United States v. State of Texas

Monitoring Team Report

Corpus Christi State Supported Living Center

Dates of Remote Virtual Review: January 24-27, 2021

Date of Report: April 18, 2022

Submitted By:	Alan Harchik, Ph.D., BCBA-D Senior Independent Monitor James M. Bailey, MCD-CCC-SLP Teri Towe, B.S. Assistant Independent Monitors
Monitoring Team:	Paula Casey, MSN, RN, CCM Jill Cuff, BS/MOT, OTR/L Teka Harris, M.A., BCBA Susan Thibadeau, Ph.D., BCBA-D Scott Umbreit, MS Rebecca Wright, MSW Wayne Zwick, MD

Table of Contents

Background

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

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

In 2021, the parties submitted to the Court, and the Court approved, various amendments and modification to the 2009 Settlement Agreement (now called the Amended Settlement Agreement). One of the modifications was the allowance of a Center to exit from a numbered provision, rather than solely from an entire lettered section, when sustained substantial compliance is demonstrated.

Methodology

In order to assess the Center's compliance with the Amended Settlement Agreement, the Monitoring Team undertook a number of activities:

a. Selection of individuals: During the weeks prior to the review, the Monitoring Team requested various types of information about the individuals who lived at the Center and those who had transitioned to the community. From this information, the Monitoring Team then chose the individuals to be included in the monitoring review. This non-random selection process is necessary for the Monitoring Team to address a Center's compliance with all provisions of the Settlement Agreement.
b. Onsite review: Due to the COVID-19 pandemic and resultant safety precautions and restrictions, the onsite review portion of this review was not conducted. Instead, the Monitoring Team used the Microsoft Teams audio and video platform to attend various meetings, conduct interviews of various staff members via Microsoft Teams (e.g., Center Director, Medical Director, Habilitation Therapies Director, Behavioral Health Services Director, Chief Nurse Executive, Lead Psychiatrist, QIDP Coordinator), and observe individuals and staff.

c. Review of documents: Prior to the review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some Center-wide documents. During the week of the review, the Monitoring Team requested and reviewed additional documents.
d. Observations: The Monitoring Team observed individuals in their homes, day/work sites, and other locations at the SSLC during regularly occurring activities. Specific activities were also scheduled and observed, such as administration of medication, implementation of skill acquisition plans, and conduct of mealtimes.
e. Interviews: The Monitoring Team 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 section of the Amended Settlement Agreement. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. A summary paragraph is also provided for each outcome. In this paragraph, the Monitor provides some details about the indicators that comprise the outcome, including a determination of whether any indicators will move to exited status. Exited indicators are not included in subsequent reports. The Monitor also makes a determination of whether an indicator will be moved to the category of requiring less oversight. Indicators that move to this category will not be scored, but may be monitored at future reviews if the Monitor has concerns about the Center's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the Center's plans for continued quality assurance and improvement. In this report, any indicators that were moved to the category of less oversight during previous reviews are shown as shaded and no scores are provided. The Monitor may, however, include comments regarding these indicators.

Organization of Report

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

a. A status summary of sections and provisions that have exited and those that are in the category of requiring less oversight.
b. The outcomes and indicators are listed along with the Monitoring Team's scoring of each indicator.

c. The Monitor has provided a summary of the Center's performance on the indicators in the outcome, as well as a determination of whether each indicator will exit, move to the category of requiring less oversight, or remain in active monitoring.
d. The Monitor has provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
e. Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers.

Executive Summary

The Monitoring Team wishes 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 Team during the remote review. The Center Director supported the work of the Monitoring Team 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 Team; their time and efforts are much appreciated.

Section C: Protection from Harm - Restraints

Substantial Compliance – Exited Status

Two of the provisions of this section met and achieved substantial compliance: C1 and C2.

Thus, the corresponding 10 monitoring indicators are no longer monitored or scored: 1-6, 8-10, and 12

Sustained High Performance – Less Oversight Status

Four of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, no additional indicators were moved to this category.

Section Summary

All restraint incidents required better description of the circumstances surrounding the restraint incident. For half of the restraint incidents, the restraint monitor arrived on the scene, but later than the required 15 minutes. Staffing shortages and COVID precautions may have been a factor in this.

Teams were not meeting as often as required after occurrences of more than three crisis intervention restraints in any rolling 30-day period. When teams did meet, there was an improvement in the content of the discussion compared with previous monitoring reviews, however, improvement remained needed to fully meet criteria.

For six of the eight restraints, nurses performed physical assessments, and documented whether there were any restraint-related injuries or other negative health effects. Nursing staff should focus on including documentation of the needed follow-up to injuries resulting from the restraint and ensuring the actions taken meet the needs of the individual.

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:			Individuals:									
#	Indicator	Overall Score										
7	There was no injury to the individual as a result of implementation of the restraint.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										

11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	
	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: All restraint incidents required better description of the circumstances surrounding the restraint incident. For half of the restraint incidents, the restraint monitor arrived on the scene, but later than the required 15 minutes. Staffing shortages and COVID precautions may have been a factor in this. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	218	227	92	149	312				
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	0% 0/8	0/2	0/2	0/1	0/2	0/1				
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A									
	Comments: 13. For four of the restraint incidents, the restraint monitor arrived on the scene, but in each case, it was beyond the 15 minute requirement and instead was at 18 to 64 minutes. For all eight restraint incidents, there was insufficient description of the circumstances around the incident, especially regarding whether the PBSP was being implemented correctly.										

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: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	218	227	92	149	312				

16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	88% 7/8	2/2	1/2	1/1	2/2	1/1				
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	0% 0/1					0/1				
Comments: 16. For Individual #227, the restraint incident with an injury (nonserious) should have resulted in some follow-up. 17. For Individual #312, there was no evidence that post-restraint review occurred, or that a CIP was created.											

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: Teams were not meeting as often as required after occurrences of more than three crisis intervention restraints in any rolling 30-day period (indicators 18 and 19). When teams did meet, there was an improvement in the content of the discussion compared with previous monitoring reviews (indicators 20, 22, and 23), however, improvement remained needed to fully meet criteria with these indicators. Overall, five of the indicators in this outcome scored higher than at the last review. All will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	218	227	149						
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.	0% 0/3	0/1	0/1	0/1						
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.	0% 0/3	0/1	0/1	0/1						
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	(No longer scored)										
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents,	50% 1/2		0/1	1/1						

	2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?										
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.	100% 2/2		1/1	1/1						
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).	100% 3/3	1/1	1/1	1/1						
26	The PBSP was complete.	N/A									
27	The crisis intervention plan was complete.	100% 3/3	1/1	1/1	1/1						
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	0% 0/3	0/1	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.	33% 1/3	0/1	0/1	1/1						

Comments:

18-19. Between 6/1/21 and 11/30/21, three individuals, Individual #218, Individual #227, and Individual #149, were placed in restraint more than three times in a rolling 30-day period.

- There was no evidence that the IDT had met for Individual #218 to discuss the repeated restraints that occurred between 6/14/21 and 6/27/21, 8/17/21 and 9/10/21, or 10/19/21 and 11/3/21.
- Individual #227 had been restrained more than three times in a rolling 30-day period on seven occasions between 8/13/21 and 11/9/21. The only evidence of his team meeting to review these restraints was on 9/25/21, however, the review included restraints that occurred as late as 10/14/21.
- Individual #149 had been restrained more than three times in a rolling 30-day period on three occasions between 6/24/21 and 8/23/21. His team had met in early June to review restraints that occurred in May, and again, on 12/30/21 to review restraints that had occurred that month.

20-23. These indicators are scored for Individual #227 and Individual #149. Individual #218's IDT did not meet to review his repeated restraints. The comments below relate to the most recent ISPA regarding repeated restraint. For Individual #227, this was a meeting held September, and for Individual #149, this was a meeting held in December.

- Individual #227's team reviewed historical information from home and listed his current diagnoses. There was no thorough review of his adaptive skills, or biological/medical/psychosocial issues. Later in the minutes, it was noted that his sleep patterns were inconsistent and he may be responding to his recent move to a new home. Although sleep charts were to be implemented, there was no evidence that this ever occurred. There were no plans to address his adjustment to his new home. Antecedents included others receiving attention, boredom, and being denied immediate access to a requested item or activity. While his PBSP included a replacement behavior of learning to cope with unfulfilled requests, it did not include plans to increase attention or an enhanced schedule of activities. Lastly, it was noted that he may engage in behavior that requires restraint when redirected from property destruction, aggression, and SIB. The last of these behaviors was not addressed in his PBSP.
- Individual #149's team did not conduct a thorough review of his adaptive skills, or biological/medical/psychosocial issues. However, it was noted that he may experience discomfort or pain in his ears. An ENT consultation was ordered and until it was completed, nursing staff were to check his ears weekly. Other actions taken included the following: a sensory assessment was completed; snack times were added to his schedule; team members were instructed to make rounds between 3:00 pm and 4:00 pm because this hour was identified as a time of frequent restraints; staff were to provide a warning in advance if the computer area hours changed; and others were to be reminded not to eat foods in front of Individual #149 that he cannot have. This last issue may need to be clearly addressed in his PBSP. As noted following the last review, it is suggested that the teamwork with the dietician to determine whether there are some foods (e.g., vegetables, flavored water/seltzer, etc.) that he could have outside of meal and snack times as he is on a restricted diet. The team is also advised to ensure that his communication books and picture schedule are readily available to him rather than in his backpack or the home office.

25. All three individuals had a Crisis Intervention Plan. Individual #218's was implemented in April 2021, Individual #227's was implemented in September 2021 with a revision noted in October, and Individual #149's was implemented in January 2021.

26. The PBSPs for Individual #218, Individual #227, and Individual #149 that were provided following the document request were reviewed in detail in the Psychology/Behavioral Health section of this report.

27. The Crisis Intervention Plan for all three individuals was considered complete. Each plan included the following information: the type of authorized restraint, often listed as SUR techniques; the maximum duration of restraint as 30 minutes; the approved restraint situation; and the criteria for terminating the restraint.

28. There was no evidence of PBSP monitoring for treatment integrity for any of the three individuals from June through December 2021.

29. There was no evidence that the IDT had reviewed the PBSP for Individual #218. Although the ISPA meeting minutes indicated that Individual #227's plan had just been approved by the Behavior Support Committee and was waiting approval by the Human Rights Committee, it was noted as early as June that his PBSP had expired. Further, the minutes reflected that he may engage in behavior that requires restraint when redirected from property destruction, aggression, and self-injurious behavior, but the last of these was not addressed in his PBSP. The team did recommend revisions to Individual #149's PBSP. One suggested revision is to include property destruction as a targeted behavior as this was noted in the ISPA meeting minutes.

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

Summary: For six of the eight restraints, nurses performed physical assessments, and documented whether there were any restraint-related injuries or other negative health effects. Nursing staff should focus on including documentation of the needed follow-up to injuries resulting from the restraint and ensuring the actions taken meet the needs of the individual. Scores for indicators a and c were higher than in previous review. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 218	227	92	149	312				
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	75% 6/8	2/2	1/2	1/1	1/2	1/1				
b.	If the individual is restrained using PMR-SIB:	N/A									
c.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	75% 6/8	2/2	0/2	1/1	2/2	1/1				
d.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	0% 0/2		0/2							

Comments:

a. Most individuals who were restrained received nursing assessments and follow-up as needed.

- For Individual #227, he was assessed by nursing post restraint on 9/15/21. The assessment lacked an adequate comprehensive description of the individual's mental status.
- For Individual #149, the nurse failed to document vital signs along with documentation of mental status.

c. Based on the results of the assessment, nursing staff acted, as applicable, and met the needs of the individuals on six of eight occasions. Exceptions were as noted.

- Individual #227 had skin abrasion on 9/15/21 to his right hand and between his fingers. There was no documentation of follow-up noted regarding this injury. Additionally, on 11/2/21, he refused assessment post injury, but there was no evidence of follow-up by nursing.

d. On zero of two occasions, the nursing staff took the needed action based upon the provided assessment. There was no documentation of follow-up to a skin abrasion that occurred to the right hand on 9/15/21 and a scratch to the outer bicep on 11/2/21 for Individual #227. In a comment on the draft version of this report, the Center reported that the documentation did exist for the abrasion, but they failed to submit it.

Section D: Protection from Harm – Abuse, Neglect, and Incident Management

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Based on performance during this review period, and the sustained high performance demonstrated over the past successive reviews, the Center has met and maintained substantial compliance with all of the provisions of this section and is exited from all five of the provisions of section D.

Sustained High Performance – Less Oversight Status

Fourteen of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review.

Section Summary
The improvements in the Center's incident management program seen over the past few years continued for this review, too.

The Center's Incident Management Coordinator was experienced, knowledgeable of State and Center systems, and provided good leadership to the incident management program at the Center.

All incidents were correctly reported, with one aspect of one incident. One incident was correctly reported to investigations, but reported slightly late to the facility director/designee.

Some investigations were not completed timely within the 10 days and did not have extensions with explanation. One investigation review by the Center did not identify the absence of thorough review of possible causes of serious injury.

All required data sets were included in the Center's report.

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
Summary: All criteria were met for this indicator (with a sole exception of an updated duty to report form for one staff member).			Individuals:								
#	Indicator	Overall Score	218	227	92	216	149	312			
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	83% 10/12	2/2	2/3	2/2	1/1	2/2	1/2			

		100% 4/4									

Comments:
The Monitoring Team reviewed 12 investigations that occurred for six individuals. Of these 12 investigations, eight were HHSC PI investigations of abuse-neglect allegations (one confirmed, six unconfirmed, one inconclusive). The other four were for facility investigations of serious injuries, unauthorized departure, or a sexual incident. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #218, UIR 21-811, PI 4187796424, unconfirmed verbal, physical, neglect, 8/27/21
- Individual #218, UIR 22-103, PI 48860093, unconfirmed emotional/verbal, 10/13/21
- Individual #227, UIR 21-712, PI 48744672, confirmed physical abuse, category 7b, 7/17/21
- Individual #227, UIR 22-159, PI 48913906, unconfirmed sexual abuse, 11/19/21
- Individual #227, UIR 22-027, sexual incident, 9/14/21
- Individual #92, UIR 22-024, PI 48817397, inconclusive neglect, 9/13/21
- Individual #92, UIR 22-053, PI 48833958, unconfirmed physical, 9/24/21
- Individual #216, UIR 21-570, unauthorized departure, 5/11/21
- Individual #149, UIR 22-115, PI 48873486, unconfirmed neglect, 10/22/21
- Individual #149, UIR 21-740, discovered fracture, forearm, 7/23/21
- Individual #312, UIR 21-816, unauthorized departure, 8/30/21
- Individual #312, UIR 22-084, PI 48852366, unconfirmed physical, 10/7/21

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

All 12 investigations met all of the criteria for this indicator with one exception: one DSP's duty to report form was out of date. She worked with two of the individuals, thus, there were two occurrences scored zero for sub-indicator 1a.

The score of 100% 4/4 in the overall score box refers to the subset of the 12 investigations that were facility-only investigations of incidents that were not allegations of abuse or neglect.

Streamlined investigations: Three of the individuals in the review group were designated by HHSC PI for streamlined investigations under certain circumstances (Individual #218, Individual #227, Individual #92). HHSC PI had reviewed the appropriateness of their placement on this list in the last quarter of the review period. Recent notes indicated a collaborative working relationship between

HHSC PI and the Center. For all three individuals, their plans (e.g., PBSPs) did not include addressing, monitoring, or recording false allegations.

Corpus Christi SSLC managed a high number of false allegations. For instance, in the Tier 1 document II.19, there were 728 allegations during the review period (many single cases contain more than one allegation). More than half of these allegations were deemed to be unfounded. One allegation was confirmed during the review period (Individual #227 UIR 21-712)

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.												
Summary: All incidents were correctly reported, with one aspect of one incident. One incident was correctly reported to investigations, but reported slightly late to the facility director/designee.			Individuals:									
#	Indicator	Overall Score	218	227	92	216	149	312			
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	92% 11/12	1/2	3/3	2/2	1/1	2/2	2/2			

Comments

2. The Monitoring Team rated 11 of the investigations as being reported correctly. The other one was rated as being reported late or incorrectly reported. All were discussed with the facility Incident Management Coordinator. This discussion, along with additional information provided to the Monitoring Team, informed the scoring of this indicator.

Of the one that did not meet criteria (below), it was not also self-identified by the Center.

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

- Individual #218 UIR 22-103: The incident occurred and 5:50 am and was correctly reported to investigations at 6:23 am. The facility director/designee notification, however, occurred a few minutes beyond the hour requirement, at 6:54 am.

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:			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:			Individuals:									
#	Indicator	Overall Score										
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments:												

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

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.												
Summary:			Individuals:									
#	Indicator	Overall Score										
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.											

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)	
	Comments:	

Outcome 7– Investigations are conducted and reviewed as required.												
Summary: Some investigations were not completed timely within the 10 days and did not have extensions with explanation. One investigation review by the Center did not identify the absence of thorough review of possible causes of serious injury.			Individuals:									
#	Indicator	Overall Score	218	227	92	216	149	312			
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, this indicator was 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/QA specialist (unless a written extension documenting extraordinary circumstances was approved in writing).	75% 9/12	1/2	3/3	1/2	1/1	1/2	2/2			
13	There was evidence that the supervisor/QA specialist 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.	75% 9/12	1/2	3/3	2/2	1/1	0/2	2/2			

Comments:

12. Two HHSC PI investigations were completed after more than 10 days and did not have any reasons given other than extraordinary circumstances (Individual #218 UIR 22-103, completed in 14 days; Individual #92 UIR 22-024, completed in 39 days).

One facility-only investigation was completed in 12 days (Individual #149 UIR 21-740).

13. Review of completed investigation met criteria for nine of the investigations.

- For Individual #218 UIR 22-103, the Center did self-identify the late completion of the investigation by HHSC PI. But the Center did not self-identify the slightly late reporting of the incident to the facility director.
- For Individual #149 UIR 22-115, the Center did not self-identify HHSC PI's form entry regarding late commencement of the investigation (though elsewhere in the report commencement was reported have been on time).
- For Individual #149 UIR 21-740, the Center's review did not identify the absence of thorough review of evidence regarding the injury and possible causes.

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.

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:			Individuals:									
#	Indicator	Overall Score										
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.											
Comments:												

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.												
Summary:			Individuals:									
#	Indicator	Overall Score										
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.											
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.											
Comments:												

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.												
Summary: This outcome consists of one facility indicator. Criteria were met. All required data sets were included in the Center's report.			Individuals:									
#	Indicator	Overall Score										

19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes									
Comments:											

Section E: Quality Assurance

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

None of the monitoring indicators of this section have been moved to the category of requiring less oversight.

Section Summary

With agreement of the Parties and the Monitor, monitoring of this section and its provisions is paused while the Center and State are receiving technical assistance and developing the Center and State quality assurance program.

Section F: Integrated Protections, Services, Treatments, and Supports

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

One of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, no additional indicators were moved to this category.

Section Summary

For the annual ISPs, none of the individuals had goals that met criteria in all six ISP areas. Across the six individuals, personal goals met criteria in one to four areas for a total of 13 goals that met criteria. This was a decrease from the 18 goals that met criteria for the last review. Healthcare goals were general expectations that did not involve active participation on the part of the individual. More work is needed regarding health and wellness goals to develop actions the individual might take to improve his or her own health and wellness and address any IRRF/risks.

Overall, goals offered few opportunities for individuals to experience new things and learn new skills. For the most part, goals were based on limited activities available at the facility. IDTs were not focused on skills that would support the individual to work, live, engage in recreational activities, and build relationships in a less restrictive environment.

Action plans supported achievement of goals for about one-third of the goals that met criteria for being individualized personal goals. Few action plans had been fully implemented and action was not typically taken by the IDT to address the lack of implementation or to ensure that individuals had the opportunity to achieve goals. Many goals and action plans had been carried over year after year with no progress and no attempt to address barriers to achievement.

As noted during the last review, action plans requiring community access were put on hold due to COVID-19 restrictions and guidelines. IDTs had not considered revising training so that individuals could continue to develop new skills despite not have consistent community access for the past two years.

For the most part, IDTs continued to have good discussion regarding living options at annual ISP meetings. They were still struggling, however, to develop individualized action plans that addressed barriers to living in a less restrictive setting.

Staff were knowledgeable about the individual's support needs and services; this was good to see.

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

Summary: None of the individuals had goals that met criteria for indicator 1 in all six ISP areas. Across the six individuals, personal goals met criteria in from one to four areas for a total of 13 goals that met criteria. This was a decrease from the 18 goals that met criteria for the last review. More work is needed regarding health and wellness goals regarding actions the individual might take to improve his or her own health and wellness and address any IRRF/risks.

The Monitor has provided additional calculations to assist the Center in identifying progress as well as areas in need of improvement. For indicator 1, the data boxes below separate performance for the five personal goal areas from the health and wellness goals. The Monitoring Team looks at two health and wellness areas that rated as being at medium or high risk (in the IRRF) plus a dental goal if that area is rated as being at medium or high risk, plus suction toothbrushing if the individual receives suction toothbrushing.

Indicator 2 shows performance regarding the writing of goals in measurable terminology. For the 13 goals that met criteria with indicator 1, eight were also measurable. One additional goal that did not meet criteria for indicator 1 was also measurable for a total of nine goals. Indicator 3 shows that five of the action plans that met criteria with indicator 1 had a good set of action plans to support achievement of the goal. These three indicators will remain in active monitoring.

Individuals:

#	Indicator		Overall Score	343	210	369	218	253	149			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	Personal goals	0% 0/6 43% 13/30	3/5	1/5	1/5	2/5	2/5	4/5			
		Health goals	0% 0/6 0% 0/18	0/3	0/3	0/3	0/3	0/3	0/3			
2	The personal goals are measurable.	Personal goals	33% 2/6 62%	1/5 1/3	1/5 0/1	1/5 1/1	2/5 2/2	1/4 1/2	3/5 3/4			

			8/13 31% 9/29									
		Health goals	0% 0/6 0% 0/18	0/3	0/3	0/3	0/3	0/3	0/3			
3	ISP action plans support achieving the individual's personal goals.		0% 0/6 38% 5/13	1/3	1/1	0/1	0/2	0/2	3/4			

Comments: The Monitoring Team reviewed the ISP process for six individuals at the Corpus Christi State Supported Living Center: Individual #343, Individual #210, Individual #369, Individual #218, Individual #253, and Individual #149. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed staff, including DSPs, Home Managers, and QIDPs, and directly observed individuals on the Corpus Christi SSLC campus via video.

Individual #343 was 62-years old and lived at the Corpus Christi SSLC since she was 11 years old. She was diagnosed with Psychotic Disorder, Severe Intellectual and Developmental Disability, Organic Brain Syndrome, Seizure Disorder, and OCD. According to historical information, she contracted meningitis when she was three-months old and was subsequently diagnosed with brain damage. As an adult, Individual #343 was not able to communicate verbally. She had good receptive language skills and was able to do most things independently. Individual #343 held a paper-shredding job on campus. She walked to work independently each day, and she was independent at most job-related tasks. She used vocalizations, facial expressions, and gestures to communicate with others. She did not have communication supports in place. Individual #343 was at high risk for falling and several falls had resulted in injuries. She wore knee pads, elbow pads, AFOs, and high-top sneakers each day. Although she had a history of aggressive behaviors, she did not require a PBSP.

Individual #210 was 43-years old and lived at the Corpus Christi SSLC since 2002. She was diagnosed with Profound Intellectual Developmental Disability, Seizure Disorder, and Cerebral Palsy. She was also legally blind and had moderate hearing loss in her left ear. Individual #210 utilized a wheelchair for mobility and relied on staff for all aspects of self-care. Although she had significant receptive and expressive language deficits, her staff recognized her vocalizations as communication attempts. She did not have communication supports in place. She did not exhibit challenging behaviors and did not have a PBSP.

Individual #369 was 52-years old and lived at the Corpus Christi SSLC since the age of five. She was legally blind and had severe hearing loss. She was at high risk for falls due to her severely impaired vision and hearing, unsteady gait, and behavioral challenges that often resulted in her losing balance. Individual #369 wore bilateral knee pads, and during the week of the review, she was wearing high-top sneakers for support. Her supervised ambulation program was on hold due to her refusals and inability to participate due to sleep issues. She was often aggressive towards the staff assisting her with ambulation. Individual #369 was unable to communicate verbally. She had a history of sign language training that was discontinued many years ago (in 1996) due to her lack of interest and lack of progress. She had reportedly retained some of the skill and had a limited sign language repertoire. Activity boards, choice boards, and

picture schedules had been tried, and were subsequently discontinued due to her refusals and lack of progress. She had a PBSP that targeted aggression and self-injury.

Individual #218 was 41-years old and was admitted to the Corpus Christi SSLC for the second time in 2017 when he requested to be transferred from the Rio Grande SC. He was diagnosed with Mild Intellectual Disability, Intermittent Explosive Disorder, Bipolar II Disorder, Metabolic Syndrome, Obesity, Type-2 Diabetes, and Nicotine Dependence. He was at high risk for respiratory and aspiration, dental, cardiac, weight, diabetes, skin integrity, and behavior. He was a heavy smoker and had recently been diagnosed with obstructive sleep apnea. He refused to wear a CPAP machine. Individual #218 was independent in all functional skill areas. He was able to communicate verbally in Spanish and English, and he could read short phrases. He did not require communication supports. He was highly motivated by food and would become aggressive, destructive, or self-injurious if he was not able to access desired food items. He would also engage in these behaviors if he was not able to access cigarettes. Individual #218 had a PBSP. He refused to be interviewed or observed during the week of the review.

Individual #253 was 33-years old and was admitted to the Corpus Christi SSLC for a second time in 2019 after a 10-month community placement. She was diagnosed with Mild Intellectual Developmental Disorder, Schizoaffective Disorder, and Borderline Personality Disorder. She had a history of ingesting inedible liquids, and there were several restrictive safeguards in place to prevent her attempts. Individual #253 was able to communicate verbally and did not require communication supports. She was independent in all functional skill areas. She worked on campus in janitorial and at the car wash where she received vocational supports. Her work attendance was not consistent. She had a PBSP that targeted aggression, unauthorized departures, and self-injury.

Individual #149 was 27-years old and lived at the Corpus Christi SSLC since 2015. He had resided with his family prior to his admission. He was diagnosed with Autism, Severe Intellectual Disability, and Landau-Kleffner Syndrome. He mostly communicated through vocalizations, gestures, and body language. His verbal skills were limited, though he had a small repertoire of single-syllable words. It was positive to see that he always carried a communication book with him. Individual #149 did not require assistance with mobility. He required prompts to initiate and follow through with ADLs and other tasks. He required verbal and physical assistance with bathing. He required 2:1 staffing due to his potential to engage in aggressive, self-injurious, and destructive behaviors. Individual #149 also engaged in food foraging. Several incidents involving aggression towards peers occurred after his attempts to access food were redirected. Individual #149 had a PBSP. He was previously reviewed by the Monitoring Team in April 2021.

1. None of the individuals had a comprehensive score that met criterion for the indicator. During the last monitoring visit, the Monitoring Team found 18 goals that met criterion for being individualized, reflective of the individuals' preferences and strengths, and based on input from individuals on what was important to them. For this review, 13 goals met this criterion. The personal goals that met criterion were:

- the leisure goal for Individual #343.
- the relationship goal for Individual #149.
- the work/day/school goal for Individual #218 and Individual #149.
- the independence goal for Individual #343, Individual #210, Individual #253, and Individual #149.
- the living options goal for Individual #343, Individual #369, Individual #218, Individual #253, and Individual #149.

Some goals did not meet criterion for the indicator because they did not reflect the individual's specific preferences, strengths, and needs or they did not provide opportunities to try new activities and learn new skills. For instance:

- Individual #343 had a work/day goal to independently choose an activity to participate in at Seabreeze for 20 minutes each week. Individual #343 held a job on campus and was independent at most work-related tasks. She walked independently to work and was described as industrious with good work ethic. The IDT should have considered and explored options for meaningful and competitive employment given Individual #343's strengths and abilities. At a Block Meeting held during the week of the review, it was positive to hear the IDT's discussion about Individual #343's skills and abilities, and the decision to support her to obtain a job on campus that paid more than what she was making.
- Individual #210 had a work/day goal to independently operate a radio using an adaptive switch. The goal was not indicative of the type of work/day program she would like to have.
- Individual #369's work/day goal was to independently make a sensory board of different items with different textures quarterly in class. The goal was not indicative of the type of work/day program she would like to have.
- Individual #369's independence goal was to apply lotion independently to her hands and arms. Her ISP meeting was held on 5/10/21. In follow-up to a discussion of the Monitor's preliminary scoring of this section with the Center and State Office on 3/8/22:
    - Individual #369's ISP meeting was held on 5/10/21
    - Page 19 of the Functional Skills Assessment says that an assessment of her ability to apply lotion to her body was completed on 2/8/21 and that she relied on full-physical prompting. The notes from that section of the FSA say that she required staff assistance for all personal care.
    - An ISPA on 12/13/21 stated that the IDT agreed to discontinue this goal because her SAP assessment could not be completed without completed manipulation (hand over hand) assistance. When she was presented with the lotion and told "Let's put on lotion," she could hold the bottle. However, the other steps to apply lotion to her hands required full assistance. When lotion was placed on her hands initially, she wiped it off on her pants. Putting lotion on did not seem to be an interest of hers.
    - During interview with QIDP Veronica Gonzalez, the Monitoring Team asked about the SAP to teach her to apply lotion. The QIDP reported that Individual #369 had been assessed in February 2021, and the goal was discontinued, because she required full physical prompts.
    - The goal was established after she had been assessed and found to require full physical prompts and staff assistance for all personal care. The SAP was never developed, and the goal remained until December 2021.
- Also, in follow-up to a discussion of the Monitor's preliminary scoring of this section with the Center and State Office on 3/8/22, regarding the IDT's rationale for Individual #369 having no relationship goal:
    - Page 6 of her ISP documented her preference to be alone and also noted that she interacted with staff more than with peers, and that she did not have a preferred staff.
    - It also stated that her long-estranged family, specifically her sister, recently contacted the Center and requested to become reacquainted and involved in her life again.
    - It might be worthwhile to explore, along with BHS, supporting her to cope and increase her ability to tolerate people in her personal space. This could be a first step towards relationship-building and prepare her as her family continues to try to re-enter her life.
- Individual #253:

    - She had a goal to increase her work attendance to 80%. This was a compliance objective that did not offer opportunities for skill development.
    - She did not have a relationships goal. She was described as social and funny, with a good sense of humor. It was not evident that her IDT had explored ways to support her to spend time and develop relationships with others who had similar interests.
    - A somewhat unique (and positive) situation arose in the monitoring of Individual #253's ISP. That is, the IDT took initiative and updated her ISP and chose three new goals for her. This occurred, however, on 1/21/22, the Friday before the review week, and two weeks after the Tier 2 documents were received. The Monitoring Team acknowledges this effort by the IDT. All three of the new goals were individualized and one of the three was written in measurable terminology.
- Individual #218 was assessed months after his ISP meeting was held. He was found to be independent at the goals that were established for the leisure, relationships, and independence life areas. The goals were subsequently discontinued. They were not replaced with achievable alternatives.
- Individual #149 had a leisure goal to shoot free throws into the basket. During the previous monitoring review, in April 2021, Individual #149's leisure goal to shoot free throws into the basket met the leisure life area indicator. Individual #149's ISP meeting had been held in January 2021, and although he had not been assessed for his interest in or his ability to develop the skill, the goal was established at the meeting. At that time, the gym was closed due to COVID-19 guidelines, and the SAP could not be implemented. The goal remained with a plan to assess Individual #149 once he was able to access the gym. The indicator was scored as met at that time because, as written, it was individualized and had the potential to enhance Individual #149's leisure life area. It was not possible to determine Individual #149's interest in the goal. During the previous review, the QIDP indicated that the IDT questioned Individual #149's interest in the goal, and that the SAP writer was planning to set up observations. During the current review, the Monitoring Team learned that the basketball assessment had been completed, and it had been determined that Individual #149 was not interested in the goal. The goal was scored as unmet for the current review because it was not based on Individual #149's preference.

None of the individuals had individualized healthcare goals based on their preferences. Healthcare goals were general expectations that did not involve active participation on the part of the individual. Goals to address the following risk areas were reviewed:

- Individual #343: dental, osteoporosis, falls and fractures, and weight.
- Individual #210: dental, skin integrity, and respiratory.
- Individual #369: dental, weight, and osteoporosis, falls and fractures.
- Individual #218: dental, respiratory, and cardiac.
- Individual #253: dental, weight, and respiratory
- Individual #149: dental, weight, and skin integrity

2. There were nine measurable goals. Eight of the measurable goals met criterion for indicator 1. Individual #210's living options goal was measurable and did not meet criterion for indicator 1. None of the individuals had measurable goals in the recreation/leisure life area or the independence life area. The goals that were measurable were:

- Recreation/Leisure: none.
- Relationships: Individual #149

- Job/School/Day: Individual #218 and Individual #149.
- Learning/Independence: none.
- Living Options: Individual #343, Individual #210, Individual #369, Individual #218, Individual #253, and Individual #149.
- Health and Safety: none.

Goals that were not measurable were not written in observable, measurable terms, and they did not indicate what the individual was expected to do, or how many times they were expected to complete tasks/activities. Goals that did not meet criterion for measurability were:

- Recreation/Leisure: Individual #343, Individual #210, Individual #369, Individual #218, Individual #253, and Individual #149.
- Relationships: Individual #343, Individual #210, Individual #369, and Individual #218.
- Job/School/Day: Individual #343, Individual #210, Individual #369, and Individual #253.
- Learning/Independence: Individual #343, Individual #210, Individual #369, Individual #218, Individual #253, and Individual #149.
- Living Options: all goals were measurable.
- Health and Safety: Individual #343, Individual #210, Individual #369, Individual #218, Individual #253, and Individual #149.

Individual #210 and Individual #149 had the same relationship goal to call their parents. As written, neither goal specified how long the individuals were expected to complete the activities. Individual #149's goal, however, had a corresponding SAP that provided guidance to staff, including the date Individual #149 was expected to achieve the goal. Individual #210's goal did not have a corresponding SAP. There was no evidence that staff had been trained to recognize when Individual #210's goal would be achieved.

During a discussion of the Monitor's preliminary scoring of this section with the Center and State Office on 3/8/22, State Office described an upcoming new addition to the ISP whereby a supplemental information box would be available for the IDT to define what the team was meaning if they used phrases, such as, will host a party, or will participate in a talent show. This sounded promising and useful to IDTs and individuals.

3. Of the 13 goals that met criterion for being personal and individualized, five had corresponding action plans that were supportive of goal-achievement. Action plans to support goals should include all necessary steps; be individualized; integrate strategies to reduce risk; incorporate needs included in ancillary plans; offer opportunities to make choices and decisions; and support opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals. Goals that had action plans that were likely to lead to achievement of goals were:

- Individual #343's recreation/leisure goal.
- Individual #210's independence goal.
- Individual #149's relationships, work, and independence goals.

Examples of goals that did not have supportive action plans that were likely to lead to goal-achievement included:

- Individual #343's work/day goal was to independently choose an activity to participate in at Seabreeze for 20 minutes each week. The action plan had one step to teach Individual #343 to use an adaptive switch to operate a radio.

- Individual #210's recreation/leisure goal was to independently use the telephone at her home to call her parents monthly. Individual #210's hands were severely contracted due to Cerebral Palsy. The SAP to teach her to use the telephone had been discontinued because an assessment revealed that the speakerphone button on the telephone was too small for her to press. The SAP was replaced with a SSO to prompt her to call her parents. The action plan no longer included steps to teach her to use the telephone. The plan also did not incorporate adaptive supports Individual #210 would need to use the telephone. It was not clear how Individual #210 would be supported to achieve the goal.
- Individual #369's recreational/leisure goal was to independently choose a preferred sensory item weekly on her home. The action plan included one step for her to participate in two off-campus outings per month.
- Individual #218's recreational/leisure goal was to participate in a talent show quarterly. The action plan included one step for staff to offer opportunities for him to engage in karaoke.

During the previous monitoring review, the action plan corresponding to Individual #149's recreational/leisure goal had met the indicator for having a supportive action plan. During the current review, it was determined that the goal that was established at the ISP meeting was not based on his preferences (see comments for indicator 1). The goal could not meet indicator 3 because it was not based on Individual #149's preferences.

Outcome 2: The individual's ISP set forth a plan to achieve goals.

Summary: Developing detailed action plans that provided sufficient details for consistent implementation and documentation was still an area that needed more work. Indicator 5 was scored for the eight goals that met criteria for indicator 1 and 2 (27% of all goals). Staff were doing a better job of documenting progress towards goals when data were available to review. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	343	210	369	218	253	149			
4	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/3 40% 2/5	0/1	0/1				2/3			
5	There is documentation (e.g., data, reports, notes) that is valid and reliable to determine if the individual met, or is making progress towards achieving, each of the personal goals.	80% 4/5 88% 7/8	1/1		1/1	1/2	1/1	3/3			

Comments:
4. In general, action plans did not outline specific implementation strategies, necessary supports, or criteria for documenting and evaluating progress. Although none of the individuals had a comprehensive set of action plans that met criterion for the indicator, two individual action plans were found to provide sufficient detailed information for implementation, data collection, and review to occur.

These were the action plans corresponding to Individual #149's relationships and independence goals. For the other individuals, action plans that did not meet the criterion for the indicator were not supportive of their respective goals and, therefore, did not meet indicator 3.

5. Of the eight goals that met criterion for indicators 1 and 2, seven had reliable and valid documentation and data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals. Findings included:

- Individual #343: living options goal.
- Individual #369: living options goal.
- Individual #218: living options goal.
- Individual #253: living options goal.
- Individual #149: relationships, work, and living options goals.

Individual #218's QIDP documented and summarized data from month to month, however, the data and documentation corresponding to his relationships and work goals were not reliable. According to the QIDP Monthly Review, his relationships and work goals had been discontinued due to independence, although the data showed that he had never been offered the minimum number of trials. For example, to master his anger management SAP, he had to complete 25 trials out of 30 trials independently for two consecutive months. For two consecutive months, Individual #218 achieved 100% score, however, he had completed five of five trials independently for the first month, and three of three trials independently for the second month. It was not possible to determine if Individual #218 had truly mastered the objectives because he had not been offered enough trials to determine progress.

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

Summary: None of the individuals had made progress towards their goals and IDTs were not taking action to address barriers to implementation and progress by revising the ISP to make progress more likely. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	210	369	218	253	149			
6	The individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/5 0% 0/7	0/1		0/1	0/1	0/1	0/3			
7	If personal goals were met, the IDT updated or made new personal goals.	N/A									
8	If the individual was not making progress, activity and/or revisions were made.	0% 0/5 0% 0/7	0/1		0/1	0/1	0/1	0/3			

Comments:
6 – 8. None of the individuals had achieved goals in any of their life areas. None of individuals were making progress towards goal-achievement. In general, action plans that had been implemented, were not implemented consistently, and individuals were not offered the minimum number of trials needed to develop skills and demonstrate progress. In many cases, goals had been established at an individual's ISP meeting, although baseline assessments had not been completed and the individual's ability to complete the activity or task had not been determined. SAPs, therefore, were either not implemented, or had to be discontinued because they were either not of interest to the individual, the individual was not capable of completing the objective, or the individual was already independent at the skill. IDTs did not meet regularly to discuss an individual's lack of progress. Instead, IDTs waited several months after the ISP meeting, and in some cases until the next annual ISP Prep meeting, to make revisions (see comments for indicators 1 and 3).

In April 2021, the Monitoring Team commented about action plans being on hold due to COVID-19 restrictions. It was suggested that IDTs replace or revise goals and action plans to be achievable on campus. During the current review, Individual #218's goal to verify correct changed he received after a purchase was placed on hold because the purchase was to be made in the community. Although the SAP to teach him to count change back could have been trained on his home, the goal was not implemented or replaced. Instead, the IDT waited seven months to discontinue the goal.

Outcome 4: ISPs, assessments, and IDT participation support the development of a comprehensive and individualized annual ISP.

Summary: For two individuals, the ISP was not revised timely. Implementation of ISPs within 30 days and meeting attendance continued to be areas where more work was needed. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	210	369	218	253	149			
9	a. The ISP was revised at least annually (or was developed within 30 days of admission if the individual was admitted in the past year).	67% 4/6	0/1	1/1	1/1	1/1	1/1	0/1			
	b. The ISP was implemented within 30 days of the meeting or sooner if indicated.	33% 2/6	0/1	0/1	0/1	1/1	1/1	0/1			
10	The individual and all relevant IDT members participated in the planning process and attended the annual meeting.	50% 3/6	0/1	0/1	0/1	1/1	1/1	1/1			
11	a. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
	b. The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
	c. Assessments were updated as needed in response to significant changes.	N/A									

Comments:
9a. Four of the six individuals had ISPs that had been revised annually.

9b. Two of the six individuals had ISPs that were implemented within 30 days of their meeting. For the other four individuals, action plans had not been fully implemented. For example:

- Individual #343's independence goal was to independently purchase a preferred item monthly. The action step supporting the goal was implemented three months after the ISP meeting.
- Individual #210's work/day and independence goals were to operate a radio by pressing an adaptive switch. The goals had been carried over from the previous ISP year with a change made to the mastery criterion. There were no data collected for four months following the ISP meeting.
- Individual #369's independence goal was to apply lotion to her hands and arms weekly. The corresponding SAP had not been developed.
- Individual #149's leisure goal was to shoot free throws into the basket. The corresponding SAP had not been developed.

10. Two of the six individuals, Individual #218 and Individual #149, had appropriately constituted IDTs, based on their strengths, needs and preferences, that participated in the planning process and attended their ISP meetings. Three of the other individuals had speech deficits and communication needs that served as barriers to goal-achievement. The SLP should have been present to discuss and support the individuals to develop or enhance their communication skills. For example:

- Individual #343 was unable to communicate verbally. She used vocalizations and gestures to express herself and get her needs met. Speech services she had received in the past were discontinued due to lack of progress and lack of compliance. The IDT did not consider utilizing behavioral supports to address Individual #343's noncompliance and support her to resume speech services. Individual #343 was unable to communicate verbally. She used vocalizations and gestures to express herself and get her needs met. Her speech evaluation asserted a variety of AAC supports had been discontinued due to a lack of progress, but did not identify which teaching learning strategies were utilized, the frequency of intervention, or context in which the supports were attempted. There was not evidence that the team collaborated on other behavior-based communication needs outside of the PBSP. The ISP did not provide evidence of what the IDT review, revised, and/or approved regarding her communication dictionary. Participation by the SLP would have been beneficial in developing supports that might expand her communication.
- Individual #210 was unable to communicate verbally. During the review week, she was observed using vocalizations to express herself. It appeared that she was attempting to engage with those who were present. Individual #210's staff was unsure of what she was attempting to communicate. It was not evident that she had been provided any communication supports. There were conflicting recommendations for use of a head switch versus implementation of a hand switch that were unresolved. Her speech therapist noted in her assessment that she would make functional recommendations for SAP training. It was not evident that recommendations were made.
- Individual #369 was unable to communicate verbally. She was also legally blind, and her hearing was severely impaired. Individual #369 had a limited sign language repertoire. Her QIDP was not knowledgeable of the signs Individual #369 knew. There were no individualized communication supports available to Individual #369, and it was not evident that the staff had been trained in ASL.

11b. One of the individuals' IDTs arranged for or obtained the needed, relevant assessments prior to the annual meeting. Late or unavailable assessments included:

- For Individual #343: Behavioral Health Assessment, Individual Capacity Assessment, and IHCP.
- For Individual #369: Individual Capacity Assessment.
- For Individual #218: Although all requested assessments had been submitted on time, assessments of his baseline and potential to develop the skills necessary to pursue goals that had been established at the ISP meeting had not been completed. He was assessed after his ISP meeting and found to be independent at SAPs corresponding to the leisure, relationships, and work life areas.
- For Individual #253: Behavioral Health Assessment, speech, and audiological assessments.
- For Individual #149: Behavioral Health Assessment and Individual Capacity Assessment.

11c. The indicator was not applicable to any of the six individuals who had no significant changes that warranted updated assessments.

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

Summary: For the most part, IDTs continued to have good discussion regarding living options at annual ISP meetings. They were still struggling, however, to develop individualized action plans that addressed barriers to living in a less restrictive setting. Indicators 12, 13, 14, and 15 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	210	369	218	253	149			
12	There was a thorough examination of living options.	83% 5/6	0/1	1/1	1/1	1/1	1/1	1/1			
13	a. 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			
	b. The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	67% 4/6	0/1	1/1	0/1	1/1	1/1	1/1			
14	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

12. For five of the six individuals, there was a thorough examination of living options. Examples included:

- Individual #369's IDT discussed her lack of exposure to community living and what she would need to live successfully in the community.

- Individual #218's IDT discussed what he would need to live successfully in the community. It was positive to see that Individual #218 was shown pamphlets describing various home settings, and that his options were explained directly to him. He participated in a group home tour in 2019. The ISP detailed his reaction to the group home tour, as well as his preference to move closer to his family in Houston. Individual #218's LAR was aware of community living options and agreed to Individual #218's long-term goal to move to a group home in Houston. The LAR requested that Individual #218 transfer to the Richmond SSLC prior to moving to the Houston community.

The indicator was not met for Individual #343, whose goal was to move to a companion care home close to her family. It was not evident that the IDT had discussed what it would take to accomplish the goal. The guardian was reported to be aware of living options, however, the guardian did not participate in the ISP planning process and did not attend the meeting. Individual #343's ISP was held during the week of the review. Although each member of the IDT agreed that Individual #343 should be referred to the community, and her previous ISP goal was to live in the community, the IDT agreed to revise the goal to remain at the Center for the upcoming ISP year. According to the IDT, Individual #343 appeared content and safe and, therefore, preferred to remain at the Center. There were no communication supports in place to help Individual #343 understand her living options or to determine her true preference. LAR preferences were also noted to be barriers to living in the community, however, the LAR was not present at the meeting and the LIDDA had not been in contact with the LAR to discuss living options.

13a. None of the six ISPs integrated encouragement of community participation and integration. Action plans generally encouraged participation in on-campus activities and singular community events.

13b. For four of the six individuals, their IDTs considered opportunities for day programming in the most integrated settings consistent with the individuals' preferences and support needs. Findings included:

- Individual #210 was assessed for her interest and ability to complete vocational tasks. She showed no interest in work. Individual #210 relied on full staff assistance to complete tasks and activities. She was legally blind and unable to communicate verbally. She was employed at the gift shop on campus three days each week, and she attended the Kaleidoscope day program each weekday. Individual #210 appeared to enjoy the social aspects of her job and day program. Her job and day program were consistent with her support needs.
- Individual #218's work goal was to obtain a part-time position as a stocker at Walmart.
- Individual #253 had a history of community employment. She had also worked in various positions on campus, including Pic Pac, paper shredding, and recycling. Individual #253 completed the Vocational Apprentice Program on campus for two quarters and received her food handler's permit. She preferred janitorial work and, at the time of the review, she was earning money doing janitorial work and car washing. The IDT had considered supporting Individual #253 to obtain a community position once she increased and maintained her work attendance.
- Individual #149's work goal was to obtain a part-time position in beautification and maintenance or recycling on campus. The IDT was attempting to expose Individual #149 to employment opportunities on campus to assess his preference for a particular area. The IDT had decided not to pursue community employment until Individual #149's food foraging behavior and his difficulty staying on task could be addressed.

For the other two individuals, it was not evident that opportunities for day programming were consistent with their support needs and preferences. Vocational training for one of the two individuals was not focused on building skills that might have led to employment in a more integrated setting.

- Individual #343 was employed in paper shredding on campus. Although she was not able to verbally communicate, she was independent at most work-related tasks. She independently walked to work each day and had good work attendance. Individual #343's work goal was to independently choose an activity to participate in at her day program. Her work goal was not consistent with her skills and abilities. It was not evident that she was working to develop skills that would lead to employment opportunities in a less restrictive and more integrated setting.
- Individual #369 was legally blind and had severe hearing loss. She did not have communication supports in place. Her work/day goal was to make a sensory board of different items and textures quarterly. The corresponding SAP taught her to manipulate a sensory board that was provided to her. Individual #369 did not have a vocational or day program assessment. It was not evident that she was being supported to develop skills or that the IDT had considered day program opportunities in a less restrictive setting.

14. None of the ISP action plans included individualized measurable plans to educate the individual/LAR about community living.

15. None of the ISPs addressed the individuals' identified obstacles to referral. For example:

- Individual #343's living option goal was to live in a companion care home close to her family. All members of her IDT thought that she could and should be referred to the community. According to the QIDP, the IDT had decided not to refer Individual #343 to the community due to the LAR's preference. It was unclear how the LAR's preference had been assessed because she did not attend the meeting. The action plan corresponding to Individual #343's living options goal did not include individualized steps to address the LAR's concerns. During the week of the monitoring review, the QIDP indicated that she would initiate a discussion about the LAR's decision at the next ISP meeting (held during the review week). At her ISP meeting, the QIDP facilitator noted the LARs wish for Individual #343 to remain at the facility, however, the IDT did not develop individualized action plans to provide further information about living options to the LAR. The IDT also cited Individual #343's lack of understanding of living options as a barrier to referral. The team agreed to continue action plans to attend group home tours and provider fairs, however, plans were not individualized.
- Individual #369 was not referred due to behavioral and psychiatric concerns, and because she did not understand community living options. The Behavioral Health Specialist (BHS) was the one member of the IDT to oppose the referral. The other members believed she could and should be referred to the community. The BHS did not cite behavioral or psychiatric concerns as the reason the referral was not recommended. The BHS opposed the referral due to Individual #369's longevity at the Center and her lack of exposure to community options. The action plan associated with Individual #369's living options goal did not include steps to address the behavioral concerns or to support her to understand her living options.
- Individual #218 was not referred to the community due to behavioral concerns that included self-injury and aggression. The action plan corresponding to the living options goal did not include individualized steps to address those concerns.

Outcome 6: Individuals' ISPs are implemented, progress is reviewed, and supports and services are revised as needed.	
Summary: For four of the individuals, staff were knowledgeable of individual's support needs, strengths, preferences, and goals. This was good to see. Overall,	Individuals:

training opportunities were limited for individuals. The implementation of action plans continued to be problematic. Although, QIDPs were completing a monthly review of services and supports for all individuals, action was not evident when there was a gap in ISP implementation or other recommended supports (i.e., medical appointments). These indicators will remain in active monitoring.											
#	Indicator	Overall Score	343	210	369	218	253	149			
16	Staff were knowledgeable of the individual's support needs, risk areas, ISP goals, and action plans.	67% 4/6	1/1	0/1	1/1	1/1	1/1	0/1			
17	Action plans in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

16. For four individuals, Individual #343, Individual #369, Individual #218, and Individual #253, staff were knowledgeable of their support needs, strengths, preferences, and goals. For the two other individuals, it was not evident that the staff were properly trained to understand their support needs or their goals or action plans. Findings included:

- For Individual #210, her DSP reported that the one SAP in place was to teach her how to apply lotion to her hands. There was no record of the SAP in Individual #210's ISP, SAP data, or QIDP Monthly Reviews.
- For Individual #149, two DSPs who were monitoring him had not been properly trained on the SAP to call his parents. According to the SAP, Individual #149 was to pick up the receiver, dial his parents' telephone number, then initiate a conversation. According to the DSPs, whenever Individual #149 picked up the telephone receiver, he would call the campus operator who would call Individual #149's parents then connect the two lines.

17. None of the ISPs met criterion for the indicator. There was a total of 38 action steps evaluated. Although 24 (63%) of the action plans had been implemented, most were not consistently implemented. In most cases, individuals were not offered the minimum number of teaching trials to develop skills and demonstrate progress. For all individuals, training opportunities were limited. Individuals had from three to eight action plans to support goals across five areas.

Individual	# Of Action Steps in ISP	Action Steps Implemented	Action Steps Not Fully Implemented
Individual #343	7	5	2
Individual #210	5	3	2
Individual #369	7	3	4
Individual #218	8	5	3
Individual #253	3	2	1

Individual #149	8	6	2

18. None of the individuals met criterion for the indicator. QIDPs did not regularly review the individuals' progress toward goal achievement. Goals and action plans were not revised when individuals were not making progress towards goal achievement. Barriers were not addressed when services and supports were either not implemented or not effective (see comment for indicators 6 through 8). Two individuals had missed or not returned to scheduled medical and dental appointments. Overall, goals and action plans did not appear to align with the skills, abilities, and preferences of the individuals.

Other findings included:

- For five of the six individuals, SAP reviews occurred on or after 12/1/21. The IDTs had not met at any other time during the ISP year to discuss goals or action plans.
- For Individual #343, the IDT did not follow-up on a vocational recommendation to teach her to unjam the paper shredder at work.
- For Individual #343, while it was positive to see that safeguards were in place to prevent injuries due to falls, it was not evident that the IDT had thoroughly explored the cause of her falling and taken steps to prevent them.
- Individual #210 was legally blind. After her vision assessment in June 2021, she had not returned to a scheduled follow-up appointment four months later.
- For Individual #369, whose ISP meeting was held in May 2021, the SAP corresponding to the independence goal to apply lotion to her hands had not been developed. The goal was discontinued in December 2021 without having been implemented. The IDT did not discuss revising or replacing the goal.
- For Individual #369, there was no evidence of integrated behavioral supports to address the aggression she exhibited towards staff who were assisting her with ambulation, or to address her refusal to participate in an ambulation program. There was also no evidence of integrated behavioral strategies to address her refusals to engage with communication supports.
- For Individual #218, he was high risk for dental concerns and had missed three dental appointments.
- Individual #218's respiratory risk rating had been changed from medium to high until his compliance with the CPAP machine could be assessed. The IDT did not consider developing a goal and supportive action plan, along with integrated behavioral supports to address his noncompliance.
- Individual #253 had a restriction on her access to inedible items, such as shampoos, soaps, and cleaning fluids, that was contingent on her attempts to ingest inedible items. If she was able to successfully complete three months without attempting to ingest any inedible items, then the restriction would be lifted. While it was positive to see the safeguards in place to prevent her from ingesting inedible items, it was not evident that the IDT had explored her motivation to ingest inedible items and developed a plan for when she regained access to the restricted items.
- Individual #149 refused to sleep in his bedroom and would dress in the doorway. He slept on a sofa in a different area of his home. In April 2021, the Monitoring Team questioned Individual #149's aversion to his bedroom and whether it was potentially related to a trauma history. At that time, the IDT had identified a desensitization plan to support Individual #149 to sleep in his bedroom. During the current review, the Monitoring Team found no evidence of follow-through to implement the plan. There was also no evidence that the IDT had explored a potential trauma history.

Section G: Integrated Clinical Services

Substantial Compliance – Exited Status

None of the provisions of this section had met and achieved substantial compliance.

Given sustained high performance on medical indicators 7a-d, Corpus Christi SSLC met the requirements for substantial compliance with provision G2 and is exited from future monitoring of these indicators.

Sustained High Performance – Less Oversight Status

Two of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, no additional indicators were moved to this category. The two indicators that were in less oversight were moved to exit status (as noted immediately above).

Section Summary
Policies for dental pre-treatment sedation were followed except for post-operative monitoring of vital signs by nursing staff.

When pre-treatment sedation was used for medical appointments, proper procedures were followed for two-thirds of the instances reviewed. The Center needs to focus on post-procedure monitoring of vital signs.

For all but one consultation, the PCPs wrote IPNs that included all required elements. This was good to see. It was also positive that see that PCPs had written orders for most of the agreed upon recommendations made by consultants.

Dental: Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: Policies for dental pre-treatment sedation were followed except for post-operative monitoring of vital signs by nursing staff. These indicators will continue in active monitoring.			Individuals:								
#	Indicator	Overall Score	343	369	146	186	234	162	253	19	210
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2			0/1					0/1	

b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	100% 1/1							1/1		

Comments:

a. Two individuals received total intravenous anesthesia (TIVA) for dental treatment.

- Individual #146 (6/16/21) and Individual #19 (12/6/21) were administered total intravenous anesthesia (TIVA) for dental treatment. Based on the evidence the Center submitted, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, and an operative note defined procedures and assessment completed. For both individuals, post-operative vital sign flow sheets showed gaps in nursing staff monitoring of the individual.

b. Individual #19 received Lorazepam on 12/2/21 prior to dental treatment received in the community. Proper procedures were followed.

Medical: Outcome 11 – Individuals receive medical pre-treatment sedation safely.

Summary: When pre-treatment sedation was used for medical appointments, proper procedures were followed for two-thirds of the instances reviewed. The Center needs to focus on post-procedure monitoring of vital signs. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	369	146	186	234	162	253	19	210
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	67% 4/6	2/2	1/2			0/1				1/1

Comments:

a. Based on the documents submitted, the following individuals had pretreatment sedation for medical procedures:

- Individual #343 received pretreatment sedation on 11/12/21 for a bone density test and on 12/2/21 for an ophthalmology appointment. In both instances, the IDT discussed/agreed to the use of Halcion prior to the appointment. The LAR also signed a consent form for the Halcion for both appointments. Nursing staff documented pre-procedure and post-procedure vital signs per Center policy.
- Individual #369 received pretreatment sedation on 10/19/21 for a gynecology appointment and on 11/1/21 for an eye appointment. In both instances, the IDT discussed/agreed to the use of Halcion prior to the appointment. The Center director signed a consent form for the Halcion for both appointments. Nursing staff documented pre-procedure vital signs and post-procedure vital signs per Center policy for the appointment on 10/19/21. They did not follow the time frames for post-procedure monitoring for the appointment on 11/1/21.
- For Individual #234, the Center reported that a consent was not found for pretreatment sedation on 11/9/21 when he was seen to have staples removed from his eyebrow. Post-procedure monitoring of his vital signs was also not completed per Center policy.

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

Summary: For all but one consultation, the PCPs wrote IPNs that included all required elements. This was good to see. It was also positive that the PCPs had written orders for most of the agreed upon recommendations made by consultants. Given high performance on these two indicators over this and the previous three reviews (with some exceptions), indicators c and d have met and sustained substantial compliance. Along with this also being the case for indicators a and b, Corpus Christi SSLC met the requirements for exiting of provision G2. Indicator e will continue to be under active monitoring.

#	Indicator	Overall Score	Individuals: 343	369	146	186	234	162	253	19	210
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
b.	PCP completes review within five business days, or sooner if clinically indicated.										
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.	94% 17/18	2/2	2/2	2/2	2/2	1/2	2/2	2/2	2/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	81% 13/16	1/2	2/2	1/1	2/2	2/2	2/2	1/2	1/1	1/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	N/A									

Comments:

For the nine individuals, the Monitoring Team reviewed a total of 18 consultations:

- For Individual #343: gynecology on 10/19/21 and neurology on 9/16/21
- For Individual #369: gynecology on 10/19/21 and ophthalmology on 11/1/21
- For Individual #146: urology on 9/3/21 and neurology on 11/17/21
- For Individual #234: neurology on 8/12/21 and 11/18/21
- For Individual #162: pulmonology on 8/26/21 and optometry on 9/22/21
- For Individual #253: neurology on 9/15/21 and 11/18/21
- For Individual #19: neurology on 12/8/21 and surgeon on 9/29/21
- For Individual #210: orthopedist on 10/7/21 and urology on 10/13/21

c. The PCP wrote an IPN that explained the reason for the consultation, significance of the results, agreement or disagreement with the recommendations, and determined whether or not there was a need for referral to the IDT for all consultations, except for Individual #234's appointment on 8/12/21 with the neurologist. An IPN that reviewed the reason for the consultation or findings was not found.

d. For 13 of 16 consultations, there was evidence that the PCP followed up on recommendations. The exceptions were:

- For Individual #343, the gynecologist recommended an annual mammogram. A mammogram had not been scheduled.
- For Individual #253, the neurologist recommended Tylenol up to 1000 mg per dose. The current order was for 650 mg every six hours prn. When interviewed, the PCP indicated that he disagreed with the recommendation, but did not document his disagreement and rationale for the disagreement.
- For Individual #210, the orthopedist recommended to stop wearing a boot and use regular socks. The order was not entered by the PCP.

Section H: Minimum Common Elements of Clinical Care

Substantial Compliance – Exited Status

One of the provisions of this section met and achieved substantial compliance: H2.

There are three corresponding indicators: medical 3b which is in less oversight, and psychiatry 14 and 18 which are exited.

Sustained High Performance – Less Oversight Status

None of the monitoring indicators of this section have been moved to the category of requiring less oversight.

Section Summary

Section I: At-Risk Individuals

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

None of the monitoring indicators of this section have been moved to the category of requiring less oversight.

Section Summary

To assign accurate risk ratings, IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information.

Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings and update the IRRFs within no more than five days.

Assessments reviewed should reflect more than just that of the QIDP and should consists of all disciplines in which the CoS or risk may impact. These indicators will remain in active monitoring.

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

Summary: Less than half of the risk ratings were rated as accurate. Most of the IRRFs were not updated as needed in response to those individuals who were newly admitted or who required and update due to a change in status. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	369	146	186	162	19			
a.	The individual's risk rating is accurate.	42% 5/12	0/2	2/2	1/2	2/2	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.	8% 1/12	0/2	1/2	0/2	0/2	0/2	0/2			

Comments:
a. Just under half of the risk ratings in the review group were rated as being accurate.

- For Individual #343's weight risk, the IRRF did not include the discussion of hypothyroidism and its impact on weight or the input from the assessments from other disciplines outside of the QIDP. For falls, the IRRF was missing information regarding his fall risk score, fracture history, and injuries related to falls. As with the weight risk, there were no assessments reflected outside of the QIDP.
- For Individual #146's risk of infections, the IRRF did not include infections requiring antibiotics and the resulting hospitalizations. Missing were the number of infections/UTIs, infections unresponsive to treatment, an updated Braden score, and the number of times catheterization was required.
- For Individual #162's respiratory compromise risk, the IRRF did not include the number of PNA episodes and the resulting hospitalizations. The plan did not address oxygen levels and the frequency of breathing treatments. For her risk of infections, the IRRF did not include infections unresponsive to treatment, the total number of infections as well as those requiring IV versus PO antibiotics.
- For Individual #19, the IRRF for constipation did not include the contributing diagnosis, bowel interventions required, and chronic bowel distention and the need for monitoring. For seizures, the IRRF did not include the number of times required STAT med (Ativan) for the past year.

b. Most of the IRRFs were not updated as needed in response to those individuals who were newly admitted or who required an update due to a change in status.

- For Individual #343, between 4/5/21 and 5/10/21, she lost 13 pounds. Between July 2021 and August 2021, she lost another five pounds. The team did not address when she had a weight loss trend or when she had an upward weight trend between September 2021 and November 2021. No addendum/CoS IRRF were entered for these events.
- Also for Individual #343, there was lack of addendum or IRRF COS was also noted when the individual fell on 8/14/21. In a comment on the draft version of this report, the Center stated that there was no fall on 8/14/21. The individual, however, experienced a fall on 8/4/21. This fall was a departure from her normal status. Nursing documentation in IView stated that the individual experienced a true fall, but there was no review provided by the IDT to determine if there was a change in status in the form of a COS IRRF or ISPA.
- For Individual #369, during the period of 9/14/21 and 10/5/21, she fell three times, but there was no initiation of a CoS or amended IRRF. The individual had falls on 6/7/21, 6/24/21, 7/2/21, 9/14/21, 9/22/21, 10/5/21, 11/12/21, 11/14/21, and 12/14/21. While the team met on 9/17/21 to address her trust fund, they did not address the fall that occurred on 9/14/21. An ISPA on 10/1/21 noted the fall on 9/14/21, but did not address the fall on 9/22/21. Additionally, there was no COS IRRF to address the three in 30 falls, nor were there any changes noted to address the falls.
- For Individual #146, the IRRF did not include a clear plan to address residuals to help mitigate aspiration risk or include preventative measures for infections.
- For Individual #186's risk of skin integrity, the IRRF was not properly updated to reflect changes in status. For example, the IRRF noted the wound as unstageable at the time of the CoS. No further COS was conducted once wounds were staged as 3/4 and wound vac applied. Regarding infections, on 8/4/21, he returned to the hospital for septic shock, PNA, and wound infection. The team did meet on 8/9/21 to review, but did not update supports.
- For Individual #162, no change of status was completed upon return to the center on 8/9/21 with a diagnosis of hypoxia, respiratory failure, septic shock, and pneumonia.

- Individual #19 had SBO surgical intervention while in the hospital on 6/28/21-7/7/21. The team did not meet upon return to the center. Regarding seizures, the individual was started on Cannabidiol in September 2021 with no evidence of a CoS being initiated. No IRRF was provided on his risk of seizures, so unable to fully review.

Section J: Psychiatric Care and Services

Substantial Compliance – Exited Status

Corpus Christi SSLC achieved and sustained substantial compliance with Section J provisions 2 to 3 and 5 to 15.

Thus, Settlement Agreement provisions J2 to 3 and J5 to J15 are exited and no longer monitored.

Thus, the corresponding 49 monitoring indicators (1 through 49) are no longer monitored or scored.

Provision J4 is monitored via indicators reported on in sections G and S.

Section K: Psychological Care and Services

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Due to performance on indicators 2, 3, and 4 during this review period, the Center will exit from provision K5.

Sustained High Performance – Less Oversight Status

Four of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, four additional indicators were moved to this category. Three of these eight will

Section Summary
The director of behavioral health services resigned one week before the start of the review week. One of the BHS staff was appointed acting BHS director during the review week.

Behavioral health assessments were current and complete for more individuals than in previous reviews. Functional assessments were present for all individuals. The content of the functional assessments, however, needed improvement.

PBSPs were current for all individuals. PBSP content contained many of the required components, but one or more were missing from each PBSP.

Training of staff on individual PBSPs remained limited. For only one individual in the review group, had 80% or more of assigned staff been trained. Challenges to staff training likely included COVID-19 restrictions, staff turnover, and turnover in the BHS department.

The Center needs to get back on track with assessing PBSP data reliability (i.e., IOA and DCT protocols). The Center also needs to correctly and regularly check treatment integrity of PBSPs.

Progress notes were not regularly completed. It is important for BHS staff to regularly review data to ensure that treatment changes are made if progress is not observed.

The behavioral health specialist did a nice job presenting her case at the BSC meeting. Thoughtful questions and suggestions were offered by several in attendance, including the acting director of behavioral health services.

Internal peer reviewed occurred as often as required, but recommendations were followed about half of the time.

Behavior health service staff can play a very positive role in assessing and addressing issues as they arise with an individual that might be outside of a typical PBSP. This includes falls, sleep issues, meal and medication refusals, work and day program refusals, etc.

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

Summary: All but one functional assessment met criteria (and needs to be corrected). This high performance was sustained over successive reviews and, therefore, indicator 4 will be moved to the category of requiring less oversight. The Center needs to get back on track with assessing PBSP data reliability with IOA and DCT protocols. Indicator 5 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	218	251	369	227	92	216	149	312
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.										
3	The psychological/behavioral goals/objectives are measurable.										
4	The goals/objectives were based upon the individual's assessments.	88% 7/8	1/1	1/1		1/1	1/1	1/1	1/1	1/1	0/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8	0/1	0/1		0/1	0/1	0/1	0/1	0/1	0/1

Comments:
4. Functional behavior assessments had been completed for four individuals (Individual #218, Individual #227, Individual #92, Individual #149). For the remaining four individuals (Individual #343, Individual #369, Individual #216, Individual #312), staff reported that an abbreviated functional behavior assessment had been completed. During the remote review, behavioral health service staff explained the this was done to expedite an updated assessment and accompanying PBSP. For everyone, but Individual #312, the behaviors reviewed in the assessment were those addressed in the PBSP. Individual #312's assessment addressed threatening behavior, but his interim PBSP addressed unauthorized departures and self-injurious behavior. Although it was reported that an updated functional behavior assessment was planned, this had not occurred prior to the development of the interim PBSP.

5. Due to either limited or no assessment of data reliability over a six month period, this indictor is rated zero for all eight individuals. There were no data available for review in Individual #312's interim PBSP.

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

Summary: As noted for indicator 5, data were not shown to be reliable and, therefore, a true determination of progress could not be made. That being said, the Center staff reported that some individuals were improving on some of their PBSP target behaviors. Actions were not taken when individuals were not progressing. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	218	251	369	227	92	216	149	312
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.	50% 2/4				0/1		1/1	0/1	1/1	
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	0% 0/2	0/1							0/1	
9	Activity and/or revisions to treatment were implemented.	N/A									

Comments:

6. Due to the noted problems with data reliability, this indicator is rated zero for all eight individuals.

For Individual #343, Individual #369, Individual #92, and Individual #216, however, at least one of their targeted problem behaviors were reported as improving. There were no data available for review for either Individual #227 or Individual #312, and the last reported data for Individual #218 were from August 2021. Individual #149's targeted problem behaviors and his replacement behaviors were worsening.

7. In November 2021, the IDTs had recognized that at least one objective identified in the PBSP for Individual #92 and Individual #149 had been met. Revisions to these objectives were recommended. Individual #369 and Individual #216 had also met at least one objective identified in their PBSP, but their teams had not discussed revisions to these objectives.

8. Individual #343's agitation was worsening and there was a recent increase in Individual #149's self-injury and aggression. There was no evidence that either team had identified or suggested corrective actions.

9. Individual #92 and Individual #149 had been recognized as meeting at least one of their PBSP objectives. However, it could not be determined whether these objectives had been revised because the December 2021 PBSP progress notes were not available for review.

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

Summary: The behavioral health assessments were current and complete for more individuals than in previous reviews. Functional assessments were present for all individuals for this review and for all but one individual in each of the previous two reviews. Therefore, indicator 11 will be moved to the category of requiring less oversight. The content of the functional assessments, however, needed improvement. Indicators 10 and 12 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	218	251	369	227	92	216	149	312
10	The individual has a current, and complete annual behavioral health update.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
11	The functional assessment is current (within the past 12 months).	100% 8/8	1/1	1/1		1/1	1/1	1/1	1/1	1/1	1/1
12	The functional assessment is complete.	38% 3/8	0/1	1/1		0/1	1/1	1/1	0/1	0/1	0/1

Comments:

10. Eight of the nine individuals had a current and complete behavioral health assessment. The exception was Individual #312. The original report had been completed in 2019, and although it was updated in 2021, much of the information referenced in the body of the report was from 2018.

11. The functional behavior assessment was current for all eight individuals who had a PBSP (full or interim). As noted above, an abbreviated assessment was reported for four of the eight individuals.

12. Three of the individuals, Individual #218, Individual #227, and Individual #92 had a complete functional behavior assessment. For the remaining five individuals, problems included the following:

- indirect assessments did not address all of the identified target behaviors;
- direct observations were not repeated when no target behaviors occurred and there was no rationale provided as to why additional observations were not necessary; and
- the identified consequences were those outlined in the individual's plan rather than those hypothesized to be maintaining the target behaviors.

Staff are advised to use caution when making statements regarding an individual's abilities to communicate their wants and needs. In Individual #343's assessment, it was noted that "…her communication does not significantly contribute to her target behaviors as she's able to express her needs and wants." As she is nonverbal, her communication skills are very compromised and likely do contribute to her behavioral challenges.

As was noted following the last review, behavioral health services staff should conduct observations throughout the year when the IDT identifies new unwanted behaviors or when chronic problems are not adequately resolved. Individual #149's sleeping outside of his bedroom was an example of a persistent problem. When a request was made regarding actions taken by behavioral health services staff, it was reported that this matter had not been addressed. Any behavior that impacts an individual's quality of life should be assessed, and if possible, addressed by behavioral health services staff.

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

Summary: Implementation of half of the PBSPs met the requirements of indicator 14. PBSPs were current for all individuals and had been for all but one of the individuals in the last two reviews, too. Therefore, indicator 14 will be moved to the category of requiring less oversight. PBSP content contained many of the required components, but one or more were missing from each PBSP. Indicators 13 and 15 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	218	251	369	227	92	216	149	312
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	50% 4/8	1/1	1/1		1/1	0/1	0/1	0/1	0/1	1/1
14	The PBSP was current (within the past 12 months).	100% 8/8	1/1	1/1		1/1	1/1	1/1	1/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/8	0/1	0/1		0/1	0/1	0/1	0/1	0/1	0/1

Comments:

13. Following the initial document request, facility staff provided consent tracking information. This did not include PBSP implementation dates, so clarification was requested during the review week. Facility staff provided dates indicated either on the PBSP or the start date identified on training rosters. Based upon this information, it was determined that the PBSP was implemented within 14 days of training for Individual #343, Individual #218, Individual #369, and Individual #312. Exclusions included the following: consent tracking could not be provided for Individual #227; Individual #92's plan had been approved by an administrator, but the implementation date was over four months later; Individual #216's plan was approved by an administrator, but no implementation date could be provided; and Individual #149's plan was implemented before it was approved by an administrator.

14. The PBSP was current for all eight individuals. Individual #312 had an interim PBSP developed in December of 2021 that had replaced his Psychiatric Support Plan.

15. Although none of the PBSPs were considered complete, the majority included the following elements:

- operational definitions of target and replacement behaviors;
- antecedent and consequent strategies;
- guidelines for training/reinforcing functionally equivalent replacement behaviors;

- treatment objectives; and
- clear, precise interventions.

Specific feedback is provided below.

- One section of the PBSP included a list of prosocial or positive behaviors to maintain or increase. As this was a general list, it will be important for staff to indicate which behaviors are relevant for the specific individual.
- Individual #343's agitation definition was not clear whether she must display any one, or all, of the identified behaviors.
- In some cases, the teaching or reinforcement of replacement behaviors was limited to one to two times daily (see Individual #343 and Individual #369). This may be insufficient in ensuring acquisition or strengthening of the skill. In other cases, there was no identified schedule for teaching or reinforcing the replacement behavior (see Individual #216 and Individual #149).
- Some plans included consequences that may inadvertently reinforce or strengthen the target behavior to which they were applied. For example,
  - Individual #343 was to be directed to a preferred activity when agitated.
  - Staff were to encourage Individual #218 to ask for a break when he displayed aggression (escape was one identified function).
  - Staff were to tell Individual #227 to stop when he displayed aggression. However, the guidelines also suggested that staff should ask him if he needed anything. If he indicated he did, he was to be encouraged to ask and then be given the item. But the hypothesized functions of his aggressive behavior were access to attention and tangible items.
  - One hypothesized function of Individual #92's instigating behavior was attention, yet he was to be encouraged to tell a joke when he displayed this behavior.
- When the individual's team makes recommendations for revisions to the PBSP, be sure these are completed in a timely manner. At Individual #218's ISP meeting in March 2021, it was noted that his plan would be updated to address self-injurious behavior and refusals. Only the first of these two behaviors was addressed.
- Individual #369 was learning to communicate with objects. However, when visiting her home, the Monitoring Team was shown a communication board that was located approximately five feet up on the wall, clearly out of her reach. Similarly, Individual #149 had guidelines for his using a picture schedule, a communication book, and a communication feelings board. When asked to see these, the first two were retrieved from his backpack that was on the back of his chair, and the third was retrieved from the office. Augmentative or alternative communication systems should be available to the individual at all times.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.												
Summary: Performance was lower than at the last review on these set of indicators. Challenges to staff training likely included COVID-19 restrictions, staff turnover, and turnover in the BHS department. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	343	218	251	369	227	92	216	149	312
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.	13% 1/8	0/1	0/1		0/1	0/1	0/1	0/1	0/1	1/1
17	There was a PBSP summary for float staff.	0%	0/1	0/1		0/1	0/1	0/1	0/1	0/1	0/1

		0/8									
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	50% 4/8	0/1	1/1		0/1	1/1	1/1	0/1	0/1	1/1

Comments:

16. A comparison was made between a list of current staff assigned to work with the individual and training rosters. This comparison revealed that 80% or more of assigned staff had been trained for Individual #312. For six of the remaining individuals, training was evident for between 41% and 78% of assigned staff. In Individual #227's case, the facility reported that there were no available training rosters for his current PBSP.

During the review week, an observation was conducted of a meeting of the Peer to Peer Committee. The last item on the agenda was a review of a videotape of an incident in which Individual #218 was repeatedly hit by another individual. One staff member suggested that the aggressor was engaging in horseplay and harm was not intended. Fortunately, the TAP-IN BCBA noted that no one should be subjected to repeated hits. Staff did note that improved training should be provided when individuals change residences even for short times such as when in quarantine.

17. None of the eight individuals had a PBSP summary available for float or substitute staff.

18. There was evidence that the functional behavior assessment and PBSP for four of the eight individuals had been developed by a BCBA or a staff member who was enrolled in completing the requirements for certification. These were Individual #218, Individual #227, Individual #92, and Individual #312. For all others, the staff member was neither certified nor pursuing certification.

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

Summary: With the exception of indicator 20, the indicators of this outcome all performed better than at the last review, though many scores were low. They will all remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	218	251	369	227	92	216	149	312
19	The individual's progress note comments on the progress of the individual.	25% 2/8	0/1	0/1		1/1	0/1	0/1	1/1	0/1	0/1
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.	100% 1/1			1/1						
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	50% 2/4		0/1			0/1			1/1	1/1

23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months.	100%	

Comments:

19. For the six month period prior to the document request (June-November 2021), monthly progress notes were available for Individual #369 and Individual #216. Five monthly reports were provided for Individual #343, four monthly reports were provided for Individual #92, three monthly progress reports were provided for Individual #312, two monthly reports were provided for Individual #218, one monthly progress report was provided for Individual #149, and there were no monthly reports for Individual #227.

As noted previously, monthly review of progress or the lack thereof is essential to ensure timely response to behavioral challenges and skill development.

It was positive to find objectives listed in many of the reports.

20. Graphs were included in the progress notes that were provided. Monthly data were provided, and in most cases, the graphs were easy to interpret. The exceptions were the most recent reports for Individual #216 as one graph included five data paths, making this difficult to read.

On the other hand, in no case were phase change lines consistently included. Significant events should be indicated. This includes, but is not limited to the following: introduction of a new or revised PBSP; medication changes, including dosage adjustments; restrictions due to Covid or other illnesses; serious injury; hospitalizations; changes in residence, even if temporarily; changes in level of supervision; restrictions, both when implemented and discontinued; changes in family; etc.

Staff should delete trend lines as these tend to interfere with an accurate view of behavior change.

21. At the psychiatric clinic for Individual #251, held the week of the review, the behavior health specialist did present relevant data.

22. In the six-month period prior to the remote review, Individual #218, Individual #227, Individual #149, and Individual #312 had been presented to the Internal Peer Review Committee. The IDT's response to recommendations are outlined for each individual below.

- The date of referral to the committee was not recorded in the minutes for Individual #218. One suggestion was to collect and review sleep data by September of 2021, but when this was requested, no graphs were available. Increased staff training on his PBSP was also recommended, but the last training rosters provided were from July 2021. Lastly, staff were to consider increasing the monitoring of treatment integrity and inter-observer agreement. No data were available regarding monitoring activities from July through December 2021.
- There were no minutes available for review regarding the committee's recommendations for Individual #227.
- As recommended by the committee, Individual #149's PBSP included the use of a communication book to address his feelings and guidelines to have him seen by nursing staff following self-injurious behavior.
- The IDT agreed to develop an interim PBSP for Individual #312 as recommended by the committee. This plan focused on two monitored behaviors, unauthorized departures and self-injury. As team members had also discussed an increase in physical aggression and property destruction, it would have been appropriate to include these behaviors in the interim plan.

23. Facility staff reported that the Internal Peer Review Committee met twice in June 2021, but thereafter, three times each month through November 2021.

An observation was conducted of a meeting of this committee held during the review week. The behavior health specialist did a nice job presenting her case and explained that she was going to complete a further analysis of the effects of varying levels of supervision on the individual's targeted problem behaviors. Thoughtful questions and suggestions were offered by several in attendance, particularly by the acting director of behavioral health services and the consulting TAP-IN BCBA.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.												
Summary: These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	343	218	251	369	227	92	216	149	312
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	50% 1/2		1/1					0/1		
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	N/A									

Comments:

24. Documentation indicated that two of the nine individuals had been referred for counseling services. Individual #218 was receiving this service. However, although a referral for counseling was recommended at Individual #216's ISP meeting, behavioral health services staff reported that they had not received a referral.

25. This indicator is rated not applicable as the therapist was a community-based counselor who had a contract with the facility to provide these services.

Outcome 8 – Data are collected correctly and reliably.											
Summary: Indicator 27 will be moved to the category of requiring less oversight. With sustained high performance, the same might occur for indicator 26 after the next review. Indicators 28 and 30 scored 0%, but some aspects of the requirements were being done for some individuals. This needs to occur for all aspects for all individuals. Indicators 26, 28, and 30 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	343	218	251	369	227	92	216	149	312
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	88% 7/8	1/1	1/1		1/1	1/1	1/1	1/1	1/1	0/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 7/7	1/1	1/1		1/1	1/1	1/1	1/1	1/1	

28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/8	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).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/8	0/1	0/1		0/1	0/1	0/1	0/1	0/1	0/1

Comments:

26. For seven individuals, a frequency measure was indicated as the system of data collection for the target behaviors identified in their PBSPs. The exception was Individual #312. His interim PBSP did not indicate what data collection system was in use.

Although a frequency measure was an adequate method for collecting data on target behaviors, there were concerns raised after reading one PBSP data sheet for Individual #149. To be specific, on the afternoon of 1/24/22, he engaged in self-injurious behavior multiple times as recorded in the narrative. However, the "number of behaviors" were documented as one. This would suggest that staff are recording episodes of targeted behavior rather than frequency. BHS staff should review all PBSPs to ensure that data collection systems are accurately identified in both the plan and the progress report graphs.

27. For seven individuals, a frequency measure was the identified data collection system for their replacement behaviors. Individual #312 was excluded from this indicator because his interim PBSP did not identify any replacement or alternative behaviors.

28. A review was completed of the PBSP Treatment Integrity Form in use at the time of the review. As this form reads, it appeared that staff were asked to list preventative strategies and identified antecedents, and then define target and replacement behaviors. The form did not allow for an observation of staff implementing the plan as written. The section used to assess inter-observer agreement did note the data recorded by two independent observers, but then it included a score for whether the staff responded correctly to observed behaviors. As discussed with the acting director of behavioral health services, it will be important to remove this score of staff response when calculating inter-observer agreement. The last section did allow for an acceptable measure of data collection timeliness because behavioral health services staff were to note whether direct support personnel documented the observed events within a two-hour period.

30. In no case, were data collection timeliness, inter-observer agreement, and treatment integrity assessed each month over a six-month period. Adequate measures of all three indicators were reported for Individual #92 for two of six months. Adequate measures were reported for inter-observer agreement and treatment integrity for one month for both Individual #343 and Individual #369. There were no data on any of the three indicators provided for Individual #218, Individual #227, Individual #216, or Individual #149. Individual #312's interim PBSP had been introduced in December 2021, but no data were available when this was requested during the review week.

Section L: Medical Care

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Four of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, eight additional indicators were moved to this category.

Section Summary

For the most part, interval medical reviews (IMR), were completed on time. The quality of IMRs varied. Additional work needs to be done to ensure that they include all relevant information needed to address chronic diagnoses and/or at-risk conditions.

Annual medical assessments need to include, as applicable, family history, past medical history, updated active problem lists, and thorough plans of care for each active medical problem.

A full range of recommended preventative care was completed for one-third of the individuals. While all individuals received some annual screenings recommended, there continued to be gaps in preventative care for many of the individuals.

Medical practitioners need to complete a more comprehensive review and address the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy. Further collaboration was needed between primary care providers, psychiatry, neurology, and pharmacy to consider alternative treatments that might reduce risk associated with prescribed medications.

PCPs were doing a better job of reviewing consultations in a timely manner and following through with recommendations. When there was a need for IDT review of recommendations, ISPAs documented that review occurred.

Outcome 2 – Individuals receive timely routine medical assessments and care.												
Summary: For eight of the nine individuals in the review group, PCPs completed quarterly interval medical reviews. Indicators a and c will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	343	369	146	186	234	162	253	19	210

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.	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 was moved to the category of requiring less oversight.										
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1

Comments:
c. Per the instruction of State Office, and as memorialized in the State Office Medical Care policy #009.3, with an effective date of 2/29/20, PCPs now are expected to complete IMRs quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable").

- Eight of nine individuals had timely periodic medical reviews per State Office policy.
- Individual #186 was missing one interval medical review that should have been completed in September 2021.

Outcome 3 – Individuals receive quality routine medical assessments and care.												
Summary: As noted during the last review, AMAs were often missing important information regarding family history, and past medical issues. PCP were not addressing all active medical problems with a plan of care, when needed. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	343	369	146	186	234	162	253	19	210
a.	Individual receives quality AMA.	11% 1/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	33% 6/18	2/2	2/2	0/2	0/2	2/2	0/2	0/2	0/2	0/2

Comments:
a. One individual (Individual #343) had an AMA that included all the necessary components and addressed the selected chronic diagnoses or at-risk conditions with thorough plans of care. For the other eight individuals, AMAs did not include a plan of care for each active problem, when appropriate. Additionally,

- Individual #369's AMA did not include her past medical history.
- Individual #146, Individual #234, and Individual #186's AMAs did not include the date of the family medical history.
- For Individual #162, the date of the updated information concerning family history was not documented, and her current medication list was not accurate. Her medication list included Prolia. But she was prescribed Fosamax. Fosamax was referenced

in the plan of care. A physical evaluation was not completed at the time of the AMA because she was at a Long-Term Care facility, however, one was not completed post- hospitalization.

- Individual #253's active problem list did not include metabolic syndrome (diagnosed in 2019), nor her overweight status.
- Individual #19's the date of updated family history and interval history were not complete. Additionally, his plan of care did not include the Ativan protocol for prolonged/cluster seizures.
- For Individual #210, the family history did not include the date of the most recent information. There were gaps in the past medical history prior to 2018 and between 2019 and May 2020. The medication list included Prolia, however, the plan of care referenced Fosamax.

c. Three of nine individuals received quality periodic medical reviews based on their individualized needs at least every six months. Those that did not meet criteria were:

- Individual #146
- Individual #186
- Individual #162
- Individual #253
- Individual #19
- Individual #210

Outcome 4 – Individuals receive preventative care.

Summary: One-third of the individuals received all preventative care needed. Even so, given the overall sustained high performance on six of the seven the preventative care indicators (a.i-a.vi) over successive reviews, these six indicators will be moved to the category of requiring less oversight. The Center should continue to make improvements regarding medical practitioners reviewing and addressing, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, as well as metabolic and endocrine risks, as applicable. Indicators a.vii and b will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	343	369	146	186	234	162	253	19	210
a.	Individual receives timely preventative care:										
	i. Immunizations	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 5/5	1/1	1/1	1/1	1/1				1/1	
	iii. Breast cancer screening	75% 3/4	0/1	1/1	1/1						1/1

	iv. Vision screen	86% 6/7	1/1	1/1		1/1	1/1	1/1	0/1		1/1
	v. Hearing screen	78% 7/9	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1
	vi. Osteoporosis	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
	vii. Cervical cancer screening	67% 4/6	1/1	1/1	0/1				1/1	1/1	0/1
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	57% 4/7		1/1	0/1	1/1	1/1	1/1	0/1	0/1	

Comments:

a. Three of the nine individuals received all the preventative care they needed.

- For Individual #343, her last mammogram was 8/2/18. Documentation indicated that a mammogram was attempted on 6/2/21 with sedation, but was unable to be completed. Her lack of cooperation was not addressed until the week of the remote review, over six months later.
- Individual #146's last cervical cancer screen was completed in 2013. The physician noted that she needed one more normal result and recommended to repeat testing in five years.
- Individual #186's immunization record did not include a flu vaccine for 2021.
- Individual #234 did not have a hearing screen.
- Individual #253's hearing and vision screens were not completed.
- Individual #210 cervical cancer screen, due October 2021, had not been completed.

b. For four of seven individuals, medical practitioners had reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, when applicable.

- Individual #146's risk for metabolic syndrome had not been addressed.
- Individual #253's PCP did not review options to reduce her high anticholinergic burden. IPN's noted that she was light-headed and dizzy. There was no discussion regarding the possible correlation with potential side effects of medications.
- Individual #19's PCP did not consider the polypharmacy risk for seizure medications.

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.	
Summary: The one individual in the review group who had a DNR in place had one that was consistent with State Office guidelines. This indicator will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	343	369	146	186	234	162	253	19	210
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	100% 1/1			1/1						
	Comments: a. One individual with a DNR order had a clinical condition that justified the order, and it was consistent with State Office guidelines.										

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Overall, performance on this set of indicators was about the same as at the last review, that is, that criteria for when there was an acute illnesses were met about two-thirds of the time. Indicator h, however, showed sustained high performance and will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	343	369	146	186	234	162	253	19	210
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.	83% 10/12	2/2	1/1	1/2		2/2		1/1	2/2	1/2
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.	67% 4/6	1/1	1/1	0/2						2/2
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	57% 4/7			1/1	1/2		1/1		1/2	0/1
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	60% 3/5			0/1	1/1		1/1		1/1	0/1
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									

f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.										
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	71% 5/7			1/1	1/2		1/1		1/2	1/1
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% 7/7			1/1	2/2		1/1		2/2	1/1

Comments:

For the seven individuals, the Monitoring Team reviewed 12 acute illnesses addressed at the Center:

- Individual #343 (rash under breast on 7/30/21 and rash to breasts on 9/14/21)
- Individual #369 (agitation on 7/1/21)
- Individual #146 (right knee ecchymosis on 7/22/21 and emesis on 11/16/21)
- Individual #234 (toenail avulsion on 11/1/21 and increased residuals on 11/12/21)
- Individual #253 (a fall on 10/4/21)
- Individual #19 (seizures on 9/7/21 and 10/4/21)
- Individual #210 (constipation on 6/1/21 and emesis on 9/27/21)

a. For the following 10 of 12 acute issues, PCPs assessed them according to accepted clinical practice,

- Individual #343 – rash under breast and rash to breasts
- Individual #369 – agitation
- Individual # 146 –emesis
- Individual #234 – toenail avulsion and increased residuals
- Individual #253- fall
- Individual #19 – seizures
- Individual #210 - constipation

Regarding those that did not meet criteria:

- For Individual #146's right knee ecchymosis, the PCP's documentation did not include the source of information.
- For Individual #210's emesis, the PCP's documentation did not include a diagnosis that clinically fit the assessment.

b. There was evidence that the PCP conducted follow-up assessments and documentation, as necessary, until the problem was stabilized or resolved for four of six acute illnesses/injuries:

- Individual #343 (rash under breast on 7/30/21)
- Individual #369 (agitation on 7/1/21)
- Individual #210 (constipation on 6/1/21 and emesis on 9/27/21)

For two, problems were found:

- For Individual #146 (right knee ecchymosis on 7/22/21), there was no documented review of the x-ray.
- For Individual #146 (emesis on 11/16/21), there was no information regarding decreasing or changing the time of g-tube feedings. The PCP identified the problem, but did not address/document the treatment to resolve the problem.

c. Four of seven individuals received timely evaluation prior to transfer to ED or hospitalization.

- Individual #186 was hospitalized on 8/21/21. The PCP's IPN was not completed within one business day.
- Individual #19 was hospitalized on 6/25/21. The PCP transfer note was not completed within one business day.
- Individual #210 was transferred to the hospital on 6/2/21. There was no transfer IPN.

d. For three of five individuals, there was a quality assessment documented prior to hospitalization, when appropriate.

- For Individual #146, the PCP did not document a working diagnosis.
- For Individual #210, the PCP did not document an on-site evaluation prior to hospitalization.

g. Five of seven individuals had a post-hospital ISPA that addressed follow-up medical, and healthcare supports to reduce risks, as appropriate. The following exceptions were noted:

- Individual #186, did not have a post-hospital ISPA to review his change in condition or change in support needs or to discuss maintenance of supports to address needs following hospitalization from 8/21/21 through 9/22/21.
- For Individual #19, there was no ISPA reflecting the IDT meeting post hospital for his hospital discharge on 7/7/21.

h. For all individuals, there was 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 upon return to the facility.

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

Summary: Medical Department staff continued to make improvements regarding the assessment and planning for individuals' chronic and at-risk conditions. For over half of the chronic or at-risk conditions, PCPs conducted medical assessments, tests, and evaluations consistent with current standards of care, and/or identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	343	369	146	186	234	162	253	19	210
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.	61% 11/18	2/2	1/2	1/2	1/2	1/2	1/2	1/2	2/2	1/2
	Comments:										

For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review:

- Individual #343: weight and osteopenia
- Individual #369: falls and weight
- Individual #146: fluid imbalance and urinary tract infections
- Individual #186: skin integrity and polypharmacy/medication side effects
- Individual #234: aspiration and weight
- Individual #162: respiratory compromise and osteoporosis
- Individual #253: diabetes and polypharmacy/medication side effects
- Individual #19: gastrointestinal issues and seizures
- Individual #210: constipation/bowel obstruction and fractures

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 PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate:

- Individual #343: weight and osteopenia
- Individual #369: weight
- Individual #146: urinary tract infections
- Individual #186: skin integrity
- Individual #234: aspiration
- Individual #162: osteoporosis
- Individual #253: diabetes
- Individual #19: gastrointestinal issues and seizures
- Individual #210: fractures

Comments regarding those that did not meet criteria for this monitoring indicator:

- For Individual #369, documentation indicated that she was discharged from her habilitation therapy program for ambulation because there were issues with her sleep pattern that did not allow participation. This was based on two visits within an eight-month period where she refused to participate. The PCP indicated that she was usually in bed during PCP visits. A major risk was her deconditioning due to the lack of ambulation. Habilitation services was aware of the concern, but visits were limited to two visits months apart. There was no information provided if they inquired when she would be in her wheelchair and how they might adapt their service schedule to see her when she was out of bed. The nursing, medical team, and habilitation therapists did not address her lack of ambulation and associated risk of deconditioning. Whether the current falls were related to worsening muscle strength and ambulatory ability was not clear, but with risk of deconditioning, falls would inevitably continue. There was no submitted documentation reflecting consultation or review by behavioral services to provide insight into the reasons for her preference to remain in bed, or to improve cooperation with participation in an ambulation program.

- Individual #146 was transferred to the ED on 9/3/21 where she was found to have severe dehydration with a sodium level of 184. She subsequently underwent a g-tube placement as she was believed to be continually aspirating. Although there was documentation of her spitting out her food, fluid, and medication at times, there was no clinical consideration of whether this

was related to pain or discomfort with swallowing. Clinical testing to rule out presbyesophagus, achalasia, gastroparesis, or worsening dysphagia was not considered. She was previously treated in the infirmary for dehydration on 7/6/21 and deteriorated rapidly prior to her emergency transfer to the hospital on 9/3/21. There was no documented discussion with the LAR about the need to place a g-tube, order hospice, or consider a DNR prior to hospital admission. Additionally, there was a lack of review of fluid intake and timely evaluation and treatment by medical and nursing departments.

- Individual #186 had a slow and progressive functional decline. A MOSES score was completed 5/26/21 and indicated that there were seven areas of concern (including speech slurring, slow movements or lack of motion, edema, weight decrease, and incontinence). It was unclear from submitted documentation if or when this information was shared with the medical team. He eventually became non-ambulatory and his functional decline continued to the point that he could no longer hold a cup. He became dependent on staff for positioning in bed and in his wheelchair. His AMA indicated an allergy to Haldol with no further details of what the adverse effect could be. The AMA also listed Invega as causing syncope. Despite the allergy to Haldol listed in the AMA, the syncopal episode to Invega listed in the AMA, and the altered mental status leading to hospitalization in May 2021, the PCP allowed Invega IM to be given on 7/14/21 without consideration of the potential side effects of this medication. (The PCP was aware of the history as that was the PCP who completed the AMA and indicated the allergy to Haldol and syncope associated with Invega.) He then declined rapidly and was transferred to the ER that same day. It was unclear the rationale to continue giving the Invega on the part of the PCP, given his somnolence and decreased function with lack of psychiatric signs or symptoms. There was no documentation of urgent need to give this medication and it would have been important to discuss with the psychiatrist the ongoing use of Invega prior to administration. The PCP did not appear to recall the recent history and continued to give an antipsychotic when there would have been time to discuss his functional decline and lack of current psychosis with the psychiatrist. The MOSES score and findings did not appear to be adequately communicated to the medical team nor interpreted by the PCP. Habilitation services, nursing, and pharmacy also were aware of the decline, but there was no in depth analysis during his prolonged decline for appropriate interdisciplinary discussion and conclusion. In the meantime, he developed life threatening illness along with complications of skin integrity.

- Individual #234 had been on a weight reduction diet prior to hospitalization in March 2021. He had lost 12.4 pounds during the hospitalization. Despite his dramatic improvement post hospital and rapid weight gain over the following months, along with being at the high end of his EDWR, the PCP did not agree with changes to his enteral feeding volume or change in his formula to address his weight gain. There was no note from the PCP justifying the lack of agreement or data that contributed to his decision. As this individual was prescribed an antipsychotic, he was at risk for weight gain and metabolic syndrome.

- Individual #162 had a history of chronic respiratory compromise and repeated bouts of acute and chronic respiratory failure. She had several recent hospitalizations. She had received a Dynavox to improve communication potential, as she communicated with her eye movement. This was of great clinical value if she were to be able to communicate early symptoms of respiratory discomfort before they were observable by staff, rather than depending only on staff evaluation when signs and symptoms developed that reflected more advanced illness. She had been waiting on replacement/repair of her AAC device for over a year. Despite it being the one communication method that allowed this individual to tell staff how she felt, there was no ongoing monitoring or advocacy by the medical team to get this repaired with any urgency.

- Individual #253 was prescribed several medications contributing to a high anticholinergic burden. The AMA listed the diagnosis of bedwetting/nocturnal enuresis, urinary incontinence, and urge incontinence in different parts of the document as the reason for prescribing oxybutynin. The AMA did not provide a history of attempts to reduce the nocturnal enuresis without medication. If nonpharmacological treatments had failed, other medications with less side effects would be a consideration in reducing her nocturnal enuresis/incontinence, which may lower the anticholinergic burden and or the side effects. The ongoing need for oxybutynin was not addressed/justified in the pharmacy QDRR review section of the AMA. Additionally, she had chronic complaints of headache and dizziness, at one point being ordered meclizine. PCP orders noted a one-time order for orthostatic blood pressure on 2/25/20. At times when she voiced issues of dizziness, there was no ongoing consideration of monitoring for orthostasis noted in any of the IPNs or IView documentation. She had several falls, some of which were consistent with postural hypotension (6/2/21, 6/8/21), but no orthostatic blood pressure values were ordered. On 3/22/21 the neurologist suggested that the symptoms could be due to medication timing and suggested the timing be re-evaluated. However, at the time of the review, three psychiatric medications were still administered at 0700hr and two at 1900hr with one at 2000hr. This may need further discussion with psychiatry as to options in timing of dosing. The PCP indicated that he had not collaborated with the psychiatrist regarding polypharmacy concerns. Her plan of care for diabetes did not address weight monitoring, abnormal labs, or need for an exercise program.

- Individual #210 had a history of chronic constipation. Her IMRs from 12/3/20 through 11/23/21 indicated that she had not been administered a laxative, suppository, or enema. IPNs, however, indicated that she had received treatment for constipation on 6/2/21 (MOM with prune juice) and on 8/3/21 (enema). Improvement was needed in documenting actual interventions. It is essential that the IMRs be accurate and complete to ensure all areas of risk are reviewed. With gaps in information or inaccurate information, it is difficult to ensure adequacy of evaluation and treatment.

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

Summary: Improvement was needed regarding the inclusion of medical plans to address identified risks in individuals' ISPs/IHCPs. These indicators will continue in active monitoring.

#	Indicator	Overall Score	Individuals: 343	369	146	186	234	162	253	19	210
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

Comments:
For the nine individuals, two of their chronic and/or at-risk diagnoses were selected for review:

- Individual #343: weight and osteopenia
- Individual #369: falls and weight
- Individual #146: fluid imbalance and urinary tract infections
- Individual #186: skin integrity and polypharmacy/medication side effects

- Individual #234: aspiration and weight
- Individual #162: respiratory compromise and osteoporosis
- Individual #253: diabetes and polypharmacy/medication side effects
- Individual #19: gastrointestinal issues and seizures
- Individual #210: constipation/bowel obstruction and fractures

a. ISPs/IHCPs did not include 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.

Risk conditions that were not adequately addressed included:

- For Individual #19, the IHCP was not updated to include a care plan for the new diagnosis of GERD.
- For Individual #234, his AMA included weight loss as a problem that needed to be addressed with a plan. His IRRF reviewed weight, but did not list specific action to be taken other than monitoring and reviewing his weights.
- For Individual #162, supports to address her risk for respiratory compromise included HOBE at 20-30 degrees, use of chlorhexidine mouth wash, and positioning for oral care were not included in the IHCP.
- Individual #253 was prescribed several medications contributing to a high anticholinergic burden. There was no evidence that other treatment options were discussed to address her nocturnal enuresis that might decrease her anticholinergic burden. Dizziness and tachycardia as potential side effects of Clozaril were also not considered.
- For Individual #19, GERD was added to his diagnosis list on 6/11/21. His IHCP was not updated to reflect the new diagnosis and supports needed.

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 seven IHCPs that included some of the necessary action steps, documentation was found to show that PCPs implemented them. This indicator will remain in active monitoring until full sets of medical action steps are included in IHCPs, and PCPs implement them.

#	Indicator	Overall Score	Individuals: 343	369	146	186	234	162	253	19	210
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	100% 7/7	1/1	1/1	2/2		1/1		2/2		

Comments:
a. For all individuals, medical interventions assigned to the PCP were implemented as evidenced by specific data reflective of the interventions.

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: Mortality reviews continue to be conducted timely. This has been the case for three consecutive reviews and, as a result, indicator a will be moved to the category of requiring less oversight. The Center should focus on clinical recommendations and follow-up included in the review. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 146	153							
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% 2/2	1/1	1/1							
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	50% 1/2	0/1	1/1							
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	50% 1/2	0/1	1/1							
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	100% 2/2	1/1	1/1							
e.	Recommendations are followed through to closure.	0% 0/1		0/1							

Comments:
a. Two deaths were reviewed, Individual #146 and Individual #153. For both individuals, a clinical death review was completed timely.

b-d. For Individual #146, the review included a list of identified issues, but no recommendations on how to address the issues noted. For example, it was noted that she had an extremely high Na level upon hospitalization, but did not address how it might have been identified sooner.

For Individual #153, the review included appropriate recommendations. The Center did not provide supporting documentation about who was included in recommendations for training or to determine if follow-up was completed.

Section M: Nursing Care

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Two of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, no additional indicators were moved to this category.

Section Summary

While the Center had stable leadership, this was not reflected in their overall staffing as vacancy rates were at approximately 62%. Due to this issue, recruitment and retention were a high priority. To help mitigate the staffing issues, nursing leadership has aided by staffing vacancies on weekends and other shifts.

The Center showed improvement regarding infection control and observations found that medications were administered in terms of the nine rights as well as the PNMP.

UTI incidents continued to decline since instituting the McGeer criteria.

In the event of a change in status, most of the individuals were assessed according to nursing guidelines as soon as symptoms were observed. However, though acute care plans were initiated, few of them were appropriate to meet the individual's specific needs.

Annual assessments lacked in their consistency as it related to comprehensiveness. Additional analysis of data was needed along with improved recommendations for interventions/treatments/strategies that could help with addressing chronic issues and promote amelioration of the at-risk condition.

The Center should also continue to review data and search for the causes regarding the high incidence of skin infections. An example of this occurring was the medical director reaching out to the local hospital system to begin discussions related to individuals' return from the hospital with pressure wounds.

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: The majority of assessments and acute care plans lacked in their comprehensiveness and were not provided in a timely manner in response to a change in status. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	343	369	146	186	162	19			
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	25% 2/5	0/1		0/1	1/1	0/1	1/1			
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% 0/5	0/1		0/1	0/1	0/1	0/1			
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	50% 1/2	0/1					1/1			
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	50% 2/4			1/1	0/1	1/1	0/1			
e.	The individual has an acute care plan that meets his/her needs.	0% 0/5	0/1		0/1	0/1	0/1	0/1			
f.	The individual's acute care plan is implemented.	0% 0/5	0/1		0/1	0/1	0/1	0/1			

Comments:
The Monitoring Team reviewed five acute illnesses and/or acute occurrences for five individuals, including Individual #343-Rash, Individual #146, Individual #186-GI, Emesis #162-Increased Oxygen, and Individual #19-Emesis.

a. The acute illnesses/occurrences for which initial nursing assessments (physical assessments) were performed in accordance with applicable nursing guidelines were for Individual #186, and Individual #19.

- For Individual #343, her IPN Notes on 7/29/21 stated she had a rash, however, the PIR completed at that time did not specify the location of the rash. On 7/30/21, the IPNs again noted that the individual had a rash, but specified that it was located under her right breast. Without the description being consistently provided, it was difficult for her team to determine if the rash had improved or declined. The PIR did not have measurements of rash or it's description according to the nursing guidelines for skin impairment. No additional IPNs were noted to provide further explanation. On the positive, the initial assessment did include measurements, pain, and a partial description of the area. In a comment on the draft version of this report, the State

wrote that it would like to go on record and note the location of the rash was documented in PIR by both the LVN and RN for individual #343 on 7/29/21 in IRIS, however, this did not print on the information submitted to the Monitoring Team.

- For Individual #146, the individual was diagnosed with a UTI on 8/25/21 at which time she was prescribed doxycycline, however, due to the infection being cultured as not sensitive to doxycycline, she was switched to Levaquin. An emesis occurred on 8/28/21 with no evidence of conducting an assessment according to nursing guidelines for vomiting as nursing only documented temperature and respiratory rate. No abdominal assessment, other than checking bowel signs, and no note of her last BM were provided. Mentation declined between 8/28/21 and 9/3/21 and on 9/3/21, she decompensated with labored breathing.
- For Individual #162, she required increased oxygen per trach beginning on 6/16/21 with no evidence of lung sound assessment documented. No IPNs were noted between 6/6/21 and 6/17/21. The individual required a gradual increase of oxygen between 6/16/21 and 6/17/21, but there was no evidence that a respiratory assessment occurred as per nursing guidelines.

b. None of the applicable individuals that had acute illnesses/occurrences had their licensed nursing staff timely inform the practitioner/physician of signs/symptoms in accordance with the SSLC nursing protocol.

- For Individual #343, no documentation was found noting that the individual was placed on campus log to be reviewed for rash. There was no documentation of when the PCP was notified other than he and the nurse were together to conduct assessment.
- For Individual #146, there was evidence that the nurse contacted the PCP, however, there was no documentation regarding what information was shared.
- For Individual #186, documentation was not in SBAR format.
- For Individual #162, there was no documentation that the provider was informed or the individual was discussed in clinic on 6/18/21 despite requiring additional oxygen and DuoNeb's.
- For Individual #19, while it was documented that the provider was notified, it only noted that they informed them of the emesis. The documentation did not contain evidence regarding the distention.

c-d. The following provide some examples of findings related to this indicator:

- For Individual #343, she was assessed by nursing on the 6-2 shift x 3 days for a skin rash. Documentation after 7/30/21 did not include assessment according to nursing guidelines for skin impairment.
- For Individual #146, a skin assessment and Braden score were not conducted prior to her being transferred to the ED according to nursing guidelines for Emergency/Hospital Transfers. Upon her return, nursing did conduct full assessment, including skin assessment, which indicated a stage 2 decubitus. In a comment on the draft version of this report, the Center said that this was an emergent situation. A skin assessment and getting a Braden score would have delayed care for individual #146.
- For Individual #186, she did not have an assessment according to nursing protocols prior to her transfer to the ED. She was experiencing skin integrity issues to her bottom prior to transfer, but received no measurement nor Braden score that day. Upon return to the facility on 8/2/21, an assessment was completed, but it did not include an assessment of his sacral area until nearly two hours later when it was discovered that he had pressure ulcers to his sacrum.
- For Individual #19, despite the nursing template being used, it was not fully completed. The Braden scale was not included as per nursing guidelines. Upon return from hospital on 7/7/21 at 1645, nursing completed a full assessment, however, it did not

measure the incision wound. On 7/8/21 at 0451, nursing noted small excoriation to the buttock and noted that it came from hospital, however, this was not addressed on transfer assessment.

e. None of the applicable individuals had an acute care plan that met their needs.

- For Individual #343, her ACP contained instructions "nursing to follow-up on 6/2 shift x 3 days," however, it did not indicate specifically which nursing guideline to follow.

- For Individual #146, she did have an ACP implemented upon return, however, it did not encompass her entire needs. Nursing did not initiate an ACP for stage II decubitus until 10/14/21 when it was originally identified on 9/23/21. Initial ACP addressed her g-tube and the needed monitoring for infection, but did not address respiratory status or aspiration despite the individual having sepsis related to Asp PNA.

- For Individual #186, an ACP was initiated prior to his discharge for skin integrity r/t to "excoriation of skin" and it was modified upon return on 8/2/21. His ACP initiated on 7/13/21 was not initiated within 12 hours. Excoriation was identified at 0111 and the ACP was initiated at 1933. Individual was subsequently sent back to the hospital on 8/4/21 for wound care/infection. His ACP was modified on 8/2/21, however, it did not have an updated outcome to address that individual now had three sacral wounds. Outcomes as they were written were not measurable to ensure validating progress with goal because they did not include measurements. Interventions were not modified upon return on 8/2/21 to address the degree of the wounds and did not then coincide with the nursing guidelines for skin impairment as interventions were to be done for 24 hours only. The wounds were at a level of severity that required care, assessment, and monitoring for much longer than 24 to 72 hours. Additionally, despite a new foley catheter, no ACP was implemented to address this change.

- For Individual #162, she had outcomes such as “AEB lung sounds back to baseline, decreased secretions, O2 sat w/in parameters (90% or greater).” This was not clearly measurable and did not identify what would be considered decreased secretions. Interventions were not in alignment with nursing guidelines for respiratory distress because they were missing monitoring, abdominal assessment, skin assessment, residual checks for G tube, and notification of the PCP if O2 sats <95%.

- For Individual #19, upon return from his hospital stay for PNA and SBO, he had two ACPs active. One was initiated prior to hospital stay for H pylori and was not discharged until 11/2/21. However, interventions listed in the ACP were for only three days. Nursing did initiate another ACP upon return to address discomfort r/t to surgery, however, it did not address respiratory for post PNA nor GI post SBO. The IHCP in place for GI was not adequate or adjusted in response to these events. The IDT did not convene to review respiratory until 8/3/21 when the individual was discharged from the infirmary. A third ACP was initiated on 7/22/21 following discharge from readmission to address wound dehiscence. In total, the individual did not have adequate ACPs to address issues that led to the surgery. He subsequently had abdominal distention that may have contributed to wound dehiscence and wound infection. The ACP upon return did not address wound care for skin integrity, respiratory distress, or constipation per nursing guidelines.

Outcome 3 – Individuals have timely nursing assessments to inform care planning.												
Summary: Two-thirds of the assessments were completed in a timely manner for their quarterly/annual reviews/assessments. For the others, some were annuals not being completed within 10 days prior to the ISP or the PE being done in excess of the 14-day allotment. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	343	369	146	186	162	19				
a.	Individuals have timely nursing assessments:											
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A										
	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.	67% 4/6	0/1	0/1	1/1	1/1	1/1	1/1				
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	67% 4/6	0/1	0/1	1/1	1/1	1/1	1/1				
Comments: • Individual #146, Individual #186, Individual #162, and Individual #19 were provided with a timely quarterly and annual physical exam and comprehensive assessment. • For Individual #343, her annual was not completed 10 days prior to the ISP. The Physical Exam (PE) was completed more than 14 days in advance, which is too distant to provide current information for the comprehensive assessment. • For Individual #369, her annual physical exam was completed three weeks prior to the comprehensive assessment. Since the PE was completed more than 14 days prior to comp assessment, the exam was not considered timely. Additionally, the quarterly PE was completed more than three weeks prior to the comprehensive assessment. The distance between the PE and the comprehensive assessment did not offer current clinical data to inform the comprehensive assessment.											

Outcome 4 – Individuals have quality nursing assessments to inform care planning.												
Summary: Overall, individuals did not receive a quality annual or quarterly nursing review. Pervasive issues were noted regarding the updating of the active problem and diagnoses lists at the time of the AMA, lack of procedure history, and inclusion of lab and diagnostic testing requiring review. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	343	369	146	186	162	19				
a.	Individual receives a quality annual nursing record review.	0%	0/1	0/1	0/1	0/1	0/1	0/1				

		0/6									
b.	Individual receives quality annual nursing physical assessment, including, as applicable to the individual: i. Review of each 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.	83% 5/6	0/1	0/1	0/1	1/1	0/1	0/1			
c.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/12	0/2	0/2	0/2	0/2	0/2	0/2			
d.	Individual receives a quality quarterly nursing record review.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
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; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	50% 3/6	1/1	1/1	1/1	0/1	0/1	0/1			
f.	On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk.	0% 0/12	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.	22% 2/9	1/2	0/1	0/2	0/2		1/2			

Comments:

a. None of the individuals received a quality annual nursing record review. Pervasive issues were noted regarding the updating of the active problem and diagnoses lists at the time of the AMA, lack of procedure history, and inclusion of lab and diagnostic testing requiring review. For example:

- Individual #343's record was missing the following per the AMA: spasticity right hemiparesis - cavus deformity with heel tightness, epilepsy, constipation, osteopenia, cataracts, and vitamin D deficiency.

- Individual #369's record was missing the following per the AMA: legally blind, aphakia, OS, phthisis bulbi OD, corneal scarring central OS, congenital cytomegalic Syndrome, and oral and pharyngeal dysphagia.
- Individual #162's record was missing abnormal labs that occurred on 1/5/21, 1/6/21, and 1/12/21.

b. 17% of the individuals received a quality annual physical assessment.

- For Individual #343, the individual refused her breast and pelvic exams, abdominal girth measurement, and most of the assessment. The assessment did not document multiple attempts between the date of 1/13/21 and 1/24/21 when the comprehensive assessment was finalized to further attempt completing PE.
- For Individual #369, her assessment did not include Abd circ / weight. For GI, it was noted that her abdomen was normal for age/size, but did not explain further, such as soft, firm, rounded, or distended. There was no listing of her last BM, and no description of urine or urinary system assessment. She was identified with pulse of 110, however, this was not addressed as an abnormal finding
- For Individual #146, her assessment did not assess functional mobility. The assessment did contain a recorded Braden and Fall score. The assessment did take VS and note Abd circ in IPN notes. It also noted specific GI detail in the IPN notes.
- For Individual #162, her assessment did not include a full body systems assessment and was missing a complete assessment of genital urinary system.
- For Individual #19, a complete body system was not conducted. Missing was information regarding BM dates, and explanation of joint impairments within the IPNs or IView.

c. For the annual ISP, none of the nursing assessments addressed the individual's at-risk conditions and were sufficient to assist the team in developing a plan responsive to the level of risk.

- For Individual #343 (Weight), while there was a summary of quarterly weights, there was not discussion related to why she had weight changes or possible contributing factors. She had THS (sic) drawn in Q 1, but nothing else was noted as well as any f/u related to medications. There was no annual summary to identify the total weight changes overall. No comparison between this year and the previous year was offered. Nursing noted a five pound weight gain over the year, but no discussion of strategies to improve weight loss. For Falls, the review did note a summary per quarter, however, it did not summarize all the events for the year or offer comparison between years. The assessment did not fully discuss the possible causes of falls. It was mentioned that she liked to carry purses, but it did not provide analysis to identify how purses could contribute to falls. This was ultimately discussed in Q3 2021, but it did not discuss what strategies had been used to decrease falls and the outcome of those strategies. When comparing fall status to previous quarters, it was stated that she was stable, but it did not provide the data to support that conclusion.

- For Individual #369 (Constipation/BO), she was not fully assessed because the assessment contained no discussion of supports other than medication. She required two interventions this past year, but no comparison to previous year was offered. There was no review of effectiveness, but still stated to continue with current supports (despite needing interventions). For Falls, the review did not indicate what supports the individual was receiving (e.g., handheld assist when ambulating) or contributing factors to fall (e.g., visual impairment). No annual summary was included in the review. The review lacked analysis of falls, or any trending related to falls. For example, it was unclear why she experienced five falls in Q1 compared to one the previous quarter or why she had 13 falls in Q4 compared to three in the previous quarter. In Q 4, 2021, a referral was made to

Habilitation and a wheelchair was added to the PNMP along with an increase in LOS. There was no discussion of preventive measures that could potentially help keep her out of the wheelchair, such as ensuring pathways are clear or identifying when she might be more tired and therefore more prone to falls.

- For Individual #146 (Aspiration), her risk review was overfilled with information/data beyond the review period and there was conflicting information regarding risk when compared to the ISP. A recommendation was noted to decrease risk from high to medium, but did not conduct a comparison to previous quarters. When comparing years, it was not clear as to why she was being considered stable (e.g., how many emesis this year compared to last). The review recommended continuing current supports as they "have been proven to be effective in maintaining stable health status." However, the individual was experiencing emesis. There was a lack of analysis regarding what was working well or why the individual was having emesis/spit up episodes. There was no discussion of other recommendations regarding treatment, interventions, or strategies that could further decrease or ameliorate the risk. For Infections, the review did not address that the individual was receiving weekly bladder scans with caths and how often per quarter. She was required to be straight cathed. An overall decline was observed over multiple quarters, but the team noted to continue current supports as "proven to be effective." Individual had multiple UTIs over the previous two years. It was noted by nursing to have declined, but they failed to provide data to support their conclusion. While a line listing of all events was noted, there was no analysis as to why the individual was continuing to have frequent UTIs. There was no review that contained suggestions for interventions to decrease or ameliorate risk such as ensuring 2000 cc fluid per day, peri care observations, or training for staff.

- For Individual #186 (Infections), his review lacked trending or analysis as to why he had PNA, UTI, and congestion in Sept 2021. The review did not discuss current supports or identify alternate supports to address infections and did not offer a comparison to previous years to trend any improvement/ decline or patterns to develop appropriate strategies. The individual was diagnosed with conjunctivitis and received treatment on 7/7/21, but this was not identified within the review of the risk as an infection. For Skin Integrity, he had a Braden score of 17 that was increased from a score of 16. There was no evidence of discussion as to why this score changed. He had a one cm superficial open area (8/5/20) on coccyx with a noted consult with Habilitation and Dietary. There was no evidence of further discussion of any alternate interventions and whether there was improvement with the open area. Nursing did not offer comparison to previous years to note skin integrity issues or annual summary of skin issues. His review lacked discussion of interventions to decrease or ameliorate risk, such as check and change q 2 hr. or nursing observation of peri care.

- For Individual #162 (Resp Compromise), the review did not identify contributing factors as part of the assessment (e.g., GERD, Trach, Asthma, Scoliosis, frequent infections), provide an analysis as to why she was having so many respiratory issues, or cite the number of respiratory issues this year to compare to last year (i.e., three times this yr., compared to one last year). There was also no inclusion regarding the number of times suctioned to previous year to provide justification for a conclusion of decline. For Infections, the review did not identify the contributing factors/diagnoses (e.g., Trach, frequent UTI, incontinence of B&B, Scoliosis). The review lacked analysis of infections, frequency of infections, and discussion of contributing diagnoses or meds receiving. The review noted regression, but did not provide any data to support. It contained no discussion of strategies or interventions to decrease the number of infections (e.g., Ensure 2000cc fluid per day, frequent check/change). Additionally,

there was no identification of the number of PO versus IV antibiotics this year compared to last year or types of infections. (e.g., PNA, UTI).

- For Individual #19 (Constipation/BO), his review did a full listing of events, however, there was no summary of the data to compare whether there had been regression or improvement between quarters or year. There was no analysis as to why he was having constipation events, especially if refusing meds that may contribute to constipation. There was no discussion of ensuring high fiber diet, exercise, fluid intake, or type of BMs according to Bristol scale or the inclusion of preventive measures other than medications. For Seizures, there was no discussion of the number of times he received Ativan intervention or tertiary care / quarter or year to compare. A line listing of all the seizures, duration, and the times he received Ativan was noted, but offered no comparison regarding the number of times between quarters or years. The assessment lacked analysis to determine the potential correlation between refusals and seizure activities as well as potential triggers that seem to surround seizures, such as noise, temperature, and/or hydration.

d. One of six of the individuals received a quality quarterly nursing review as applicable. Issues noted included absence of active problems and diagnoses list, social history, and lab and diagnostic testing.

e. Half of the quarterly nursing assessments were comprehensive.

- For Individual #343, Individual #369, and Individual #146, the nursing assessments included updates of the individual's current medical and behavioral/mental health risks and reflected a full system review.
- Individual #186, Individual #162, and Individual #19 did not have a full review completed. Some examples included lack of a full GI assessment or lack of explanation regarding the absence of a specific system review (e.g., did not examine tympanic membrane due to lack of available otoscope).

f. On a quarterly basis, none of the nursing assessments addressed the individual's at-risk conditions and were sufficient in assisting the team in maintaining a plan responsive to the level of risk.

- For Individual #343 (weight), her review lacked comparison of weight between quarterly reviews despite noting weight loss. There was a lack of analysis regarding potential causes to the weight loss and lack of recommendations other than to refer to the dietitian.
- Individual #369's (falls) review lacked discussion of what factors may be contributing to falls. There was a lack of discussion regarding what supports may be in place other than medications.
- Individual #146's (infections) review provided a line list of events, but lacked analysis regarding the potential causes of the UTIs. There was no discussion of supports that could decrease UTIs or a review of catheterization's and how they may contribute to the infections.
- For Individual #186 (skin integrity), his review did include discussion of the IVAB for wound and the diagnostic testing to determine osteomyelitis, but lacked discussion of strategies/supports/interventions to decrease or ameliorate risk.
- For Individual #162 (respiratory compromise), her review lacked analysis or review of events for the quarter. It noted that she had improved compared to previous quarters, but did not provide detail as to how she had improved or data to justify. There was no discussion of supports or strategies to improve or decrease risk and no discussion of how they planned to decrease

oxygen levels. The assessment lacked review of the contributing factors to risk (e.g., trach, scoliosis, w/c bound) and/or review of the number of times required suctioning to previous quarter.

- For Individual #19's review for constipation/bowel obstruction, the review contained a detailed description of events r/t to post surgery as well as wound dehiscence and treatment of wound infection, however, it did not fully address constipation issues. The review noted abdominal girth trends, but did not link these back to previous quarters to help establish trends. There was no evidence of an assessment addressing constipation with comparison between previous quarters r/t to constipation events. The assessment lacked discussion of alternatives to improve constipation other than the use of medicine.

g. Two of nine individuals that had a change in status, received a nursing assessment that was completed in accordance with nursing protocols/standards of practice.

- For Individual #369, she fell on 10/5/21, but did not receive an assessment according to nursing guidelines for the fall. Missing from the assessment were the following: BP to ensure full set of VS, Cognitive assessment, Neuromuscular assessment to include ROM, and changes in ambulation per IView note at 7:10.
- For Individual #146, she experienced an emesis on 11/11/21. She did not receive an assessment according to nursing guidelines for vomiting. The assessment did assess bowel sounds, but did not note whether abdomen was tender.
- For Individual #146, she was diagnosed with a UTI on 7/5/21. On 7/4/21, she presented with increased agitation and refusal of meal and supplement. There was no assessment regarding this change of behavior on 7/4/21 or 7/5/21.
- For Individual #186, on 7/7/21, he was diagnosed with conjunctivitis and received an order of erythromycin ointment. There were no IPN notes between 7/2/21 and 7/7/21 with no assessment in IView r/t eyes.
- For Individual #186, his PIR was initiated at 0111 on 7/13/21 when excoriation of skin to buttocks was found. There was no IPN noted and the PIR did not assess according to nursing guidelines for skin integrity as it did not provide measurements or description of wounds. No further assessment was conducted until 1400 on 7/13/21, per IPNs.
- For Individual #19, during his assessment on 10/26/21, the nurse identified that his abdominal girth had increased, but did not conduct an assessment according to guidelines. The assessment was missing the checking of lung sounds, N/V, appetite/meal refusals, and hydration.

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: Individuals did not consistently have a plan developed that set forth to clearly mitigate the at-risk condition. Goals were often not measurable and contained actions steps that did not clearly support the objective or goal. The frequency of monitoring to ensure effectiveness of the plan was not clearly stated within the ISP. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	342	369	146	186	162	19			

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.	8% 1/12	1/2	0/2	0/2	0/2	0/2	0/2			
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/12	0/2	0/2	0/2	0/2	0/2	0/2			
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	25% 3/12	1/2	1/2	1/2	0/2	0/2	0/2			
d.	The IHCP action steps support the goal/objective.	0% 0/12	0/2	0/2	0/2	0/2	0/2	0/2			
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	33% 4/12	1/2	2/2	1/2	0/2	0/2	0/2			
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	25% 3/12	1/2	1/2	1/2	0/2	0/2	0/2			

Comments:
a-b. While all the individuals did have IHCPs in place, one of the 12 IHCPs sufficiently addressed the health risks and needs in accordance with applicable SSLC nursing protocols or current standards of practice, and none of the 12 included preventative approaches to minimize the at-risk conditions.

c. A quarter of the IHCPs included measurable objectives to fully address the at-risk condition /allow the team to track progress in achieving the plan's goals.

d. None of the IHCP nursing action steps supported the goals/objectives

e. A third of the IHCP interventions included specific clinical indicators to be monitored

f. A quarter of the IHCP interventions included frequency of monitoring/review of progress.

Comments regarding these six indicators:

- For Individual #343 (weight), her goal was not appropriate nor measurable as written because it did not address the desired weight loss. The plan did not coincide with nursing standards of care (SSLCs) for weight loss because it did not address educating the individual regarding healthy diet choices or weekly exercise and/or weights until target achieved. The individual was an independent ambulator, so exercise was a viable option. The plan did note the frequency of weight loss monitoring, which was monthly, but did not set associated indicators of progress at these same intervals.

- For Individual #369 (constipation), the IHCP did not include assessing for LOC, lung sounds, bowel sounds, and hydration. The plan did include monitoring for meal refusal and N/V, but did not indicate to monitor BM status according to Bristol scale and the criteria for notification.
- For Individual #146 (aspiration), the IHCP did address positioning and checking of lung sounds before and after meds, but it did not indicate how to address enteral feedings.
- For Individual #186 (infections), the IHCP did not coincide with nursing guidelines for respiratory distress (r/t PNA). The IHCP did note that an assessment will be done quarterly, however, that was not frequent enough for an individual with multiple infections, including MDRO. The individual did have an ACP to address COVID PNA from 9/22/21-11/20/21.
- For Individual #162 (respiratory compromise), her IHCP did include her target for O2 sats, but did not state how frequently those were to be monitored. Additionally, the plan did not indicate how frequently progress would be monitored.
- For Individual #19 (seizures), the IHCP did not coincide with the nursing guidelines for seizures and status epilepticus of which he had had multiple events.

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

Summary: 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. None of the individuals at high risk for respiratory issues and/or aspiration pneumonia had proper documentation by a nurse of an assessment of respiratory status. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	342	369	146	186	162	19			
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% 0/12	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	0/1	0/2	2/2	0/2	0/2			
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	17% 2/12	0/2	0/2	1/2	0/2	0/2	1/2			
d.	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 of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/3			0/1	0/1	0/1				

Comments:
The Monitoring Team reviewed 12 specific risk areas for six individuals, and as available, the IHCPs to address them.

a. and c. As noted above, for individuals with medium and high mental health and physical health risks, the IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether they were implemented. 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. At times, gaps in implementation were identified.

The positive exceptions were for Individual #146 (infections) and Individual #19 (seizures), where nurses implemented the interventions in their IHCPs.

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

b. As illustrated in indicator a, there was the lack of urgency with which IDTs addressed individuals' changes of status through the completion of comprehensive reviews and analyses to identify and address underlying causes or etiologies of conditions that placed individuals at risk. The following provide some examples of IDTs' responses to the need to address individuals' risks:

- For Individual #343, no ISPA was developed to discuss weight loss and falls
- For Individual #369 regarding falls, the individual had three falls in 30 days between 6/7/21, and 7/7/21. She experienced three falls again between 9/14/21 and 10/5/21. An ISPA occurred on 10/1/21, but noted that the individual was already at a high risk for falls and recommended no changes or interventions to decrease falls or evaluate the reason for falls.
- For Individual #146 (aspiration), the nurse noted emesis on 11/3/21 with an ISPA occurring on 11/18/21 to address the PNMP. Emesis was noted during the ISPA, but no evidence of a plan to address the emesis. An ISPA was held on 11/19/21 to discuss LOS and g-tube safety along with dysphagia therapy. The ISPA noted that the episodes of emesis began on 10/18/21 and increased since 11/2/21 with some events occurring around feeding times which is when the g-tube rate was increased. There was no discussion of changes made to the plan due to the amount of emesis. For Infections, despite having a UTI on 5/31/21, 7/5/21, 7/15/21, and 8/25/21, the IDT did not meet to discuss frequency of UTIs and possible modification of plan.
- For Individual #186 (infections), the ISPA 7/9/21 showed that the IDT met to discuss contact precautions for the individual r/t to conjunctivitis, but did not address infection rates for individual. For Skin Integrity, the ISPA dated 7/14/21 was held to discuss wound supports for the individual. He presented with a skin tear to the buttocks that was discovered during hygiene care on 7/13/21. A PIR was noted at 7/13/21 at 0118, however, it did not include an assessment of injury.
- For Individual #162 (respiratory compromise and infections), on 6/18/21 she was admitted to the hospital. The team met before the individual returned from the hospital and because of that meeting, identified various supports. There was no evidence that the IDT met after she returned to validate proposed supports or to identify if further supports were needed.
- For Individual #19 (constipation/bowel obstruction), there was no IPSA post exploratory laparotomy/ SBO surgery upon return from the hospital on 7/7/21. The individual retuned to the hospital and was subsequently discharged on 7/22/21 to the

infirmary. The team met on 8/3/21 when d/c from infirmary. At that time, the team noted a CoS for Skin integrity and infection, but did not note any changes related to constipation despite noting that he had two SBO instances (April 2021 and June 2021), one of which required surgery.

d. None of the individuals at high risk for respiratory issues and/or aspiration pneumonia, had proper documentation by a nurse of an assessment of respiratory status that includes lung sounds in IView or the IPNs. of the interventions as specified in the IHCP.

- For Individual #146, there was a lack of consistent documentation r/t to listening to LS before and after meds and after feedings.
- For Individual #186, his IHCP stated to auscultate lungs daily. The Monitoring Team reviewed between 7/1/21 and 7/14/21 for daily auscultation, but there was no evidence of auscultation on 7/9/21. Upon review of notes from 10/1/21 to 10/10/21 for TIC LS, there was no evidence that this was completed on 10/3/21 or 10/9/21.
- For Individual #162, there was a lack of consistent documentation before and after meds of lung sounds.

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

Summary: There was improvement in performance on most of these indicators, with the exception of indicators l and m regarding a medication adverse reaction. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	369	146	186	162	19	210	234	253
a.	Individual receives prescribed medications in accordance with applicable standards of care.	Not scored									
b.	Medications that are not administered or the individual does not accept are explained.	Not scored									
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).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
d.	In order to ensure nurses administer medications safely: For individuals who exhibit signs and symptoms of respiratory issues and /or aspiration during medication administration, the nurse will immediately stop the medication administration and complete an assessment which will include lung sounds and may include a full set of vital signs, pulse oximetry, etc. as indicated at the time of the assessment.	100% 1/1								1/1	

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.	75% 6/8	0/1	1/1	0/1	1/1	1/1	1/1	N/A	1/1	1/1
f.	Individual's PNMP plan is followed during medication administration.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	83% 5/6	1/1	1/1				0/1	1/1	1/1	1/1
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	0% 0/1						0/1			
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	N/A									
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	100% 10/10	1/1	1/1	1/1	2/2	1/1	1/1	1/1	1/1	1/1
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	80% 4/5	1/1	1/1	0/1	1/1		1/1			
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/A									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	0% 0/1				0/1					
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	0% 0/1				0/1					

Comments:
The Monitoring Team conducted observations of 10 individuals, including Individual #343, Individual #369, Individual #146, Individual #186, Individual #162, Individual #19, Individual #210, Individual #234, and Individual #253.

a-b. The Monitor continued to work with State Office on a method for the Monitoring Team to have access to readable formats of MARs for the monitoring review period.

e. Six of eight applicable individuals received pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicated its use, including individual's response.

- For Individual #343, Magnesium Citrate was given on 10/31/21 with no documentation for reason given or results.
- For Individual #146, an emesis occurred, and the individual received a promethazine suppository on 11/8/21 at 2044. There were no instructions provided to the individual, or staff documentation in the IPNs that the individual was informed why they

received or what to look for as side effects of the medication. There was no documentation found regarding results of the provided suppository.

g. All but one of the individuals observed had Infection Control Practices followed by Nursing before, during, and after the administration of the individual's medications.

Example of not following infection control practices was:

- For Individual #19, the nurse had misplaced her hand sanitizer, so she washed her hands between touching individuals. She dried her hands from mid-arm down to fingers. Her mid-arm had not been washed, thus, contaminating her washed hands. Afterwards, the nurse turned off the water with a towel, then dried hands again with that same towel, resulting in additional contamination. The nurse auditor did not identify any of these infection control issues.

h. All of the individuals had instructions provided to the individual and staff regarding new orders or when orders change.

i. For 80% of the occurrences when a new medication was initiated, there was a change in dosage, or after discontinuing a medication, documentation showed the individual was monitored for possible adverse drug reactions. The exception was or Individual #146, where there was no evidence of documented f/u regarding possible ADR for Nitrofurantoin initiated on 6/4/21.

l-m. There was one individual in the review group that had a documented medication variance. For Individual #186, the Monitoring Team noted documentation in the IPNs regarding Invega being administered into the wrong site. There was no documentation r/t whether there were any untoward effects from giving in wrong site or evidence of it being reported to physician (deltoid instead of gluteal).

Section N: Pharmacy Services and Safe Medication Practices

Substantial Compliance – Exited Status

Seven of the provisions of this section have met and achieved substantial compliance: N1, N2, N3, N4, N5, N6, N7.

Thus, the corresponding 13 monitoring indicators are no longer monitored or scored: N1a-b, N2a-e, N3a-d, N4a-b.

Monitoring indicators for section N8 remain in development.

Sustained High Performance – Less Oversight Status

Section Summary

Section O: Minimum Common Elements of Physical and Nutritional Management

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Two of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, one additional indicator was moved to this category.

Section Summary

The Center showed an improved ability to ensure that individuals identified with a PNM related risk was reviewed/assessed by the PNMT in a timely manner.

The reviews continued to lack in their level of comprehensiveness, however, the full assessment did show improvement.

The majority of ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs.

Observations of PNMP implementation demonstrated approximately 61% implementation, about the same as at the last review.

Positives included the consistent or increased use of adaptive and assistive equipment intended to mitigate risk. Positioning was noted to be appropriate for most individuals during and outside of mealtime.

Outcome 1 – Individuals' at-risk conditions are minimized.

Summary: All individuals identified as potentially having a PNM related event/concern were referred to the PNMT as appropriate. This reflected an improvement from the previous review. This indicator will remain in active monitoring, though with sustained high performance, it might be moved to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	334	369	253	210	186	234	162	146	19
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;	100% 10/10	1/1		1/1	1/1	2/2	2/2	1/1	1/1	1/1

Comments:
b. For 10 PNM related events, the individuals were referred to the PNMT as appropriate. For example:

- For Individual #186, a PNMT referral was made by the team on 5/19/21 due to his return from hospitalization on 5/18/21. The PNMT initiated their review on 5/19/21.
- For Individual #234, a self-referral was made for a general decline in mobility associated with falls on 1/29/21. The PNMT initiated their review on that same day
- For Individual #162, a PNMT referral was made by the PNMT on 1/5/21 due to a diagnosis of pneumonia. The PNMT initiated their review on 1/11/21.

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: Most of the individuals in need of PNMT review/assessment were referred either by the IDT or self-referred within five days of an event. Based on the issue, the type or level of review met the needs of the individual. Issues noted were surrounding the timeliness of the review as well as its comprehensiveness. The comprehensiveness of the PNMT assessment has shown improvement since the previous review. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	343	369	253	210	186	234	162	146	19
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	90% 9/10	1/1		1/1	1/1	2/2	1/2	1/1	1/1	1/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	50% 5/10	0/1		1/1	1/1	1/2	2/2	0/1	0/1	1/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	67% 2/3					2/2	1/1		0/1	N/A
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	100% 3/3	1/1			1/1	2/2	1/2	1/1	1/1	1/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	89% 8/9	1/1			1/1	2/2	1/2	1/1	1/1	1/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses:	17% 1/6	0/1		0/1	0/1			1/1		0/1

	• Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.										
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	67% 2/3 97% 32/33					1/1 11/11	0/1 10/11		1/1 11/11	

Comments:

a. For the eight individuals that should have been referred to and /or reviewed by the PNMT, all were referred to the PNMT in a timely manner, except for Individual #234 who was self-referred on 1/29/21 due to a decline in mobility, but did not have a signed review completed until 3/9/21.

b. The PNMT review was completed within five days of the referral for 40% of the individuals. Examples of reviews not completed within a timely manner were for Individual #343 and Individual #146.

- For Individual #343, the PNMT nurse initiated a referral for pneumonia following the hospitalization on 3/31/21. The PNMT review was completed on 4/13/21.
- For Individual #146, the IDT initiated a referral for weight loss and general decline on 8/24/21. The PNMT review was completed on 9/3/21 and signed 9/9/21.

c. Two of the three individuals requiring a comprehensive assessment received one in a timely manner of less than 30 days.

- For Individual #146, the PNMT assessment was completed on 10/15/21, which was more than 30 days. The PNMT notes did not address the expected delay due to a second hospitalization

d. All of the individuals received the type/level of review/assessment to meet their needs.

f. All but one individual received a review/assessment with the collaboration of disciplines needed to address the identified issue.

- For Individual #234, the review lacked collaboration with Behavioral / Emotional Health to address the significant changes in physical functioning and how this will impact his life.

g. One of the individuals received a PNMT review that fully met their identified needs. For the others:

- For Individual #343, her presenting problem, dx/medical hx, risk ratings, and status were addressed. Clear early warning signs were identified in the PNMT review, but were not clearly indicated in the recommendations to the IDT resulting in no update to triggers, risks, IHCP, and/or communication dictionary.

- Individual #253, experienced a choking incident that required the Heimlich maneuver. The precipitating event was noted as talking while eating. Triggers were indicative of choking or near-choking event, but did not address talking while eating as a trigger. Review did not address presence or frequency of precipitating events as a proactive tracking, monitoring, or intervention strategy.
- For Individual #210, her review contained an excellent discussion of physical nutritional health, precipitating events, perpetuating factors, and identification of potential contributing factors. However, environmental concerns at home was noted as a potential contributing factor, yet there was no definition of these factors.
- For Individual #234, the review contained recommendations to address protecting him for continued falls and reducing physical mobility. The assumption that the falls will reduce with use of a wheelchair, or adding padding in case he does fall, were all reactive. Evidence shows that individuals who can ambulate and have cognitive impairment, are at increased fall risk when transitioning to wheelchair usage, especially with leg-rests and foot plates in place. Standards of practice necessitate therapeutic intervention to prevent further regression of strength and stamina as well as complete client and caregiver education on wheelchair use and safety.
- For Individual #19, the review contained good discussion, but this discussion did not lead to proactive recommendations. Review of events leading up to the event showed clear early warning signs for constipation/BO to be emesis of increasing frequency. There was no evidence of proactive nursing interventions associated with the bowel assessment.
- Two of the three individuals received a comprehensive PNMT Assessment to the depth and complexity necessary. For Individual #234, several potential contributing factors were discussed in the PNMT Summary / Analysis, however, the possible cause of the UTI was implied, but not discussed from a prevention standpoint, therefore, recommendations for early warnings and reporting were missed, and not integrated into the IHCP.

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(s) or etiology(ies) of the PNM issues in the action steps. Less than half included individualized triggers and actions to take when they occurred. Also lacking were the clinical indicators necessary to measure if the goals/objectives were being met. The frequency of monitoring was not well defined outside of the nurse's responsibilities. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	343	369	253	210	186	234	162	146	19
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).	22% 4/18	0/2	0/2	1/2	0/2	0/2	1/2	1/2	0/2	1/2

b.	The individual's plan includes preventative interventions to minimize the condition of risk.	22% 4/18	0/2	0/2	1/2	0/2	0/2	1/2	0/2	1/2	1/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	33% 6/18	0/2	1/2	1/2	1/2	0/2	1/2	0/2	1/2	1/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	39% 7/18	0/2	0/2	0/2	1/2	1/2	1/2	2/2	1/2	1/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	22% 4/18	0/2	0/2	0/2	0/2	0/2	1/2	2/2	1/2	2/2
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 were IHCPs related to: Individual #343 – aspiration and falls; Individual #369 -falls and weight; Individual #253 – choking, and GI problems; Individual #210 – fractures and skin integrity; Individual #186 – respiratory compromise and skin integrity; Individual #234 – aspiration and falls; Individual #162 – aspiration and skin integrity; Individual #146 – skin integrity and weight; and Individual #19 – choking and constipation/bowel obstruction.

a. Four of 18 of the ISPs/IHCPs sufficiently addressed the individuals' PNM needs as presented in the PNMT assessment/review or PNMP.

- For Individual #343's aspiration risk, the IHCP lacked specific strategies to mitigate the aspiration risk. The IHCP stated to follow the PNMP, but did not specify diet texture modification or other strategies, such as encouraging drinks between bites, etc. The PNMT assessment and PNMP did not include aspiration as a medium risk as stated in the IHCP. For falls, the IHCP lacked detailed strategies to mitigate the risk. The IHCP stated to "follow PNMP R/T assistive equipment to minimize injuries." The PNMP stated the individual was independent with transfers, but if unable to transfer then the individual used an Arjo lift, but it was not specifically listed in the IHCP. In addition, the PNMP stated that they used a wheelchair per medical, but this was not included in the IHCP. Both alternatives increase the risk for falls and fractures, thus, requiring additional supports, indication for use, and tracking criteria.
- For Individual #369's fall risk, the IHCP identified the specific strategies as detailed on the PNMP, however, there was a lack of integration of specific recommendations, such as the use of knee pads and a floor mat that were identified within the PT assessments. For weight, the related ISP goal did not match the IHCP goal as one focused on losing weight toward EDWR while the IHCP goal focused on the losing of 12 lbs. For fall risk, the PT assessments following falls identified several risk mitigating recommendations that were not included in the IHCP. In addition, nursing reported the wheelchair was used for long distances, while the PNMP stated the wheelchair can be used on the home as needed per medical.
- For Individual #253's GI risk, on 7/2/21 the PNMT review reported gastritis and a GERD diagnosis. On 7/29/21, the HOBE stated that she did not require head elevation due to no diagnosis.

- For Individual #210's risk of fractures, although early warning signs of fracture were identified in the IHCP and PNMP, these were reactive in that nursing was to evaluate when the individual showed signs of pain, that is, after a potential fracture had occurred. For skin integrity, the IHCP outcome was associated with remaining UTI free. However, the PNMP noted that she utilized multiple positioning supports and environmental modifications during a variety of ADLs to prevent skin integrity difficulties, but this was not noted within the IHCP. Palmar, axillary, and inguinal skin integrity may also be of concern with recent discontinuation of the gentle movement program and with musculoskeletal contractures.
- For Individual #186's risk of respiratory compromise, the IHCP plan to address Impaired Gas Exchange did not include integrated positioning recommendations and supports identified by the PNMT and active therapy interventions. His IHCP addressed impaired skin integrity and included measurable wound sizes for comparison, reactive interventions, behavioral and social supports, wound vac application, and foam boots, but did not include specific positioning and repositioning strategies, or use of pressure mapped wheelchair cushion as recommended per the PT.
- For Individual #234's risk of falls, his IHCP did not include known signs and symptoms, nor specific supports recommended. For example, the PNMP stated unsteady gait, drowsiness, swelling, pain or bruising, and inability to walk as individualized triggers and the IHCP stated to notify nurse of falls and injuries. The IHCP also did not provide direction, such as reminding the individual to leave gait belt on and the seat belt secured, or what to do when the individual started ambulating independently.
- For Individual #162's risk of aspiration, her IHCP lacked specific details related to positioning supports as listed on the PNMP. For example, the PNMP provided specific instructions for positioning during activities when the individual was at high risk for aspiration (such as during and after enteral medication administration, oral care, and bathing), while the IHCP stated ensure proper positioning at all times.
- For Individual #146's risk of skin integrity, her IHCP did not address skin integrity from a pressure development perspective, The IHCP identified reactive actions, such as consult HT after skin impairment occurs, and report to nursing open areas, redness, etc. For her weight risk, a CoS weight IHCP was initiated on 11/24/21, however, this was significantly delayed as weight loss was what initiated a referral to the PNMT on 8/24/21
- For Individual #19's risk of choking, the IHCP contained general details about diet texture, fluid consistency, and positioning modifications, but no specific details were listed.

b. Overall, ISPs/IHCPs did not include preventative physical and nutritional management interventions to minimize the individuals' risks. The positive exceptions were for Individual #253 - choking; Individual #234 –aspiration; Individual #146 – skin integrity and Individual #10 for constipation/bowel obstruction.

d. Six IHCPs included the steps necessary to meet the measurable goal/objective. Pervasive issues across the review group included lack of specific strategies related to mitigation of the risk, and inclusion of assessment recommendations. Exceptions were noted for Individual #369 for weight, Individual #253 for choking, Individual #210 for fractures, Individual #234 for aspiration, Individual #146 for skin integrity, and Individual #19 for constipation/bowel obstruction.

e. Eight IHCPs identified the necessary clinical indicators to measure progress. Issue noted across most individuals were that the clinical indicators were often reactive and did not measure the actual mitigation skill. For example, Individual #369's IHCP focused on falls as the primary indicator rather than use of supports to prevent falls.

f. Four IHCPs identified triggers and actions to take should they occur. Primary issues noted included lack of proactive triggers or lack of carryover of triggers located in the PNMP.

g. None of the IHCPs identified the frequency of monitoring and review of progress. Frequency of review by nursing and medical staff was included, however, these did not include monitoring completed by other disciplines and personnel, such as frequency of monitoring of assistive equipment by PNMPCs or positioning, transfers, and intake monitoring by HT personnel.

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

Summary: Nine of the IHCPs included all the necessary PNM action steps to meet individuals' needs. Many of the PNM action steps that were included were not measurable, making it difficult to collect specific data. Substantially more work is needed to document that the individuals receive the PNM supports they require. In a little over half of the instances, the IDTs took immediate action when individuals' PNM risk increased or when they experienced changes of status. Improvement was noted in the discharge process of the PNMT back to the IDT. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	369	253	210	186	234	162	146	19
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.	60% 9/15	0/2	0/2	1/2	1/2		1/1	2/2	2/2	2/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	64% 7/11	0/1	0/1	0/1	2/2	1/2	1/1		2/2	1/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	100% 2/2					1/1	1/1			

Comments:

a. Nine of 15 ISPs (60%) reflected evidence that the action plan steps were completed in a timely manner with adequate documentation reflecting rationale for delays. A pervasive issue across all other plans was the lack of specific strategies to clearly mitigate the targeted risk. Examples included not specifying diet texture recommendation or strategies to decrease rate or size of intake, use of adaptive items such as knee pads and helmets to mitigate injury, or clear positional supports to mitigate aspiration or maintain skin integrity.

b. Seven ISPs demonstrated evidence of taking immediate action when there was a change in status. When an individual required increased intervention in response to a CoS, the team referred the individual to PNMT and in several cases took immediate action while awaiting PNMT involvement. With a few exceptions, documentation lacked the presence of ISPAs to reflect interdisciplinary involvement in the steps taken, timelines, responsibilities, and outcomes. For example:

- Individual #253 experienced a choking event requiring abdominal thrusts on 6/24/21. The home SLP completed a dysphagia assessment on 6/24/21 and provided recommendations to address immediate concerns. The IDT also held a CoS meeting and increased the choking risk. The IDT referred to the PNMT on 6/25/21 after implementing immediate actions. There was no ISPA presented to reflect interdisciplinary involvement in these actions.
- A fracture of Individual #210's leg was discovered on 6/2/21. While the individual was in the hospital, the IDT met on 6/3/21 and 6/4/21 to identify potential causes, update risk, prepare for the return home, establish several preliminary recommendations (i.e., d/c TED hose, fabricated a LE positioner), and define assessments to be completed. No follow-up notes were provided related to nursing's assessment and/or use of assistive and positioning supports during the interim and there was no ISPA presented to reflect the timelines, actions, and outcomes until the PNMT review on 6/9/21.
- Following hospitalization and significant decline in status returning on 8/3/21, Individual #186 did have an ISPA on 8/4/21 that outlined intermediate steps, taken, actions, and recommendations. Another ISPA was held on 5/27/21 highlighting actions and outcomes and demonstrating planning for his move home and ongoing therapeutic interventions.
- Upon Individual's #234's return from the hospital, an ISPA and CoS were held on 3/26/21 to update risk, prepare for the return home, and establish several preliminary recommendations (i.e., head elevation, dining plan changes to NPO, medication administration positioning).

c. All of the individuals discharged by the PNMT had a discharge meeting with the IDT which was documented in an ISPA. For example, Individual #186 was discharged from PNMT simultaneous with the facility discharge. A comprehensive ISPA was held on 10/26/21 to include discussion of all physical nutritional supports. For Individual #234, a PNMT discharge was held 5/18/21 and included comprehensive discussion of risks, actions taken, supports, and preventative measures.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked and are implemented thoroughly and accurately.			
Summary: PNMPs were implemented as written during about two-thirds of the observations. This indicator will remain in active monitoring.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	61% 22/36	
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.	Not rated	

Comments:

a. The Monitoring Team conducted 36 observations of the implementation of PNMPs/Dining Plans. This included observations of meals, positioning, and transfers. Based on these observations, individuals were positioned correctly during seven of eight (88%) opportunities. Staff followed individuals' dining plans during 11 out of 26 mealtime observations (42%). Staff completed transfers correctly during two out of two observations (100%).

The following provides more specifics about the observations:

- Regarding Dining Plan implementation, the errors that occurred often related to staff and the individuals not positioned correctly at mealtime or strategies not being implemented correctly or consistently.

The Monitoring Team observed two transfers, with both demonstrating appropriate staff set-up and individual transfer

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.

Summary: The ISP/IRRF did not consistently document the clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and the discussion regarding the potential of the individual's return to oral intake. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	369	253	210	186	234	162	146	19
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.	25% 1/4				0/1		0/1	1/1	0/1	
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	100% 2/2						1/1		1/1	

Comments:

a. One of four IRRFs documented clinical justification for the continued medical necessity, the least restrictive method, and discussion regarding potential of the individual to return to oral intake. An example of meeting the need of the individual was Individual #162's IRRF which clearly described the rationale for enteral tube use covering a variety of risk categories and provided clear justification for continued use such as medical fragility, nutritional needs, and positioning limitations.

- For Individual #210, the IRRF demonstrated integration of the risks associated with enteral tube use, such as GI and aspiration, and rationale for associated supports, such as positioning and monitoring of physical health status. It also included the rationale for continued enteral tube use with long-term dependence. Missing was additional information, such as rationale for placement, dysphagia status, saliva management skills, etc.
- For Individual #234, the IRRF included a succinct description of rationale associated with aspiration and the need for an enteral tube, however, lacking was detail continued enteral tube as it merely stated, "Details from MBSS." Additionally, the section for least restrictive enteral nutrition method was left blank.
- Individual #146's IRRF CoS on 9/9/21 for aspiration did not specifically address rationale for enteral tube use, but did determine to increase the risk due to new g-tube status, and admission to hospice.

b. Both individuals were determined to be clinically appropriate to progress along the continuum to oral intake and included an ISPA when initiating, progressing, and discontinuing intervention. For example, Individual #234 had ISPAs on 6/2/21 to initiate NMES intervention and outline the return to oral intake.

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.

Summary: The Center consistently included measurable strategies and plans into the ISP/ISPA for a number of consecutive reviews. Thus, given this sustained high performance, indicator a will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals:								
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.	100% 2/2						1/1		1/1	

Comments:

a. Both individuals receiving enteral nutrition and progressing along the continuum towards oral intake were provided with the proper assessment and plan.

- For Individual #234, an ISPA was provided on 11/24/21 to provide an update on progress and to initiate PNMP changes. Another ISPA was held on 12/6/21 to advance diet and discontinue direct intervention.
- For Individual #146, ISPAs were held on 9/30/21 and 10/4/21 to initiate NMES intervention and on 11/12/21 and 11/18/21 to discuss progress, implementation of pleasure feeding, and PNMP changes. Another ISPA was held on 11/19/21 to discuss the completion of therapy.

Section P: Physical and Occupational Therapy

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Four of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, one additional indicator was moved to this category.

Section Summary

The Center showed improvement regarding the writing of clinically relevant and measurable goals. The breakdown occurred due to a lack integration of the goals into the ISP process as well as consistent review and integration of the goal in the ISP monthlies.

Regarding assessments, the Center showed growth when providing functional descriptions within the OT/PT assessments. This process should help lead to improved comparative analysis for future assessments. Rationale for the assistive/adaptive equipment was also noted with improved consistency.

The Center should focus on improving the identification of therapeutic interventions to address or mitigate decline/risk. These include but are not limited to:

- ambulatory to wheelchair.
- recurrent referrals (falls, injuries).
- When potentially restrictive interventions are added (e.g., padding, and intense cues).

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.												
Summary: The majority of individuals had clinically relevant and measurable goals, however, these goals were not integrated as part of the ISP progress reports and had documentation of progress limited to the IPNs. There was progress since the last review in that three of these indicators scored higher than they had in previous reviews. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	343	369	253	210	186	234	162	146	19

a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	70% 7/10	0/1	0/1	2/2		2/2	2/2		1/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	80% 8/10	0/1	0/1	2/2		2/2	2/2		1/1	1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/10	0/1	0/1	0/2		0/2	0/2		0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/10	0/1	0/1	0/2		0/2	0/2		0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	13% 1/8	0/1	0/1			0/2	0/2		1/1	0/1

Comments:
a. through e.
Ten individuals were identified as requiring OT/PT and dysphagia supports and/or services.

- Individual #343 did not have an OT/PT goal despite being at moderate fall risk with decreased safety awareness and having several referrals associated with falls and mobility during the past year. There was a lack of justification as to why she was not currently or previously receiving intervention focused on decreasing fall risk, addressing variability of mobility supports, and caregiver education as per standard of practice.
- Individual #369 did not have an OT/PT goal despite being identified as high fall risk with multiple personal (sensory aversive combined with visual deficits and need for external assistance) and environmental contributing factors and having experienced multiple falls during the past year. In addition, a supervised ambulation program using a Merry-walker was initiated with PNMPC before completing direct therapy that would include trailing strategies, caregiver education, and determining strategies to prevent behaviors, perhaps even co-intervention with BHS. Several of the incidents with the Merry Walker could have been planned for and possibly prevented with proper therapeutic intervention. In addition, during the ISPA on 12/13/21, the IDT agreed to consult HAB therapies to gain insight into condiment use and self-dressing to inform SAP development. No consult or follow-up was provided in the record.
- Individual #253 and Individual #234 had clear, measurable goals, but these were not reflected nor integrated and tracked in the ISP progress reports (when associated with skill development) nor the IHCP (when associated with risk). The clinicians documented regular progress reports in the IPNs, but did not review progress and changes with the IDT.
- Individual #146 had one goal that was measurable, specific, and included timeframes. The goal related to dysphagia therapy with NMES. Since the goals, strategies, and data were not included in the IHCP or Monthly QIDP reviews, there was no evidence of progress of the goal. However, when there was difficulty, two ISPAs were held to discuss holding therapy (11/18/21) and ultimately discontinuing therapy (11/19/21) due to risk.
- Individual #19 had an indirect PT program for walking with measurable goal and timeframes. Regular data collection was completed by the PNMPC and the PT reviewed and documented results in a monthly IPN, however, the goals and progress were not integrated into the ISP progress reports nor IHCP and not part of the integrated, interdisciplinary review.

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The quality of the assessments declined as 11% of the assessments were considered comprehensive. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	343	369	253	210	186	234	162	146	19
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.										
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									

d.	Individual receives quality Comprehensive Assessment.	11% 1/9 64% 64/100	0/1 6/10	0/1 5/10	0/1 4/10	0/1 8/10	0/1 6/10	0/1 9/10	0/1 9/10	0/1 7/10	1/1 10/10
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	N/A									

Comments:
Comprehensive assessments were recommended for nine individuals with one of the nine receiving an assessment that consisted of all the needed components to be considered comprehensive.

Common components missing included, but were not limited to:

- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living included qualitative measures, but lacked quantitative measures when indicated.
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and service.
- Clear clinical justification as to whether the individual would benefit from OT/PT supports and services.

Most, but not all, assessments, met criteria, as applicable, regarding:

- Pertinent diagnosis, medical history, and current health status.
- The individual's preferences and strengths were used in the development of OT/PT supports and services.
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services.
- If the individual required a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale).
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments.

The Center should focus most on the sub-indicators listed above that were noted as missing from the assessments.

In addition to the areas of focus identified above, there was a need to address potentially restrictive interventions (e.g., intense prompting or limits when eating, diet texture modifications associated with rate/impulsivity, helmets, knee-elbow pads). Timelines for review, criteria for reduction, and potential for therapeutic intervention and or SAPs should be included in the plan.

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: Individuals' ISPs included functional descriptions of their statuses from an OT/PT perspective. The Center sustained progress in this area across a number of consecutive reviews. Because of this, indicator a will be moved to the category of	Individuals:

requiring less oversight. Improvement was needed for the remaining indicators. To move forward, QIDPs and OTs/PTs should work together to make sure IDTs discuss and include information related to individuals' OT/PT supports in ISPs and ISPAs. These indicators will remain in active monitoring.

#	Indicator	Overall Score	343	369	253	210	186	234	162	146	19
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	44% 4/9	0/1	0/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.	63% 5/8			0/2		1/2	2/2		1/1	1/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	71% 5/7			0/2		2/2	1/2		1/1	

Comments:

a. Eighty-nine percent of the individuals' ISPs included a general description of their OT/PT related skills. The exception was for Individual #343 whose ISP lacked information outside of her independence with mobility. For example, missing was information regarding potential challenges, barriers and/or strengths, and quantitative measures of performance.

b. For four of the individuals, the ISP provided evidence of what the IDT reviewed, revised, and/or approved regarding their PNMPs. Positive examples included Individual #210 whose ISP included discussion of comprehensive review and verification of accuracy of the PNMP, and Individual #146 whose ISP included "reviewed at ISP meeting, no changes required," and Individual #19 whose PNMP review during the ISP resulted in a change of positioning for skin integrity.

Others lacked a formal review of the PNMP by the IDT during the ISP with documentation limited to "yes" under the ISP's PNMP approval section. Therapists should work with the relevant QIDPs to make improvements

c. Five applicable individuals had their ISPs/ISPAs consistently include the strategies, interventions, and programs as recommended in the assessment or initiated outside of the annual ISP meeting. When physical and occupational therapies (skilled or indirect) were initiated, the plan of care, goals, intervention strategies, progress review, and discharge were not consistently integrated into the ISPAs.

d. For five of seven occasions when a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) was initiated outside of an annual ISP meeting or a modification or revision to a service was indicated, an ISPA meeting was held to discuss and approve

implementation. Examples of positive observations included Individual #234 whose dysphagia therapy were initiated following his ISPA on 4/18/21 and Individual #146 whose dysphagia therapy was initiated following her ISPA on 9/30/21. Individual #253 dd not have an ISPA to clearly discuss and approve her PT plan of care noted in Outcome #1.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.

Summary: The majority of action plans and strategies were not integrated into the ISP monthlies. Notation of progress was done in isolation in the IPNs by the providing therapist. The presence of an ISPA in response to a discharge by OT/PT showed improvement since the previous review. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	369	253	210	186	234	162	146	19
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	13% 1/8			0/2		0/2	0/2		1/1	0/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	71% 5/7			0/2		2/2	2/2		1/1	

Comments:

a. For one of eight occasions where there were direct or indirect interventions, an ISPA was held to discuss changes and document progress. Since no goals and interventions were integrated into IHCP or monthly QIDP reviews, outcome reviews were all completed in isolation by a clinician and documented in the IPNs, instead of integrated with the ISP process.

b. For five of seven occasions where a support was discontinued, an ISPA meeting was held to discuss and approve the change. One positive example was Individual #234 whose physical therapy was discharged with an ISPA meeting on 5/24/21 and ST NMES therapy discharged with an ISPA meeting on 11/22/21. Another positive example was Individual #146 whose documented ISPAs on 11/12/21 to update progress with intervention and implemented intermediate changes, then again on 11/18/21 following emesis and request to hold for medical concerns and risk.

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

Summary: Eighty-two percent of the individuals had assistive and adaptive equipment that was of proper fit, about the same as at the last review. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals:

a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.											
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	82% 27/33										

Comments:
c. Eighty-two percent of the individuals had assistive/adaptive equipment that appeared to be the proper fit.

Some examples of individuals for which issues were noted included:

- Individual #155 had difficulty maintaining proper alignment in wheelchair despite repositioning.
- Individual #15's headrest did not appear to support appropriate thoracic and cervical positioning.
- Individual #216 was using both a small-bowled spoon and a weighted spoon, but neither appeared to reduce bite size as indicated.
- Individual #306 had significant tremors and poor motor control that resulted in increased risk of injury or damage to his dentures.
- Individual #354 did not tolerate the wearing of shoes when in his wheelchair. His feet extended beyond the footbox and this increased a risk of injury to his ankle/foot.

Section Q: Dental Services

Substantial Compliance – Exited Status

Corpus Christi SSLC achieved and sustained substantial compliance with Section Q.

Thus, Settlement Agreement provision Q1 was exited and no longer monitored.

Thus, the corresponding monitoring indicators are no longer monitored or scored.

Section R: Communication

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Five of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, one additional indicator was moved to this category.

Section Summary
It was positive to see that there was a growing number of individuals with communication supports.

Active speech therapy for swallowing showed the positive impact of providing direct therapy.

While the assessments overall were timely, the majority did not meet the needs of the individual because they lacked detail regarding the expansion of communicative skills and the development of related goals. There was often the need for the ST to collaborate with the QIDP and BHS to better identify communication needs, then expand opportunities (or qualifications) for individuals to develop their foundational skills for AAC.

Additionally, focus should be on developing opportunities for higher level communication skill interventions.

For the AAC devices currently in place, the Center should review the functionality of existing communication supports to ensure proper access points through interdisciplinary assessment and expand options for existing boards/devices to improve function.

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: All individuals had communication needs, but did not have communication goals/objectives. The Center should focus on improving the identification of opportunities and contexts in which to expand communication skills. This should flow from the development of a more comprehensive assessment. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	343	369	253	210	186	234	162	146	19

a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	25% 1/8	0/1	0/1	0/1	0/1	0/1	0/1	1/1		0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1

Comments:

a. through e. Eight individuals were identified as needing communication supports and actions to effectuate progress and none were addressed effectively. Examples included:

- Individual #162 had the following SSO goal: "Staff will have a conversation with Individual #162 using her TOBii device daily." While the goal was clinically relevant, it was not achievable due to unavailability of the device. While there were regular updates provided in the monthly QIDP reviews, there was a lack of progress for more than one year. Her goal was appropriately written to meet social needs and practice device use, but given there was no device, the IDT failed to meet the individual's needs, including lack of implementation of the goal using the available low-tech alternative. During observations, staff reported the low-tech communication book was only used a few times per week.
- Individual #343's ST evaluation asserted a variety of AAC supports had been discontinued due to lack of progress, but did not identify which teaching-learning strategies were utilized, frequency of intervention, and contexts in which the supports were attempted.
- Individual #369 experienced frequent behavior-related falls leading up to the comprehensive assessment where incident descriptions and video reviews showed communicative intent prior to the falls. The ST failed to collaborate with OT, PT, and BHS to expand communication skills associated with serious risk.
- Individual #253's ISP section regarding rights restrictions noted the individual needed to learn to communicate feelings appropriately. During observation, she stated she would like to improve her behaviors, so she can go back to community living, however, behaviors associated with deficits in higher level communication skills were not addressed by ST.
- Individual #19's ST assessment identified clear concerns of learned helplessness, passive communication, initiating little communication, irritable mood, and mood swings, however, lacked follow-through in recommendations.

Common components that the Center should focus on include, but are not limited to, the following:

- Lacked identification of opportunities and contexts in which to expand communication skills.
- Lacked consideration for teaching-learning strategies and physical stability/mobility to increase pre-AAC skills.
- Failure to recognize needs for expansion of current communication skills and communication dictionaries.
- Failure to address increased complexity of communication and social skills.
- Lacked adequate collaboration with other disciplines to address communication needs associated with medical issues, emotional awareness, self-regulation, and sensory-processing needs.

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: Most individuals received an assessment in accordance with their needs and given sustained high performance over this and the previous three reviews, indicator b will be moved to the category of requiring less oversight. However, that being said, the majority of the assessments did not include all of the necessary components to be considered comprehensive in meeting the individual's needs. Common elements missing from the assessments included proper assessment of AAC, expansion of skills, consistent collaboration with behavioral health, and using the results to provide related recommendations. These other indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	343	369	253	210	186	234	162	146	19
a.	Individual receives timely communication screening and/or assessment:	N/A									
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.										
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.										
b.	Individual receives assessment in accordance with their individualized needs related to communication.	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. 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:	N/A									

	a. Vision, hearing, and other sensory input; b. Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	11% 1/9 67% 49/73	0/1 5/8	0/1 5/9	0/1 4/9	0/1 2/8	0/1 5/7	1/1 8/8	0/1 7/8	0/1 7/8	0/1 6/8
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	N/A									

Comments:

b. All individuals with the exception of Individual #253 received an assessment in accordance with their needs.

- Upon interview, Individual #253 was observed to have difficulty with word finding and auditory distractibility that may impact social skills. Per ISP, she would like to improve her behaviors, so she can go back to community living. Behaviors associated with deficits in higher level communication needs were not addressed by the ST. Rights restrictions in ISP noted need for teaching communicating feelings appropriately.

d. Comprehensive assessments were recommended for nine individuals with one of the nine receiving an assessment that consisted of all the needed components to be considered comprehensive.

Common components missing included, but were not limited to:

- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether the individual would benefit from communication supports and services. Lengthy justification was provided in several cases that asserted why the individual would not benefit from services and how it had been tried in the past and failed. These discussions lacked decision making informed by solid clinical practice with teaching-learning strategies, environments, and direct intervention trials. These discussions also lacked integration of day-to-day communication needs that were consistently being identified by the IDT as behaviors.
- Collaboration between Speech Therapy and Behavioral Health Services was indicated for five of the nine individuals and was evidenced in two of the five. The discussion of target behaviors was sufficient for Individual #343 and Individual #234, however, the team did not collaborate on other behavior-based communication needs outside of the PBSP. For example, Individual #369 experienced several falls categorized by PT as behavior-related even though descriptions included clear communicative intent. Individual #253 had difficulty completing her replacement behavior when emotionally dysregulated, which was not addressed by ST and BHS.

- 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. Repetitive recommendations, such as refer to communication dictionary and follow communication strategies on PNMP were, in most cases, but not all, integrated into the ISP for every goal, however, individualized recommendations were often missed. For example:
    - For Individual #210 there were conflicting recommendations for use of a head switch versus implementation of a hand switch that were unresolved.
    - For Individual #186, audiology provided recommendations for staff positioning and background noise reduction that were not integrated into the ISP nor PNMP.
    - Individual #162's leisure/recreation goals did not include use of existing low-tech communication book that would have allowed the individual to drive the conversation.

It was positive that the most, but not all, met criteria, as applicable, regarding:

- Pertinent diagnosis, medical history, and current health status.
- The individual's preferences and strengths were 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 comparative analysis of current communication function with previous assessments.

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: The majority of individuals who required communication dictionaries did not have those dictionaries properly reviewed and approved the IDT. The ISP often noted "Yes" under approval and did not offer any other statement verifying appropriateness. For the one goal that was developed, the IDT did document approval of the goal through the ISP process. These indicators will remain in active monitoring. Indicators c and d, although showing 100% performance on successive rounds, was not moved to the category of requiring less oversight because of the small number of individuals to whom the indicator was able to applied (i.e., a small denominator).

Individuals:

#	Indicator	Overall Score	343	369	253	210	186	234	162	146	19
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	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

	descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.										
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	20% 1/5	0/1	0/1		0/1			1/1		0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.	100% 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:
b. For one of five individuals, the ISP provided evidence of what the IDT reviewed, revised, and/or approved regarding the communication dictionary. A positive example was Individual #162 whose ISP included a review of communication instructions at the onset of the ISP and the communication dictionary was noted as comprehensively reviewed. Others lacked a formal review of the Communication Dictionary by the IDT during the ISP and documented only "yes" to Communication dictionary approval.

c. Individual #162's ISP included the strategies, interventions, and programs as recommended in the assessment. The IDT did not account for the extended absence of the indicated communication device and did not initiate alternative methods and interventions, such as use of the low-tech support to accomplish the same goal.

The Center should focus most on the sub-indicators listed above that were noted as missing from the assessments. In addition to the areas of focus identified above, there was a need to address the expansion of communication supports through direct intervention and cooperative treatments with other professionals such as BHS, OT, and PT in daily contexts. Teams should focus on identifying high risk situations as well as non-critical behaviors with communicative intent to expand communication dictionaries and opportunities to meet social, physical, and emotional needs.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: The developed SSO was not implemented due to device unavailability. QIDPs and SLPs should work together to implement alternative choices in the interim to allow continued facilitation of communication. This indicator will remain in active monitoring. Further, the denominator for this indicator was small because of the few occurrences of a measurable strategy and action plan in the ISP/ISPA.			Individuals:								
#	Indicator	Overall Score	343	369	253	210	186	234	162	146	19

a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/1							0/1		
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									

Comments:
a. For the single occasion where an SSO was recommended, the SSO was integrated into the monthly QIDP reviews. For Individual #162 the evidence demonstrated that the SSO was not implemented.

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.

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

#	Indicator	Overall Score	Individuals: 297	219	367	330	372	136	137	290	132
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	69% 9/13	1/1	1/1	1/1	1/1	1/1	0/1	1/2	0/1	1/1

#	Indicator		Individuals: 222	67	345						
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		1/1	1/1	0/1						

Comments:
b. Many of the individuals were noted to be actively using their devices in a functional manner within the appropriate setting. For some individuals, it was unclear how the device was utilized or why it was in place in the setting in which it was observed.

For example:

- For Individual #345, staff reported that he understood verbal instructions and he was redirected verbally throughout observation. Functional utilization was questionable because staff were unable to describe a time used and purpose.

- Individual #136 was actively utilizing communication board, however, staff indicated that he used only about 10% of the symbols regularly, and many of the symbols were Holiday- or Activity-specific, which cannot always be offered as he selects, but can be discussed. He may benefit from seasonal boards and more daily use symbols to increase repertoire.
- Individual #137 repeatedly activated "No" on her VOCA. "No" was the closest to her functional LUE despite verbalizing "Yes." IDT may want to consider evaluation of physical access.
- Individual #290 became agitated during meal. Some staff stated that this meant he was too warm, had a wet brief, or needed a preferred staff. This communicative function was not represented in his communication dictionary.

Section S: Habilitation, Training, Education, and Skill Acquisition Programs

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Six of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, three additional indicators were moved to this category.

Section Summary

The Monitoring Team observed many positive interactions between DSPs and individuals. Staff were pleasant, often encouraging independent completion of an activity or task, and providing feedback.

There were few SAPs for individuals at Corpus Christi SSLC. One individual had no SAPs and one-third of the other individuals had one SAP.

Many of the SAPs had many of the required components, but every SAP was missing one or more required component. Every SAP needed to have better instructions for DSPs to be able to implement them correctly and consistently.

Half the SAPs were implemented as written. For the other half, staff were very pleasant and positive during the interaction, but didn't follow the SAP as written. The Center did not have a system and was not regularly observing and assessing SAP implementation integrity.

The data for SAPs were not checked for reliability. Without any assessment and ensuring of SAP data reliability, progress could not be determined. Even so, Center staff reported that more than half of the SAPs were showing progress.

Some individuals were regularly engaged in activities when observed by the Monitoring Team, others were not. Individuals' schedules revealed very limited planned activities for two-thirds of the individuals, that is, limited to between five hours and 10 hours weekly. Based on observations, individuals were rarely engaged in meaningful activity.

One individual at Corpus Christi SSLC was attending school. Activities showing integration between the Center and the school were not occurring as required.

IDTs were discussing and reviewing the need for, and usage of, pretreatment sedation. This was the case for a number of consecutive reviews. In no cases, did the IDT determine that an action plan was needed to reduce future use of PTS for the individuals.

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

Summary: There were few SAPs for individuals at Corpus Christi SSLC. Even so, those that were created were based on assessment results. This was the case for a number of consecutive reviews, therefore, indicator 3 will be moved to the category of requiring less oversight. The data for SAPs were not checked for reliability. Indicators 4 and 5 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	343	218	251	369	227	92	216	149	312
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.	86% 12/14	1/2	1/1	2/2	1/1	No SAPs	2/2	1/1	2/3	2/2
4	SAPs are practical, functional, and meaningful.	86% 12/14	2/2	1/1	2/2	0/1	No SAPs	1/2	1/1	3/3	2/2
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/14	0/2	0/1	0/2	0/1	No SAPs	0/2	0/1	0/3	0/2

Comments:
Eight of the nine individuals had at least one skill acquisition plan (SAP). The exception was Individual #227 who had no plans. Three SAPs were reviewed for Individual #149. Individual #343, Individual #251, Individual #92, and Individual #312 each had two SAPs, while Individual #218, Individual #369, and Individual #216 each had one SAP only. As a result, a total of 14 SAPs were reviewed.

Of the 14 SAPs, eight were implemented between four and seven months after the individual's annual ISP meeting. Timely development of plans is essential to ensure ongoing development of new skills that will expand one's repertoire, improve independence, and enhance one's quality of life.

3. Twelve of the 14 SAPs were based on the results of the Functional Skills Assessment (FSA) and/or an assessment of the individual's current level of performance. The exceptions were Individual #343's turn on radio SAP and Individual #149's sanitize hands SAP. Individual #343 had been assessed one year prior to the current SAP, and Individual #149 had last been assessed in 2018. Baseline performance should be reviewed prior to SAP implementation.

4. Twelve of the 14 SAPs were considered practical, functional, and/or meaningful. The exceptions Individual #369 was learning to manipulate sensory items, something she reportedly did independently, and it did not address her goal of learning to make a necklace; and Individual #92 was learning to be respectful when conversing with his peers, but this did not address his goal of visiting his father.

5. Facility staff reported that no monitoring had been completed on any of the 14 SAPs. An updated request was submitted at the start of the review. It remained that SAP monitoring had not occurred. Assessment of data reliability is one component of this monitoring and, thus, this indicator is rated zero for all 14 SAPs.

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 any assessment and ensuring of SAP data reliability (indicator 5), progress could not be determined. Even so, Center staff reported that more than half of the SAPs were showing progress. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	218	251	369	227	92	216	149	312
6	The individual is progressing on his/her SAPs.	0% 0/14	0/2	0/1	0/2	0/1	No SAPs	0/2	0/1	0/3	0/2
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/1					No SAPs	0/1			
8	If the individual was not making progress, actions were taken.	0% 0/5	0/2		0/1	0/1	No SAPs			0/1	
9	(No longer scored)										

Comments:

6. Based upon a review of the data presented in the Client SAP Training Progress Note or reviewed in the QIDP monthly report, it was determined that progress was being made on nine of the 14 SAPs. The exceptions were the following: Individual #343's coin identification SAP and radio SAP; Individual #251's care for her wig SAP; Individual #369 manipulate items SAP, and Individual #149's DVD SAP.

Based on the lack of data reliability, all 14 SAPs are rated zero.

7. Based upon the data provided, it was determined that Individual #92 had met the goal of his learning to verbally identify respectful behavior. When this SAP was discontinued in October 2021, it was noted that he would be assessed on using a keyboard. When asked about the status of this replacement SAP, facility staff reported that when assessed, he had not shown any interest. No alternative was identified.

8. There was no evidence of action taken to address the lack for progress on the five SAPs identified above.

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: Assessments were conducted, available, and included recommendations for skill acquisition. Although indicator 10 is in, and will remain in, the category of requiring less oversight, two individuals did not have vocational/day assessments. Indicators 11 and 12 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	218	251	369	227	92	216	149	312
10	The individual has a current FSA, PSI, and vocational assessment.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	86% 6/7	1/1	1/1			1/1	1/1	1/1	1/1	0/1

Comments:
11. Based upon the QIDP tracking document, the completed assessments/inventories were available to the IDT 10 days prior to the ISP meeting for everyone, but Individual #216 whose FSA was one day past the due date.

12. The FSA for eight of the nine individuals clearly identified recommended SAPs. The exception was Individual #312. Additionally, one SAP recommendation was found in the vocational assessments for Individual #343, Individual #218, Individual #227, Individual #92, Individual #216, and Individual #149. Individual #312's vocational assessment suggested that SAPs were "not applicable" due to his ability to carry out many tasks independently. It is suggested that this 33 year-old man could be learning more advanced and varied work skills.

Individual #251 and Individual #369 did not have a vocational or day assessment and therefore were not scored on this indicator.

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

Summary: Many of the SAPs had many of the required components, but every SAP was missing one or more required component. Every SAP needed to have better instructions for DSPs to be able to implement them correctly and consistently. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	218	251	369	227	92	216	149	312
13	The individual's SAPs are complete.	0% 0/14	0/2 14/19	0/1 7/9	0/2 18/20	0/1 7/10	No SAPs	0/2 17/19	0/1 7/10	0/3 23/30	0/2 13/20

Comments:

13. Although none of the 14 SAPs were considered complete, in over 75% of the SAPs, the following elements were present and were scored positively:

- a task analysis where appropriate,
- a behavioral objective,
- an operational definition of the behavior,
- a teaching schedule,
- reinforcement following correct responding,
- guidelines following incorrect responding, and
- documentation methodology.

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 scored positively for all of the SAPs chosen/available for review.

Note that all components were present, but the ones that were scored 0 were scored this way as described below.

- Individual #343 had two SAPs, one of which guided staff to avoid using physical prompting because this may cause her to become agitated. The second SAP did not address this potential problem. There should be consistency across instructions to avoid creating an uncomfortable situation for the individual.
- In some cases, the discriminative stimulus was not appropriate to the skill. Individual #218 was learning to name the possible side effects of his medication, but he was asked to tell the staff member what he knew about it. Individual #149 was to learn to sanitize his hands, but he was told to flip open the cap.
- The instructions were not clear in any of the 14 SAPs. Examples included the following:
    - Individual #343 was expected to choose the named coin from a group of coins, but it was not clear how she was to learn to discriminate each coin.
    - The instructions in Individual #218's medication SAP did not indicate whether his mastered steps were reviewed at each medication administration.
    - It was not clear how Individual #251 was to learn to write her full name, for example, whether she was to be prompted through the remaining letters.
    - It was not clear how Individual #369 understood what was in the box she was expected to explore.
    - There were no instructions for teaching Individual #92 or Individual #312 where to find the change identified on the receipt.
    - Individual #216's use of a ledger SAP did not indicate how she was to know her weekly earnings.
    - It was not clear how staff were to prompt Individual #149 through conversing with his parents.
- Eight of the SAPs were scheduled to occur four to eight times per month, resulting in minimal learning opportunities for the individual. An increase in the number teaching trials can likely better ensure skill acquisition.
- Maintenance and generalization were not always adequately addressed.

- Specific sub-indicators scored 0 were:

- Individual #343, for coins: instructions, consequences for correct responding, and maintenance/generalization; and for radio, for behavioral objective and consequences for correct responding.
- Individual #218, for medication: discriminative stimulus and specific instructions.
- Individual #251, for wig: maintenance/generalization; and for write name: specific instructions.
- Individual #369, for manipulate item: specific instructions, consequences for correct responding, and maintenance/generalization.
- Individual #92, for receipt: instructions; and for respect: operational definition.
- Individual #312, for receipt: operational definition and instructions; and for medication: task analysis, discriminative stimulus, specific instructions, responses to incorrect responding, and documentation.
- Individual #216, for ledger: discriminative stimulus, specific instructions, and maintenance/generalization.
- Individual #149, for parents: specific instructions; for DVD: specific instructions; and for hands: discriminative stimulus, specific instructions, consequences for correct responding, responses to incorrect responding, maintenance/generalization.

Outcome 5- SAPs are implemented with integrity.

Summary: Half the SAPs were implemented as written. For the other half, staff were very pleasant and positive during the interaction (which was great to observe), but didn't follow the SAP as written. The Center did not have a system and was not regularly observing and assessing SAP implementation integrity. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	218	251	369	227	92	216	149	312
14	SAPs are implemented as written.	50% 3/6	1/1	Attempted	0/1	1/1	No SAPs	Attempted	0/1	1/1	0/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/14	0/2	0/1	0/2	0/1	No SAPs	0/2	0/1	0/3	0/2

Comments:

14. Although teaching sessions were scheduled for the eight individuals who had SAPs, the Monitoring Team was unable to observe at the scheduled times for Individual #218 and Individual #92. For the remaining six individuals, SAP observations are described below.
    - For Individual #343, Individual #369 and Individual #149, the observed SAPs were implemented as written.
    - Individual #251 was observed working on her wig care SAP. The staff member presented the wig and the mannequin head on the tabletop, but the mannequin head was off to the side and not in front Individual #251. The staff member did not present the instruction as noted, rather she repeatedly asked Individual #251 if she could remember what she need to do next. When she did deliver the verbal prompt, the staff member did so appropriately and praised Individual #251 for her efforts. She next

provided Individual #251 the option of combing the wig or not. It was difficult for both Individual #251 and the staff member to secure the wig to the mannequin head.

- The staff member did a nice job working with Individual #216 on her budgeting SAP, but she did not follow the SAP as written. Individual #216 did not use a ledger, nor was she required to record the amount of money she received and add it to her balance. Instead, the staff member recorded $20 on a sheet of paper and then had Individual #216 use a calculator to deduct the cost of items she identified in a store flyer.
- The nurse was very patient with Individual #312 while working on his medication SAP. However, she did not follow the SAP as written. Individual #312 was not required to remove each medication from the blister pack after naming the medication, the prescribed dose, or the reason it was prescribed. The nurse reviewed all four medications with Individual #312 and then repeated this process before he took his medications.

15. The policy indicates that integrity will be assessed once within the first three months of SAP implementation, and then again within nine months. Based upon the documentation provided both before and during the remote review, none of the 14 SAPs had been monitored.

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

Summary: SAP data were not reviewed monthly as required. About half of the SAPs also had no graphs. This needs to be corrected if indicator 17 is to remain in the category of requiring less oversight after the next review. Indicator 16 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 343	218	251	369	227	92	216	149	312
16	There is evidence that SAPs are reviewed monthly.	14% 2/14	0/2	1/1	0/2	0/1	No SAPs	1/2	0/1	0/3	0/2
17	SAP outcomes are graphed.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
16. There was evidence in the QIDP monthly reports that two of the 14 SAPs were reviewed each month. These were the medication SAP for Individual #218 and the respect SAP for Individual #92.

For five SAPs (Individual #343 - identify coins; Individual #149 - operate DVD, sanitize hands, and call parents; and Individual #312 - medication), data were reported for at least four of six months, but the step was not identified.

For four SAPs (Individual #343 - operate radio; Individual #251 - wig care and write last name; and Individual #369 - manipulate items), either there was no review or no data reported until October 2021.

Individual #92's check receipt SAP was on hold from May through August 2021, and then for the next two months noted to be undergoing revision. Data were reported for May and June 2021 for Individual #216's budgeting SAP, but there was no further review. Similarly, data were reviewed in May 2021 for Individual #312's check receipt SAP, but there was no information in subsequent reports.

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

Summary: Some individuals were regularly engaged in activities when observed by the Monitoring Team, others were not. The Center was measuring engagement and reporting high levels. Indicators 18 and 21 will remain in active monitoring. With sustained high performance, indicator 21 might be moved to the category of requiring less oversight after the next review.

#	Indicator	Overall Score	Individuals: 343	218	251	369	227	92	216	149	312
18	The individual is meaningfully engaged in residential and treatment sites.	67% 6/9	0/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	The day and treatment sites of the individual have goal engagement level scores.										
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

18. Over four days, seven of the nine individuals were observed a minimum of three times. The exceptions were Individual #218 and Individual #369, both of whom were in quarantine at least part of the week. Based upon these observations, it was determined that four of the nine individuals were most-often engaged in some meaningful activity. These were Individual #218, Individual #227, Individual #216, and Individual #312.

For the remaining five individuals, either there was no engagement at the time of the observation, or the activity presented did not appear of interest to the individual.

It was positive to observe the staff member working with Individual #251, as she frequently encouraged Individual #251 to complete part of the activity independently. However, Individual #251 appeared disinterested in coloring and creating crystals. Individual #92 was most engaged with completing multiplication problems, but otherwise he was not actively engaged. Individual #149 was most often observed wandering about his home or the campus.

In comments on the draft version of this report, the Center provided more information about what was happening before and during the engagement observations for Individual #251 and Individual #92. As a result, both individuals were scored 1 for this indicator.

During the remote review, the Monitoring Team learned that several classes had been cancelled because teaching staff were re-assigned to serve as direct support professionals. This resulted in limited scheduled programming for many of the individuals. The schedules that were provided prior to the review indicated scheduled program times from five hours per week to 24 hours per week. Although all of the individuals were of working age, only seven had scheduled employment.

- Individual #218 had the most hours of scheduled work at 22.5 hours weekly, Individual #343 was scheduled for 15 hours of work each week, Individual #216 was scheduled for 10 hours of work each week, and Individual #227 was scheduled for five hours of work each week.
- Individual #92, Individual #149, and Individual #312, ages 27 to 33, were scheduled to work two and one half hours each week.
- It will be important for teams to assess work interests and develop employment opportunities for all those of working age.

Several of the individuals were scheduled to participate in specialty classes including Men's Group, Women's Group, and Anger Management. The Center should ensure that the staff providing and supervising these educational activities are appropriately qualified and follow established curricula that serve as instructional guides.

The Monitoring Team was able to observe the initial one and one half hours of the annual ISP meeting for Individual #216. Individual #216's input was often not addressed, such as her living options, which would be discussed later in the meeting, and the leisure goal. Individual #216 noted that she liked cleaning, and when asked for additional ideas, she stated that she like coloring and math. The IDT did not address any of these interests, rather they decided upon a goal involving music.

21. Data provided by the facility indicated that between July and December of 2021, engagement was regularly assessed at above 80% in all homes and day program/work sites.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.												
Summary: Throughout the six-month period prior to the remote review, there were restrictions regarding community-based recreational activities and SAP training in response to the Covid pandemic. For this reason, these indicators are not scored.			Individuals:									
#	Indicator	Overall Score	343	218	251	369	227	92	216	149	312
22	For the individual, goal frequencies of community recreational activities are established and achieved.	N/A due to COVID									
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	N/A due to COVID									
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	N/A due to COVID									

Comments:
22-24. Throughout the six-month period prior to the remote review, there were restrictions regarding community-based recreational activities and SAP training in response to the Covid pandemic. For this reason, these indicators are scored not applicable.

However, it is important to note that community-based activities were reported over a six and one half month period for each of the nine individuals. Seven individuals experienced between one and nine outings, while Individual #218 and Individual #216 experienced 35 and 25 respectively. The ISP for Individual #369 indicated two community-based activities each month, while Individual #312's ISP noted that these activities were on hold due to Covid. None of the remaining ISPs addressed this activity. As Covid restrictions ease, teams should ensure that planning for community involvement is again addressed in the individual's ISP.

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

Summary: One individual at Corpus Christi SSLC was attending school. Activities showing integration between the Center and the school were not occurring as required. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	343	218	251	369	227	92	216	149	312
25	The student receives educational services that are integrated with the ISP.	0% 0/1									

Comments:
25. At the time of the remote review, Individual #330 was the only individual in residence at the facility who was attending school. To score this indicator, a review of his ISP, IEP, and most recent QIDP monthly reported was conducted. Additionally, any ISPAs regarding school were requested.

Based upon the information contained in these documents, it was determined that he was not enrolled in school until the end of September 2021, although he had been admitted to the facility in February of that same year. No explanation for this delay was provided.

At his ISP meeting, held in March 2021, it was noted that enrollment in public school would be explored and there was an action plan addressing this matter. His IEP provided evidence of participation by his QIDP and discussion regarding inclusion and an extended school year. There was no evidence of his IDT reviewing his progress in school in his QIDP monthly report completed in January 2022.

PTS: 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: IDTs were discussing and reviewing the need for, and usage of, pretreatment sedation. This was the case for a number of consecutive reviews. Therefore, indicators 1 and 2 will be moved to the category of requiring less oversight. In no cases, did the IDT determine that an action plan was needed to	Individuals:

reduce future use of PTS for the individuals. Behavioral Health Services staff should be working with individuals, their teams, and the dental services department to improve daily toothbrushing for the three individuals who had surgery for teeth extraction. These indicators will remain in active monitoring.

#	Indicator	Overall Score	343	218	251	369	227	92	216	149	312
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% 6/6	1/1	1/1	1/1	1/1	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% 6/6	1/1	1/1	1/1	1/1	1/1				1/1
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	N/A									
4	Action plans were implemented.	N/A									
5	If implemented, progress was monitored.	N/A									
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A									

Comments:

1. The facility reported the use of pretreatment sedation for six individuals in the review group. The individuals and the required procedures were the following: Individual #343 - mammogram, gynecology exam, and ophthalmology exam; Individual #218 - dental exam and extraction of one tooth; Individual #251 - dental exam; Individual #369 - dental exam, gynecology exam, and ophthalmology exam; Individual #227 - emergency room visit due to injured finger, dental exam, extraction of four teeth, and echocardiogram; and Individual #312 - dental exam, removal of lesion on upper lip, and extraction of two teeth.

There was evidence of a review of the need for pretreatment sedation with interfering behaviors noted, and consent by either the individual's guardian or the facility director when the individual did not have a guardian.

2. Facility staff had determined that the use of pretreatment sedation was necessary for the documented exams and procedures. No plans were developed to reduce the use of pretreatment sedation in the future for similar events.

3-6. These were not applicable at this time.

Behavioral Health Services staff should be working with individuals, their teams, and the dental services department to improve daily toothbrushing for the three individuals who had surgery for teeth extraction.

Section T: Serving Residents in the Most Integrated Settings Appropriate to Their Needs

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Two of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, two additional indicators were moved to this category.

Section Summary
Two individuals transitioned since the last review and the Center currently had 13 active referrals.

During the review week, the Monitoring Team also observed ISP meetings during which the IDT members generally recommended referrals, but referrals were not made due to perceived barriers. It appeared that IDTs and QIDPs could use some additional technical assistance and education about how to address possible barriers with action plans, or even how to recognize that a perceived barrier might not be one after all.

A new Admissions and Placement Coordinator (APC) began work in July 2021. She and her team were very knowledgeable and had implemented, or continued to implement several improvements to the Center's transition processes:

- Transition staff had devised a comprehensive interdisciplinary settings assessment that began with the 14-day ISPA meeting, during which the IDT identified settings questions each discipline would want to address with the provider. Transition staff had devised a template for the disciplines to use during a specific settings assessment meeting with the provider in which all appropriate disciplines participated. Each discipline then provided written feedback from the meeting, relevant to their area, to the QIDP and the QIDP was charged to complete a formal ISPA document to capture the proceedings as a whole.
- As well documented in ISPAs, and particularly well in the individuals' transition logs, transition staff maintained ongoing and collaborative communications with IDT members, offering reminders, tools and support.
- Center staff had modified the discipline assessment process to include prompts to address certain pre-move training needs. While some disciplines used this more effectively than others, the prompts are a good tool to help increase that focus going forward.

It was also very positive to see that the PMM provided clear, concise and typically comprehensive comments for each post-move support, based on the supports as written. There were also some good examples of thorough follow-up when needs were not met.

As the foundation for safe and successful transitions and to support overall compliance with all indicators, the Center needed to focus improvement efforts on developing pre-move provider training supports that include clear competency criteria and sufficient testing to ensure provider staff demonstrated competencies for all criteria. While a few pre-move supports reviewed provided clear competency criteria, which was positive, most did not. None of the competency testing reviewed were sufficiently comprehensive to ensure provider staff were prepared to meet the individuals' needs prior to transition.

Center staff should also focus on ensuring that all important needs, and particularly health and safety needs, are addressed with appropriate post-move supports. For the CLDPs reviewed, many important post-move support needs were not included, even when the assessments clearly identified them.

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: CLDP supports continued to improve, however, more work was needed in writing the supports in a measurable way. Furthermore, there were some needed supports that did not make it into the CLDP list of supports for both individuals. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	291	166							
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: Despite ongoing COVID-19 challenges to the transition process, the Center had completed two transitions since the previous review. Both (Individual #291, Individual #166) were included in this review. Individual #291 transitioned to a group home operated by Corpus Christi SSLC, while Individual #166 transitioned to the home of his parents with provider host home supports. The Monitoring Team reviewed these two transitions and discussed them in detail with the Corpus Christi SSLC Admissions and Placement staff.

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how individuals' needs and preferences will be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. This process needs to start with the development of clear and detailed pre-move training supports that include specific competency criteria. Those criteria should answer the question "what are the important things provider staff need to know, and know how to do, to meet an individual's needs?" Once these important things are identified, the IDTs will need to ensure provider staff know, and can perform, each one. Examples of supports that both met and did not meet criterion are described below:

- Pre-move supports: The respective IDTs developed seven pre-move supports for Individual #291 and seven pre-move supports for Individual #166. Some pre-move supports called for delivery of 30-day supplies of needed items (e.g., medications, meal supplements, etc.) and these were measurable. Otherwise, for both individuals, the remaining several pre-move training supports addressed pre-move training for provider staff. To meet criterion, pre-move training supports should address the content of provider staff training as well as describe the staff to be trained, the training methodologies to be used, and the competency criteria. The Center must also describe how it will verify provider staff have the knowledge and competence to provide each individual's unique set of needed supports prior to relinquishing day-to-day responsibility for his or her health and safety. Previously, the Monitoring Team found that Center staff needed to prioritize ensuring that all pre-move training supports provide specific competency criteria for each topic. For this review, while some pre-move training supports provided clear criteria, most did not. The following provides examples of supports that were measurable and those that were not:
    - For Individual #291, the best example of defining competency criteria was for the diet regimen pre-move training support, which provided specific expectations. On the other hand, the training pre-move support for nursing only referenced that training would address her nursing and medical needs, but otherwise provided no specific topics or expectations. The habilitation pre-move training support did reference broad topics (i.e., Physical Nutritional Management Plan PNMP, diet plan, diet texture, diet card, transfers, uses of assistive equipment) and did not provide any detail about the specific and individualized knowledge by which provider staff competency could be measured (e.g., her specific diet needs, transfer procedures, or individualized assistive equipment.).
    - For Individual #166, it was very positive to see that the pre-move training support related to his nursing needs generally provided specific competency criteria provider staff would need to meet. But, the competency criteria were not consistently comprehensive, based upon his needs (i.e., the criteria did not address his seizure disorder), but this was still an area of significant improvement. Two other pre-move training supports addressed his appropriate meal texture and an instruction for providing him with verbal prompts to swallow between bites of food.
    - The Monitoring Team reviewed the Center's pre-move provider testing to assess whether it clearly and comprehensively evidenced staff knowledge and competence based on the individuals' assessments. Overall, the testing still did not fully address many of the assessed needs or what provider staff would likely need to know, or know how to do. The following provides examples:
        - For Individual #291, the CLDP did not specify any behavioral pre-move training supports or provide any training to ensure that provider staff knew how to respond to her historical and current behavioral concerns, as described further below with regard to Indicator 2.
        - While Individual #291's CLDP did not specify a pre-move training support for her communication needs, it was positive that Center staff provided some related training. However, while the competency testing focused on some of ways the individual communicated, it did not test provider staff knowledge of how they should respond (e.g., use parallel talk, assist her to move to quieter space).
        - Also for Individual #291, the PNMP competency test indicated that provider staff would need to demonstrate how to prepare the correct ground texture of foods and the tests indicated all provider staff had achieved that competency. However, in interview, transition staff acknowledged that only one of the provider staff had actually completed the demonstration. It will be important to ensure that Center staff keep accurate competency records that reflect the actual experience and outcome.

- For Individual #166, the nursing pre-move training support provided 16 distinct criteria, which was positive overall, and it appeared from the materials provided that the pre-move training was extensive. However, the competency testing only consisted of five true/false questions that did not address many of his needs (e.g., signs and symptoms of various conditions, health care monitoring requirements, bowel tracking, etc.).
- For both individuals, Center staff sometimes did not construct competency testing in a rigorous manner that would test actual knowledge of individual's specific needs. For example:
    - For Individual #291, based on the materials provided for review, Center staff delivered extensive nursing and health care training. However, the competency test was limited to five questions. While this would not have been sufficient to test provider staff knowledge of her many needs in these areas in any event, one of the five questions was also irrelevant to her needs. It asked what she was allergic to, to which the correct answer was nothing.
    - For Individual #166's Occupational Therapy quiz, one of five questions asked provider staff to select the correct answer to describe what the risk of not receiving his chopped diet would be. The choice of answers included "nothing," I don't know," and "he might choke." Center staff should focus on questions that more effectively probe knowledge than on questions that lead provider staff to the correct response.
- In addition to focusing on the development of more appropriate and comprehensive competency testing, Center staff should take care to ensure their scoring is correct. For both individuals, the Monitoring Team noted incorrect provider staff responses that were scored as accurate.

- Post-Move: The respective IDTs developed 24 post-move supports for Individual #291, and listed 35 post-move supports for Individual #166. At the time of the previous review, the Monitoring Team noted that CLDPs still needed to ensure all supports provided the PMM with clear and measurable criteria or indicators that could be used to ensure those supports were being provided. There was some progress noted for this review, particularly for Individual #291's CLDP, but there continued to be examples of post-move supports that used vague language and did not provide clear expectations about needed staff actions or about outcomes:
    - Both CLDPs included post-move supports that called for provider staff to judge whether changes in function occurred, including OT/PT needs for Individual #291 and communication needs for both individuals, but neither CLDP provided any baseline criteria or examples of what might constitute a change that would require action.
    - For both individuals, the CLDP included some post-move supports that did not provide needed criteria or parameters for implementation. The following provides examples:
        - For Individual #291, a post move support indicated that she was last seen by gastrointestinal specialist on 10/13/20 and that the timing for follow-up would at the discretion of the primary care provider, however, the CLDP did not include a support that indicated when she would see the PCP. The CLDP couched another support for a urology consult in the same manner.
        - The CLDP for Individual #166 included post-move supports for tracking his blood pressure and blood sugar, but neither provided any parameters by which provider staff could judge if they needed to take action (e.g., notify the nurse).

- For Individual #166, it was unclear why the CLDP did not require starting to track many of health care monitoring needs (e.g., the aforementioned blood pressure and blood sugar levels) until 30 days after his transition.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for this indicator to be scored as meeting criterion. Neither of the CLDPs reviewed fully and comprehensively addressed the individuals' support needs and did not meet criterion. The following provides examples:

- Past history, and recent and current behavioral and psychiatric problems: Of note, based on his assessments, Individual #166 did not have any identified behavioral or psychiatric needs or significant history in those areas and did not require related supports. On the other hand, Individual #291's CLDP did not include any supports for her identified behavioral health needs, other than to have an annual behavioral health assessment (BHA). Based on her BHA, she had a history of gumming her arm when she was unhappy and twirling her hair when irritated or experiencing anxiety. According to her CLDP Profile, the latter behavior had led to hair loss in the past. The BHA noted that simple redirection was an effective strategy and that, if or when the behavior occurs, provider staff should seek the reasons for why Individual #291 is unhappy and assist with helping her. The CLDP did not provide any pre-move or post-move for provider staff to be knowledgeable of these needs and strategies. While the BHA noted these were not behavioral issues that resulted in injury, Center staff should not limit the provision of such information, or the development of needed supports, based on whether an injury was likely to result, but should seek to inform new provider staff about how best to provide positive behavior supports as well.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The respective IDTs developed supports in some areas related to safety, medical, healthcare, therapeutic and risk needs, such as for scheduling of health care appointments. To meet criterion, though, the IDTs still needed to develop comprehensive supports in this area.
    - For both individuals, the respective IDTs did not include post-move supports that addressed their supervision needs.
    - Per their Integrated Risk Rating Forms (IRRFs), both individuals had specific nursing assessment and/or health care monitoring requirements, but neither CLDP consistently included sufficiently clear and succinct post-move supports describing these expectations. It was positive that Individual #166's CLDP included post-move supports for monitoring of pertinent signs and symptoms, including for hypo or hyperglycemia, seizure activity, cerumen accumulation, and nail care. However, this did not address all of his monitoring needs, nor did the CLDP include any related post-move supports. For example, the CLDP included a post-move support for tracking his bowel movements for "regularity," but not for reporting to nursing if he did not have one within two days. For Individual #291, while the nursing assessment included many requirements in the nursing medical area, the CLDP included very few related supports. For example, the assessment indicated provider staff should notify nursing if she did not have a bowel movement in two days or had hard/dry, or bloody stool and to notify nursing of all vomiting, diarrhea, and meal refusals. The CLDP did not include any related supports.
    - For Individual #291, other assessments also contained important recommendations the CLDPs did not fully address or address at all.
        - Based on her medical assessment, she had a history of a dilated atonic colon in 2018 and a continued need for monitoring for abdominal distension, in addition to regular bowel movements. The CLDP did not include any specific pre- or post-move supports to ensure staff competence and knowledge.

        - Bases on her assessments, positioning and mobility needs included the following: a hemi-height wheelchair with seatbelt, a standard leg rest, padded foot plates, a built up pad on the right footrest, a removable arm rest and headrest and a home shower bench to be used with staff assistance. She was also to be offered time out of her wheelchair for 30·60 minutes, at least twice a day, using her choice of her home recliner or her bed, with a head of bed elevation (stated variously among the documentation at 30 to 45 degrees). The CLDP did not include any specific pre- or post-move supports to ensure staff competence and knowledge.
        - According to her IRRF, due to her elevated risk for choking, provider staff needed to observe the following instructions: assist her to eat as needed, ensure she is always in the most upright position when eating or drinking, and use a chair with armrests and footrests for positioning. In addition, she had a high-sided divided plate. The CLDP did not include any specific pre- or post-move supports to ensure staff competence and knowledge.
        - She communicated non-verbally using gestures, body language, facial expressions, and limited speech. She required a Communication Dictionary, which provided examples of how she communicated (e.g., when she wants something, she will point to the item or get it herself; will indicate "No" by shaking her head; will indicate she is angry or frustrated by raising her hand and pushing away, etc.) . The CLDP did not include any pre-move supports for provider training or any post-move supports to ensure provider staff knew that she had a Communication Dictionary or what was in it. The only related post-move support was to obtain a communication assessment or screening if a change in status occurred.
    - For Individual #166, the CLDP more often included post-move supports for his specific needs, but there was still need for improvement.
        - He had a diagnosis of Borjeson-Forssman-Lehmann syndrome, which was stable. The medical assessment noted that the central nervous system of affected people show other symptoms, including impaired vision (cataracts and hyperopia, particularly) and nystagmus. It further recommended that he have an ophthalmology exam to follow-up on several related conditions, but the CLDP did not include a post-move support for this need.
        - The medical assessment noted he was due for an injection to treat his osteoporosis. The PCP “strongly” recommended that, once the individual had his second dose of COVID vaccine, he should switch to Prolia injections every six months, with a repeat bone density in six months. The CLDP did not include related supports.

- What was important to the individual: Neither of the CLDPs met criterion. The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. Findings included:
    - For Individual #291, the CLDP stated her preferred outcomes as independently retrieving her work materials and living in an ICF group home in the Corpus Christi community. Based on documentation provided for review, the IDT had opportunities to more assertively define what was known to be important to her and create supports to help her achieve them. As examples, her Functional Skills Assessment (FSA) recommended that she be able to attend church in the community with her friend from the Center. It also noted her enjoyment of community outings and leisure activities, but stated that she needed staff support to engage in them. This CLDP did not meet criterion.

- For Individual #166, the CLDP referenced only his desire to live at home with his parents. However, based on his ISP and PSI, it appeared that, with his permanent move to the family home, he also had the opportunity to engage in those things most important to him. This CLDP met criterion.

- Need/desire for employment, and/or other meaningful day activities: Individual #166's CLDP met criterion, but Individual #291's did not.
  - For Individual #291, her assessments indicated she enjoyed her vocational day program at Corpus Christi SSLC and would continue to attend the program there following her transition. However, the CLDP did not address participation in any meaningful day activities in any integrated community settings.
  - Individual #166's CLDP did not include any supports for employment or day habilitation, as he had indicated that he used to work, but now enjoyed being retired. While the CLDP did not address participation in any meaningful day activities in any integrated community settings, it appeared from documentation that Individual #166 was actively engaged, on an ongoing basis, in community activities with his family.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success. Neither CLDP included any post-move supports in this area and did not meet criterion.

- Teaching, maintenance, participation, and acquisition of specific skills: Both CLDPs met criterion. Individual #291's CLDP included several post-move supports for continued skill acquisition (i.e., to independently serve herself frozen yogurt in a community shop, to apply blush, and to gather her materials for work). Individual #166's CLDP did include supports in this area, but included discussion noting that his family indicated he could already perform the recommended skill acquisition plans (SAPs). Given that he had already been home for a lengthy period, it appeared the family was the best source of information in this area and that formal supports were not needed.

All recommendations from assessments are included, or if not, there is a rationale provided: As reported at the time of the previous review, the documentation of the IDTs' discussion of assessments and recommendations continued to need improvement. As described throughout this section, the CLDPs did not consistently ensure that recommendations from assessments were addressed and/or that the IDT provided a coherent rationale when recommendations were deferred or declined. Transition staff and disciplines should work together to ensure that both the source assessments and the corresponding CLDP summaries specifically highlight all important recommendations and ensure that the CLDP includes the necessary post-move supports for implementation and post-move monitoring to occur.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.	
Summary: Post move monitoring was occurring and every support was reviewed. The determination of support provision needed to occur somewhat more in depth and also needed some better direction from the IDT. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	291	166							
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 was moved to the category of 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 assessment is correct based on the evidence.	0% 0/2	0/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	0% 0/2	0/1	0/1							
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	Not rated									
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	Not rated									

Comments:

4. The PMM Checklists often did not provide reliable and valid data for these individuals' support needs, as a result of several practices that needed to be improved, but even so, some progress was noted. Findings included:

- It was very positive to see that Center staff had modified the PMM Checklist template to include a specific description of evidence needed in the three prongs of evidence that IDTs should consider, including 1) interviews of appropriate staff and, whenever feasible, the individual; 2) review of documentation (e.g., various logs); and 3) observations. Whenever possible, IDTs should require at least two, or preferably, all three prongs, and it was good to see the IDTs had done this for these two CLDPs. To ensure that comments address all of the required evidence and nothing is missed, the Monitoring Team recommended the PMM consider documenting comments using the same format.
- It was also positive to see the PMM regularly interviewed direct support staff, in addition to supervisory staff. This was a noted improvement in practice.
- However, as described with regard to Indicator 1 above, IDTs needed to continue to work toward improving measurability of supports to provide guidance to the PMM as to what criteria would constitute the presence of various supports.
- IDTs also needed to continue to work on developing comprehensive pre and post-move supports for verifying provider staff knowledge and competence, thereby ensuring that the PMM would have the necessary prompts to assess whether provider staff were able to meet individuals' needs, as well as needed benchmarks for making an accurate assessment. As described with

regard to Indicator 2 above, both individuals had significant supervision, behavioral health and/or health care needs for which the IDTs did not develop supports.

5. Based on information the Post Move Monitor collected, the Monitoring Team could often not evaluate or confirm whether individuals had consistently received needed supports due to the lack of reliable and valid data. The PMM's comments and evidence should address the full scope of each support so that its presence could be reliably assessed. However, as described above with regard to the lack of measurability of some supports (i.e., in Indicator 1), as well as the lack of certain needed formal supports (i.e., in Indicator 2), the CLDP supports often did not provide the PMM with sufficient information to be able to fully assess for the presence of all needed supports. The following provides additional examples:

- Due to the lack of many needed post-move supports for Individual #291, it was particularly difficult to determine whether she had all needed supports in place. Otherwise, the PMM noted that Individual #291 did not consistently work on her SAPs and did not receive her gynecology appointment in a timely manner. At the time of the seven-day PMM visit, the documentation did not show she received oral care as indicated in the post-move support. However, it was positive to see that the PMM followed-up on all of these noted deficiencies and determined they had been corrected.
- For Individual #166, as described with regard to Indicator 1 above, it was unknown if he had received some needed supports (e.g., blood pressure monitoring, weekly blood sugar monitoring) at the time of the seven-day PMM. Going forward, IDTs should select a due date that is commensurate with the frequency with which a support is needed, rather than 30 days after transition.

6. For both individuals, it was very positive to see that the PMM provided clear, concise, and typically comprehensive comments for each post-move support, based on the manner in which the supports were written. In that same vein, the PMM's scoring was typically correct to the extent that it reflected the supports as written. In terms of process by the PMM staff, these CLDPs met criterion. However, the IDTs will need to continue to work to improve both the comprehensiveness and measurability of the supports, to which the PMM will be able to apply her documentation and scoring acumen.

7-8. These indicators focus on the implementation of corrective action in a timely manner when supports described or listed in the CLDP are not provided as needed and that every problem is followed up through to resolution. Whether follow-up is completed as needed relies heavily on whether the PMM has been able to assess the presence of the described or listed supports, and then on the accuracy of the PMM's assessment of whether supports were, or were not, in place.

It was positive to see there were many good examples of thorough follow-up by the PMM when needs were not met. However, the PMM often did not document assessing whether needs described in the CLDP were in place, primarily because the IDT did not consistently create post-move supports to address those needs as described. As described with regard to Indicator 2 above, while this was a more significant issue with Individual #291's CLDP, Individual #166's also had some examples of this. In other words, compliance with this indicator requires that follow-up be implemented for the supports described and recommended in the CLDP, even when the IDT fails to develop an appropriate post-move support.

9-10. At the time of the monitoring review week post-move monitoring did not occur. As a result, these indicators were not rated.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.											
Summary: It was good to see that these individuals had no negative events following transition. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	291	166							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	100% 2/2	1/1	1/1							
Comments: 11. Neither of the individuals had experienced a PDCT event.											

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: Overall, there was progress when looking at this set of transition activities. In fact, due to sustained high performance on indicator 13, it will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	291	166							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	100% 2/2	1/1	1/1							

14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1								
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1								
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	100% 2/2	1/1	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.	100% 2/2	1/1	1/1								
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
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 and this remained an area of need. For this review, as described further below, Center staff made some progress with regard to the content and quality of assessments, although some were still not timely and/or comprehensive. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated with 45 Days of transition:
  - The Center did not provide for review an updated nutritional assessment for Individual #291.
  - Most of Individual #166's assessments were not completed within 45 days of transition. Of note, however, this was an unusual circumstance. Individual #166 had been living with his parents since early in the COVID-19 pandemic, so it was positive that transition staff had coordinated an opportunity for Individual #166 to come to the Center so that disciplines could complete their assessments. Unfortunately, following that, the final transition date was further delayed, causing the assessments to become outdated. Going forward, if such circumstances recur, disciplines should be requested to complete a review of the recent to confirm its currency, or make any updates needed.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: It was positive that Individual #166's IDT made a concerted effort to update his assessments despite his having been living elsewhere for a lengthy period. For Individual #291, most assessments provided a summary of relevant facts. It was positive that habilitation staff updated her OT/PT assessment when her functional status showed signs of decline; however, other assessments (e.g., the FSA) that referenced her functional skills did not reflect those declines and presented a confusing picture of her status.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: It was very positive to see that a number of assessments used a template that called for disciplines to describe needed post-move training, including the topic, competency criteria, type of training, and how

competency needed to be demonstrated. While there remained much work to be done to use this template in a meaningful way across all disciplines, it was positive to see that some made a good effort in this regard.

- 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. Assessment recommendations varied considerably in comprehensiveness and individualization. As described with regard to Indicator 2 above, there were also missed opportunities to make recommendations for meaningful community integration for Individual #291.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator, including the following: 1) There was documentation to show IDT members actively participated in the transition planning process; 2) the CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed; 3) the CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting. These two CLDPs met criterion. Section IV of the CLDP document, entitled Community Living, provided a summary of transition activities that described the involvement of the individual and LAR/ family, the LIDDA, and Center staff. These were helpful in understanding how the Centers transition processes ensured necessary participation, and both CLDPs met criterion.

14. Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required: As described with regard to Indicator 1 above, training did not yet meet criterion for these two CLDPs. The Monitoring Team requested and reviewed the materials, rosters, and competency testing for all training provided related to these transitions. The CLDP pre-move training supports did not yet consistently identify the expected provider staff knowledge or competencies that would need to be demonstrated. In addition, competency testing did not clearly document provider staff had knowledge of all essential supports. The tests did not include questions for many supports, as also described with regard to Indicator 1 above.

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

It was positive that Center staff had begun using discharge assessment and CLDP templates that were modified to prompt the specific disciplines, as well as the IDT as a whole, to address this issue. However, for both individuals, this indicator did not yet meet criterion. IDT members often determined that collaboration was not needed because the individual did not yet have an established practitioner in a particular field. Instead, the IDT should make those determinations based on the needs of the individual and, if needed, schedule them as a post-move support once the community counterparts are identified.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs.

This was an area of significant progress and both CLDPs met criterion. Transition staff had devised a comprehensive interdisciplinary settings assessment that began with the 14-day ISPA meeting, during which the IDT identified settings questions each discipline would

want to address with the provider. Transition staff had devised a template for the disciplines to use during a specific settings assessment meeting with the provider in which all appropriate disciplines participated. Each discipline then provided written feedback from the meeting, relevant to their area, to the QIDP, and the QIDP that was charged to complete a formal ISPA document to capture the proceedings as a whole. Based on review of the documentation provided, with assistance and guidance from transition staff, both IDTs implemented this process effectively.

17. The CLDP should include a specific statement of the IDT considerations of activities Center 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 Facility, Facility direct support staff spending time with the individual in the community, and Facility and provider direct support staff meeting to discuss the individual's needs.

For this review, Center staff used discharge assessment and CLDP templates that were also modified to prompt the specific disciplines, as well as the IDT as a whole, to address this issue. This was a positive practice. In both CLDPs, the IDTs determined whether any such activities were needed and made a specific statement. For Individual #166, who had been living at home with his parents for many months, the IDT determined this activity was not needed. For Individual #291, the IDT agreed that a Center direct support professional (DSP) should stay with her on her first overnight to assist and answer any questions her new provider staff might have and documented that this had been accomplished. Both CLDPs met criterion.

19. The pre-move site reviews (PMSRs) for both individuals were completed prior to the transition date. However, it is essential the Center can directly affirm provider staff competency to ensure health and safety prior to relinquishing day-to-day responsibility, and the PMSRs for these two individuals did not accomplish this. The CLDP pre-move supports for pre-move training did not meet criterion for ensuring that provider staff were competent for either individual, as described under Indicator #1 and Indicator #2.

Outcome 5 – Individuals have timely transition planning and implementation.

Summary: The Center was attentive to individuals' transitions and transition planning. This indicator will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 291	166							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	100% 2/2	1/1	1/1							

Comments: Less Oversight

20. Both CLDPs met criterion for this indicator.

- Individual #291 was referred on 2/8/20 and transitioned on 9/15/21. This exceeded 180 days, but the transition log indicated ongoing transition activity.
- Individual #166 was referred on 10/15/20 and transitioned on 8/30/21. This also exceeded 180 days, but the transition log indicated ongoing transition activity.