals:								
#	Indicator	Overall Score									
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments:											

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
Summary: These two aspects of consent content sustained high performance. Therefore, indicators 30 and 31 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	38	58	372	178	248	129	92	135	143
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.										

30	A risk versus benefit discussion is in the consent documentation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
32	HRC review was obtained prior to implementation and annually.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
30. The risk benefit discussion that accompanied each consent was present in each consent.

31. The written documentation also listed alternate pharmacological and behavioral interventions. The latter included more options than simply referencing the PBSP.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: Individuals who needed a PBSP, had a PBSP. This was a return to 100% after lower performance at the previous two reviews. With sustained high performance, this indicator might be moved back to the category of requiring less oversight after the next review. Two individuals did not have behavioral health goals, which was also the case at the last review. For indicator 2 to remain in the category of requiring less oversight, this needs to be corrected. When there were goals, they remained measurable, but most did not correspond with the behavioral health assessment. Further, data were not shown to be reliable, either by the Center's own assessment of reliability or by the Monitoring Team's observation of behavior occurrences that were not recorded in the Center's data system. Indicators 1, 4, and 5 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	58	372	178	248	129	92	135	143
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 10/10	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									

3	The psychological/behavioral goals/objectives are measurable.										
4	The goals/objectives were based upon the individual's assessments.	25% 2/8	1/1	0/1		0/1	0/1	0/1	0/1	0/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8	0/1	0/1		0/1	0/1	0/1	0/1	0/1	0/1

Comments:

1. Eight of the nine individuals reviewed by the behavioral health monitoring team were identified as having a Positive Behavior Support Plan (PBSP) at the time of the document request. This was based on the information provided in the master list of individuals with a PBSP. The facility indicated that Individual #372 was followed by a Psychiatric Support Plan. Of the six individuals reviewed by the physical health monitoring team, two (Individual #184, Individual #268) had a PBSP.

After meeting with the individuals and talking with staff, it would be advisable for behavioral health services staff to complete an updated functional behavior assessment for three of the individuals who did not have a PBSP because staff reported some concerning behaviors: Individual #372 reportedly screamed and grabbed others, Individual #104 reportedly put his hands in his mouth and pulled up his pants legs to scratch himself, and Individual #8 reportedly pulled on her G-tube.

2. Six of the eight individuals with PBSPs reviewed by the behavioral health monitoring team had measurable goals related to their psychological behavioral health. The exceptions were Individual #58 and Individual #178 for whom there were no goals identified in either the Behavior Health Assessment or the PBSP.

4. For Individual #38 and Individual #143, the goals were based upon their assessments. For the others, behaviors addressed in the BHA and/or functional behavior assessment were not addressed in the individual's PBSP (e.g., Individual #129 - self-injury, Individual #92 – refusals, Individual #135 - verbal aggression), or the PBSP addressed behaviors that had not been identified in the BHA/FBA (e.g., Individual #178 - disruptive behavior and suicidal threats/gestures, Individual #248 - self-injury, Individual #129 - verbal threats, Individual #92 - disruptive behavior).

5. Although IOA and data timeliness measures had been reported for six consecutive months for Individual #38 and Individual #58, the BHS director reported that the assessment of data timeliness remained a problem. Therefore, the reported data were not reliable. Further, during the onsite review, several individuals were observed engaging in identified problem behavior. A check of their PBSP data, revealed the following:

- Data were not recorded for Individual #141 who was observed crying and displaying aggression towards staff during her psychiatric clinic.
- Individual #58 began grabbing staff and displaying property destruction at his psychiatric clinic; data were not recorded of these events.
- Individual #248 was observed hitting the van side view mirror with his umbrella as he walked back home - one occurrence was recorded during this shift.
- As noted elsewhere is this report, both Individual #129 and Individual #92 were observed threatening harm to themselves and/or others; these behaviors were not targeted in their PBSPs.

- During an ISPA meeting at the Atlantic Unit, the Monitoring Team heard an individual engaged in loud, disruptive, and potentially harmful behavior. He was pounding on doors and screaming. Several staff exited the meeting to assist. When information was requested, a report was provided that described a situation in which Individual #100 sustained an injury to his head. When the PBSP data were requested, there was no documentation of this event.

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

Summary: Performance decreased for all three indicators from previous reporting periods, to 0% for indicators 10 and 11. These important assessments set the occasion for proper behavioral treatment planning. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	58	372	178	248	129	92	135	143
10	The individual has a current, and complete annual behavioral health update.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
11	The functional assessment is current (within the past 12 months).	25% 2/8	0/1	1/1		0/1	0/1	1/1	0/1	0/1	0/1
12	The functional assessment is complete.	0% 0/8	0/1	0/1		0/1	0/1	0/1	0/1	0/1	0/1

Comments:

10. At the time of the document request, the Center indicated that Behavioral Health Assessments were not available for four of the nine individuals. These individuals were Individual #178, Individual #248, Individual #135, and Individual #143. These were provided when requested onsite. The other five individuals did have a current BHA. These contained most, but not all, components. For instance, none of the BHAs included a review of the individual's physical health over the previous 12 months.

The original document provided onsite for Individual #143 was completed in January 2018. It did not include a review of her physical health over the previous year, did not review her cognitive abilities or adaptive behavior, and did not include a functional behavior assessment. Later in the week, a second BHA was provided from September 2018. This document addressed the missing information (with the exception of a review of her physical health).

11. Individual #58 and Individual #129 had a current functional behavior assessment. The FBAs for Individual #178, Individual #248, Individual #135, and Individual #143 were not current due to the problems identified above. Additionally, there was no information regarding the completion of an FBA in the BHA provided for Individual #38 or Individual #92.

12. None of the FBAs were considered complete.
    - In some cases (e.g., Individual #38, Individual #129, Individual #92), there was no review of indirect or descriptive assessments.
    - For others (e.g., Individual #58, Individual #248, Individual #135), observations were completed, but no target behaviors were

observed. There was no explanation as to why additional observations weren't necessary.

- For Individual #178 and Individual #143, no consequences to their targeted problem behaviors were identified.
- In several reports, the summary statement reviewed the individual's psychiatric diagnoses and needs, but did not provide any information related to the FBA.

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

Summary: Performance again remained about the same, that is, at criteria for about half of the individuals for indicators 13 and 14, and at 0% for indicator 15. As the comments and examples detail for indicator 15 below, there were numerous inconsistencies in target behaviors included and not included in PBSPs, and follow-up to recommendations from team meetings did not occur. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	58	372	178	248	129	92	135	143
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	57% 4/7	0/1	0/1		N/A	0/1	1/1	1/1	1/1	1/1
14	The PBSP was current (within the past 12 months).	50% 4/8	1/1	1/1		0/1	0/1	1/1	1/1	0/1	0/1
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/8	0/1	0/1		0/1	0/1	0/1	0/1	0/1	0/1

Comments:

13. For four individuals (Individual #129, Individual #92, Individual #135, Individual #143), there was evidence that the PBSP had been implemented within 14 days of all necessary consents. For three others, the PBSP was implemented more than 14 days after consents were obtained. It was approximately three weeks later that Individual #58's PBSP was implemented, over 1.5 months later that Individual #38's PBSP was implemented, and three months later that Individual #248's PBSP was implemented.

14. The PBSP was considered current for four individuals, including Individual #38, Individual #58, Individual #129, and Individual #92. Similar to individual BHAs, the PBSP was not available for Individual #178, Individual #248, Individual #135, and Individual #143 at the time of the document request.

The Monitoring Team looked at the documents provided onsite and those available to staff in the Individual-Books (I-Book). Individual #178's I-Book contained a Psychiatric Support Plan, although minutes from an internal peer review meeting in August 2018 indicated that she had an interim PBSP. Individual #248's I-Book contained an interim PBSP from March 2018, Individual #135's I-Book contained a plan implemented in August 2017, and Individual #143's I-Book contained a PBSP from April 2017.

15. None of the PBSPs were considered complete. About two-thirds of the plans included operational definitions of targeted problem behaviors and functional replacement behaviors. Half of the plans included antecedent strategies.

Less than one-third of the plans included operational definitions of replacement behaviors, the adequate use of positive reinforcement, consequent strategies for all targeted problem behaviors, training guidelines and sufficient opportunities for strengthening/developing replacement behaviors, and treatment objectives for both targeted problem behaviors and replacement behaviors.

Not all targeted problem behaviors were addressed in plans (e.g., Individual #38 - getting into others' beds, Individual #58 - pulling his g-tube, Individual #178 – refusals, Individual #143 - refusals). In other cases, there were no identified consequences for identified problem behaviors (e.g., Individual #178 - suicidal threats/gestures; Individual #248 - self-injury, aggression, suicidal threats/gestures; Individual #92 - disruptive behavior, property destruction; Individual #143 - unfounded allegations). Lastly, in some cases, intervention was outlined for behaviors that were neither defined nor measured (e.g., Individual #129 - verbal threats, self-injury, Individual #135 - self-injury; and Individual #143 - work refusals).

Several individuals were observed engaged in problematic behavior during the onsite visit. This included Individual #129 threatening to harm herself and Individual #92 threatening harm to himself, his family, and staff. Neither of these behaviors were addressed in the individual's PBSP. In Individual #129's PBSP, "statements to harm self in an attempt to be placed on an increased level of supervision" were identified as a continuing behavioral concern. In other cases, documents noted specific problem behaviors that were later confirmed by staff. This included Individual #38 getting into others' beds, and Individual #58 engaging in property destruction, masturbation, and pulling his g-tube. During the psychiatric clinic for Individual #321, staff noted she had temper outbursts that were infrequent, but intense. These were not addressed in her PBSP. Ritualistic behavior was also discussed, but this also was not addressed in her PBSP.

When reviewing Individual #129's PBSP, a title given to one of her targeted problem behaviors was False Accusations. As defined, this implied that any report of fear of others or harm perpetrated by a peer, including rape, was not true. The title creates a bias because any complaint may be considered not credible. If an allegation is made by the individual, it must be taken seriously and investigated thoroughly.

There were reported problems with identified replacement behaviors as well. Staff reported that Individual #38 didn't use sign language and that Individual #58 didn't appropriately ask for attention. Further, his communication board on his lap tray was often not attached to his wheelchair and, instead of objects, it consisted of pictures of ball, wash hands, radio, and outside.

In addition to the annual PBSP, there were often recommendations for the development of other supports for the individuals. When identified supports were requested, the response by Center staff was inconsistent. For example, contracts had been developed for both Individual #178 and Individual #135. Conversely, several other recommendations had not been addressed by the time of the onsite visit. These included the following:

- Completion of observations of Individual #58 at a variety of locations while engaged in a range of activities following discussion regarding his attempts to dislodge his g-tube (May 2018).
- Behavior contract for Individual #248 to attend anger management class.
- Collection of data to assess precursors and antecedents related to Individual #129's ingestion of batteries as recommended in an ISPA meeting in July 2018.

- Staff instructions related to trauma informed care for Individual #135.
- Social story for Individual #143 developed by BHS and SLP staff to address smoking as recommended at her ISP meeting in February 2018.

In other cases, issues that arose for several individuals did not result in BHS staff working with other members of the team to develop action plans. This included the following:

- Individual #58's learning to tolerate a helmet.
- Individual #38 learning to wear grippy socks - although a probe was reported, this did not preclude developing a shaping program to reinforce this behavior.
- A plan to address Individual #38's possible scratching of her face when she returned home following cellulitis to her left eye (when asked about a plan, staff reported that they were to redirect her).
- Criterion-based fading plans following an increase in assigned level of supervision.
- Staff instructions related to trauma informed care for Individual #135.

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

Summary: The Center continued to work on obtaining counseling services for those who needed it. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	58	372	178	248	129	92	135	143
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	17% 1/6	N/A	N/A		1/1	0/1	0/1	0/1	0/1	0/1
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		0/1	N/A	N/A	N/A	N/A	N/A

Comments:

24. The IDT recommended counseling for six of the nine individuals (Individual #178, Individual #248, Individual #129, Individual #92, Individual #135, Individual #143). At the time of the visit, Individual #178 was receiving counseling offered by a community provider. Although Individual #135 was reported to have participated in one session, this service was not ongoing. For all others, there were no immediate plans to address this identified need.

At an ISPA meeting, it was positive to see the BHS director agree to explore increased counseling sessions for Individual #178. She also offered scheduled meetings with BHS staff and ongoing assessment of the success of her new job location by BHS staff.

25. A treatment plan and progress notes for Individual #178 were not available for review.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Medical Department staff should work with QIDPs to 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 continue in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	100% 1/1	N/A	1/1	N/A	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.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." Interim reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interim reviews will need to occur more frequently. The IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.											

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Center staff should continue to improve the quality of the medical assessments, with a particular focus on complete problem lists, and plans of care for each active medical problem, as appropriate. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
a.	Individual receives quality AMA.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. It was positive that Individual #247's AMA included all of the necessary components, and addressed the individual's medical needs with thorough plans of care. Problems varied across the remaining medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, family history, social/smoking histories, childhood illnesses, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Most, but not all included past medical histories. Moving forward, the Medical Department should focus on ensuring medical assessments include updated/complete active problem lists, and plans of care for each active medical problem, when appropriate.

c. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions [Individual #129 – gastrointestinal (GI) problems, and choking; Individual #178 – other: urinary incontinence, and weight; Individual #184 – falls, and seizures; Individual #303 – GI problems, and osteoporosis; Individual #268 – seizures, and weight; Individual #307 – other: impaired physical mobility, and urinary tract infections (UTIs); Individual #247 – respiratory compromise, and GI problems; Individual #8 – GI problems, and circulatory; and Individual #104 – aspiration/respiratory compromise, 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.

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

Summary: As indicated in the last several reports, much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.

#	Indicator	Overall Score	Individuals: 129	178	184	303	268	307	247	8	104
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions (i.e., Individual #129 – GI problems, and other: ingestion of batteries; Individual #178 – other: urinary incontinence, and weight; Individual #184 – falls, and seizures; Individual #303 – GI problems, and osteoporosis; Individual #268 – seizures, and weight; Individual #307 – other: impaired physical mobility, and UTIs; Individual #247 – respiratory compromise, and GI problems; Individual #8 – GI problems, and circulatory; and Individual #104 – aspiration/respiratory compromise, and skin integrity).

None of the IHCPs included action steps to sufficiently address the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.

b. As noted above, 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: Given that during the last two reviews and during this review, individuals reviewed generally had comprehensive annual dental summaries (Round 12 – 88%, Round 13 – 100%, and Round 14 – 100%), Indicator c will move to the category requiring less oversight. In order to improve dental exams, individuals with periodontitis need periodontal probing and charting, and if this is not possible, the Dentist needs to document challenges and decisions to recall the individual to complete the periodontal charting. Indicator b will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
a.	Individual receives timely dental examination and summary:	Due to the Center's sustained performance, these indicators 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.	33% 3/9	0/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments: b. It was positive that for three of the nine individuals reviewed, the dental exams included all of the required components. It was also good to see that all of the remaining dental exams reviewed included the following:

- A description of the individual's cooperation;
- An oral hygiene rating completed prior to treatment;
- Periodontal condition/type;
- The recall frequency;
- Caries risk;
- Periodontal risk;

- An oral cancer screening;
- Information regarding last x-ray(s) and type of x-ray, including the date;
- A summary of the number of teeth present/missing;
- Sedation use;
- Treatment provided/completed;
- An odontogram; and
- A treatment plan.

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

- Periodontal charting. The dental audit tool explains: "For individuals with periodontitis, if the individual did not have periodontal probing completed, this indicator will be marked as '0.' Dental Progress Notes or the description of cooperation section of the dental exam is where auditors would find documentation of any challenges and decisions to recall the individual to complete periodontal charting." Based on the documentation submitted, the Dentist had not documented the reason, if any, for the decision not to complete at least annual periodontal probing.

  In its comments on the draft report, the State disputed this finding, and stated: "Periodontal charting for ALL types of periodontal conditions (including Type I=Normal to Type III Moderate Periodontitis there were no Type IV Severe) were included at the end of Annual Examination Reports (some included a NEW Periodontal chart that is easier to read-has no graphic dentition printed only pocket depth) as the dental audit tool initial instructions requested. Only one did not have a periodontal chart but reason was noted why we have not been able to complete…credit was given by Ind. Mon… Annual periodontal probing is not a requirement…" As illustrated in the dental audit tool, annual periodontal charting has been an expected part of the "annual dental exam." Moreover, as has been agreed with the with the State Office Dental Discipline Lead, the standards used for periodontal disease are those of the American Academy of Periodontology. As their website (i.e., https://www.perio.org/consumer/perio-evaluation.htm) states: "In 2011, the American Academy of Periodontology published the Comprehensive Periodontal Therapy Statement, which recommends that all adults receive an annual comprehensive evaluation of their periodontal health." General dentists and hygienists can complete such evaluations. As indicated in the draft report, the Dentist should document any challenges related to adhering to the generally accepted standard of dental care for adults, as well as any decisions to recall the individual to complete it. A number of individuals reviewed had not had periodontal probing/charting in two or more years. Although some of these individuals' dental exams described fair or poor behavior, during the past year, they reportedly completed procedures such as prophylactic care, fluoride treatments, and/or x-rays. If the dentist or hygienists were not able to complete periodontal charting, then records should indicate the specific behaviors they exhibited during these attempts, as well as a plan for next steps, including, if necessary consultation with the IDT.

c. It was very good to see that all of the dental summaries reviewed included the following:

- Effectiveness of pre-treatment sedation;
- Recommendation of need for desensitization or another plan;
- A description of the treatment provided (i.e., treatment completed);
- The number of teeth present/missing;
- Dental care recommendations;

- Dental conditions that could cause systemic health issues or are caused by systemic health issues;
- Treatment plan, including the recall frequency;
- Provision of written oral hygiene instructions; and
- Recommendations for the risk level for the IRRF.

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.

Summary: For seven out of nine individuals reviewed, nurses completed timely annual or new-admission nursing reviews and physical assessments. Problems were noted with regard to nurses' timely completion of quarterly nursing record reviews and/or physical assessments. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 129	178	184	303	268	307	247	8	104
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	100% 1/1	N/A	1/1	N/A	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.	88% 7/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	0/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	38% 3/8	0/1	N/A	0/1	0/1	1/1	1/1	0/1	1/1	0/1

Comments: a.i. and a.ii. Many of the individuals reviewed had timely annual comprehensive nursing reviews and physical assessments. For Individual #104, the nurse completed the physical assessment for the annual nursing review on 7/31/18, which was after the ISP meeting (i.e., on 7/24/18).

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

- Individual #129's quarterly record review, for the period between 3/22/18 and 6/26/18, included information from beyond that time period.
- For Individual #184, the nurse completed the physical assessment, dated 5/30/18, a month after the quarterly time frame (i.e., from 2/1/18 through 4/30/18). In addition, the quarterly provided no update for the quarter (i.e., it contained identical information to the annual).
- For Individual #303, on 3/16/18, the nurse completed the quarterly for the period between 12/1/17 and 2/28/17; and on 6/25/18, the nurse completed the quarterly for the period between 3/1/18 and 5/31/18.

- For the period between 7/1/18 and 9/30/18, the nurse completed Individual #247's quarterly on 10/3/18.
- For Individual #104, the dates on the quarterly assessments submitted did not make sense: 5/1/18 to 7/31/18, and 5/29/18.

Outcome 4 – Individuals have quality nursing assessments to inform care planning.

Summary: It was positive that for most individuals reviewed, nurses completed annual and quarterly physical assessments that addressed the necessary components. Work is needed to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to individuals' at-risk conditions. In addition, when individuals experience changes of status, nurses need to complete assessments in accordance with current standards of practice. All of these indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 129	178	184	303	268	307	247	8	104
a.	Individual receives a quality annual nursing record review.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual receives quality annual nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual receives a quality quarterly nursing record review.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality quarterly nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score;	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.										
f.	On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
g.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/9	0/2	0/1	0/1	N/A	0/1	N/A	0/1	0/1	0/2

Comments: a. It was positive that all of the annual or new-admission nursing record reviews included the following:

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

Most, but not all included:

- Social/smoking/drug/alcohol history.

The components on which Center staff should focus include:

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

b. It was positive that for most individuals reviewed, nurses completed annual physical assessments that addressed the necessary components. The exception was that Individual #178's new-admission physical assessment did not include a Braden scale score, or a fall risk score.

c. and f. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #129 – other: pain, and behavioral health; Individual #178 – weight, and osteoporosis; Individual #184 – falls, and constipation/bowel obstruction; Individual #303 – constipation/bowel obstruction, and skin integrity; Individual #268 – falls, and infections; Individual #307 – constipation/bowel obstruction, and UTIs; Individual #247 – skin integrity, and constipation/bowel obstruction; Individual #8 – circulatory, and osteoporosis; and Individual #104 – constipation/bowel obstruction, and choking).

Overall, none of the annual comprehensive nursing or quarterly assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. However, on a positive note, for about a quarter of the risk areas reviewed, nurses included status updates in annual assessments, including relevant clinical data (i.e., Individual #129 – other: pain, Individual #178 – weight, Individual #268 – infections, and Individual #247 – skin integrity). Unfortunately, nurses had not analyzed this information, including comparisons with the previous quarter or year, and/or made recommendations regarding treatment,

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

For three of the four risk areas for which nurses included relevant information in annual assessments, nurses also included necessary updates in the most recent quarterly assessment: Individual #129 – other: pain, Individual #178 – weight, and Individual #247 – skin integrity.

d. Most, but not all of the quarterly nursing record reviews included:

- Active problem and diagnoses list updated at time of the quarterly assessment;
- List of medications with dosages at time of quarterly nursing assessment;
- Immunizations;
- Consultation summary;
- Lab and diagnostic testing requiring review and/or intervention; and
- Tertiary care.

The components on which Center staff should focus include:

- Family history;
- Procedure history;
- Social/smoking/drug/alcohol history; and
- Allergies.

e. It was positive that for the individuals reviewed, nurses completed quarterly physical assessments that addressed the necessary components.

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

- In an IPN, dated 6/5/18, a nurse noted giving Individual #129 Tylenol for "body aches." The nurse did not document any information indicating when the pain began, what made it better or worse, was it in the joints or muscles, where it started, where it was most intense, and/or whether or not it interfered with activities.
- An IPN, dated 5/10/18, at 8:47 p.m., indicated Individual #129 self-reported swallowing two batteries. The assessment did not include palpation of the abdomen, or bowel sounds, and the nurse did not document providing staff with directions to call the nurse when the individual needed to have a bowel movement.
- A Nutrition Note, dated 8/3/18, indicated that Individual #178 had lost 11.5 pounds (7.7% of her body weight) in one month as a result of meal refusals due to decreased appetite and disliking some of the food. However, nursing staff did not conduct and/or document an assessment for rapid weight loss.
- An IPN, dated 5/29/18, indicated that staff found Individual #184 sitting on the floor. However, the nurse did not indicate where he was found, by who, what time he was found, or other details of the situation. The nursing assessment was not comprehensive. It was unclear if the scratches to his forehead were a new injury or had been there previously.
- An IPN, dated 3/21/18, noted Individual #268 had a seizure, fell, and sustained a scratch to the right forehead and two abrasions to the right posterior shoulder. The note indicated that this was a "non-serious" injury. However, the nurse did not

conduct and/or document an assessment of his mental status, range of motion, gait, neurological checks, or vital signs.

- An IPN, dated 5/12/18, noted that the nurse gave Individual #247 pro re nata (PRN, or "as needed") medication based on the order for no bowel movement (BM) for two days. However, the nurse did not document the completion of an assessment prior to administering the medication.
- A PCP IPN, dated 4/21/18, noted that Individual #8's family reported she had bilateral edema to her lower legs, and the PCP started her on Lasix. Prior to the PCP's note, nurses had not documented her edema, or assessment of it. In the subsequent IPNs, no documentation was found to show that nurses conducted assessments. The quarterly nursing assessment, dated 2/2/18 to 4/30/18, indicated the individual started on Lasix, but did not include any information regarding her bilateral lower edema.
- Based on the IPN documentation submitted for Individual #104, in the six months prior to the review, nurses only wrote a couple of IPNs. For a constipation episode listed in the Center's response to document request #TX-CC-1810-IV.1-20, no nursing assessment was found. Similarly, the documents submitted did not include a nursing IPN addressing a choking episode on 7/16/18.

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

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

#	Indicator	Overall Score	Individuals: 129	178	184	303	268	307	247	8	104
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	6% 1/18	0/2	0/2	0/2	0/2	0/2	1/2	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).	6% 1/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	6% 1/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2

Comments: b., c., and f. Individual #307's IHCP included an intervention to monitor voids every shift. The specific criteria needed to be listed in the IHCP, such as color, odor, clarity, amount, and frequency.

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: When individuals reviewed were referred to the PNMT, the PNMT completed timely reviews and/or assessments. However, at times, when individuals should have been referred to the PNMT, IDTs did not refer them, and the PNMT did not make self-referrals. Although additional work was needed, some progress was noted with regard to the quality of PNMT comprehensive assessments. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	60% 3/5	N/A	N/A	1/1	N/A	0/1	1/1	0/1	N/A	1/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	60% 3/5			1/1		0/1	1/1	0/1		1/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	75% 3/4			1/1		N/A	1/1	0/1		1/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	60% 3/5			1/1		0/1	1/1	0/1		1/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/5			0/1		0/1	0/1	0/1		0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and	0% 0/1			N/A		0/1	N/A	N/A		N/A

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

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

- On 2/3/18, Individual #184 was diagnosed with aspiration pneumonia as well as significant weight loss. A post-hospitalization RN review was completed on 2/15/18, with a PNMT review completed on 2/20/18. The IDT did a nice job referring to the individual to the PNMT in a timely manner and initiating interventions at the IDT level.
- In December 2017, Individual #268 weighed 172 pounds. In February 2018, his weight decreased to 158 pounds. In the following months, his weight continued to decrease: March 2018 - 153, April 2018 - 150, May 2018 - 150, June 2018 - 145, and September 2018 - 142. Even when he met criteria for PNMT referral (i.e., greater than five-pound weight loss), the IDT did not make a referral, and the PNMT did not make a self-referral or conduct a review. The IDT did not request a Nutrition consult until 8/31/18, and it was not provided until 9/14/18. The IDT had not developed an IHCP for weight.
- Individual #307 as referred to the PNMT post a prolonged hospital stay due to a hemorrhagic stroke, a new G-tube, and weight loss. On 4/27/18, a referral was initiated with PNMT review initiated on 5/3/18, and an assessment completed on 5/5/18.
- The IDT did not refer Individual #247 to the PNMT, and the PNMT did not make self-referrals in response to a diagnosis of dysphagia, and four areas of skin breakdown, as reported in the ISPA, dated 6/21/18. Although on 6/22/18, the OT/PT completed a consult, the severity of the breakdown and the associated dysphagia, paired with a declining status warranted a PNMT referral and assessment.
- On 6/19/18, Individual #104's IDT initially referred him to the PNMT due to a diagnosis of an unstageable pressure sore. On 6/25/18, the PNMT reviewed this issue with a transition to an assessment. During the assessment process, the IDT did a nice job notifying the PNMT of any other PNM-related issues, such as coughing episode.

f. As the Monitoring Team has discussed with State Office, without signature pages that include dates, it is not possible to determine which members of the PNMT participated in the PNMT assessments.

h. As noted above, Individual #247 should have had a comprehensive PNMT assessment, but did not. The following summarizes some of the findings related to the three assessments that the PNMT completed:

- The PNMT assessment for Individual #184 met most of the criteria. Some of the positives included: the assessment laid out the history of provided supports and consults related to the PNM issue. The potential correlation between the onset of the flu, and the spike in seizures, which ultimately led to the aspiration, was well documented. One problem was that the PNMT listed medications, but did not conduct a complete analysis of whether side effects were actually noted. The PNMT did state that the individual exhibited tremors that could be related to Aripiprazole; the practitioner decreased the dosage, but the PNMT offered no statement as to if whether or not this change was successful in decreasing the tremors.
- The PNMT assessment for Individual #307 met many of the criteria. Some of the positives included sufficient breakdown of PNM-related risk areas and related supports. Medications were also thoroughly listed with thought given to whether or not the potential side effects were present. Some of the problems included that the PNMT listed upper and lower extremity

functioning, but the implications with regard to the individual's completion of activities of daily living (ADLs) were lacking. The assessment referred the reader to the OT assessment, but the PNMT assessment should have included basic information. The PNMT mentioned that there were several episodes during which the individual's feeding had to be held due to increased residuals, but did not offer a thorough assessment of head-of-bed elevation (HOBE) or positioning and its impact on gastric emptying.

- In the PNMT assessment for Individual #104, the PNMT just listed generic criteria for re-referral that were not specific to the individual. Due to his extensive history with skin issues as well as respiratory issues, these should have been more discreet. The assessment lacked details surrounding PNM events. For example, it stated that wheezing occurred on 5/28/18, but did not provide details of the event, or hypotheses related to the cause of the event. The individual's surroundings at the time of the event, as well as his level of alertness would have been important to document. The PNMT only provided Individual #104's history back to 2016, and did not include data regarding his past history of related aspiration triggers.

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

Summary: Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. The plans were missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps. In addition, many action steps were not measurable. Although PNMPs included many of the necessary components, most of those reviewed were missing important instructions or information. With minimal effort and attention to detail, the Habilitation Therapy staff could make the needed corrections. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 129	178	184	303	268	307	247	8	104
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% 1/16	0/1	0/1	0/2	0/2	1/2	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.	11% 1/9	0/1	0/1	0/1	0/1	0/1	1/1	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.	50% 9/18	2/2	2/2	0/2	0/2	1/2	2/2	0/2	1/2	1/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to	29%	1/2	1/2	0/2	1/2	1/2	0/1	0/1	0/1	0/1

	take when they occur, if applicable.	4/14									
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: Individual #129 – GI problems, and weight; Individual #178 – weight, and GI problems; Individual #184 – GI problems, and aspiration; Individual #303 – choking, and aspiration; Individual #268 – choking, and falls; Individual #307 – skin integrity, and aspiration; Individual #247 – aspiration, and skin integrity; Individual #8 – aspiration, and skin integrity; and Individual #104 – skin integrity, and aspiration.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP. The exception was for Individual #268 – falls, for whom the IDT did a nice job of ensuring all of the PNMP components related to falls were included in the IHCP for falls.

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

c. All individuals reviewed had PNMPs and/or Dining Plans.

- It was positive that the dates on all of the PNMPs/Dining Plans showed they had been reviewed and/or updated within the last 12 months, and as applicable to the individuals' needs, the PNMPs/Dining Plans included:
  - Photographs;
  - Positioning instructions;
  - Transfer instructions;
  - Mobility instructions;
  - Bathing instructions;
  - Handling precautions or moving instructions;
  - Mealtime instructions;
  - Medication administration instructions; and
  - Complete communication strategies.
- As applicable to the individuals, most, but not all of the PNMPs reviewed included:
  - Descriptions of assistive/adaptive equipment (i.e., Individual #184's did not include his chair alarm); and
  - Toileting/personal care instructions.
- The components of the PNMPs on which the Center should focus on making improvements include:
  - Most PNMPs/Dining Plans had problems with regard to the lists of risks and triggers, including, for example, missing risks, missing risk levels, and/or triggers not identified; and
  - Oral hygiene instructions, for which often times the only instruction was "most upright position," which did not address individuals' specific areas of risk.

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

e. The IHCPs reviewed that identified the necessary clinical indicators were those for: Individual #129 – GI problems, and weight; Individual #178 – GI problems, and weight; Individual #268 – choking; Individual #307 – skin integrity, and aspiration; Individual #8 – aspiration; and Individual #104 – skin integrity.

f. The IHCPs that identified triggers and actions to take should they occur were those for: Individual #129 – GI problems; Individual #178 – GI problems; Individual #303 – aspiration; and Individual #268 – choking.

g. The IHCPs reviewed did not include monitoring of PNMPs or PNM progress.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: For this review and the last one, IDTs for the individuals reviewed documented clinical justification for enteral nutrition, as applicable, and discussed individuals' potential to move along the continuum to oral eating. If the Center sustains this progress, after the next review, Indicator a might move to the category requiring less oversight. At this time, these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
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% 3/3	N/A	N/A	N/A	N/A	N/A	1/1	1/1	1/1	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.	50% 1/2						0/1	N/A	1/1	

Comments: a. and b. The IRRFs for Individual #307, Individual #247, and Individual #8 provided clinical justification for the continued medical necessity of their enteral nutrition. IDTs also discussed the individuals' potential for return to oral intake.

For Individual #307, the Speech Language Pathologist (SLP) provided neuromuscular electrical stimulation (NMES) in an attempt to improve her oral motor functioning. However, the IDT did not develop a formal plan to define baseline information or the therapy provided. The SLP reported that Individual #307 had no change in swallow function after the treatment.

In 2014, Individual #8's IDT developed a plan to move her along the continuum to oral eating that focused on improving oral motor

functioning, but discontinued the plan due to no evidence of progress.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: Since the last review, 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 improved. The quality of OT/PT assessments continues to be an area on which Center staff should focus, but some improvement was noted there too. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
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.	100% 1/1	N/A	1/1	N/A	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.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	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.	88% 7/8	1/1	N/A	0/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength;	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	▪ 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.										
d.	Individual receives quality Comprehensive Assessment.	16% 1/6	N/A	0/1	0/1	0/1	N/A	N/A	1/1	0/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/2	N/A	N/A	N/A	N/A	0/1	0/1	N/A	N/A	N/A

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

- The OT/PT completed Individual #184's comprehensive assessment when he was in the hospital, so he was not present for the assessment. The OT/PT did not complete another comprehensive assessment upon his return from the hospital.

c. Individual #129's screening provided a comparison of her skills between the present and previous screenings, and described her participation in ADLs, including her level of independence. It did not include a review of medications and their potential impact on her OT/PT functioning.

d. It was positive that the assessment for Individual # 247 met criteria for a quality assessment. As discussed above, the assessment completed for Individual #184 should have been redone once he returned from the hospital. It was positive that all of the remaining three comprehensive assessments reviewed met criteria, as applicable, with regard to:

- The individual's preferences and strengths were used in the development of OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living; and
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments.

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

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- 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; and
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services.

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

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;

- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

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

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

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

- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services; and
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings.

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: Center staff continued to make improvements with regard to the inclusion of OT/PT strategies and interventions in individuals' ISPs. To move forward, QIDPs and OTs/PTs should work together to make sure IDTs discuss and include in ISPs information related to individuals' OT/PT functioning, and that IDTs review PNMPs and/or Positioning Schedules, and document the results in the ISPs. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall	129	178	184	303	268	307	247	8	104

		Score									
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	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.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	75% 3/4	0/1	N/A	1/1	N/A	N/A	1/1	N/A	N/A	1/1

Comments: a. The ISPs reviewed did not include concise, but thorough descriptions of individuals' OT/PT functional statuses. Therapists should work with QIDPs to make improvements.

b. In the ISPs reviewed, evidence was not found to show that IDTs reviewed PNMPs and/or Dining Plans, made changes to them, and/or approved them.

c. It was good to see that IDTs generally included OT/PT strategies and programs in individuals' ISPs, or incorporated them through ISPAs. The exception was for Individual #129, for whom no ISPA was submitted in response to an OT consult, dated 3/28/18, that addressed bike riding.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: Significant work is needed to improve the quality of communication assessments and updates in order to ensure that SLPs provide IDTs with clear understandings of individuals' functional communication status; AAC options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104

a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1	N/A	1/1	N/A	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.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	75% 6/8	0/1	N/A	0/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	78% 7/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • 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.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/4	0/1	0/1	0/1	N/A	N/A	N/A	0/1	N/A	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/5	N/A	N/A	N/A	0/1	0/1	0/1	N/A	0/1	0/1
Comments: a. through c. The following provides information about problems noted: • Individual #129's screening noted that she had impaired cognitive functioning, but offered no additional review of its impact on											

communication, reasoning, problem-solving, etc. Moreover, the Speech Language Pathologist (SLP) did not recommend further assessment to determine whether or not the individual had deficits that supports and services could address.

- The SLP completed Individual #184's comprehensive assessment when he was in the hospital, so he was not present for the assessment. The SLP did not complete another comprehensive assessment upon his return from the hospital.

d. As noted above, Individual #129 should have had a comprehensive assessment, but did not. In addition, Individual #184 should have had a comprehensive assessment, when he was present at the Center. Of the assessments reviewed, most, but not all met criteria, as applicable, with regard to:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- The individual's preferences and strengths are used in the development of communication supports and services; and
- A comparative analysis of current communication function with previous assessments.

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

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;
- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication.

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

- The individual's preferences and strengths are used in the development of communication supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- A 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;
- The effectiveness of current supports, including monitoring findings; and
- 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; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal

and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

Summary: For the individuals reviewed, ISPs provided complete functional descriptions of their communication skills. In addition, for the individuals reviewed, IDTs incorporated into the individuals' ISPs the communication strategies, interventions, and programs that SLPs recommended in assessments. If the Center sustains these improvements, after the next review, Indicators a and c might move to the category of less oversight. Focus should be on ensuring IDTs review, and QIDPs document in ISPs decisions about individuals' Communication Dictionaries. At this time, these indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 129	178	184	303	268	307	247	8	104
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/6	N/A	N/A	0/1	0/1	N/A	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.	100% 8/8	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: a. It was good to see that for the individuals reviewed, ISPs provided complete functional descriptions of their communication skills.

b. In the ISPs reviewed, evidence was not found to show that IDTs reviewed Communication Dictionaries, made changes to them, as needed, and/or approved them.

In its comments on the draft report, the State disputed these findings for three individuals, and indicated:

- "Individual #303 ISP document (TX-CC-1810-II.01-…), page 5 of 29, includes information regarding changes that were

recommended for the CD based on the SLP assessment. Under IDT Determination, IDT includes a statement agreeing to the recommended changes indicating that there was discussion and approval of the changes."

- "Individual #247 ISP document (TX-CC-1810-II.01-…), page 6 of 30, includes information on the CD and states that no changes were made based on the SLP assessment and lists current communication strategies. Under IDT Determination, IDT includes the statement "Team reviewed SLP recommendation and noted, no action step required" indicating that there was discussion and approval."
- "Individual #8 ISP document (TX-CC-1810-II.01-…), page 7 of 43, includes information regarding changes that were recommended for the CD based on the SLP assessment. Under IDT Determination, IDT states 'Team and LAR agrees with Speech recommendation. LAR commented that [Individual #8} might enjoy this (tactile/sensory) experience." Statement indicates that there was discussion of the SLP recommendation for paper mache activity and recommended changes to CD.

As illustrated in the State's comments, the IDTs relied on the SLPs' assessments and recommendations related to the Communication Dictionaries. Although the State's comments indicated that "there was discussion and approval," re-review of these individuals' ISPs confirmed that the only "discussion" documented was the IDT's agreement with the SLPs' recommendations. The ISP meeting is the IDT's opportunity to review the Communication Dictionary, discuss its effectiveness, and seek input from the entire IDT, including the direct support professional(s), LAR, and individual, as appropriate, to determine whether or not additions, deletions, or changes are needed. This discussion should reflect whether or not the nonverbal means of communication documented in the Communication Dictionary remain accurate based upon observation or interview with staff.

c. It was positive that for the individuals reviewed, IDTs incorporated into the individuals' ISPs the communication strategies, interventions, and programs that SLPs recommended in assessments.

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 individuals continued to have SAPs and that many/some were based on assessment results, meaningful, and had reliable data. The percentage of SAPs that met these characteristics (indicators 3, 4, and 5) was about the same as at the last review. The Center has shown that it can meet criteria for some and now should be able to meet it for all SAPs. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	58	372	178	248	129	92	135	143
1	The individual has skill acquisition plans.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The SAPs are measurable.										
3	The individual's SAPs were based on assessment results.	56%	1/3	1/3	2/2	0/2	1/3	3/3	3/3	2/3	1/3

		14/25									
4	SAPs are practical, functional, and meaningful.	40% 10/25	1/3	1/3	0/2	0/2	2/3	2/3	2/3	1/3	1/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	35% 8/23	0/3	1/3	1/2	0/2	1/3	3/3	0/3	0/1	2/3

Comments:
Three SAPs were reviewed for seven of the nine individuals. The exceptions were Individual #372 and Individual #178 who had two SAPs each. Of the 25 SAPs that were reviewed, all were measurable.

3. Fourteen of the 25 SAPs were based on assessments. These were Individual #38 going to the van, Individual #58 using headphones, both of Individual #372's SAPs, Individual #248 using a community calendar, all three of Individual #129's SAPs, all of Individual #92's SAPs, Individual #135's budgeting and stating appropriate use of hotline, and Individual #143's ironing.

For three SAPs (Individual #178 - relaxation and money management, and Individual #135 - personal boundaries), either the FSA or the current level of performance indicated the individual could perform the skill. Eight other SAPs included an objective that indicated the skill would be performed with the same prompt required in baseline, therefore, new skill development was not addressed. These were Individual #38 - operate a recliner and make coffee, Individual #58 grow a plant and open the door, Individual #248 - anger management and medication identification, and Individual #143 - calculate pay and appropriate public behavior.

4. Ten of the 25 SAPs were considered practical, functional, and/or meaningful. These were Individual #38 - make coffee, Individual #58 - use headphones, Individual #248 - use a community calendar and identify his medication, Individual #129 - bike safety and money management, Individual #92 - play pool and count change, Individual #135 - budget, and Individual #143 - ironing.

The exceptions were SAPs that addressed skills the individual could already perform, SAPs that addressed compliance issues, SAPs that did not address the individual's expressed area of interest, and SAPs that focused on verbal behavior, but not actual skill performance.

It is suggested that this last group of SAPs would be better addressed by shaping and reinforcing appropriate behavior and through counseling services provided by a professional practitioner. In some cases (e.g., Individual #129's exploitation SAP and Individual #135's hotline use SAP), staff who worked with the individual every day were being asked to discuss very personal matters related to past trauma. Such personal matters should be explored with someone with whom there is a designated personal and confidential relationship.

5. Twenty-three of the 25 SAPs were reviewed for data reliability. Two of Individual #135's SAPs were excluded from this analysis as they had been just recently introduced and were not yet scheduled for monitoring. Of the remaining 23 SAPs, eight had been assessed to have good data reliability. These were Individual #58 - grow a plant, Individual #372 - make a scrapbook, Individual #248 - use a community calendar, Individual #129 - bike safety, exploitation, and money management, and Individual #143 - ironing and calculate pay.

The remaining SAPs either had not been monitored for data reliability, or when the monitoring was conducted, the skill was not

performed, necessary materials were missing, or the resulting score was below the established level.

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: It was good to see that all individuals had the required assessments for this outcome. With sustained high performance, this indicator (10) might be moved to the category of requiring less oversight after the next review. Not all of these assessments, however, were available to the IDT as required, and not all included recommendations for skill acquisitions. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	58	372	178	248	129	92	135	143
10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	67% 6/9	1/1	1/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	44% 4/9	0/1	1/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1

Comments:

10. All nine individuals had a current FSA, PSI, and vocational assessment.

11. Based upon the documentation provided, it was evident that six of the nine individuals' assessments were available to their IDTs at least 10 days prior to the ISP meeting. The exceptions were the vocational assessment for Individual #372, and the assessments for Individual #248 and Individual #92. For these last two individuals, most or all of their assessments were provided by the due date identified by the QIDP, but the date was only five days before their ISP dates.

12. Assessments for four of nine individuals included recommendations for skill acquisition. Ideas for skill acquisition had been included in the FSA for all, but Individual #178. The vocational assessments identified skill development for all, but Individual #129, Individual #38, Individual #248, and Individual #92. For the last three individuals, it was noted that they weren't working at the time of the assessment. It is suggested that this should not preclude recommendations for skill acquisition.

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

This domain contains 40 outcomes and 176 underlying indicators the provision of clinical services. Twenty-eight of these indicators, in restraints, psychiatry, medical, dental, and OT/PT, were moved to, or were already in, the category requiring less oversight after the last review. For this review, two other indicators were added to this category, in dental, and OT/PT.

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

Regarding frequent use of crisis intervention restraint, IDTs met regularly, which was good to see. They did not, however, use that time to discuss the topics detailed (and required) by indicators 20-23.

In behavioral health, progress notes were completed monthly and contained the required components for almost all individuals. Peer reviews were regularly occurring. Behavioral health services staff need to ensure that data are available for review at all clinical meetings. This includes PBSP data and, when appropriate, data on sleep, medications, hygiene, program refusals, etc.

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

In behavioral health, without data that are trusted and reliable, a true determination of progress cannot be determined. Even so, when individuals were not making progress, no modifications were made to their programs (or rationale as to why not).

Acute Illnesses/Occurrences

With regard to acute illnesses/occurrences, in the months prior to the review, State Office provided training to all of the Centers on the development of acute nursing care plans. During this round of reviews, the Monitoring Team is working with State Office on ensuring Centers provide the correct documentation for review of acute care plans. Given the timing of the Corpus Christi SSLC review, the Center was in the initial stages of implementing the revised acute care plan template/process. Center staff should continue to work with State Office to correct the issues with this critical nursing function.

Although for a few of the acute issues reviewed, individuals received medical care consistent with current standards of practice, a number of problems were noted with regard to the timeliness of care, the PCPs' completion and/or documentation of assessments, and IDTs' development of plans to address the individuals' follow-up healthcare and medical needs.

In psychiatry, once Corpus Christi SSLC routinely obtains reliable data for psychiatric indicators, indicators 8 and 9 can then be assessed by the Monitoring Team. That being said, the Monitoring Team acknowledges the efforts of the psychiatry staff in taking action for individuals when their conditions warranted it.

PMR-SIB was discontinued for the one individual for whom it was used for many years. The individual was no longer wearing mittens or a helmet.

Implementation of Plans

The psychiatric team continued to meet the timeline and content requirements for the psychiatric clinics, the side effect monitorings, and the periodic CPE updates. The individual's psychiatric clinic, as observed, included the standard components. The department participated in the initiative to begin a neuro-psychiatric polypharmacy committee that will monitor the use of anticonvulsants for those individuals who were receiving multiple anticonvulsant agents for refractory seizure disorders.

Severe turnover in the staff of the behavioral health services department, and the loss of Board Certified Behavior Analyst (BCBA) certified staff resulted in problems getting staff trained in PBSPs, and developing summaries for float staff. Many BHS staff were enrolled or will be enrolling in coursework to being the certification process. It was good to see behavioral health services staff present onsite throughout the week.

In behavioral health services, data collection showed improvement from the last review for some individuals, thus, indicating that the Center had the capacity to meet the various criteria. Staff should assess variables around self-care routines whenever there are regular refusals to participate. For example, increased showering may be a matter of providing preferred times of day, personal time, and/or preferred materials.

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.

For only about 50% of individuals' chronic or at-risk conditions that the Monitoring Team reviewed, 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. Moreover, IHCPs did not include a full set of action steps to address individuals'

medical needs. Although documentation generally was found to show implementation of those action steps assigned to the PCPs that IDTs included in IHCPs, until IHCPs include a full set of action steps related to medical interventions, this is not a true measure of the Medical Department's success (i.e., a false positive).

Overall, it was good to see improvement with regard to PCPs conducting timely reviews of non-facility consultations, indicating agreement with recommendations or providing rationales for disagreements, and writing orders for agreed-upon recommendations. PCPs should focus on writing complete IPNs related to non-facility consultations, including referring consultation recommendations to IDTs, when appropriate.

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

It was good to see that for the three applicable individuals, IDTs included suction tooth brushing strategies/plans in their ISPs/IHCPs. However, staff did not consistently implement the suction tooth brushing, and/or document its implementation. The Dental Department staff had not conducted monitoring of staff's implementation of suction tooth brushing for quality, as well as safety. In addition, ISP action plans did not define the frequency of monitoring expected to meet the individuals' needs.

The Quarterly Drug Regimen Reviews (QDRRs) reviewed generally addressed the required components, and offered recommendations to prescribers, as needed. For the individuals reviewed, prescribers reviewed QDRRs timely, and indicated agreement with recommendations, or provided justification, if they did not agree. If the Center sustains its progress in this area, after the next review, the related indicator might move to the category requiring less oversight. Often, prescribers implemented agreed-upon recommendations.

Data generally were not included in monthly integrated reviews to confirm the implementation of physical nutritional management (PNM) action steps.

In numerous instances, IDTs did not take immediate action, when individuals' healthcare risk increased or they experienced changes of status.

On a positive note, for the individual reviewed whom the PNMT discharged, the IDT and the PNMT held an ISPA meeting, during which they shared comprehensive discharge information.

Adaptive equipment observed was generally clean. The related indicator will move to the category requiring less oversight. For the most part, the adaptive equipment observed fit individuals properly, which was good to see.

Overall, PNMP/Dining Plan implementation at Corpus Christi SSLC continued to improve (i.e., Round 9 – 25%, Round 11 – 40%, Round 13 – 60%, and now, Round 14 – 69%). Based on observations, staff completed transfers correctly. However, efforts are needed to continue to improve Dining Plan implementation, and positioning. Often, the errors that occurred (e.g., taking large bites, and/or eating at an unsafe rate without staff intervention) placed individuals at significant risk of harm. Implementation of PNMPs is non-negotiable. The Center, including Habilitation Therapies, as well as Residential and Day Program/Vocational staff should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them. As necessary, Skill Acquisition/Behavioral Health staff should assist IDTs in developing programs to teach individuals to slow their eating paces, to reduce the significant risk this practice poses.

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: IDTs met regularly, which was good to see. They did not, however, take advantage of that time to review the occurrence of frequent restraints and discuss the components of indicators 20-23. Further, there were problems with the content of PBSPs, CIPs, and reviews/modifications of these plans. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	135	143								
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	100% 2/2	1/1	1/1								
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 2/2	1/1	1/1								
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/2	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	0% 0/2	0/1	0/1								

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

Comments:

18-19. There was evidence that the IDTs for both Individual #135 and Individual #143 met within 10 business days following the fourth restraint within a rolling 30-day period. For Individual #143, this event occurred once. For Individual #135, he met criterion of more than three restraints in a rolling 30-day period a total of five times in a six-month period. There was evidence that his IDT met a sufficient number of times to address this matter.

20-23. The minutes from the ISPA meetings held to review repeated restraint reflected very little discussion of the potential role of the individual's adaptive skills, and biological, medical, and psychosocial issues. While psychiatric diagnoses and medication supports were reviewed for both Individual #135 and Individual #143, there was limited discussion regarding the range of adaptive skills. Although it was noted that progress on SAPs was limited for both individuals, no actions were identified to address this matter. Similarly, though counseling was recommended for Individual #135, there was no discussion regarding gender identity issues frequently noted in other

documents related to Individual #143. Although both had been referred for counseling, this service was not yet in place at the time of the repeated restraints, or at the time of the onsite visit. Additionally, while immediate antecedents were identified for both Individual #135 and Individual #143, no action was taken to address these matters.

24. Both Individual #135 and Individual #143 had a current Positive Behavior Support Plan (PBSP) at the time of the identified restraints.

25. Following the document request, the facility indicated that Crisis Intervention Plans (CIP) were not applicable for either Individual #135 or Individual #143. However, a CIP was referenced in the ISPA meeting minutes for Individual #135, but Individual #135, in particular, did not have a CIP. Physical holds were attempted or applied multiple times in a six-month period. Reports suggested that he often was able to free himself from the hold or moved so that staff were required to release the hold. Given the dangerous nature of some of his identified problem behavior, it would be advisable for staff to consider working with the state Discipline Coordinator for Behavioral Health Services to develop a CIP or an approved, modified CIP if necessary.

26. Review of the PBSPs for Individual #135 and Individual #143 can be found in the Psychology/Behavioral Health sections of this report. It is important to note, however, that several behaviors described in the review of restraint were not addressed in the individual's PBSP. Individual #135 engaged in verbal threats and self-injurious behavior, but neither of these were identified as targeted problem behaviors in his PBSP. Similarly, Individual #143 was threatening harm to herself during her repeated restraints, but this was not addressed in her plan.

28. From March 2018 through August 2018, treatment integrity was assessed twice for Individual #135 and once for Individual #143. The policy indicated that this should be assessed at a minimum of once each month. As both individuals had experienced the use of repeated restraint, it is suggested that enhanced monitoring of treatment integrity should have occurred.

29. There was no evidence that the PBSP for either Individual #135 or Individual #143 had been reviewed in detail by their respective IDTs. Although recommendations for Individual #135 included the completion of an updated functional behavior assessment (FBA) and the development of a new PBSP (his current plan was to expire in August 2018), this was not completed until September 2018. His FBA was incomplete.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.												
Summary:			Individuals:									
#	Indicator	Overall Score										
1	If not receiving psychiatric services, a Reiss was conducted.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was											

	conducted.	
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	
	Comments:	

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Once Corpus Christi SSLC routinely obtains reliable data for psychiatric indicators, then indicators 8 and 9 can be assessed by the Monitoring Team. Similarly, indicators 10 and 11 can then be assessed, too. That being said, the Monitoring Team acknowledges the efforts of the psychiatry staff in taking action for individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	58	372	178	248	129	92	135	143
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments. 8-9. In the absence of reliable data (indicator 7), it was not possible to assess if the individuals were making progress. 10-11. Even so, it was clear that the psychiatric treatment team intervened and performed a psychiatric consult in between quarterly reviews. Evidence of these interventions were presented in the records of all of the individuals (except Individual #58 who had not required one). The interventions recommended were routinely implemented.											

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary: Performance improved to 100% for both indicators for the first time. Efforts of the psychiatry staff were evident. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	58	372	178	248	129	92	135	143
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	of the psychiatric disorder upon the presentation of the target behaviors.										
24	The psychiatrist participated in the development of the PBSP.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
23. There was detailed documentation in the behavioral sections of the record that referred to the psychiatric diagnosis and its relevance to the individual's behavioral prevention. There were also references in the psychiatric sections of the record to the behavioral data and the influence of environmental factors.

24. There were discrete sentences in the behavioral documentation for each individual that described the date of the collaboration between the behavioral health service professional and the psychiatrist as well as the content of the discussion. This reference appeared in the PBSP for all of the individuals, except for Individual #372, where it appeared in the PSP and Individual #38 for whom this documentation was contained in the Behavioral Health Assessment.

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 psychiatric team coordinated the treatment of all of the individuals who were prescribed psychotropic medication with the neurologist if they were also seen in the neurology clinic. The Neurology clinic that took place on 10/17/18 was observed by the Monitoring Team. One of the psychiatric nurses attended all of these clinics for the individuals that are also followed by psychiatry. This ensured that the neurologist was aware of the individual's psychiatric medications and status. This information was reflected in the neurologist's note and the information relative the consult was referenced in the quarterly psychiatric reviews.

The psychiatric team working in conjunction with the neurologist and the primary care physicians also developed a review process for individuals who were prescribed a psychotropic medication and two or more anticonvulsant agents. This meeting as referred to as the Neuro-Psychiatric review committee and met quarterly independent of the polypharmacy committee.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.												
Summary: Given sustained high performance over this and the previous two reviews, indicator 35 will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	38	58	372	178	248	129	92	135	143
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	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 35. The psychiatric clinic for Individual #58 was observed by the Monitoring Team on 10/17/18. The required team members were present and participated in the meeting. The behavioral health services specialist initially presented the data only though the end of the prior month, but when the psychiatrist inquired about the most recent data from October 2018, she was able to both present and discus this information.												

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 medication received.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments:												

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

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.												
Summary: These indicators remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	38	58	372	178	248	129	92	135	143
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:

40. The dosages of the psychiatric medications did not suggest that the goal of treatment was to sedate the individuals.

41. There was no indication that medications were being used for punishment or as substitute for treatment.

42. There was a treatment program in the record of each individual.

43. The Center did not utilize 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, two of the individuals met their goals, but they were never updated. Another six 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	38	58	372	178	248	129	92	135	143
6	The individual is making expected progress	0% 0/8	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% 0/2	N/A	0/1		N/A	N/A	0/1	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% 0/6	0/1	N/A		0/1	0/1	N/A	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

Comments:

6. While graphs suggested progress in all or most targeted problem behaviors for Individual #38, Individual #178, and Individual #92, none of the individuals were rated as making progress due to the problems with data reliability (indicator 5).

7. Progress notes suggested that most goals for targeted problem behaviors had been met for Individual #58 and Individual #129, however, their goals had not been revised.

8. For the six individuals for whom data suggested an increase in at least one targeted problem behavior and/or a decrease in their replacement behavior, there was no evidence that corrective actions had been identified or suggested.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.
Summary: Severe turnover in the staff of the behavioral health services department, and the loss of BCBA certified staff resulted in problems getting staff trained in PBSPs, developing summaries for float staff, and meeting the requirements of indicator 18. These three indicators will remain in active monitoring. All that being said, many staff were enrolled or will be enrolling in coursework to being the certification process. In addition, behavioral health services staff were present onsite throughout the week. Individuals:

#	Indicator	Overall Score	38	58	372	178	248	129	92	135	143
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/8	0/1	0/1		0/1	0/1	0/1	0/1	0/1	0/1
17	There was a PBSP summary for float staff.	0% 0/8	0/1	0/1		0/1	0/1	0/1	0/1	0/1	0/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	25% 2/8	1/1	0/1		0/1	0/1	1/1	0/1	0/1	0/1

Comments:

16. A comparison was made between a list of staff assigned to work with the individual and training rosters. This comparison indicated that between 42% and 70% of assigned residential staff had been trained on the individuals' PBSPs. Rosters also identified day program staff, however, the list of these assigned staff was not provided to allow for a comparison.

17. PBSP summaries were developed for four of the eight individuals who had PBSPs. These one-page summaries provided instructions, listed as Do's and Don'ts, for staff working with Individual #38, Individual #129, Individual #92, and Individual #135. However, these summaries did not list target and replacement behaviors and were not dated, making it difficult to ensure that these matched the current PBSP. No summary was provided for Individual #58, Individual #178, Individual #248, and Individual #143.

18. The BHA and PBSPs for Individual #38 and Individual #129 were completed by staff members who were enrolled in coursework. All other assessments and PBSPs were developed by staff who were not a BCBA and who had not yet begun classes.

Note that the BHS department had undergone quite a bit of change since the last visit by the Monitoring Team. At the time of this onsite visit, only the BHS director was a BCBA. There were three Behavior Health Specialist, two of whom had just completed new employee orientation. All three were planning on enrolling in coursework. This left several unfilled positions. All Behavior Specialist Assistant positions were filled. One of these assistants was planning on completing coursework in pursuit of certification.

It was noteworthy that a total of four assistants had work scheduled that ensured someone from the department was available at the Center between the hours of 7:00 am to 7:00 pm.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.	
Summary: Progress notes were completed monthly and contained the required components for all but one individual. Peer reviews were regularly occurring. This was good to see. The aspects of regular review in indicators 20, 21, and 22, regarding graphic summaries, data presentations in clinical meetings, and follow-up to peer review were not at criteria. This set of indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	38	58	372	178	248	129	92	135	143
19	The individual's progress note comments on the progress of the individual.	88% 7/8	1/1	1/1		0/1	1/1	1/1	1/1	1/1	1/1
20	The graphs are useful for making data based treatment decisions.	0% 0/8	0/1	0/1		0/1	0/1	0/1	0/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	0% 0/4	N/A	0/1		N/A	N/A	0/1	0/1	0/1	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.	17% 1/6	N/A	0/1	N/A	0/1	0/1	0/1	0/1	1/1	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100%									

Comments:

19. For seven of the eight individuals, the progress note did comment on his/her progress. The exception was Individual #178 whose progress notes commented on her PSP although her PBSP was often referenced.

There were problems regarding the timely completion of monthly progress notes. Following the document request submitted in September 2018, the facility was unable to provide several months of progress notes until the Monitoring Team was onsite. This included the April 2018 notes for Individual #129, Individual #92, and Individual #143, the May 2018 notes for Individual #248, Individual #135, and Individual #143, and the July note for Individual #135. No progress notes were provided for Individual #178.

20. Although graphs were included in all progress notes, these lacked the consistent use of phase change lines to indicate potentially significant events. This includes the introduction of a PBSP or specific behavioral contract (e.g., Individual #178, Individual #135), medication changes, changes in level of supervision (e.g., Individual #129, Individual #92, Individual #135), resumption of oral feeding (e.g., Individual #58), transition to the community and return to the facility following a failed placement (e.g., Individual #178, Individual #92), etc. In some cases, the ordinate or vertical axis was not labeled, or was mislabeled (e.g., episodes labeled as frequency). In one case, the replacement behavior graph was labeled percentage of successful trials out of four, but whole numbers exceeding four were graphed.

21. During Individual #58's psychiatric clinic, graphs were presented on his targeted problem behaviors and replacement behaviors. This is scored a zero, however, because it required a prompt from the psychiatrist to locate and provide the October 2018 data. It should be noted that the behavior health specialist did report October 2018 data for two other individuals who were reviewed before Individual #58. As noted elsewhere in this report, two of the graphs for target behaviors were labeled as a partial interval record over a two-hour period. When the accuracy of this measure was questioned, another staff member reported that this should be labeled as a frequency recording.

ISPA meetings were observed for Individual #129, Individual #92, and Individual #135 during the onsite visit. Individual #129's meeting addressed her need for individualized staffing, Individual #92's addressed his completion of hygiene routines, and Individual #135's meeting addressed his problem behavior and sleep. A thorough review of related data was not evident at any of these meetings.

22. Six individuals had been presented at internal and/or external peer review over a six-month period. Evidence suggested that recommendations had been addressed for Individual #135. For the other five individuals, the following recommendations had not been addressed: Individual #58 - PBSP objective to address his pulling his g-tube; Individual #178 - false allegations addressed in PBSP; Individual #248 - PBSP to address head banging, biting others, and unauthorized departures; Individual #129 - PBSP to track sleep patterns and program refusals; and Individual #92 - instigation and theft are not addressed in the PBSP, and there is no intervention described for disruptive behavior.

23. There was evidence that the internal peer review committee met three times each month in the past six months. Additionally, the external peer review committee met five times in the past six months.

Outcome 8 – Data are collected correctly and reliably.

Summary: Although scores were low for four of these five indicators, all (except 28) improved from the last review, thus, indicating that the Center had the capacity to meet the various criteria. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	58	372	178	248	129	92	135	143
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	38% 3/8	0/1	0/1		1/1	1/1	0/1	1/1	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.	25% 2/8	1/1	1/1		0/1	0/1	0/1	0/1	0/1	0/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/8	0/1	0/1		0/1	0/1	0/1	0/1	0/1	0/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 8/8	1/1	1/1		1/1	1/1	1/1	1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	25% 2/8	1/1	1/1		0/1	0/1	0/1	0/1	0/1	0/1

Comments:

26. In the PBSP for three individuals (Individual #178, Individual #248, Individual #92), there were adequate measures of the targeted problem behaviors. In the plans for Individual #38 and Individual #58, a partial interval recording system was implied by the graphic review of data. For Individual #129, Individual #135, and Individual #143, episodes separated by two to three minutes without the occurrence of the target behavior were recorded. Because these were graphed as frequency, there is no indication of the duration or intensity of these episodes.

27. The PSBPs for Individual #38 and Individual #58 indicated a clear description of data collection for replacement behaviors. In the PBSP for Individual #178 and Individual #248, the replacement behavior described staff behavior. For the remaining three individuals, the plan did not clearly indicate how or when to document the replacement behaviors.

28. There were established acceptable measures for determining IOA and treatment integrity. As explained by the BHS director, problems remained with assessing data timeliness, particularly because the visual prompt to record data was not working in all kiosks.

29. Staff were expected to assess data timeliness, IOA, and treatment integrity at least once each month. The expected level for all three measures was 80%.

30. Over a six-month period, there was evidence that goal frequencies and levels of data timeliness, IOA, and treatment integrity were met for Individual #38 and Individual #58. For the remaining six individuals, none of these measures were regularly assessed. Inter-observer agreement and data timeliness were assessed twice in a six-month period for Individual #248, Individual #129, Individual #92, Individual #135, and Individual #143. Similarly, treatment integrity was assessed once for Individual #248 and twice for Individual #129, Individual #92, Individual #135, and Individual #143. There was no evidence of assessment of these three measures for Individual #178 since her return to the facility.

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.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
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	1/2	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(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 #129 – GI problems, and other: ingestion of batteries; Individual #178 – other: urinary incontinence, and weight; Individual #184 – falls, and seizures; Individual #303 – GI problems, and osteoporosis; Individual #268 – seizures, and weight; Individual #307 – other: impaired physical mobility, and UTIs; Individual #247 – respiratory compromise, and GI problems; Individual #8 – GI problems, and circulatory; and Individual #104 – aspiration/respiratory compromise, 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 individual's progress or lack thereof: Individual #178 – weight.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports on these goals with data and analysis of the data often were not available to IDTs. Often, QIDPs provided narrative summaries of IPNs, but did not provide summary data and analyses. 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: Five of the nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, these indicators will continue in active oversight until the Center's quality assurance/improvement mechanisms related to preventative care can be assessed, and are deemed to meet the requirements of the Settlement Agreement. In addition, the Center needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

Individuals:

#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
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% 5/5	N/A	N/A	1/1	1/1	N/A	1/1	N/A	1/1	1/1
	iii. Breast cancer screening	100% 3/3	N/A	N/A	N/A	1/1	N/A	1/1	N/A	1/1	N/A
	iv. Vision screen	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	v. Hearing screen	67% 6/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1
	vi. Osteoporosis	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
	vii. Cervical cancer screening	100% 5/5	1/1	1/1	N/A	1/1	N/A	1/1	N/A	1/1	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	13% 1/8	0/1	1/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1

Comments: a. The following problems were noted:

- On 6/12/17, Individual #129 attended her last ophthalmology appointment. Reportedly, she did not want to attend the one scheduled in 2018, but in the documents submitted, no documentation was found of follow-up/an IDT meeting. In addition, her last audiological screening occurred on 5/12/17, and she was due for another one in a year.
- On 3/8/17, Individual #184 attended his last audiological screening, and he was due for a repeat within a year.
- On 7/29/15, Individual #268's DEXA scan showed a T-score of -1.7. A repeat was overdue.
- On 7/20/17, Individual #8 attended her last audiological screening, and she was due for a repeat within a year.

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

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

Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	50% 1/2	N/A	N/A	N/A	N/A	N/A	N/A	1/1	0/1	N/A

Comments: a. Individual #247 was on hospice, and had Ethics Committee review of his DNR status. The IDT provided clinical justification for his DNR. On 7/2/18, he died.

Since 3/16/06, Individual #8 has had an out-of-hospital DNR. The qualifying condition is listed as a genetic disorder. At an ISPA meeting on 12/14/17, the IDT discussed possible qualifying conditions, such as multiple medical problems related to cri di chat

syndrome, and osteoporosis. On 1/2/18, the IDT held an ISPA meeting to discuss a change to full code status, but the Legally Authorized Representative (LAR) had questions for the Medical Director. At the time of the review, she continued with DNR status. During the onsite review, the State Office Discipline Lead explained to the Acting Medical Director that Individual #8 did not have a qualifying condition, because she had not been hospitalized or seriously ill in past year.

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Although for a few of the acute issues reviewed, individuals received care consistent with current standards of practice, a number of problems were noted with regard to the timeliness of care, the PCPs' completion and/or documentation of assessments, and IDTs' development of plans to address the individuals' follow-up healthcare and medical needs. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
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.	46% 6/13	1/2	N/A	1/2	N/A	0/1	0/2	1/2	1/2	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.	56% 5/9	1/1		0/1		0/1	1/2	2/2	1/2	N/A
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	67% 4/6	N/A	1/1	N/A	N/A	1/1	0/2	1/1	N/A	1/1
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	50% 1/2		N/A			1/1	0/1	N/A		N/A
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	100% 5/5		1/1			1/1	2/2	N/A		1/1
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	80% 4/5		0/1			1/1	2/2	N/A		1/1
g.	Individual has a post-hospital ISPA that addresses follow-up medical	0%		N/A			N/A	0/2	N/A		N/A

	and healthcare supports to reduce risks and early recognition, as appropriate.	0/2									
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% 4/4		N/A			1/1	2/2	N/A		1/1

Comments: a. For seven of the nine individuals reviewed, the Monitoring Team reviewed 13 acute illnesses addressed at the Center, including: Individual #129 (vomiting on 8/7/18, and swallowing batteries on 7/10/18), Individual #184 (left knee injury on 6/4/18, and fall on 5/11/18), Individual #268 (five-minute seizure on 7/27/18), Individual #307 (rash on 8/24/18, and redness to lip and pustules to incision site on 8/30/18), Individual #247 (tachypnea on 6/16/18, and unstable vital signs on 6/22/18), Individual #8 [edema to legs on 4/20/18, and gastrostomy tube (G-tube) leakage on 6/18/18], and Individual #104 (toe ulcer with cellulitis on 6/18/18, and self-inflicted bites on his hand on 8/8/18).

PCPs assessed the following acute issues according to accepted clinical practice: Individual #129 (vomiting on 8/7/18), Individual #184 (fall on 5/11/18), Individual #247 (tachypnea on 6/16/18), Individual #8 (G-tube leakage on 6/18/18), and Individual #104 (toe ulcer with cellulitis on 6/18/18, and self-inflicted bites on his hand on 8/8/18).

b. For the following acute issues, the PCPs conducted follow-up assessments and documentation at a frequency consistent with the individuals' status and the presenting problem until the acute problem resolved or stabilized: Individual #129 (swallowing batteries on 7/10/18), Individual #307 (rash on 8/24/18), Individual #247 (tachypnea on 6/16/18, and unstable vital signs on 6/22/18), and Individual #8 (G-tube leakage on 6/18/18).

The following provide examples of concerns noted:

- When Individual #129 ingested batteries, on 7/10/18, the PCP IPN, at 3:11 p.m., did not describe a focused physical exam, including documentation of all positive and negative findings. The PCP also did not document the source of the information. The PCP ordered lactulose and stool screening. On 7/13/18, the PCP documented that the individual had passed two AA batteries.
- A nursing IPN, dated 6/2/18 (i.e., Saturday), at 9:10 p.m., documented swelling of Individual #184's left knee and purple discoloration to his left posterior thigh. The nurse notified the PCP, who ordered an x-ray for 6/3/18. A nursing IPN, dated 6/4/18, indicated that after reviewing the x-ray results, the PCP gave a verbal order to consult orthopedics. The initial PCP IPN was dated 6/4/18. The orthopedist saw the individual and did not consider the injury a fracture. However, based on the IPNs, the PCP conducted no follow-up concerning the bruise and knee swelling.
- Based on nursing IPNs, Individual #268 experienced a five-minute seizure while outside on the grounds of the Center. Nursing staff called the PCP who decided to meet the individual at the Infirmary, but staff were unable to redirect the individual to the Infirmary and the individual returned home. Based on nursing IPNs, the PCP went to home to see Individual #268, and the individual was not compliant with an exam. However, based on the documentation submitted, the PCP did not write an IPN reflecting what happened, and/or documenting the PCP's observations of the individual's health status at the time.
- On 8/30/18, at 9:30 a.m., a nurse wrote an IPN indicating that Individual #307 had redness to her left upper lip and pustules at

an incision site on her scalp. Although the nursing IPNs indicated the PCP saw the individual, the PCP did not document an assessment in the IPNs submitted. Based on review of the orders and nursing IPNs, the PCP ordered warm compresses to the individual's upper lip twice a day for five days, and the PCP planned to review progress on 9/4/18. Similarly, the PCP ordered wound care orders for five days and planned to review progress on 9/4/18. The PCP also ordered PT/OT and dietary consults. In addition, the PCP ordered Rocephin 1 gram (gm) intramuscular (IM) for three days, with a review scheduled for 9/1/18. On 9/4/18, the PCP saw the individual for wound care follow-up, but the note was brief, only indicating that the scalp incision was intact with no infection. However, the nursing IPN, dated 9/4/18, at 8:10 p.m., indicated: "yellow drainage on lower half of incision." The two IPNs appeared inconsistent without further detail from the PCP as to what the PCP meant by "intact." because he planned on continued wound care daily (which included Santyl cream). The PCP also did not document closure to the red lesion/area of her lip.

- Until Individual #8's family complained, the PCP did not assess the individual's edema. On 4/20/18, the PCP documented an assessment. The PCP started the individual on Lasix. In an IPN, the PCP stated: "unable to elevate her leg due to feeding times." A PCP IPN, dated 5/16/18, at 11:18 a.m., documented that the individual continued to have swollen legs, and that the Lasix did not help. The PCP referred the individual to a vascular surgeon for possible TED hose. The PCP also increased the Lasix to 40 milligrams (mg) daily from 20 mg. The PCP ordered a basic metabolic panel (BMP) in three weeks. The PCP noted the individual spent most of her time in a wheelchair, and seldom moved to a recliner with her legs elevated.

  On 6/13/18, nursing staff conducted an assessment of edema and contacted the PCP, who indicated Lasix should continue. On 6/20/18, the PCP reviewed the BMP results from 6/12/18, and gave a verbal order to discontinue Lasix. Based on documentation submitted, the PCP did not see the individual again, but relied only on nursing reports. On 8/3/18, the family again raised concerns about the individual's edema.

c. For five of the nine individuals reviewed, the Monitoring Team reviewed six acute illnesses/occurrences that required hospitalization, Infirmary admission, or an ED visit, including those for Individual #178 (ED visit for foreign body in her arm on 8/11/18), Individual #268 (ED visit for laceration to scalp on 5/27/18), Individual #307 (hospitalization for neurological change on 7/22/18, and hospitalization for refusal of food and fluid on 4/6/18), Individual #247 (Infirmary admission for respiratory distress on 6/22/18), and Individual #104 (ED visit for cyanosis on 5/28/18).

c. through e., g., and h. The following provide examples of the findings for these acute events:

- It was positive to see that the following individuals displaying signs/symptoms of acute illness received timely acute medical care, and follow-up care, when applicable: Individual #268 (ED visit for laceration to scalp on 5/27/18), and Individual #247 (Infirmary admission for respiratory distress on 6/22/18).

- On 4/2/18, Individual #307 was transferred to the Infirmary due to refusals of food and fluid. The PCP ordered labs, fluids, and transfer to the hospital. According to a nursing IPN, dated 4/2/18, at 3:00 p.m., on 4/2/18, the PCP saw the individual, but did not write a note at that time. The PCP wrote a note, dated 4/3/18, at 2:21 p.m., but this note did not provide significant information as to the findings and clinical decision-making process. The PCP made a diagnosis of dehydration and indicated she was receiving intravenous (IV) fluids, but the history only indicated: "eating all food, not drinking all fluids" with no information as to the actual by mouth fluid intake over the prior 24 or 48 hours. The history did indicate no fever or emesis.

The PCP referenced lab tests, but did not provide the date these were done (that morning, prior day, etc.). The content of the note left many gaps in critical information.

On 4/30/18, at 10;16 a.m., the IDT held an ISPA meeting, but the resulting action steps were not applicable to Individual#307's post-hospital course. Then, on 4/30/18, at 10:39 a.m., the IDT held another ISPA meeting at which time it reviewed her need for one-to-one staffing due to her feeding tube. However, the IDT did not address her ongoing need to be in the Infirmary, when discharge to her home would be appropriate, local wound care at the site of 59 staples, feeding rates, PT and OT evaluations, change in medication, etc.

- According to a nursing IPN, dated 7/22/18, at 4:35 p.m. (i.e., a Sunday), staff noticed Individual #307 had facial drooping and drooling on left side. The on-call PCP gave a verbal order to transfer her to the ED. Based on the documents submitted, the PCP did not write an IPN within one business day. On 7/30/18, Individual #307 had a ventriculoperitoneal (VP) shunt placed.

  On 8/15/18, her IDT held an ISPA meeting to discuss her Infirmary discharge back to home. The IDT's discussion focused on programming and SAPs, but not action steps to address her post-operative course. The ISPA included one paragraph that outlined important areas of care, but these were not brought forward as action steps [e.g., computed tomography (CT) scan scheduled on 9/24/18, orders for dressing to scalp incision site, etc.).

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

Summary: Overall, it was good to see improvement with regard to PCPs conducting timely reviews of non-facility consultations, indicating agreement with recommendations or providing rationales for disagreements, and writing orders for agreed-upon recommendations. PCPs should focus on writing complete IPNs related to non-facility consultations, including referring consultation recommendations to IDTs, when appropriate. These indicators will continue in active oversight.

Individuals:

#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	100% 13/13	1/1	N/A	2/2	N/A	2/2	2/2	2/2	2/2	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	92% 12/13	1/1		2/2		2/2	1/2	2/2	2/2	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	62% 8/13	1/1		2/2		0/2	0/2	1/2	2/2	2/2

d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	83% 10/12	1/1		1/1		1/2	2/2	1/2	2/2	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/1	N/A		N/A		N/A	N/A	0/1	N/A	N/A

Comments: For seven of the nine individuals reviewed, the Monitoring Team reviewed a total of 13 consultations. The consultations reviewed included those for Individual #129 for gynecology on 6/11/18; Individual #184 for orthopedics on 7/12/18, and neurology on 8/16/18; Individual #268 for neurology on 8/15/18, and neurology on 9/12/18; Individual #307 for neurosurgery on 8/14/18, and neurology on 8/15/18; Individual #247 for neurology on 3/14/18, and neurology on 6/27/18; Individual #8 for neurology on 7/19/18, and cardiology on 7/25/18; and Individual #104 for neurology on 3/22/18, and ophthalmology on 8/15/18.

a. For all of the consultation reports reviewed, PCPs indicated agreement or disagreement with the recommendations, and provided rationales for disagreements. This was good to see.

b. Only one of these reviews did not occur timely (i.e., the one for Individual #307 for neurology on 8/15/18).

c. About 60% of the PCP IPNs related to the consultations reviewed included all of the components State Office policy requires. The exceptions were for Individual #268 for neurology on 8/15/18 (no IPN submitted), and neurology on 9/12/18 (no PCP IPN submitted); Individual #307 for neurosurgery on 8/14/18, and neurology on 8/15/18 (both missing components); and Individual #247 for neurology on 6/27/18 (no PCP IPN submitted).

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, with the exceptions of the following: Individual #268 for neurology on 9/12/18 (no order for follow-up in one month); and Individual #247 for neurology on 6/27/18 (no order for follow-up in three months).

e. For Individual #247's neurology consultation on 6/27/18, the PCP did not indicate whether or not referral to the IDT was necessary.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
Summary: For only about 50% of individuals' chronic or at-risk conditions that the Monitoring Team reviewed, 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. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	56% 10/18	0/2	1/2	1/2	2/2	1/2	2/2	2/2	0/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #129 – GI problems, and other: ingestion of batteries; Individual #178 – other: urinary incontinence, and weight; Individual #184 – falls, and seizures; Individual #303 – GI problems, and osteoporosis; Individual #268 – seizures, and weight; Individual #307 – other: impaired physical mobility, and UTIs; Individual #247 – respiratory compromise, and GI problems; Individual #8 – GI problems, and circulatory; and Individual #104 – aspiration/respiratory compromise, and skin integrity).

a. For the following individuals' chronic or at-risk conditions, PCPs conducted medical assessment, tests, and evaluations consistent with current standards of care, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #178 – weight; Individual #184 – seizures; Individual #303 – GI problems, and osteoporosis; Individual #268 – seizures; Individual #307 – other: impaired physical mobility, and UTIs; Individual #247 – respiratory compromise, and GI problems; and Individual #104 – skin integrity. The following provide examples of concerns noted:

- Individual #129 had a history of gastritis and gastroesophageal reflux disease (GERD) and was prescribed a proton pump inhibitor (PPI). She had a smoking habit, and since 4/14/16, had a skill acquisition plan (SAP) for smoking cessation. The SAP included increasing her knowledge and understanding of her smoking habit, such as examples of how tobacco usage negatively affects her body, the consequences of long-term tobacco use, the cost of tobacco use, general health risks of smoking, and alternatives to tobacco use. Her PCP prescribed the nicotine patch in an attempt to eliminate her smoking habit, but she smoked while on the patch, and on 4/14/18, became ill. An ISPA, dated 4/18/18, discussed her refusal to use the patch, based on wanting to smoke and the ill effects of smoking while on the patch. The plan was for a social worker to educate her about resuming the nicotine patch in the future, if she desired. On 4/12/18, 4/16/18, 4/27/18, 5/14/18, 7/21/18, and 8/7/18, she also had emesis. On 4/16/18, her vomiting was associated with lying down immediately after drinking a large amount of fluid. On 8/7/18, her emesis was associated with excessive smoking and responded to Zofran, bed rest, and drinking water, and the PCP recommended she avoid smoking.

  It appeared that staff did not inform the PCP of all of the episodes of emesis. On further review, it was found that direct support professionals (DSPs) recorded episodes of emesis in the CareTracker system, but this information was not available to the PCPs. Reportedly, nurses reviewed the CareTracker information and determined the validity of the documentation. Although recorded as emesis, sometimes DSPs recorded other events, such as spitting, and other oral secretions as emesis, and in CareTracker this information fell under the category of emesis. These issues indicated the need for education of the DSPs, standardization of terminology, and clear definitions of terms.

  Individual #129 continued to have gastritis and possible GERD symptoms. The ongoing smoking habit indicated that the SAPs implemented over the past three years were ineffective, and the IDT, with the involvement of the PCP, needed to review and revise/improve the plan(s) to assist the individual to reduce her smoking habit prior to or in conjunction with the PCP ordering any additional smoking cessation medication. Although the plan was for the social worker to communicate the option of resuming cessation of smoking in the future, the content of that discussion was unclear. The social worker or other IDT members might need specialized training in health education to ensure a consistent approach and information to assist her to stop smoking successfully. The involvement of Behavioral Health Services staff also likely would be helpful.

  She had a history of insomnia, but she voiced complaints about the medication used to improve her sleep. She also had a

history of sleep apnea, but the documents submitted did not include information about an evaluation to confirm this problem, which could lead to daytime headaches and other physiological effects and adverse behaviors.

In summary, the IDT, with the leadership of the PCP, had not collected reliable data, and analyzed it to identify and develop plans to address the many potential contributing factors to her gastritis/GERD. As discussed above, nurses' lack of communication to the PCP when Individual #129 had emesis, as well as the PCP's lack of access to documentation in CareTracker of such signs and symptoms were problematic. She had many stressors in her life, but it was unclear whether or not Behavioral Health Services staff were addressing these issues. Her ongoing smoking habit also was potentially a contributing factor, but the IDT did not appear to have an effective plan to address this health issue.

- Recently, Individual #129 developed a behavior of swallowing AA or AAA batteries, which placed her at high risk of choking, as well as other negative health sequela. Dates of battery ingestion included: 4/23/18, 5/10/18, 6/1/18, 7/9/18, and 9/16/18. The PCP provided prompt treatment and staff implemented monitoring to ensure the batteries were passed without complications. However, the IDT, including the PCP, did not appear to respond in a timely manner to develop a plan to prevent further battery ingestion. As a response to the first battery ingestion, ISPA documentation indicated the IDT concluded the ingestion was not a trend, and as an isolated incident, it did not require restrictions. The IDT planned to enroll her in programming with the women's group, but she did not attend until 7/10/18. An ISPA, dated 5/31/18, documented action steps including anger management, and the ISPA, dated 7/18/18, indicated the IDT developed a SAP for anger management, but when the Monitoring Team member requested evidence of implementation, the Center did not submit any. The 5/31/18 ISPA also mentioned referral for behavior health counseling, but this was tabled. As of 8/6/18, no counseling had occurred, even though the individual had requested it for some time.

  It was not until the ISPA, dated 5/31/18, that the IDT included a referral to the Human Rights Committee (HRC) for a battery restriction as an action step, but it was not clear when that actually occurred. An ISPA, dated 7/10/18, indicated staff at various locations were alerted to her battery ingestion behavior. Three months after the first battery ingestion, guardian agreement with not having access to batteries was documented. Environmental checks were not part of the action steps until the ISPA, dated 7/10/18. However, an ISPA, dated 7/18/18, indicated she would have continued access to batteries.

  During the onsite review, when the Monitoring Team member discussed the role of the PCP in working with the IDT to develop needed actions in a timely (urgent) manner, the PCP indicated he was not invited to meetings at which the IDT discussed such issues, and was not even aware of when such meetings occurred to allow him to review the results. Although the IDT clearly should have invited the PCP to such meetings, the PCP/Medical Department were aware of the incidents of battery ingestion (i.e., because they provided treatment), and should have prompted/requested IDT meetings if they did not receive invitations to them. Overall, the IDT did not appear to consider all of the potentially serious health complications of this ongoing behavior, and act with urgency to address the numerous risks it posed.

- Individual #178 had urinary incontinence. In the past, she was prescribed Desmopressin, but this had little effect. She also had been treated for overactive bladder with Darifenacin. In September 2017, she saw a urologist, but her urinary incontinence remained. Her AMA did not describe any past urologic procedures, if completed, as part of an evaluation. Documentation

indicated that she was incontinent all of the time and that it did not bother her. However, when she lived briefly in the community, she developed skin breakdown. She had a diagnosis of spastic quadriplegia, and required a wheelchair for mobility. Her PCP should pursue evaluation of her incontinence, if not already completed in the past, as well as treatment options. With input from the PCP, the IDT should consider development an interdisciplinary plan to address her urinary incontinence, including a program to increase her motivation for success in this area, as well as Habilitation Therapy's assistance in developing a schedule in which DSPs assist her from the wheelchair to a commode throughout the day.

- In the recent past, Individual #184 had a number of falls. On 4/4/18, he fell. Due to increased tremors during that time period, the neurologist lowered his dose of valproic acid (VPA). On 5/1/18, the PNMT discharged him, as he was self-propelling his wheelchair around campus, and had been participating in the walking program using his Rifton walker. Habilitation Therapy staff detailed transfer instructions for DSPs. On 5/1/18, he fell, but it appeared no injury report was filed. On 5/11/18, he fell in his bedroom, which staff did not witness, and he sustained a superficial scrape to his left shoulder blade and a one-centimeter (cm) laceration to his left ear. On 5/17/18, at an ISPA meeting, the IDT reviewed the event. At that time, staff had been conducting bed checks hourly, and in the morning, staff observed him walking unassisted in his bedroom to get to his wardrobe. Although staff noted no rough or sharp edges on the wall or wardrobe, the IDT sent a consult request to the OT/PT to assess for the need for wall padding. He already had a large floor mat by his bed, which was utilized when he was sleeping. On 5/28/18, staff found him sitting on the floor of the restroom. On 5/29/18, the IDT held an ISPA meeting due to Individual #184 falling three times in 30 days. At that time, Habilitation Therapies placed a chair alarm on the wheelchair, so he could signal for assistance. Staff put in a work order for automatic door openers for the restrooms. Staff were to undergo in-service training "for zoning every 2 hours" in the back area and restroom of his home. Additionally, a toilet widget was to be created in IRIS to prompt staff to determine if he needed to use the restroom.

  On 6/2/18, Individual #184 then developed left knee swelling with discoloration to the posterior left thigh, with no associated pain. The PCP consulted OT and PT, and referred him to orthopedics due to a possible fracture noted on an x-ray. The IDT initially placed him on one-to-one level of supervision (LOS) during the night, and tapered this LOS, starting 6/21/18. On 7/12/18, the IDT returned him to routine LOS with 15-minute checks at night. An orthopedic consult confirmed he did not have a fracture, but incidental bone exostosis. He progressed on his ambulation program, and during an 8/21/18 ISPA meeting, the IDT decided to transfer him to an indirect therapy program. The PCP interpreted the reason for the falls during the prior months as his increasing physical strength leading to attempts at independent maneuvering. The PCP was not aware of the condition of his footwear, or when his last vision check had occurred. It was unclear whether or not the PCP was aware of the number of times Individual #184 fell, or just the falls that resulted in an injury. The PCP did not attend any of the ISPA meetings related to falls, and might not have been aware of or invited to the ISPAs. Based on interview, the PCP could not provide a list of causes of falls that had been ruled out, and was not able to provide options for further evaluation should falls recur. Without the participation of the PCP, the evaluation and treatment of falls was incomplete.

- Over the previous six months, Individual #268 had ongoing weight loss. On 3/1/18, the dietitian noted a 14-pound weight loss since December 2017. Staff noted that at times, he did not eat snacks, so changes were made to offer snacks according to his preferences. On 4/24/18, the dietician completed a follow-up consult, and indicated that in the previous six months, he had lost 22 pounds, and he was active in walking around campus all day. Additional supplements were added to his snack regimen

that added 900 calories per day. An ISPA, dated 8/31/18, indicated he had some meal refusals, but these were not enough to explain his weight loss, and a dietary consult was requested. An IPN, dated 9/13/18, stated that the individual's father indicated Individual #268 looked very thin. It was noted that he "has lost at least 30 pounds since August 2017, below estimated desirable weight (EDWR) range slightly." On 9/14/18, the IDT documented in an ISPA that he had gone from 172 to 145 pounds and was eight pounds below his EDWR. Additional supplements were added at medication passes, and if he refused a meal or ate less than 50% of a meal, staff were to offer a nutritional supplement, as well as additional supplements during snacks. This added 1570 calories per day. Despite the individual's significant weight loss and despite the increase in dietary calories offered, the PCP appeared unaware of the weight loss. It was not clear how the PCP remained unaware of the series of changes in dietary recommendations/orders, and this suggested a critical lack of communication. The PCP had conducted no medical evaluation of his weight loss. The IDT had failed to include the PCP in ISPA meetings concerning weight loss, and there were obvious gaps in communicating these health care concerns to the PCP. Additionally, periodic interval medical reviews would have alerted the PCP to the trend in weight loss.

- Individual #8 had a history of dysphagia and subsequent G-tube placement. In 2017, several notes indicated leaking at the ostomy site of the G-tube placement (i.e., 1/13/17, 2/16/17, 3/27/17, 9/18/17, and 12/19/17). More recently, this appeared to have improved, with leakage noted only on 6/18/18. However, during the time period of the submitted documents, a series of G-tube dislodgements occurred (i.e., 3/7/18, 3/14/18, 3/28/18, 5/6/18, 5/26/18, 6/11/18, 6/25/18, 7/14/18, 8/8/18, 8/25/18, 8/26/18, and 9/8/18). In its previous report, the Monitoring Team raised the concern about this G-tube complication, and specifically, the lack of PCPs' inquiry to determine what the cause(s) was, and whether or not there were solutions to the causes. Staff reported that in-service training sessions were completed. However, the problem continued. For Individual #8, as well as any other individuals for whom this is a problem, an analysis to determine the underlying cause(s) is indicated (e.g., defective tubes, the individual pulling the tube, the tube becoming caught on clothing or bedside apparatus, incomplete staff training, etc.). Once the cause(s) is identified, whenever possible, IDTs, with input from the PCP, should develop and implement action plans to address the cause(s).

- Individual #8 had aortic regurgitation, and cardiology followed her. An echocardiogram, dated 6/16/17, indicated a normal ejection fraction, and results were considered unchanged from the prior echocardiogram, dated 3/3/15. As of 2/6/18, her renal function was normal. Her family then reported edema in both her legs. A PCP IPN, dated 4 /20/18, indicated that the edema was due to the inability "to elevate her legs due to feeding times." Rather than address positioning issues, the PCP started a diuretic. A PCP IPN, dated 5/16/18, indicated the swelling continued and the diuretic did not help. The PCP increased the dosage of the diuretic, and referred her to a vascular surgeon. The PCP again noted that she was in her wheelchair most of the day and staff seldom placed her in a recliner with leg elevation. An ISPA on that same date indicated that she had orders in the past for below the knee TED hose, but not currently. She had a tilt in space wheelchair, but it did not allow for sufficient elevation of her legs above her heart. Staff reported that the foot of the bed was rarely elevated. Due to her schedule of feeding time and classes, she was not spending time out of the wheelchair to allow for leg elevation. Although the nurse indicated it was safe to feed her in the recliner, feedings continued to occur in the wheelchair.

  On 5/31/18, the vascular surgeon saw her. Arterial and venous ultrasounds were ordered and completed. Findings indicated no significant atherosclerotic plaque or venous insufficiency, and the surgeon recommended continuation of conservative

measures. From 6/13/18 to 6/20/18, the PCP prescribed an additional diuretic. Blood testing was completed to monitor adverse effects on her renal function and electrolytes. After this course of diuretics was completed, the PCP did not examine the individual. On 7/25/18, she had a routine cardiology follow-up visit, and no pedal edema was noted in the consultant note. Then, on 8/3/18, the family reported swelling in her legs, and requested staff elevate her legs and provide her with loose-fitting socks. The PCP ordered a diuretic for six months and a Habilitation Therapies consult. At the time of the Monitoring Team's visit in October 2018, the PNMT had not scheduled a review of her, which was the first step in determining whether or not further PNMT involvement was needed.

It was concerning that the family had to bring Individual #8's edema to staff's attention twice before the clinical team took any further action. The PCP and clinical team should have been proactive in resolving the issue. Given that vascular and cardiac issues were ruled out, positioning throughout the day, including elevation of her legs would have been an important step to take, prior to the PCP prescribing a diuretic. Initially, the PCP reported the diuretic had no effect, yet later prescribed a long-term course without ensuring staff consistently assisted the individual to elevate her legs. In addition, based on the notes submitted, the PCP did not periodically examine her to determine the long-term effect of the diuretic on her edema. The IDT should have worked with the PCP to review the individual's daily routine to ensure a safe feeding schedule and participation in activities, but also to allow for needed leg elevation. Leg elevation might have resolved her edema without the use of long-term medication, which has the potential to cause adverse effects (e.g., elevation of blood urea nitrogen and creatinine, and reduction of the potassium level).

- Individual #104 had a long history of dysphagia, as well as GERD, erosive esophagitis, and hiatal hernia, and in the past, underwent fundoplication, truncal vagotomy, pyloroplasty, and gastrostomy. In the past, a G-tube was placed, but complications led to the decision to remove the G-tube and allow gastrostomy closure (i.e., in March 2000). He continued to have bouts of broncho pneumonia (i.e., in 2009, and 2011), sepsis (i.e., in 2013) and erosive gastritis (i.e., in 2008). More recently, on 3/3/16, an esophagogastroduodenoscopy (EGD) revealed a grade A esophagitis and benign esophageal ulcer, with large hiatal hernia. A Modified Barium Swallow Study (MBSS), dated 8/22/16, indicated no aspiration, and that he was safe to have a pureed diet with moistened gravy/sauce in amounts of ½-teaspoon-sized bites, with time allowed between boluses. Liquids were pudding thick. Additional reflexive swallows were needed to clear each bolus. On 9/14/16, milk was removed from his diet. On 10/14/16, a subsequent EGD indicated a grade C esophagitis, at which time, the PCP increased Protonix to twice a day, positioning was reviewed, and the PCP made a referral to surgery for possible repair of the hiatal hernia. On 1/4/17, a surgical consult did not recommend surgery due to risk of post-operative complications. Meanwhile, dental care indicated moderate plaque on 7/6/17, and mild plaque on 10/26/17. On 11/21/17, the PCP again increased the dosage of the PPI. In an IPN, dated 3/14/18, staff indicated significant spillage when the individual ate and drank due to movement and involuntary tightening of the neck muscles. At that time, the neurologist added clonazepam for muscle spasticity and a scopolamine patch for drooling. Habilitation Therapies added a new head rest during meals to improve Individual #104's body alignment and reduce neck postures, which might lead to choking and aspiration during meals. On 5/28/18, Individual #104 developed respiratory distress during/after a meal, and became cyanotic with a loss of consciousness. He was sent to the ED. He recovered uneventfully. The SLP and OT then monitored him. On 6/4/18, staff observed a change in breathing pattern during dinner, with associated apneic episodes. The PCP then referred him to gastroenterology (GI). An ISPA indicated the feeding rate would be unchanged while awaiting the GI/surgical consult, and portion size would be reduced at each meal.

Nursing staff began recording weekly weights. The GI consult indicated he was a candidate for a percutaneous endoscopic gastrostomy tube (PEG-tube). On 7/17/18, he acutely choked after eating, with hypoxia, but nursing staff suctioned him and he recovered. On 7/25/18, a MBSS was attempted, but could not be completed due to the configuration of his wheelchair. During July and August 2018, the IDT developed and implemented several action steps, including changing his headrest to reduce fatigue and excessive motion, having staff assist in feeding him while visualizing his entire face for signs of distress, and providing instructions about when to stop feeding him and ask the nurse to assess him. The IDT did not want to pursue G-tube placement, because the IDT all agreed he was clinically stable. In the Monitoring Team member's discussion with the PCP, the concern was raised about the optimal time for surgical intervention, while he was nourished and hydrated, rather than waiting for him to become malnourished or dehydrated, with a weakened state that would further increase his surgical risk. The IDT, with the leadership of the PCP, had not identified objective threshold events, lab test results, or other parameters indicating the need to proceed with G-tube placement, and at that time, the IDT was not in agreement with the GI consultant's recommendations. Individual #104's respiratory distress on 5/29/18, apneic episode on 6/4/18, and choking after eating on 7/17/18, were indicators that he might not have been as stable as the IDT had concluded. The IDT, with the leadership of the PCP needed to further review his ongoing care and the treatment of his dysphagia and GERD.

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, for four of the 18 IHCPs reviewed/needed, documentation was found to show implementation of those few action steps assigned to the PCPs that IDTs had included. 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	129	178	184	303	268	307	247	8	104
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	100% 4/4	1/1	1/1	N/A	1/1	1/1	N/A	N/A	N/A	N/A

Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, the action steps assigned to the PCPs were implemented for the following: Individual #129 – GI problems, Individual #178 – weight, Individual #303 – osteoporosis, and Individual #268 - seizures.

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; recommendations are made about any necessary additional laboratory testing regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.

Summary: N/R			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and										
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.										
Comments: a. and b. The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.											

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
Summary: Overall, the QDRRs reviewed generally addressed the required components, and offered recommendations to prescribers, as needed. For the individuals reviewed, prescribers reviewed QDRRs timely, and indicated agreement with recommendations, or provided justification, if they did not agree. If the Center sustains its progress in this area, after the next review, Indicator c might move to the category requiring less oversight. Often, prescribers implemented agreed-upon recommendations. At this time, the remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
a.	QDRRs are completed quarterly by the pharmacist.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
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;	86% 12/14	2/2	2/2	1/1	1/1	2/2	2/2	N/A	2/2	0/2
	ii. Benzodiazepine use;	100% 11/11	N/A	2/2	1/1	N/A	2/2	1/1	2/2	1/1	2/2
	iii. Medication polypharmacy;	100% 12/12	2/2	2/2	2/2	2/2	2/2	1/1	N/A	N/A	1/1
	iv. New generation antipsychotic use; and	100% 8/8	2/2	2/2	2/2	N/A	2/2	N/A	N/A	N/A	N/A

	v. Anticholinergic burden.	93% 13/14	2/2	2/2	2/2	2/2	2/2	N/A	1/2	N/A	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	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% 8/8	2/2	2/2	2/2	N/A	2/2	N/A	N/A	N/A	N/A
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	67% 2/3	1/1	1/2	N/A	N/A	N/A	N/A	N/A	N/A	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.	N/R									

Comments: b. For Individual #247, the QDRR, dated 5/21/18, did not identify Reglan as a medication with anticholinergic burden (i.e., low), and the count was not correct (i.e., the Clinical Pharmacist only listed six points, but stated the burden was seven points).

The Clinical Pharmacist did not include a full set of lab information in Individual #104's QDRRs.

c. For the individuals reviewed, it was good to see that prescribers reviewed QDRRs timely, and documented agreement or provided a clinical justification for lack of agreement with Pharmacy's recommendations.

d. One of the three recommendations in Individual #178's QDRR, dated 6/4/18, was to review a potential drug-drug interaction: "Carbamazepine and Topiramate may diminish the therapeutic effect of medroxyprogesterone. Contraceptive failure is possible." Based on the documents submitted, the PCP had not addressed this recommendation in a timely manner, and the Clinical Pharmacist noted it again in the QDRR, dated 9/11/18, before a PCP provided closure.

e. As noted with regard to Outcome #1, the Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved and the Monitoring Team is able to identify the full scope of new medications requiring interventions, this indicator is not being rated.

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 two individuals reviewed, IDTs developed clinically relevant, measurable dental goals, but QIDPs had not summarized and analyzed data in monthly reviews. For the remaining individuals, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	22% 2/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	22% 2/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. The IDTs for Individual #129 and Individual #247 rated the individuals dental risk as low. However, both had risk factors that placed them at least at medium risk. Such factors included, for example, fair oral hygiene, inconsistent tooth brushing, periodontal disease, and/or missing teeth.

Individual #303 and Individual #104 had a number of dental goals/objectives. Most of them were not clinically relevant and/or measurable. However, the goal for home staff to brush their teeth 2 to 3 minutes twice a day were both clinically relevant and measurable. (It should be noted that for both individuals, different documents, such as the IRRF – Document Request #2, IHCP – Document Request #3, and the ISP – Document Request #1, contained differing goals/objectives. The Monitoring Team chose to give the IDTs credit for the goals/objectives in the ISP, but moving forward, it is important IDTs ensure that all documents are consistent.)

The Monitoring Team will be working with State Office on this issue so that State Office can provide more guidance to the Centers. A good way to think about it, though, is: "what would the dentist tell the individual he/she or staff should work on between now and the next visit?" For different individuals, the causes of their dental problems are different, and so the solution or goal should be tailored to the problem. For example, should an individual reduce the amounts of sugary snacks he/she consumes, should an individual brush his/her teeth twice a day for two minutes instead of once a day, should a goal revolve around the individual tolerating tooth brushing for 30 seconds leading up to an eventual two minutes? These are the type of questions IDTs should be asking themselves when

deciding upon a goal.

c. through e. In addition to the goals/objectives for most individuals reviewed not being clinically relevant, achievable, and measurable, integrated progress reports on existing goals 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. For all nine individuals, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
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									
Comments: c. As indicated in the dental audit tool, this indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will be marked "N/R." At the time of the review, State Office had not yet developed and/or implemented a process to ensure inter-rater reliability with the Centers.											

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
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, these indicators moved to the category requiring less oversight.									
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.										
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.										
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.										
e.	If the individual has need for restorative work, it is completed in a timely manner.										

f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	
Comments: N/A		

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
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, these indicators 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: N/A											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	100% 3/3	N/A	N/A	N/A	N/A	N/A	1/1	1/1	1/1	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	33% 1/3						0/1	0/1	1/1	
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/3						0/1	0/1	0/1	
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/3						0/1	0/1	0/1	
Comments: a. It was good to see that for the three applicable individuals, IDTs included suction tooth brushing strategies/plans in their ISPs/IHCPs. b. Based on documentation submitted, for two of the individuals, lapses occurred in the provision of suction tooth brushing in terms of the number of times per day, and/or the duration required in the ISP.											

c. The Dental Department staff had not conducted monitoring of staff's implementation of suction tooth brushing for quality, as well as safety. In addition, ISP action plans did not define the frequency of monitoring expected to meet the individuals' needs.

d. QIDP reports reviewed did not include specific data related to suction tooth brushing, and as such, provided no analysis of such data. Moving forward, specific suction tooth brushing data is needed to summarize the frequency of sessions completed in comparison with the number anticipated (e.g., 60 out of 62 sessions). Additionally, a second data subset is needed on the number of such events during which the individual completed the expected duration of suction tooth brushing (e.g., of the 60 completed sessions, in 12 sessions the individual completed two minutes of suction tooth brushing).

Outcome 9 – Individuals who need them have dentures.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
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, this indicator moved to the category requiring less oversight.									
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. N/A											

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: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
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	0%									

	assessments.										
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	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. In the months prior to the review, State Office provided training to all of the Centers on the development of acute care plans. During this round of reviews, the Monitoring Team is working with State Office on ensuring Centers provide the correct documentation for review of acute care plans. Given the timing of the Corpus Christi SSLC review, the Center was in the initial stages of implementing the revised acute care plan template/process. It was decided that the Monitoring Team would not search for needed acute care plans that might not exist throughout the preceding six months. However, as a result of the ongoing systems issue since the implementation of IRIS, these indicators do not meet criteria. Center staff should continue to work with State Office to correct the issues. By the time of the next review, the Monitoring Team plans to conduct a full review of acute care plans.											

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 Score	129	178	184	303	268	307	247	8	104
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	11% 2/18	0/2	2/2	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: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #129 – other: pain, and behavioral health; Individual #178 – weight, and osteoporosis; Individual #184 – falls, and constipation/bowel obstruction; Individual #303 – constipation/bowel obstruction, and skin integrity; Individual #268 – falls, and infections; Individual #307 – constipation/bowel obstruction, and UTIs; Individual #247 – skin integrity, and constipation/bowel obstruction; Individual #8 – circulatory, and osteoporosis; and Individual #104 – constipation/bowel obstruction, and choking).											

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 #178 – weight, and osteoporosis.

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

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

Summary: Nurses often did not include interventions in IHCPs to address individuals' at-risk conditions, and even for those included in the IHCPs, documentation was not present to show nurses implemented them. In addition, often IDTs did not collect and analyze information, and develop and implement plans to address the underlying etiology(ies) of individuals' risks. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 129	178	184	303	268	307	247	8	104
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/11	0/2	0/2	0/1	0/1	0/1	N/A	0/1	0/1	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

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

b. The following provide some examples of IDTs' responses to the need to address individuals' risks:

- Although the IRRF noted that Individual #129 had been requesting pain medications for various issues. and more so this year,

than during the previous year, the IHCP did not include a plan to address, review, or analyze her pain issues. Such an analysis would have been particularly important, because the pain could be a factor impacting her behavior issues, sleep issues, mood, and activity. Clearly, the IDT has not been reviewing this issue, even though they identified it as a high-risk area.

- Based on the documentation provided, for several additional issues, Individual #129's IDT did not conduct necessary review, and analysis, and they did not develop plans to address the issues. For example:
    - She had a diagnosis of sleep apnea, but the IDT was not collecting 24-hour sleep data, even when the ISPA, dated 4/11/18, indicated that Trazodone was being started "to assist her with her sleep disturbance." Staff need to monitor her sleep to identify sleep patterns, and correlations with mood, behavior, and pain issues.
    - The AMA, dated 3/1/18, did not indicate why she was not prescribed continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BiPAP) to treat her sleep apnea, as opposed to melatonin and Trazadone. The PCP did not document a specific diagnosis of the type of apnea.
    - The documentation submitted did not provide a reason for her urge incontinence, particularly given her young age of 28. Based on documentation submitted, the IDT had not reviewed this issue or identified if there were any trends regarding, for example, her sexual activity and/or UTIs.
    - It was not clear from the AMA if her previous pregnancy (then miscarriage) was a result of sexual assault. Because of the potential impact on her pathology, her history should be clearly documented to the extent it is known.
    - Individual #129's step-father and step-brother abused her, and then she was sent away. It was not clear that the IDT recognized the impact of these early childhood experiences on her, and the need to consider them in their interactions with her, so as to not reinforce negative feelings about her self-worth.
- A review of the ISPAs indicated that Individual #178's IDT was not reviewing her weights. An IPN, dated 8/3/18, from the Dietician indicated that the individual voiced concerns about losing weight too rapidly (10 pounds in one month), and that she reported she was not eating all her meals due to a lack of appetite or dislike of some of the food. The note indicated that she had actually lost 11.5 pounds (7.7% of her weight) in one month and that "visually, it was apparent to this writer that [Individual #178] has lost weight." Although the IPN noted that her weight loss was likely due to her emotional issues, there was no indication that this issue was brought to the IDT. In addition, there was no indication that nurses were regularly assessing Individual #178 regarding her mood, sleep patterns (she had complained of having nightmares), appetite, meal refusals, activity levels, progress in counseling sessions, medication changes, medication refusals noting the specific medications that she refused, or her migraine headaches, and her associated rapid weight loss.
- Individual #178's IRRF indicated that she had a standing program one to two times a week, which would have possibly helped to increase her DEXA score. However, the IRRF did not indicate if this program was being implemented, and if so, what data were being generated. In addition, there was no mention of this program in the ISPAs reviewed to indicate if it actually was being conducted.
- The following describe problems with regard to the IDT's response to Individual #184's falls and fracture:
    - In the ISPAs provided, the IDT had not analyzed his falls to identify a cause(s) of his increased falls.
    - According to the AMA, the individual had sustained previous fractures, which increased his risk for fractures. These fractures included: left distal fibula in 2008, 9th and 10th ribs in 2008, and 3rd digit on right hand in 2016. It did not appear the IDT took this into consideration.
    - During an ISPA meeting, on 6/5/18, the IDT discussed four falls in 30 days, as well as a fracture to his left lateral epicondyle of his leg, which he sustained on 6/3/18. However, the IDT did not increase his risk level for falls/fractures

from medium to high.
    - In addition, the ISPA, dated 8/21/18, noted that he would transition from direct to indirect service in the PNMP Coordinator program in relation to his walking program. However, no data were included in the ISPA indicating how often he refused or participated, or if he had made any progress.
- When the Monitoring Team member observed the nurse administer milk of magnesia (MOM) (pudding consistency), Individual #303 experienced significant spillage with each spoonful (i.e., ½ to ¾ of each bite). The nurse reported that this spillage was typical during each medication pass and not just with her MOM. Based on the documentation provided, nursing staff had not documented this problem, or made the PCP aware that the individual did not consume full doses of her medications. Medication variances did not document these problems, and the Center's medication observations had not identified this as a significant clinical issue. Due to the individual's chronic constipation issue, the PCP prescribed a daily rectal suppository. However, because nursing staff did not alert her PCP to the spillage issue, the PCP did not have the opportunity to assess the effectiveness of her oral medications for constipation (or her other medications). Her significant spillage could also be affecting her food and fluid intake, further complicating her constipation status.
- Based on the documents provided for Individual #268, the following problems were noted regarding his IDT's review, and analysis of his falls, as well as their implementation of interventions to prevent his falls:
    - The ISPAs provided did not include any analysis of his falls. The documentation (e.g., IRRF) indicated that his falls were related to his seizures, and that an increase in aggression was happening prior to some of his seizures. However, the IDT did not present any data to support this conclusion. In addition, the IDT did not mention reviews of blood levels for his anticonvulsants, his weight loss, or medication changes.
    - Documentation was not presented to show that the IDT implemented interventions to prevent his falls and injuries.
    - It appeared that because Individual #268 had not experienced many serious injuries from his falls, the IDT did not approach them with a sense of urgency. For example, documentation in the nursing annual and quarterly assessments, and the IRRF noted that his falls were "non-serious," discounting the potential for harm and injury. However, on 5/27/18, an ED visit due to a laceration to his scalp was in fact a serious injury related to a fall.
    - The IDT did not include any nursing interventions in the IHCP for this high-risk area.
    - A significant discrepancy existed between the number of falls noted in the IRRF (33) and in the annual nursing assessment (59).
- Individual #247 had the following diagnoses of dehydration: on 1/26/17, he went to the ED with a diagnosis of dehydration, and tube dislodgment; and on 3/20/17, and 5/17/18, he was admitted to the Infirmary for dehydration. Based on the documentation submitted, his IDT did not meet to address his recurring issue with dehydration, which also could have been a factor in his episodes of constipation. Unfortunately, the annual nursing assessment did not include the dates when he warranted a PRN medication for constipation, which would have assisted the IDT in determining whether or not there was any possible correlation. Also, it was not clear from the documentation provided why he was becoming dehydrated (i.e., he had a G-tube), and whether or not leakage from the G-tube stoma or an increase in residuals were possible factors. In addition, the IDT did not include regular nursing assessments in the IHCP to address constipation/dehydration.
- An ISPA, dated 5/16/18, indicated that Individual #8's IDT met regarding the LAR's concerns about edema to both her legs. Based on a review of the documents provided, the following significant issues were noted:
    - As discussed previously, a PCP IPN, dated 4/21/18, noted that Individual #8's family reported she had bilateral edema to her lower legs, and the PCP started her on Lasix. Prior to the PCP's note, nurses had not documented her edema, or

assessment of it.
    - In the subsequent IPNs, no documentation was found to show that nurses conducted assessments.
    - The quarterly nursing assessment, dated 2/2/18 to 4/30/18, indicated the individual started on Lasix, but did not include any information regarding her bilateral lower edema.
    - The ISPA indicated that the PCP ordered TED hose in the past, but the date and rationale for their discontinuation could not be located, possibly indicating that the PCP never discontinued them.
    - The ISPA also indicated that: "observations also suggest she is not getting time out of the wheelchair due to her schedule of feeding and class." Given the number of IPNs that described a reddened area to her groin and scratches or scabs to her buttocks, this was particularly concerning. However, the RN Case Manager included none of these episodes in the quarterly assessments.
    - The ISPA also indicated the PCP would refer Individual #8 to a vascular specialist. However, no follow-up ISPA was found indicating whether or not that appointment occurred, as well as a status update regarding her edema.
    - The quarterly nursing assessment, dated 5/31/18 to 7/31/18, noted the on 5/31/18, and 6/13/18, she was seen for her edema. However, the nurse included no information about these appointments in the quarterly assessment.
- It was concerning that Individual #104's had a wound to his great toe and left lateral foot, scratches to his skin (i.e., 15 from 1/1/18 through 9/18/18, per the ISPA, dated 9/19/18), and episodes of choking. Discrepancies in the IRRF made it difficult to determine his actual status regarding constipation. The IRRF noted: "it appears he has improved as he had 13 bowel protocol interventions in the previous year and this year with 2 noted." However, part of the justification for the IDT's medium risk rating was: "He had 13 protocol bowel movement interventions this year."

  In addition, the IRRF indicated that Individual #104 "had no choking episodes this year or last." However, then, it noted that the IDT rated him at high risk due to "incidents of choking requiring transportation to the emergency room." No additional data were included in the IRRF addressing these "incidents." The AMA, dated 7/2/18, indicated that on 5/28/18, he was sent to ED for a presumed choking episode, and on 6/4/18, he experienced changes in breathing while eating. A dietary consultation, dated 6/6/18, for choking resulted in a change from a regular diet to an 1800-calorie pureed diet.

  Regarding the nursing annual and quarterly assessments, the nurse made no mention of fluid intake, activity level, specific dates he required PRN medications for constipation, or any analysis of this risk area. In addition, the nurse did not mention the specific incidents of choking, and the IDT did not conduct any analysis of this risk area.

Outcome 7 – Individuals receive medications prescribed in a safe manner.	
Summary: For at least the two previous reviews, as well as this review, the Center did well with the indicators related to: 1) nurses administering medications according to the nine rights; 2) nurses following medication administration, and positioning instructions in PNMPs; and 3) nurses adhering to infection control procedures while administering medications. However, given the importance of these indicators to individuals' health and safety, these indicators will continue in active oversight until the Center's quality assurance/improvement mechanisms	Individuals:

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	129	178	184	303	268	307	247	8	104
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% 6/6	N/R	N/R	1/1	1/1	1/1	1/1		1/1	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	75% 3/4	N/A	N/A	0/1	N/A	N/A	N/A	1/1	1/1	1/1
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	67% 4/6	N/A	N/A	0/1	N/A	N/A	2/2	1/1	1/1	0/1
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.	83% 5/6	N/R	N/R	1/1	1/1	1/1	1/1		1/1	0/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 6/6	N/R	N/R	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 six individuals, including Individual #184, Individual #303, Individual #268, Individual #307, Individual #8, and Individual #104. Center staff indicated that another individual in Individual #129's home was very agitated, and requested that the Monitoring Team member not observe her medication pass. Individual #178 requested that the Monitoring Team member not observe her medication pass.

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. The following concerns were noted:

- The medication nurse assessed Individual #184's lungs sounds prior to the medication administration the Monitoring Team member observed. However, the IDT had not included lung sounds prior to medication pass as part of the IHCP.
- The medication nurse did not have the stethoscope in the proper position to accurately assess Individual #104's lungs sounds. The Center's nurse observer did an exceptional job identifying such issues during the medication pass.

f. Generally, medication nurses used the individuals' PNMPs and checked the position of the individuals prior to medication administration. The exception was that Individual #104's medication nurse had to be prompted to check the individual's position prior to administering medications. The Center's nurse auditor pulled the medication nurse for immediate retraining.

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: Improvement is still needed with regard to, as appropriate, IDTs referring individuals to the PNMT, or the PNMT making self-referrals. Overall, IDTs and/or the PNMT did not have a way to measure clinically relevant outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
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% 0/12	0/2	0/2	0/1	0/2	0/2	0/1	N/A	0/2	N/A
	ii. Individual has a measurable goal/objective, including timeframes for completion;	17% 2/12	1/2	1/2	0/1	0/2	0/2	0/1		0/2	
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/12	0/2	0/2	0/1	0/2	0/2	0/1		0/2	
	iv. Individual has made progress on his/her goal/objective; and	0% 0/12	0/2	0/2	0/1	0/2	0/2	0/1		0/2	
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/12	0/2	0/2	0/1	0/2	0/2	0/1		0/2	
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	N/A	N/A	1/1	N/A	0/1	1/1	0/2	N/A	2/2
	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	0/2		0/2
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/7			0/1		0/1	0/1	0/2		0/2
	iv. Integrated ISP progress reports include specific data	0%			0/1		0/1	0/1	0/2		0/2

	reflective of the measurable goal/objective;	0/7									
	v. Individual has made progress on his/her goal/objective; and	0% 0/7			0/1		0/1	0/1	0/2		0/2
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/7			0/1		0/1	0/1	0/2		0/2

Comments: The Monitoring Team reviewed 12 goals/objectives related to PNM issues that seven individuals' IDTs were responsible for developing. These included goals/objectives related to: Individual #129 – GI problems, and weight; Individual #178 – weight, and GI problems; Individual #184 – GI problems; Individual #303 – choking, and aspiration; Individual #268 – choking, and falls; Individual #307 – skin integrity; and Individual #8 – aspiration, and skin integrity.

a.i. and a.ii. 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 #129 – weight; and Individual #178 – weight.

b.i. The Monitoring Team reviewed seven areas of need for five individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goals/objectives were included. These areas of need included for: Individual #184 – aspiration; Individual #268 – weight; Individual #307 – aspiration; Individual #247 – aspiration, and skin integrity; and Individual #104 – skin integrity, and aspiration.

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

- In December 2017, Individual #268 weighed 172 pounds. In February 2018, his weight decreased to 158 pounds. In the following months, his weight continued to decrease: March 2018 - 153, April 2018 - 150, May 2018 - 150, June 2018 - 145, and September 2018 - 142. Even when he met criteria for PNMT referral (i.e., greater than five-pound weight loss), the IDT did not make a referral, and the PNMT did not make a self-referral or conduct a review. The IDT did not request a Nutrition consult until 8/31/18, and it was not provided until 9/14/18.
- The IDT did not refer Individual #247 to the PNMT, and the PNMT did not make self-referrals in response to a diagnosis of dysphagia, and four areas of skin breakdown, as reported in the ISPA, dated 6/21/18. Although on 6/22/18, the OT/PT completed a consult, the severity of the breakdown and the associated dysphagia, paired with a declining status warranted a PNMT referral and assessment. Although the audit tool provides a list of criteria that requires referral to the PNMT, it qualifies that list by stating: "Appropriate referral for assessment is defined at a minimum according to the following qualifying event/threshold…" (emphasis added). IDTs still need to refer or the PNMT needs to make self-referrals of individuals who otherwise are at significant risk due to PNM issues. This individual's continuing decline placed him at significant risk of harm.

b.ii. and b.iii. Individual #104's goal/objective the PNMT recommended related to skin integrity was clinically relevant (i.e., provision of wound care, proper positioning, and nutritional supports), but it was not measurable, and the IDT had not adopted it/incorporated it into the IHCP.

The IDT did not include the goal/objective that the PNMT recommended for Individual #268, which focused on residuals, in the IHCP/ISP.

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

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

Summary: Data generally were not included in monthly integrated reviews to confirm the implementation of PNM action steps. In numerous instances, IDTs did not take immediate action, when individuals' PNM risk increased or they experienced changes of status. On a positive note, for the individual reviewed whom the PNMT discharged, the IDT and the PNMT held an ISPA meeting, during which they shared comprehensive discharge information. If the Center sustains its progress in this regard, after the next review, Indicator c might move to the category of less oversight. At this time, these indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 129	178	184	303	268	307	247	8	104
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	33% 3/9	0/1	N/A	1/1	N/A	0/1	2/2	0/2	N/A	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% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. In addition, monthly integrated reviews often only included statements such as "ongoing," or "continues in place," without specific information or data about the status of the implementation of the action steps.

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

- Individual #129's IDT did not implement a plan to address her emerging behavior of swallowing batteries. She had the following incidents of swallowing AA or AAA batteries: April 2018 – 1, May 2018 – 1, June 2018 - 1, and September 2018 – 1. On 4/24/18, the IDT stated the ingestion was an isolated incident, and only education would be provided. After the individual again swallowed batteries on 5/10/18, the IDT did not develop a comprehensive plan to address this dangerous behavior, including assessing and addressing the etiology of the behavior. The PCP did not attend the ISPA meetings for battery ingestion.

- Between March and August 2018, Individual #268 fell 10 times. However, his IDT did not meet to discuss a comprehensive plan to address his falls, including, for example, ruling in or out potential causes for the falls in addition to seizures, addressing the underlying cause or etiology of the falls, as well as addressing the use of his helmet. He often did not wear his helmet, but it was not clear that his IDT had exhausted behavioral and other options for increasing his willingness to wear the helmet. According to documentation the Center provided, on 5/27/18, he had a seizure, which caused him to fall and hit his head. He required three staples to close the laceration on his head.
- It was good to see that Individual #307's IDT made a quick referral to the PNMT, on 4/27/18, after she had a stroke. In addition, the IDT implemented lung sounds four times daily, initiated NMES to address her decline in swallowing, and the PT implemented range-of-motion (ROM) exercises to address the decreased movement on her left side.
- On 6/21/18, Individual #247 was diagnosed with skin breakdown as well as dysphagia. Based on review of the ISPAs, his IDT did not request a consultation related to his positioning, which might have impacted both of these diagnoses.
- Dating back to at least 1998, Individual 104 had a significant history of swallowing problems (both oral and pharyngeal). Since 2016, he experienced considerable triggers associated with aspiration, and a number of respiratory events (e.g., 5/28/18, and 7/16/18) as a result. Within its assessment, the PNMT noted many other coughing episodes, but did not provide the specific dates. Other concerns included falling asleep during meals (5/30/18, and 8/7/18) and a general struggle during meals with gagging, etc. In an ISPA, dated, 7/17/18, the Ombudsman noted reports of staff overfeeding Individual #104. The Ombudsman also witnessed this. The IDT's plan was to train staff and monitor, but the ISPAs that followed provided no evidence of training or monitoring, or the results of the monitoring.
- When Individual #104 experienced skin breakdown on 4/22/18, the IDT identified the cause as staff not implementing the positioning plan. However, other than increasing monitoring, the IDT did not develop and implement a training/education plan to improve direct support professionals' understanding of the PNMP and its importance.

c. It was positive that for Individual #184, the PNMT and IDT held an ISPA meeting, and thoroughly discussed his discharge from the PNMT, as well as next steps to address his risk for aspiration.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.	
Summary: Overall, PNMP/Dining Plan implementation at Corpus Christi SSLC continued to improve (i.e., Round 9 – 25%, Round 11 – 40%, Round 13 – 60%, and now, Round 14 – 69%). Based on observations, staff completed transfers correctly. However, efforts are needed to continue to improve Dining Plan implementation, and positioning. Often, the errors that occurred (e.g., taking large bites, and/or eating at an unsafe rate) placed individuals at significant risk of harm. Implementation of PNMPs is non-negotiable. The Center, including Habilitation Therapies, as well as Residential and Day Program/Vocational staff should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them. As necessary, Skill Acquisition/Behavioral Health staff should assist IDTs in developing programs to	

teach individuals to slow their eating paces, to reduce the significant risk this practice poses. These indicators will continue in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	69% 36/52	
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.	100% 3/3	
Comments: a. The Monitoring Team conducted 52 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 15 out of 20 observations (75%). Staff followed individuals' dining plans during 19 out of 30 mealtime observations (63%). Staff completed transfers correctly during two out of two observations (100%).			

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	129	178	184	303	268	307	247	8	104
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.	50% 1/2						1/1	N/A	1/1	
Comments: a. Individual #307 received NMES, but the IDT had not developed a clear plan with baseline measurements in which to fully gauge progress. For Individual #8, the IRRF and latest OT/PT assessment noted a past attempt in 2014 to regain oral intake and clearly documented the reason for discharge due to lack of progress.											

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: A number of individuals reviewed did not have clinically relevant, and measurable goals/objectives to address their needs for formal OT/PT services. In addition, QIDP interim reviews often did not include data related to existing goals/objectives. As a result, IDTs did not have information in an integrated format	Individuals:

related to individuals' progress or lack thereof. These indicators will remain in active oversight.											
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	20% 1/5	N/A	0/1	0/1	N/A	0/1	1/1	N/A	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	20% 1/5		0/1	0/1		0/1	1/1		0/1	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/5		0/1	0/1		0/1	0/1		0/1	
d.	Individual has made progress on his/her OT/PT goal.	0% 0/5		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% 0/5		0/1	0/1		0/1	0/1		0/1	

Comments: a. and b. Individual #129 had functional mobility and activities of daily living skills, so did not require formal programming. Although Individual #303, Individual #247, and Individual #104 had OT/PT needs and supports, they did not require formal goals/objectives.

The goal/objective that was clinically relevant and achievable, as well as measurable was for Individual #307 (i.e., sitting on the edge of the bed for 15 minutes).

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. 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: For the individuals reviewed, evidence often was not found in ISP integrated reviews to show that OT/PT supports were implemented, even when therapists might have maintained data on the implementation of the direct therapy goals/objectives. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	25% 1/4	1/1	N/A	0/1	N/A	N/A	0/1	N/A	0/1	N/A

b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that supports were implemented. Sometimes, OTs/PTs maintained data on direct therapy goals/objectives, but QIDPs did not summarize it and analyze it for review by other IDT members. OTs and PTs should work with QIDPs to ensure data are included and analyzed in ISP integrated reviews. b. On 5/1/18, Individual #184 was discharged from direct therapy, but no ISPA was found to show the IDT reviewed and approved the discharge.											

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: Given that over two previous review periods and during this review, individuals observed generally had clean adaptive equipment (Round 11 – 95%, Round 12 – N/R, Round 13 – 87%, and Round 14 - 88%), Indicator a will move to the category requiring less oversight. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, 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	222	240	334	146	128	293	305	70	181
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	88% 23/26	1/2	1/1	2/2	1/2	1/1	1/1	1/1	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	Due to the Center's sustained performance, this indicator 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.	88% 23/26	1/2	1/1	2/2	1/2	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		113	150	244	328	376	297	132	283	285

a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	2/2	1/1	1/1	2/2	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	2/2	1/1	1/1	2/2	1/1	1/1
		Individuals:									
#	Indicator		178	251	294						
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		0/1	1/1	1/1						
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	1/1	1/1						

Comments: a. The Monitoring Team conducted observations of 26 pieces of adaptive equipment. Individual #222 and Individual #146's elbow pads were missing.

The individuals the Monitoring Team observed generally had clean adaptive equipment, which was good to see. The exception was Individual #178's wheelchair.

c. Based on observation of Individual #178's wheelchair, it did not provide needed support, and the individual complained that it did not support her hips and bottom. It is the Center's responsibility to determine whether or not these issues were due to the equipment, 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, one additional indicator will move 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.

In ISPs, without reliable useable data or without adequate implementation, it was impossible to determine progress. Action steps were not consistently implemented for any individuals.

Staff in individuals' homes were frequently aware of individuals' preferences, but often unfamiliar with their personal goals, or communication and behavioral needs and strategies.

In skill acquisition, it was good to see that a small number of SAPs were progressing (and had data to support that progress). For many SAPs, progress was not occurring, but no actions were taken to make changes to the SAPs. Monthly reviews were conducted for about half of the individuals' SAPs. Graphs were created for all SAPs.

Many SAPs contained some of the required components, and no SAPs contained all of the required components. Some SAPs, though less than half, were implemented correctly as written. Even so, when observing SAP implementation, it was positive to observe the positive interactions between the individual and the assigned staff. It was also good to meet with staff who were very open to discussion regarding skill acquisition planning.

During the onsite visit, individuals were observed in their homes. Overall, there was little active engagement during these observations. Visits were also made to day program and work sites, but individual attendance was quite variable/low.

The Cyber Spot was open seven days per week for extended hours of the day. This was a popular spot for several individuals.

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

The Center should continue to focus on ensuring individuals have their alternative and augmentative (AAC) devices with them. Most importantly, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Without reliable useable data or without adequate implementation, it is impossible to determine progress. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	178	129	135	184	268			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
Comments: As Corpus Christi SSLC further develops individualized personal goals, it should focus on developing and implementing 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 Indicators 1 through 3 is a pre-requisite for evaluating whether progress has been made. For these six individuals, no personal goals met the required criterion.											

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	178	129	135	184	268			
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. The Monitoring Team's evaluation of this indicator is based on observations and interviews to assess staff knowledge and review of documentation that reflects implementation. Staff in individuals' homes were frequently aware of individuals' preferences, but often unfamiliar with their personal goals, or communication and behavioral needs and strategies. This was due in part to implementation plans (SAPs, SOs, and/or PBSPs) that were sometimes absent or were poorly constructed and missing important content. In addition,											

none of six ISPs had documentation that reflected 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.

#	Indicator	Overall Score	Individuals: 38	58	372	178	248	129	92	135	143
6	The individual is progressing on his/her SAPs.	13% 3/23	0/3	0/3	1/2	0/1	0/3	2/3	0/3	0/2	0/3
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% 0/16	0/3	0/3	N/A	N/A	0/1	0/1	0/3	0/2	0/3
9	(No longer scored)										

Comments:

6. For those eight SAPs for which there were reliable data, and based upon a review of the data presented in the QIDP monthly reports and/or the Client SAP Training Progress Note, it was determined that progress was being made on three: Individual #372 making a scrapbook, and Individual #129 bike safety and money management. Another four SAPs were identified by the Center as making progress: Individual #372 gathering her work materials, Individual #178 learning to budget, and Individual #248 describing ways to interact with others and identifying a medication. Two SAPs were excluded from the analysis because there was only one month of data. These were Individual #178's practicing relaxation techniques and Individual #135's describing personal boundaries.

7. None of the goals had been met.

8. Of the 16 SAPs in which progress was not being made, there was no evidence that actions had been taken to address this issue. It was recommended that two SAPs be discontinued: Individual #38's learning to make coffee, largely due to the closing of the coffee house, and Individual #143's learning to iron patches on a blanket. In neither case, were replacement SAPs identified. It was also recommended to remind staff to implement all scheduled training sessions for Individual #143's learning to calculate her pay and identify appropriate public behavior, but even so, her progress was so limited that a review of the entire SAP was warranted.

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. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	38	58	372	178	248	129	92	135	143
13	The individual's SAPs are complete.	0% 0/25	0/3 18/30	0/3 14/30	0/2 11/20	0/2 16/ 20	0/3 23/30	0/3 22/ 30	0/3 24/30	0/3 17/30	0/3 22/ 30

Comments:
13. In order to be scored as complete, a skill acquisition plan (SAP) must contain 10 components necessary for optimal learning.

Because all 10 components are required for the SAP to be judged to be complete, the Monitor has provided a second calculation in the individual boxes above that shows the total number of components that were present for all of the SAPs chosen/available for review.

While none of the SAPs were considered complete, however, in more than 80% of the 25 SAPs, the following elements were present: a task analysis where appropriate, a behavioral objective, an operational definition, a relevant discriminative stimulus, plans to address maintenance and generalization, and documentation methodology.

Missing from the majority of the SAPs were specific instructions for teaching the skill and a teaching schedule that allowed for multiple trials on identified training days.

While five SAPs were scheduled for 30 training opportunities each month, the remaining SAPs were not frequently addressed. In fact, of the 25 SAPs reviewed, 16 were scheduled for only four training opportunities per month. Four others were to occur between one and eight times each month. Limited training will impact the development of any new skills.

The use of identified preferred items/activities was evident in 68% of the SAPs. Particularly when progress is not evident, staff are advised to review the consequences for correct responding to ensure motivation is maintained. When providing guidelines following incorrect responding, staff are advised to ensure that the verbal prompt differs from the initial discriminative stimulus.

While it was positive to review SAPs that focused on community-based training, staff are advised to consider teaching some of these skills (e.g., using switch to open door, approaching a van) on campus to allow for a greater number of teaching opportunities. Generalization probes could occur whenever the individual attends appointments or enjoys time off campus.

Outcome 5- SAPs are implemented with integrity.	
Summary: Some, though less than half, of SAPs were implemented correctly as	Individuals:

written. Similarly, less than half of the SAPs were assess regularly for integrity of implementation and/or met criteria for integrity. These two indicators will remain in active monitoring.											
#	Indicator	Overall Score	38	58	372	178	248	129	92	135	143
14	SAPs are implemented as written.	40% 2/5	Attempted	1/1	0/1	Attempted	0/1	1/1	Attempted	0/1	Attempted
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.	40% 10/25	0/3	1/3	1/2	0/2	1/3	3/3	0/3	2/3	2/3

Comments:

14. During the onsite visit, facility staff were asked to schedule one SAP training observation for each of the nine individuals. A list of two to three SAPs per person was provided from which the staff could choose. While nine observations were scheduled, only five were completed. Individual #38 was engaged in hygiene activities at the time of her scheduled training, Individual #178 declined to leave Cyber Spot to participate, Individual #129 declined to complete the SAP, and Individual #143 did not attend work the day of her scheduled SAP training. For the other individuals, feedback is provided below regarding the observed training session.

- Individual #58 - The two staff members working with Individual #58 were very positive and supportive as they interacted with him. The SAP was implemented as written, with Individual #58 completing more than the required number of steps in the behavior chain. He appeared to enjoy both the music and the interactions with his staff. Praise and time to listen to music were provided after he put on the headphones, and his independent response was scored correctly.
- Individual #372 - The staff member set up the environment and provided the discriminative stimulus as written in the SAP. This same staff member also did a nice job responding to Individual #372's initial request by allowing her to draw before completing the SAP. Photos from a magazine were offered to Individual #372 and after she made a choice, she applied glue to the paper on which she placed the photo. This was different than described in the SAP, but was a good accommodation that staff may want to address in the written guidelines. Although Individual #372's completion of the task required repeated verbal prompting, the staff member scored an independent performance.
- Individual #248 - The staff member transitioned with Individual #248 to a smaller room in his home and delivered the discriminative stimulus as written. Although Individual #248 independently described three ways in which to interact with others, the staff member scored his performance as requiring a verbal prompt.
- Individual #92 - The first step in this training requires Individual #92 to apply chalk to a cue stick. Because chalk was not available, the staff member provided a slightly different, although appropriate, discriminative stimulus. She asked Individual #92 to show her how he would do this if the chalk were available. He did this well and then proceeded to play pool for a short period of time. His performance was scored accurately.
- Individual #135 - The staff member found a quiet room in which the SAP could be trained. He did a nice job delivering the discriminative stimulus and following-up with a verbal prompt when necessary. When the SAP writer encouraged the staff member to ask Individual #135 to provide examples of abusive situations, it became clear that this may not be an appropriate SAP for all staff to implement with Individual #135. As noted earlier in this report, this matter may be better addressed with a professional counselor, his psychiatrist, or the chaplain with whom he is reported to have a good relationship. Individual #135

appeared uncomfortable (there were several observers) and declined to continue. The staff member was very responsive to Individual #135's communication.

15. As described by facility staff, SAP assistants conduct integrity checks three months after initiation of training, and again after six months of training. If the staff member implementing the SAP scores less than 80% on the integrity checklist, re-training occurs. An attempt is made later in the week to observe the same staff member implement the same SAP. If the SAP assistant determines that the individual is not interested in the SAP, or conversely, completes the SAP with ease, he/she notifies the SAP writer to consider a revision or change of SAPs.

Evidence provided suggested that SAP integrity had been assessed at an acceptable level for 10 of the 25 SAPs. Reports of integrity assessment were provided for six additional SAPs, but either the score was below 80% (Individual #92 - respect), necessary materials were missing (Individual #58 - headphone use), or the report suggested the training was not completed (Individual #38 - operate recliner, Individual #178 – budgeting, and Individual #248 - anger management and medication identification).

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

Summary: Monthly reviews were conducted for about half of the individuals' SAPs. Graphs were created for all SAPs, which has been the case for this review and the previous two reviews, too (with two exceptions in May 2017). Therefore, indicator 17 will be moved to the category of requiring less oversight. Indicator 16 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	58	372	178	248	129	92	135	143
16	There is evidence that SAPs are reviewed monthly.	48% 12/25	1/3	3/3	1/2	2/2	2/3	0/3	2/3	1/3	0/3
17	SAP outcomes are graphed.	100% 25/25	3/3	3/3	2/2	2/2	3/3	3/3	3/3	3/3	3/3

Comments:

16. A review was completed of six consecutive monthly reports completed by the individual's QIDP. The exception was Individual #178 whom two monthly reports were provided due to her recent re-admission to the facility. There was evidence that 12 of the 25 SAPs were consistently reviewed in these monthly reports. These were Individual #38 - make coffee, all of Individual #58's SAPs, Individual #372 - gather work materials, both of Individual #178's SAPs, Individual #248 - anger management and medication identification, Individual #92 - play pool and count change, and Individual #135 - budgeting.

Evidence indicated that reports were consistently completed at some point in the following month for Individual #38, Individual #58, and Individual #372. For all others, monthly reports were not consistently completed in a timely manner. Without regular monitoring of progress, there is the risk of missed opportunities to advance steps or to address limited progress.

17. Graphs were provided for all 25 SAPs.

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
Summary: During the onsite visit, individuals were observed in their homes. Overall, there was little active engagement during these observations. Visits were also made to day program and work sites, but individual attendance was quite variable/low. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	38	58	372	178	248	129	92	135	143
18	The individual is meaningfully engaged in residential and treatment sites.	0% 0/9	0/1	0/1	0/1	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. During the onsite visit, individuals were observed in their homes. Overall, there was little active engagement during these observations. Visits were also made to day program and work sites, but individual attendance was quite variable. A review of scheduled time out of the home and attendance records from March 2018 through mid-September 2018 showed low levels. Further, when asked, the Education and Training Director reported that positive attendance generally reflected the individual being present for a minimum of 15 minutes. Data below summarizes this information for eight of the individuals (hours are per week, attendance is in parentheses). Individual #38 was excluded because she had no time scheduled out of her home.

- Individual #58 - day program 12.5 hours (73%).
- Individual #372 - day program 5 hours (67%), work 5 hours (57%).
- Individual #178 - day program 4.5 hours (had attended cooking class one time), work 5 hours (52%).
- Individual #248 - day program 13.25 hours (30%), work 5 hours (76%).
- Individual #129 - day program 10.75 hours (47%) work 9 hours (50%).
- Individual #92 - day program 17.5 hours (69%), work 5 hours (35%).
- Individual #135 - day program 8.5 hours (53%), work 1 hour (9%).
- Individual #143 - day program 10.75 hours (8%) work 7.5 hours (35%).

Based upon observations and a review of individual schedules and attendance records, none of the individuals were considered to be meaningfully engaged. All individuals should be encouraged to work and attend activities outside of their homes. This is particularly true for six individuals, four of whom were in their twenties and two of whom were in their thirties. If they are to be successful in a less restrictive environment, they will need to learn to work and engage in a range of leisure activities.

As explained by the director of the Education and Training Department, staff leading classes are neither certified teachers, nor do they have specialized training in the subject matter. This is concerning, particularly when addressing anger management or other sensitive topics. It is suggested that these matters would be better addressed by professional counselors with expertise in an appropriate therapy modality, such as perhaps dialectical behavior therapy.

Overall, the most active engagement was observed at Cyber-Spot and when individuals were engaged in their assigned work. It was positive to learn that the computer center was open all week long between the hours of 8:00 am and 8:00 pm.

The homes were often chaotic environments. Individuals occasionally displayed very disruptive behavior (e.g., screaming, punching walls) and several individuals reported fear of others. Several bedrooms were for three to four individuals living together, another condition that could lead to discomfort and fear.

21. For six of the nine individuals, engagement was assessed each month in both their homes and day program sites. Engagement was assessed in three of six months in Individual #92's, Individual #135's, and Individual #143's homes. While engagement goals were met in all day program and work sites, these goals were not met in any of the homes.

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

Summary: These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 38	58	372	178	248	129	92	135	143
22	For the individual, goal frequencies of community recreational activities are established and achieved.	44% 4/9	0/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

22. Although there was evidence that all nine individuals participated in community recreational activities over a six-month period, four individuals had goal frequencies identified in their ISPs. These were Individual #58, Individual #372, Individual #248, and Individual #92. Staff acknowledged that this was an area that required increased attention and effort.

23-24. Community-based training was not identified for each of the individuals reviewed. In some cases (e.g., Individual #58 - open door, Individual #178 – relaxation, Individual #248 - community calendar, and Individual #143 - public behavior), goal frequencies were not met. Obstacles to achieving community-based training goals were not identified or addressed.

Staff are advised to ensure that the principle of normalization is adhered to at all times, but particularly when individuals are engaged in community-based activities. The dignity of the individual is of paramount importance. One example of where this was compromised

was Individual #129 wearing a backpack that had her name written in magic marker where anyone could view this. If it is necessary to label possessions, this should be done in a manner that respects the individual's right to privacy (e.g., inside the pack, on a covered name tag).

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	129	178	184	303	268	307	247	8	104
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/3	0/1	0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/3	0/1	0/1	0/1						
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/3	0/1	0/1	0/1						
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/3	0/1	0/1	0/1						
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/3	0/1	0/1	0/1						
Comments: a. through d. For two of the three individuals that had refused dental services, IDTs had not developed specific goals/objectives related to their refusals. Although Individual #178's IDT had developed a goal, it did not address the underlying cause of the dental refusals.											

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: Most individuals reviewed did not have clinically relevant, and measurable goals/objectives to address their needs for communication supports and services. In addition, QIDP interim reviews often did not include data related to existing goals/objectives. As a result, IDTs did not have information in an integrated format related to individuals' progress or lack thereof. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	33% 3/9	0/1	0/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	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% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. For a number of individuals, communication assessments identified deficits, but the SLP offered no plan to address the individual's limitations.

The goal/objective that was clinically relevant, as well as measurable was Individual #8's goal/objective related to turning on the radio using an adaptive switch.

Individual #247's goal/objective to track large objects to midline was clinically relevant, but not measurable.

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 #303 (i.e., activating the radio using a head switch), and Individual #268 (i.e., answering open-ended questions about a story).

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

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: To move forward, QIDPs and SLPs should work together to make sure QIDP monthly reviews include data and analysis of data related to the implementation of communication strategies and SAPs. In addition, when communication plans are not implemented as written, IDTs need to act to correct the problems. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	129	178	184	303	268	307	247	8	104
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	17% 1/6	N/A	0/1	0/1	0/1	0/1	N/A	0/1	1/1	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	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. At times, communication plans were not implemented at the frequency required, but IDTs did not act to address the issue. In addition, the lack of measurable action steps or goals/objectives made it difficult to determine whether or not implementation occurred.											

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 continue to focus on ensuring individuals have their AAC devices with them. Most importantly, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner. These indicators will remain in active monitoring.			Individuals:						
#	Indicator	Overall Score	137	40	107	132	136	General Shared Devices - Coral Sea	Object Board – Coral Sea
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	43% 3/7	1/1	1/1	0/1	0/1	1/1	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% 0/7	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Staff working with the individual are able to describe and	0%							

	demonstrate the use of the device in relevant contexts and settings, and at relevant times.	0/3
Comments: a. and b. It was concerning that often individuals' AAC devices were not present or readily accessible, and/or that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them. The general shared devices in Coral Sea were outside of individuals' bedrooms, and simply stated "bedroom." The SLP stated that they were designed to help individuals associate the device to the bedroom. However, evidence was not available to show that staff were measuring individuals' progress, or that the devices were meaningful to the individuals. The object board in Coral Sea, as well as the general shared devices were placed too high for individuals in wheelchairs to use them, and most of the individuals in Coral Sea use wheelchairs.		

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

This Domain contains five outcomes and 20 underlying indicators. At the time of the previous review, one indicator moved to the category requiring less oversight. At this time, one additional indicator will be 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.

For both individuals reviewed, the pre-move training developed for their physical and nutritional management needs frequently stated clear and comprehensive measurable criteria for expected staff knowledge and specified the documentation to be completed as evidence. Return demonstration was often the method used to confirm staff's competency, a very appropriate methodology to test provider staff ability to perform certain hands-on tasks. This was a very positive practice, but not yet consistent across all disciplines. Although progress continued, 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.

Some of the areas in which further efforts were needed related to the PMM basing decisions about supports on reliable and valid data, and accurately identifying when supports were not in place, and then taking appropriate action toward resolution.

Both individuals had experienced multiple PDCT events, including the return of one individual to the Center. For both individuals, IDTs met and identified some of the actions necessary to ensure the provision of supports that would have reduced the likelihood of the negative events occurring. In neither case, though, did their IDTs develop a full list of necessary supports to reduce the likelihood of negative events recurring.

Discipline assessments still needed improvement to provide a thorough summary of relevant facts of the individual's stay at the Center, and/or a comprehensive set of recommendations setting forth the services and supports individuals needed to successfully transition to the community. The Center had implemented some improved processes in this area. For example, transition staff had developed training materials such as a "cheat sheet" to guide the disciplines about requirements for assessment recommendations. The Center also provided good documentation of persistent follow-up by transition staff for clarifications and additional information. Although IDTs included individuals and their guardians in the transition process, some of one individual's important contributions during the meetings were not incorporated into her CLDP. It was positive that Local Authority staff and Center staff collaborated during and after the transition processes. The related indicator will move to the category requiring less oversight. Although some work was still needed, it was good to see SSLC clinicians completing

assessment of settings as dictated by the individual's needs, and for one individual, providing hands-on technical assistance to facilitate a smooth transition. These indicators will remain in active oversight.

One of the individuals reviewed transitioned after the opening of a High Needs Medical home that could meet her intensive needs for medical and physical/nutritional supports. Previously, few resources had existed in the community that provided the types of support she required. It was positive the State had invested in the development of homes that could facilitate community living for individuals with medically-intensive needs.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.

Summary: For both individuals reviewed, the pre-move training developed for their physical and nutritional management needs frequently stated clear and comprehensive measurable criteria for expected staff knowledge and specified the documentation to be completed as evidence. Return demonstration was often the method used to confirm staff's competency, a very appropriate methodology to test provider staff ability to perform certain hands-on tasks. This was a very positive practice, but not yet consistent across all disciplines. Although progress continued, 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	178	68							
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, four individuals transitioned from the Center to the community. Two were included in this review (i.e., Individual #178, and Individual #68). Individual #178 transitioned to a home and community-based services (HCS) group home and Individual #68 transitioned to a High Medical Needs Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD) home. The Monitoring Team reviewed these two transitions and discussed them in detail with the Corpus Christi SSLC Admissions and Placement staff. In interview, transition staff described enhancements to their planning processes. These included significant improvements to pre-move training practices, as described further below. The Monitoring Team commends the Center for these efforts.

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.

Findings included, but were not limited to:

- Pre-move supports: The respective IDTs developed six pre-move supports for Individual #178, and nine pre-move supports for Individual #68.
- Overall, the Monitoring Team was impressed with the pre-move training developed for the physical and nutritional management needs for both individuals reviewed. These supports frequently stated clear and comprehensive measurable criteria for expected staff knowledge and specified the documentation to be completed as evidence. Return demonstration was often the method used to confirm staff's competency, a very appropriate methodology to test provider staff ability to perform certain hands-on tasks. This was a very positive practice, but not yet consistent across all disciplines. For example:
    - For Individual #178, the CLDP included four pre-move training supports regarding the use of her gait belt; the care of her power wheelchair; how to safely assist her with stand-pivot transfers; and, behavioral/psychiatric issues. It was positive that supports for training about how and when to use her gait belt spelled out three clear competency criteria, and required return demonstration as the evidence that provider staff had both the knowledge and the skills for implementation. It was equally impressive that the training documentation indicated staff had demonstrated competence in each of the three criteria.
    - At the same time, another pre-move training support for maintenance of Individual #178's wheelchair was not comprehensive, as it did not ensure provider staff knowledge of potential for skin breakdown due to incontinence.
    - Individual #68's CLDP included extensive pre-move training supports for her many habilitation and nursing requirements, with the only notable exception related to her ongoing physical therapy standing program.
- Post-Move: The respective IDTs developed 43 post-move supports for Individual #178, and 27 post-move supports for Individual #68. Most post-move supports were measurable, and it was positive the IDTs cited both documentation and interviews with staff and the individual as required evidence. This was good progress, but IDTs still sometimes needed to clearly describe required evidence that would provide the PMM with clear measurable indicators. Examples of post-move supports that did not meet this criterion included, but were not limited to:
    - For both Individual #178 and Individual #68, some post-move supports for consults, appointments, and/or laboratory tests indicated the initial due date, but did not include the recommended frequency.
    - Individual #178's CLDP included a support to give pro re nata (PRN, or as-needed), medications as prescribed. This support was not measurable in terms of defining how staff would determine if a medication was needed. For example, one of the PRN medications was Nicorette gum for tobacco cessation. At the seven-day PMM visit, Individual #178 questioned why she had the gum. Further, she indicated she had no plans to stop smoking, in which case a PRN medication for that purpose would not be needed; still, the PMM notes only documented she received the PRN medications as prescribed.
    - Individual #68's CLDP included a post-move support to offer opportunity to participate in a staff service objective (SSO) for washing her hands, but did not indicate how this would be measured, either in terms of frequency or expectation for her level of participation.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for the indicator to be scored as meeting criterion. The Center had identified many supports for these two individuals and it was positive they had made a diligent effort to address their needs. 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: Individual #68 did not have significant behavioral or

psychiatric needs/history that required supports. For Individual #178, the IDT did develop some post-move supports related to current behavioral needs. This was positive, but these supports were not consistently clear and/or comprehensive. For example:

- Individual #178's supports did not address her behavioral/psychiatric history in an assertive manner. Leading up to her last admission to the Center, behavioral reports from the community provider included refusals of medications and showering, cutting her arms and legs with a razor, threats to kill herself, police interventions for threats of suicide and physical aggression, and threats to strip her clothes off. The IDT did not include this specific history in any staff knowledge supports. Instead, the IDT developed a non-specific support indicating provider staff would be tested on possible behavioral and psychiatric issues, and how to respond if they occurred. The testing for this support did not have probes about the nature of her self-injurious behaviors or threats of suicide.
- The IDT also did not assertively address Individual #178's need for ongoing counseling, even though she had begun to develop some anxiety issues about the transition in the weeks before it occurred, per the pre-move ISPA. In addition, she expressed concern at the CLDP meeting about not being able to continue to see a familiar counselor she had grown to trust. When the provider and IDT could not assure her that she would be able to do so, she declined a support for counseling. This was short-sighted; the IDT should have made a concerted effort to contact the counselor prior to the move to affirm this much-needed continuity rather than simply discarding the support.

- 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. To meet criteria, the IDTs still needed to develop clear and comprehensive post-move supports in these areas. Findings included:
  - Individual #178 needed assistance with dressing, bathing, toileting, and transferring due to the lack of functionality in her lower extremities. The CLDP did not include any related post-move supports.
  - For Individual #68, who did not communicate verbally, the CLDP did not include any supports for provider staff to know or use any communication strategies. It was positive transition staff followed up with the speech/language pathologist (SLP) prior to the CLDP meeting about the lack of recommendations in the communication assessment, but this unfortunately did not result in the IDT assertively considering or addressing her needs in this area.
  - Individual #68's CLDP also did not include a clear and comprehensive competency-based support to train provider staff on prevention of gastrostomy-tube (G-tube) dislodgement.
  - Although the IDT developed competency-based pre-move training supports that addressed most of Individual #68's physical and nutritional management needs, it did not address an ongoing standing program implemented by physical therapy at the Center. The documentation indicated the equipment used in this program was not hers and would not be sent with her. Further, the IDT indicated it would discontinue the program, but would share information about it with provider staff. The CLDP did not include any related support, either regarding the potential benefit for Individual #68 or for sharing information with the provider.
  - For Individual #68, although she moved to an ICF/IDD that provided 24-hour nursing supports, the CLDP did not set forth a comprehensive set of nursing supports to meet her individualized needs. Often, the CLDP referenced "staff" as responsible for action steps, but did not specify whether nursing staff or direct support professionals were responsible. In addition, when the action steps did reference nursing staff, their role most often was to review logs or trigger sheets, but the CLDP did not also require ongoing nursing assessments to address the individual's medium and high risk areas. The only notable exception was a post-move support requiring a quarterly nursing assessment, but even this support

had minimal specific requirements for the individualized needs that should be addressed.

- What was important to the individual: The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, the Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. While both CLDPs did address some outcomes important to each individual, neither CLDP did so assertively. Examples included:
    - For Individual #178, the CLDP documented three important outcomes. These included employment, being able to prepare meals, and moving to California to live near her family. The IDT did not address any of these in an assertive manner.
        - The CLDP included a post-move support indicating the provider would assist her to find a clerical job working four to six hours a week and indicated "possible" steps might include benefits counseling and filling out applications. Written in this manner, this support could have been considered satisfied whether or not the outcome was achieved.
        - The CLDP did not include supports to assist her in developing independence in meal preparation; while the narrative documented that the provider stated she could participate in baking and cooking, the IDT did not formalize this expectation with any supports.
        - The IDT also documented a discussion in the CLDP about Individual #178's desire to move to California. Per the Profile section, Individual #178 kept in touch with her aunt and grandmother who lived there and, further, that she wanted to only live in this group home for a few months and then move to California. The provider said the agency had operations in California and that should help make the transition smoother. Individual #178's aunt had reported she agreed with these plans and was aware that the provider could assist with the transfer. The CLDP meeting narrative that followed indicated provider staff looked surprised by this during the CLDP discussion, but said they might be able to transfer everything easily to California and help her get set up with whatever services for which she might qualify. The IDT and Individual #178 agreed with this plan, but the CLDP did not include any related supports.
    - For Individual #68, the IDT did not document any important outcomes. This begged the question as to why she was transitioning. At the least, important outcomes of community transition can be assumed to be increased community experiences, integration, and participation. The IDT did not develop any supports in this area, going so far as to discontinue an SSO for nature walks she enjoyed, because the new home would have an accessible back yard patio. This decision only served to limit her community experiences rather than expand upon them.
- Need/desire for employment, and/or other meaningful day activities: Neither CLDP met criterion:
    - The IDT acknowledged that employment was an important outcome for Individual #178. Her vocational assessment indicated employment was a high priority for her. It also documented she had completed the vocational apprentice program at the Center and could operate different office equipment and follow complex instructions. That assessment also noted some support needs for successful employment, including that she would need the job duties to be explained, staff support to use restroom, and a job trainer. The provider responded that she would have an office job at the day habilitation program, working four to six hours a week at $7.50 an hour. It was positive the IDT discussed a specific plan in this area, but they did not develop a support to formalize this expectation or provide any pre-move in-service for provider staff about her needs in this area.
    - For Individual #68, the IDT did not prescribe any supports for a day program, or even any supports to leave the house

and be part of the community. Per her Transition Log, the new setting had three options for day habilitation, a day program without walls, and an in-home day program, but the CLDP did not document any discussion about these options, or any discussion about what the in-home program might include.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success. Neither CLDP addressed this assertively.
- Teaching, maintenance, participation, and acquisition of specific skills: Neither CLDP met criterion. Examples included, but were not limited to:
    - The IDT did discuss ongoing skill acquisition programs in the CLDP meeting for Individual #178, but indicated she chose not to continue these. Instead, she wanted to rely on experiential learning, such as participating in meal preparation. As described above, the CLDP did not include supports in that area. She also indicated she wanted to learn to use public bus transportation. The CLDP included a support for the provider to assist her to fill out an application to use the public para-transit system, but did not include any additional steps to facilitate learning.
    - For Individual #68, the CLDP included minimal supports for learning specific skills or even participation in or maintenance of such skills. Her functional skills assessment (FSA) indicated she had skill acquisition programs (SAPs) to turn on an audio device with a switch and to choose a doll, both with partial physical assistance. She also had an SS0 for cleansing her hands with wipes. The FSA recommended to continue current the SAPs and the SSO. Per the CLDP narrative, the IDT stated she had not made much progress with using the switch and so did not develop a support to continue this skill development. The IDT further noted she could make choices if two objects were placed in front of her and therefore they would recommend discontinuation of the choice-making SAP as well, with no supports for offering choices or maintaining her skills in this area. The CLDP included a support for offering her the opportunity to cleanse her hands with wipes, but this was a characterized as passive rather than active undertaking.
- All recommendations from assessments are included, or if not, there is a rationale provided: Corpus Christi SSLC had a process in place for documenting in the CLDP the team's discussion of assessments and recommendations, including the IDT's rationale for any changes to, or additional recommendations. For both individuals included in this review, the IDTs did not yet address all recommendations with supports or otherwise provide a justification. The Center should address issues such as the following examples:
    - As described above, IDTs needed to be cautious about not including formal supports in the CLDP, because the provider indicates they have a plan for addressing certain needs. The CLDP is an agreement among the SSLC, the provider, and the LIDDA to provide specific supports to meet individuals' needs and should include all expectations.
    - Assessments still sometimes included important information about needed supports in the narrative that were not reflected in the recommendations section. As transition staff and the IDT review assessments prior to the CLDP meeting, they should ensure both the narrative and recommendation sections are reviewed and reconciled. For example, Individual #68's social assessment indicated she would benefit from having an advocate in the community, but the IDT did not develop any support in this area.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.											
Summary: Some of the areas in which further efforts were needed related to the PMM basing decisions about supports on reliable and valid data, and accurately identifying when supports were not in place, and then taking appropriate action toward resolution. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	178	68							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
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 scoring 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, the IDT/Facility implemented corrective actions 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: 4. The PMM Checklists provided some good examples of documenting valid and reliable data, but this was not yet consistent. To continue to move toward compliance, the Center should continue to focus on improving overall clarity and measurability of supports that provide guidance to the PMM as to what criteria would constitute the presence of various supports. Findings included:

- As described above with regard to Indicator #1, the CLDPs did not yet consistently specify the competency criteria the PMM needed to be able to accurately collect valid data for all pre-move training supports.
- At the time of the 45-day PMM visit, Individual #178 had engaged in aggressive and self-injurious behaviors. Per the support, provider staff were to complete three steps including: 1) ensure the safety of Individual #178 and others and contact the nurse, if needed; 2) redirect her away from peers; and 3) talk with her to help her come up with a solution to the problem or re-direct her to a preferred activity. The PMM Checklist indicated the PMM reviewed several incident reports in March. Two of the three

indicated provider staff "questioned" her about the incident, but none included any description about helping her to come up with a solution. The PMM also documented interviews with provider staff, but none of these described staff actions to help Individual #178 come up with a solution or their knowledge of this strategy. Instead, the documentation indicated only that staff described the nature of the problem, which was characterized as Individual #178 being impatient and not liking to wait.

- For Individual #68, the IDT developed pre-move supports that described her equipment needs, such as the bathing trolley and mechanical lift, but did not require checking the pre-move supports again at all PMM visits or developing corresponding post-move supports to ensure the equipment was still in place and in good working order. The PMM then relied on observations from the pre-move site visit to confirm the presence of the needed equipment.

5. Based on information the PMM collected, both individuals 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 received supports due to the lack clarity and measurability in the supports as written and/or a lack of reliable and valid evidence that demonstrated a support was in place as required. Examples of important supports not in place as required included, but were not limited to, the following:

- For Individual #178, supports not in place at the time of the 45-day PMM visit included:
  - The required chain to measure her head-of-bed elevation was not present;
  - The required half bedrails were not present;
  - Appointments with the community psychiatrist and the registered dietitian had not been completed as required; and
  - Individual #178 had not begun working as scheduled.
- For Individual #68, supports not in place as required included:
  - At the time of the seven-day PMM visit, provider staff had not administered PRN medication for constipation as indicated;
  - At the time of the 45-day PMM visit, provider staff had not completed the daily aspiration trigger sheet or maintained the daily bowel log as required;
  - The quarterly nursing report did not include her Braden Score as required at the time of the 90-day PMM visit; and
  - The provider had not scheduled her dental appointment within the required timeframe at the time of the 90-day PMM visit. This was concerning because the support was due to be completed the day after the 90-day PMM took place and had not yet been scheduled.

6. Based on the supports defined in the CLDP, the Post-Move Monitor's scoring was frequently correct, but there were still exceptions in which the evidence provided did not clearly substantiate the finding with valid and reliable data. Findings included:

- For Individual #178, as described in detail above, the PMM indicated a behavioral support was in place for provider staff to take three actions in the event of aggression or self-injurious behavior. The evidence provided did not reflect that provider staff had implemented one of these steps, which was to assist Individual #178 to come up with a solution to the problem.
- For Individual #68, it was concerning that the pre-move supports for some of her adaptive equipment and staff competencies were not probed in the absence of corresponding post-move supports. As a result, the PMM Checklist indicated only that those supports were in place based on evidence from the pre-move site review (PMSR.)

7. through 8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed 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. This, in turn, relies on accuracy, completeness, and measurability of the supports. Overall, the PMM often accurately identified when supports were not in place and then took appropriate action toward resolution. This was positive; however, as described above with regard to the previous indicator, this was not yet consistent. For example, for Individual #178, it might have been possible to take more assertive follow-up action if the PMM had correctly identified that provider staff had not focused on helping her problem-solve as required. For Individual #68, the failure to document whether provider staff continued to demonstrate competency in preventing G-tube dislodgment might have caused the PMM to miss identification of a need for assertive re-training. This, in turn, might have prevented the occurrence of the ensuing dislodgements that necessitated ED care.

9. through 10. These indicators were not scored, because post-move monitoring did not occur for these two individuals during the Monitoring Team's visit.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of preventable negative events following transition into the community.

Summary: Both individuals had experienced multiple PDCT events, including the return of one individual to the Center. For both individuals, IDTs met and identified some of the actions necessary to ensure the provision of supports that would have reduced the likelihood of the negative events occurring. In neither case, though, did their IDTs develop a full list of necessary supports to reduce the likelihood of negative events recurring. This indicator will continue in active oversight.

Individuals:

#	Indicator	Overall Score	178	68							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	0% 0/2	0/1	0/1							

Comments: 11. Both individuals experienced multiple PDCT events. At the time of the Monitoring Team's onsite visit, Individual #178 had returned to the Center, but Individual #68 was still residing in her new home. Overall, the Center had not identified the issues that led to the PDCT events, but should have been able to do so based on the individuals' needs and histories; as a result, these transitions did not meet criterion. At the same time, it was very positive the Admission Placement Coordinator's (APC's) office supported the respective IDTs to assist in attempting to critically analyze these events and identify certain things they could have done differently to reduce the likelihood of their occurrence. This should enable the IDTs to apply these important lessons learned to future transitions, and thus, reduce the likelihood of similar consequences.

- Individual #178's IDT met four times within the first two months after her transition to discuss PDCT events. At the related PDCT ISPA meetings, the IDT discussed several factors that might have been anticipated and planned for at the time of transition. Examples included, but were not limited to:

- The IDT met on 3/22/18 to discuss Individual #178's decision to move to another home operated by the same provider. The documentation indicated she had begun exhibiting depressive symptoms and behavioral concerns within two days of her transition, on 3/1/18. She indicated she felt alone and no one talked to her. She said the other individuals living in the home did not communicate verbally and provider staff were always too busy. On 3/14/18, the PMM and Center IDT agreed to add some supports, including weekly meetings with the program coordinator and seeing a counselor on a regularly scheduled basis to assist in dealing with transition, depression, and feeling lonely. Individual #178 agreed, but on 3/16/18, also visited another group home and decided she wanted to move because there were other individuals with whom she could talk. The IDT acknowledged it had not anticipated the issue of having a peer group in her new home, but should have done so based on Individual #178's needs.
- By 4/16/18, Individual #178 continued to report not feeling safe due to her mental instability. She stated no one listened to her, that she had racing thoughts and difficulty sleeping and was hearing voices in her head. She considered requesting to return to the Center at that time, but was not ready to feel like she was giving up. She stated she would like to continue to pursue looking for alternate placement in the San Antonio area, but also wanted Center staff to in-service staff in any new setting in more detail about her needs, particularly her psychiatric diagnoses. It was also noted that the community primary care practitioner (PCP) had made a recent medication change from Ativan to Xanax, and that Individual #178 did not want to see the counselor because she did not know her. The IDT did not discuss that Individual #178 had expressed concerns about both issues during the CLDP meeting. The provider had assured her they did not typically make medication changes during the first 90 days after transition, but the IDT did not include a support that formalized this agreement. Further, after the provider indicated they could not assure her she could continue to see a counselor she knew and trusted, Individual #178 chose to decline counseling as a support. The IDT should have considered both of these issues as factors that should have been anticipated.
- On 4/17/18, the IDT met to discuss an ED visit on 3/26/18, when Individual #178 experienced nausea, vomiting, and severe back pain. On the day and evening before the event, she had refused medications and engaged in self-injurious behaviors. The IDT correctly concluded they could have provided more in-depth historical information about self-injurious behavior. While the IDT indicated that they could not have anticipated the episodes of vomiting, they might well have considered that the stress of the situation had contributed to her physical symptoms.
- On 5/21/18, the IDT met to discuss Individual #178's return to the Center. She had continued to report she did not feel safe. She believed she was going to end up in jail, because provider staff were accusing her of running them over with her wheelchair and had reported feeling afraid and intimidated. The IDT again indicated they could have shared more specific details about historical behaviors to prepare the provider staff to address with needs.

- Individual #68 experienced two ED visits related to dislodgment of her G-tube. Prior to the ED visits, an incident report, dated 5/5/18, indicated the G-tube had not been cleaned properly and not kept dry as required. The incident report indicated staff had noticed bloody and green drainage in her stoma site area. It was re-cleaned and the provider nurse was notified. The next evening, on 5/6/18, the provider staff lifted Individual #68's shirt and noticed the tube had been pulled out of place. She was taken to the ED for re-insertion. The provider staff determined group home staff had accidentally pulled out the G-tube while repositioning her in bed. On 5/7/18, the G-tube was draining uncontrollably, and she was again taken to the ED for treatment. In considering things that might have been done differently, the IDT noted Corpus Christi SSLC nursing staff provided training on G-tube care to provider staff prior to transition and that a Center nurse was at the new home for the first 24 hours after

	transition to assist provider nursing with hands-on training, G-tube feeding, and any questions/concerns they might have with her medications and nursing care. These were positive and proactive strategies, given Individual #68's history of dislodgement. Still, the IDT correctly identified additional actions it might have taken, including providing actual hands-on training on how to replace and re-insert the tube rather than a general didactic approach. The IDT further agreed that when choosing a provider, they should ask about the specific training provider nursing staff had in this area. The IDT did not, but should have, also identified the need to provide more assertive training to provider direct support staff on how to avoid dislodging the G-tube when providing care and re-positioning.

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: Discipline assessments still needed improvement to provide a thorough summary of relevant facts of the individual's stay at the Center, and/or a comprehensive set of recommendations setting forth the services and supports individuals needed to successfully transition to the community. The Center had implemented some improved processes in this area. For example, transition staff had developed training materials such as a "cheat sheet" to guide the disciplines about requirements for assessment recommendations. The Center also provided good documentation of persistent follow-up by transition staff for clarifications and additional information. Although IDTs included individuals and their guardians in the transition process, some of one individual's important contributions during the meetings were not incorporated into her CLDP. It was positive that Local Authority staff and Center staff collaborated during and after the transition processes. Given that during the last two reviews and during this review, this collaboration was evident (Round 12 – 100%, Round 13 – 100%, and Round 14 – 100%), Indicator 18 will move to the category requiring less oversight. Although some work was still needed, it was good to see SSLC clinicians completing assessment of settings as dictated by the individual's needs, and for one individual, providing hands-on technical assistance to facilitate a smooth transition. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	178	68							
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	50% 1/2	0/1	1/1							

	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.										
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.	50% 1/2	0/1	1/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	50% 1/2	0/1	1/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	50% 1/2	0/1	1/1							
18	The APC and transition department staff collaborates with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition.	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. Discipline assessments still needed improvement to meet criterion for providing a thorough summary of relevant facts of the individual's stay at the Center, and/or a comprehensive set of recommendations setting forth the services and supports these individuals needed to successfully transition to the community. The Center had implemented some improved processes in this area. For example, transition staff had developed training materials such as a "cheat sheet" to guide the disciplines about requirements for assessment recommendations. The Center also provided good documentation of persistent follow-up by transition staff for clarifications and additional information. Transition staff should continue to pursue these strategies, with the expectation that discipline assessment practices will improve over time. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated with 45 Days of transition: Most assessments provided for review met criterion for timeliness. Assessments that did not meet criterion included:
  - The communication assessment for Individual #178 was dated more than 45 days prior to transition.
  - The Center did not provide a day program assessment for Individual #68.
- Assessments provided a summary of relevant facts of the individual's stay at the Center: Many discipline assessments provided a summary of relevant facts, but some did not. Examples included Individual #178's medical assessment, which did not consistently document current status, and Individual #68's communication assessment, which did not assertively describe her

communication strengths and needs.

- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments that did not yet thoroughly provide recommendations to support transition included:
    - For Individual #178, the behavioral health assessment provided only minimal and non-specific recommendations: continue work of choice, counseling, and psychiatric care.
    - Individual #68's communication assessment provided no recommendations for supporting her communication needs. The assessment indicated she had a communication dictionary for use by Center staff that described her nonverbal communicative behaviors and how staff should respond to her. It went on the state this was not an essential support for her living in the community, so it would be discontinued when she left the Center. When the APC followed up about not having any recommendations to support transition, the SLP replied the communication dictionary had no communication-specific individualized communicative gestures for Individual #68, so it would not be needed as a support. It was concerning that the Center could not provide any individualized communication information for Individual #68, especially since the assessment noted she could express pain, discomfort, anger/agitation, and contentment through her behavior. The SLP assessment should have described how she expressed these needs and feelings so that provider staff could recognize and be responsive to her communicative expressions.
    - As discussed above, the role of nursing in supporting Individual #68 was not clearly defined. Both nursing assessments focused largely on appointments and consultations needed, as opposed to recommendations for the supports that nurses specifically needed to provide the individuals (e.g., ongoing nursing assessments, oversight of medication administration and other delegated responsibilities, assistance with medical appointments, etc.).
- 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. Currently, assessments did not consistently meet criterion in this area.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator, including the following: 1) There was documentation to show IDT members actively participated in the transition planning process; 2) the CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed; and 3) the CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting: For both individuals, the Center maintained detailed Transition Logs. These were helpful in understanding how the Centers transition processes ensured necessary participation. Section IV of the CLDP document, entitled Community Living, also provided details of transition activities that described the involvement of the individual and LAR/ family, the LIDDA, and Center staff. For Individual #178, however, it was concerning that the IDT did not ensure that her CLDP formalized expectations agreed-upon during the discussion. For example, she clearly expressed her desire for this transition to serve as a short-term bridge to moving to California to be near her family, but the CLDP did not include any supports to facilitate this goal.

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: This training did not yet meet criterion for these two CLDPs, as described with regard to Indicator 1 above and further below, but some important improvements were noted. Findings included:

- On a very positive note, the Habilitation Therapies Department developed some excellent pre-move training supports for these

two individuals. These supports often included clear and comprehensive competency expectations and appropriately required provider staff to demonstrate the ability to implement the various skills. In addition, the testing methodology was detailed and provided a reliable gauge of provider staff competence.

- The IDTs should expand upon this model for other discipline-specific training, which did not as clearly identify the expected provider staff knowledge or competencies that needed to be demonstrated. These trainings also did not provide sufficient evidence the Center had confirmed provider staff had the knowledge and competencies to address the individuals' health and safety needs or otherwise ensure supports were implemented as required.

15. When necessary, Center staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The IDT should include in the CLDP a specific statement as whether any collaboration was needed, and if any was completed, summarize findings and outcomes.

- Individual #178's CLDP included a statement about the need for collaboration for each discipline in the review of assessments. This was a good practice in theory, but the IDT still needed to better document the discussion and resulting rationales in a clearer and more complete manner.
- For Individual #68, the CLDP documented robust collaborative practices, beginning with IDT members meeting and sharing information with provider counterparts during the initial tour of the home, and continuing with appropriate provider disciplines coming to the Center for training and sending a Licensed Vocational Nurse (LVN) to model and assist on the first night of the roll-over transition.

16. SSLC clinicians (e.g., OT/PT) complete assessment 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.

- For Individual #178, the pre-move ISPA indicated Habilitation Therapy staff completed assessments at both the home and the day program, which indicated all support needs were in place. This was positive overall, but post-move evidence indicated her bed rails had not, in fact, been provided as needed.
- Individual #68's CLDP met criterion. It was very positive to see the IDT members take personal initiative to ensure the new home would meet her needs. The CLDP documented that Habilitation Therapies staff had requested a visit to approve the home in January 2018. On 2/8/18, the QIDP, registered nurse case manager (RNCM), and Habilitation Therapies staff toured the home and met with provider staff to share information.

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. Neither CLDP provided a specific description of any considerations for the involvement of direct support staff in such activities.

18. The APC and transition department staff collaborate 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 PMSRs for both individuals were completed in a timely manner. 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. For both individuals, the PMM documented receiving the signed training rosters after the completion of the training, but even with the progress made in provider training as described with regard to Indicators 1and 14 above, these were still insufficient as evidence that provider staff were competent in all areas.

Outcome 5 – Individuals have timely transition planning and implementation.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	178	68							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	50% 1/2	0/1	1/1							

Comments: 20. One of two CLDPs (i.e., for Individual #68) met criterion for this indicator.

- On 6/9/17, Individual #178 was referred, and she transitioned on 3/1/18. This exceeded180 days. The Transition Log indicated some avoidable delays when the IDT did not meet in a timely manner to formalize transition activities and decisions, despite requests from the Admissions and Placement Department.
- On 11/24/15, Individual #68 was referred, and she transitioned on 4/9/18, after the opening of a High Needs Medical home that could meet her intensive needs for medical and physical/nutritional supports. Previously, few resources had existed in the community that provided the types of support she required. It was positive the State had invested in the development of homes that could facilitate community living for individuals with medically-intensive needs. The Transition Log documented the ongoing efforts to develop the home and the continuing contacts made on Individual #68's behalf.

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