United States v. State of Texas

Monitoring Team Report

Denton State Supported Living Center

Dates of Onsite Review: September 26th to 30th, 2016

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Table of Contents

Background

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

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

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

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

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

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

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

Methodology

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

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

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

Organization of Report

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

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

Executive Summary

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

Status of Compliance with the Settlement Agreement

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

This Domain currently contains 22 outcomes and 60 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, and mortality review. Thirteen of these indicators had sustained high performance scores and will be moved to the category of requiring less oversight. This included three outcomes: Outcomes 4, 8, and 9 for Abuse, Neglect and Exploitation.

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

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

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

Restraint

Four indicators showed sustained high performance and were moved to the category of requiring less oversight, and many others showed good performance at this review. The use of crisis intervention restraint remained low, was lower than during the last two reviews, and was the second lowest when census-adjusted compared to all of the other SSLCs. There were, however, recent increases in the frequency and duration of crisis intervention physical restraint and the number of individuals who were restrained. The facility was using its data regarding crisis intervention restraint to plan actions. Also, the facility was being attentive to the requirements of PMR-SIB.

In addition to improving the timeliness of restraint monitoring, nursing staff need to assess respirations even when individuals refuse other vital signs. Nurses need to provide more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline. When injuries are noted, nurses should indicate whether or not they occurred as a result of the restraint, or indicate this is unknown.

Abuse, Neglect, and Incident Management

Overall the facility demonstrated a very high level of performance, with nine indicators (and three outcomes) moving to the category of requiring less oversight. Of significant note was a well organized and maturing incident management system at Denton SSLC. In particular, all of the investigations met the criteria for reviewing and acting upon previous occurrences and trends. Overall, the facility took appropriate action after an allegation, the required specific elements for the conduct of a complete and thorough investigation were present, and injury audits and non-serious injury investigations were done regularly and competently. Two DFPS investigations did not meet criterion for timely completion; this is important to continue to monitor. Also, Denton SSLC had an excellent system for tracking and managing UIR recommendations.

Other

IDTs were talking about the pretreatment chemical restraint needs of individuals. But even so, plans were not being implemented. Overall, PTCR practices needed more focus in order to meet the outcomes and indicators evaluated by the Monitoring Teams.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.

Summary: The use of crisis intervention restraint remained low at Denton SSLC. Occurrences received review by the facility as well as by QAQI Council. There were, however, recent increases in the frequency and duration of crisis intervention physical restraint and the number of individuals who were restrained. Indicator 1 scored slightly lower than during the last review, and indicator 2 scored somewhat higher. These two important indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 41	468	491	411	212	25	127	17	110
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	75% 9/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	73% 8/11	New	1/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1

Comments:

1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (November 2015 through July 2016) were reviewed. The overall frequency of use of crisis intervention restraint at Denton SSLC was lower than during the last two reviews and was the second lowest when census-adjusted compared to all of the other SSLCs. The use of crisis intervention physical restraints paralleled the overall use of crisis intervention restraint because all of crisis intervention restraints were physical restraints. The ordinate on the census-adjusted graph was too large, resulting in the graph line being compressed. The physical restraint graph had a more reasonable ordinate, and looking at that graph, an ascending trend was evident due to an increase in frequency in April,

May, and June 2016. Similarly, the average duration of a physical restraint was also showing an ascending trend over the past five months.

The facility provided some detail that described the restraints that occurred in April 2016 and May 2016. This information was helpful in understanding the detail. The June 2016 QAQI Council report included information about this increasing trend in the use of crisis intervention restraint. This was good to see and, further, the report showed that the facility was using its data regarding crisis intervention restraint to plan actions, such as having the BCBAs attend the ISPAs related to crisis intervention restraints to facilitate a complete discussion and identify environmental factors, and considering modified restraints for those individuals for whom staff reported difficulty in implementing the restraint properly.

There were no occurrences of crisis intervention chemical or mechanical restraint. There was a single instance of injury during restraint implementation; it was reported to be a non-serious abrasion. The number of individuals for whom crisis intervention restraint was used each month also showed an ascending trend across the nine-month period because of an increase in the same three months (April, May, June 2016). The graph showed zero use of protective mechanical restraint for self-injurious behavior (PMR-SIB). The facility, however, re-classified the use of protective helmets as PMR-SIB for two individuals in the weeks prior to the onsite review. By the time of the onsite review, one of those had been discontinued and changed to a crisis intervention restraint. The other remained in place (Individual #41), though it was utilized only during specific times of day (e.g., during bathing). Thus, overall, and especially in the past few weeks, the facility was being attentive to the requirements of PMR-SIB. The use of non-chemical and chemical restraints for medical and dental procedures was low or showing a decreasing trend.

Thus, state and facility data showed low usage and/or decreases in nine of these 12 facility-wide measures (i.e., use of crisis intervention restraint, use of crisis intervention chemical and mechanical restraint, the number of injuries that occurred during restraint, the number of individuals with protective mechanical restraint for self-injurious behavior, and the use of chemical and non-chemical restraints for medical procedures, and the use of non-chemical restraints for dental procedures).

2. Four of the individuals reviewed by the Monitoring Team were subject to restraint. In addition, the Monitoring Team reviewed restraint incidents for three additional individuals (Individual #459, Individual #96, Individual #7) for a total of seven individuals. Six received crisis intervention physical restraints (Individual #127, Individual #17, Individual #110, Individual #459, Individual #96, Individual #7) and one received PMR-SIB (Individual #41). Data from state office and from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for three (Individual #110, Individual #459, Individual #7). Data for Individual #41 were too new to be included in the scoring of this indicator (i.e., September 2016). The other five individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period.

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.	
Summary: Overall, Denton SSLC implemented restraint according to criteria for about half of the indicators this outcome. In particular, three indicators (3, 4, and 8) had high scores for this review and the last two reviews. These three indicators will be moved to the category of requiring less oversight. With sustained performance,	Individuals:

two indicators (5 and 10) might move to the category of requiring less oversight after the next review. Three indicators (6, 7, and 11) can likely be corrected with additional attention to the restraint documentation in the restraint documents and in the ISP. Indicator 9 will require attention and documentation. These six indicators will remain in active monitoring.											
#	Indicator	Overall Score	127	17	110	41	459	96	7		
3	There was no evidence of prone restraint used.	100% 9/9	2/2	2/2	1/1	1/1	1/1	1/1	1/1		
4	The restraint was a method approved in facility policy.	100% 9/9	2/2	2/2	1/1	1/1	1/1	1/1	1/1		
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 8/8	2/2	2/2	1/1	N/A	1/1	1/1	1/1		
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	63% 5/8	2/2	0/2	0/1	N/A	1/1	1/1	1/1		
7	There was no injury to the individual as a result of implementation of the restraint.	78% 7/9	2/2	2/2	0/1	1/1	0/1	1/1	1/1		
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 9/9	2/2	2/2	1/1	1/1	1/1	1/1	1/1		
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/5	0/2	0/2	Not rated	Not rated	Not rated	0/1	Not rated		
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 8/8	2/2	2/2	1/1	N/A	1/1	1/1	1/1		
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	33% 3/9	2/2	0/2	0/1	0/1	0/1	1/1	0/1		

Comments:
The Monitoring Team chose to review nine restraint incidents that occurred for seven different individuals (Individual #127, Individual #17, Individual #110, Individual #41, Individual #459, Individual #96, Individual #7). Of these, eight were crisis intervention physical restraints, none was a crisis intervention chemical restraint, and one was a protective mechanical restraint for self-injurious behavior (Individual #41). The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

6. Three restraint checklists showed a release code Y (release completed) instead of code S (Individual #17 5/27/16 and 7/18/16, Individual #110 4/30/16).

7. Two restraint checklists had no entry regarding injury (Individual #110 4/30/16, Individual #459 6/30/16). The facility reported only one injury (non-serious) over the past nine months (see indicator 1). Even so, this important piece of the restraint checklist needs to be completed for every restraint occurrence.

9. Because criterion for indicator #2 was met for three of the seven individuals, this indicator was not scored for them. Also, because Individual #41's PMR-SIB was recently implemented, the Monitoring Team did not score this indicator for her, too. For the other three, criteria were not met for their five restraints. The facility has struggled with meeting criteria for this indicator over the past reviews. Denton SSLC conducted internal crisis intervention restraint audit reviews that covered some, but not all, of the sub-indicators that comprise this indicator. The Monitoring Team determined that some, but not all, of the sub-indicators were occurring.

11. For five of the individuals, the IRRF section of the ISP was not correctly completed regarding considerations in the use of crisis intervention restraint. This important information needs to be included.

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

Summary: This is an area of focus for Denton SSLC. In March 2015, the facility had poor performance. This improved at the last review, but has again slipped. Thus, this indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 127	17	110	41	459	96	7		
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	57% 4/7	1/1	0/1	1/1	0/1	1/1	0/1	1/1		

Comments:
12. All staff for four individuals answered all, or most, questions correctly. For the other three, 30 percent of their staff did not correctly answer the question regarding whether any types of restraint were prohibited by policy.

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: Indicator 13 showed good improvement compared to the previous two reviews and with sustained performance might move to the category of requiring less oversight. It will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 127	17	110	41	459	96	7		
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 8/8	2/2	2/2	1/1	N/A	1/1	1/1	1/1		
14	There was evidence that the individual was offered opportunities to	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		

	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.										
Comments:											

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
Summary: In addition to improving the timeliness of restraint monitoring, nursing staff need to assess respirations even when individuals refuse other vital signs. Nurses need to provide more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline. When injuries are noted, nurses should indicate whether or not they occurred as a result of the restraint, or indicate this is unknown. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	127	17	110	459	96	7			
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	22% 2/9	1/2	0/3	0/1	1/1	0/1	0/1			
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	67% 6/9	1/2	3/3	0/1	0/1	1/1	1/1			
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	56% 5/9	2/2	1/3	0/1	1/1	1/1	0/1			

Comments: The crisis intervention restraints reviewed included those for: Individual #127 on 5/14/16 at 12:05 p.m., and 6/5/16 at 9:34 p.m.; Individual #17 on 5/27/16 at 12:23 a.m., 5/27/16 at 1:49 a.m., and 7/18/16 at 10:42 p.m.; Individual #110 on 4/30/16 at 9:00 a.m.; Individual #459 on 6/30/16 at 3:50 p.m.; Individual #96 on 4/24/16 at 6:07 p.m.; and Individual #7 on 4/12/16 at 5:50 p.m.

a. For five of the nine restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint. The exceptions were for Individual #127 on 5/14/16 at 12:05 p.m.; Individual #17 on 5/27/16 at 12:23 a.m., and 5/27/16 at 1:49 a.m.; and Individual #7 on 4/12/16 at 5:50 p.m.

For seven of the nine restraints, nursing staff monitored and documented vital signs. The exceptions were for: Individual #17 on 5/27/16 at 12:23 a.m., and 7/18/16 at 10:42 p.m. for whom all vital signs were marked as refused, but respirations can be obtained without the individual's cooperation.

Nursing staff monitored and documented mental status of the individuals for four of the nine restraints. In one case, no mental status assessment was documented (i.e., Individual #7 on 4/12/16 at 5:50 p.m.), and in other instances, sufficient description was not provided of the individual's mental status (e.g., "awake and alert") (i.e., Individual #17 on 5/27/16 at 12:23 a.m., and 7/18/16 at 10:42

p.m.; Individual #110 on 4/30/16 at 9:00 a.m.; and Individual #96 on 4/24/16 at 6:07 p.m.).

b. and c. Examples of problems noted included:

- For Individual #127, the IPN on 6/5/16 at 9:56 p.m. noted a superficial scratch to the individual's neck and a red area on the individual's back. These injuries were not clearly documented as related or unrelated to the restraint procedure. An area to the individual's left wrist was identified as an area where the individual bites himself per his statement. While the Restraint Checklist noted there were no injuries, it was not clear in the IPN if the additional areas described were a result of the restraint.
- The injury section of Individual #110's Restraint Checklist was left blank. On 4/30/16 at 9:24 a.m., an IPN noted the individual complained of pain to the left arm with slight blue bruising noted to the left forearm approximately two inches by one inch, and a superficial abrasion to lower right leg two centimeters. No injury report was provided.
- For Individual #459, the injury section of the Restraint Checklist was left blank, although the IPN noted no injuries.

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

Summary: Indicator 15 showed good improvement compared to the previous two reviews. With sustained performance, including documentation of PMR-SIB, it might move to the category of requiring less oversight. It will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 127	17	110	41	459	96	7		
15	Restraint was documented in compliance with Appendix A.	89% 8/9	2/2	2/2	1/1	0/1	1/1	1/1	1/1		

Comments:
15. Individual #41's long-term use of a protective helmet was re-classified as PMR-SIB in the week prior to the onsite review. It was good to see that this occurred, however, little documentation was available. The more recent checklists were more complete than those in the first few days of implementation. The variability in correct completion of documentation resulted in a 0/1 score for her for this indicator.

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

Summary: These indicators showed good performance for this review. Indicator 16 showed improved performance compared to the last two reviews. Indicator 17 was rated at 100% for this review and the past two reviews, too. It will be moved to the category of requiring less oversight. It was good to see that recommendations were implemented. Indicator 16 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 127	17	110	41	459	96	7		
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 8/8	2/2	2/2	1/1	N/A	1/1	1/1	1/1		

17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 8/8	2/2	2/2	1/1	N/A	1/1	1/1	1/1		
Comments:											

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)											
Summary: There were no instances of crisis intervention chemical restraint, therefore, this indicator was not applied. These indicators will remain in active monitoring. With continued zero occurrences of crisis intervention chemical restraint and/or good performance on these indicators if there are occurrences, these indicators might be moved to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score									
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	N/A									
48	Multiple medications were not used during chemical restraint.	N/A									
49	Psychiatry follow-up occurred following chemical restraint.	N/A									
Comments: 47-49. There were no chemical restraint episodes.											

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
Summary: Criteria were met for all investigations. This showed excellent and continual progress compared to previous reviews. Given this was the first time this level of performance was demonstrated, this indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	468	440	491	212	411	25	127	17	110
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	100% 11/11	1/1	1/1	1/1	1/1	1/1	2/2	2/2	1/1	1/1
Comments: The Monitoring Team reviewed 11 investigations that occurred for nine individuals. Of these 11 investigations, seven were DFPS investigations of abuse-neglect allegations (two confirmed, three unconfirmed, one inconclusive, one administrative referral back to the facility). The other four were for facility investigations of a serious injury fracture, an unauthorized departure from the facility, and											

sexual behavior related incidents. 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 #468, UIR 16-277, DFPS 44387214, admin referral physical abuse allegation, 6/6/16
- Individual #440, UIR 16-179, DFPS 44268062, unconfirmed neglect allegation, 3/17/16
- Individual #491, UIR 16-134, fracture, left knee, 1/15/16
- Individual #212, UIR 16-137, sexual incident, 1/17/16
- Individual #411, UIR 16-276, DFPS 44384045, unconfirmed physical abuse allegation, 6/6/16
- Individual #25, UIR 16-144, DFPS 44202285, confirmed physical abuse allegation, 1/27/16
- Individual #25, UIR 26-172, unauthorized departure, 3/8/16
- Individual #127, UIR 16-247, DFPS 44351107, unconfirmed neglect allegation, 5/16/15
- Individual #127, UIR 16-247, sexual incident, 5/9/16
- Individual #17, UIR 16-191, DFPS 44280107, confirmed verbal/emotional abuse, 3/27/16
- Individual #110, 16-183, DFPS 44271623, inconclusive physical abuse allegation,

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

All 11 of the investigations met the criteria for this indicator, including reviewing and acting upon previous occurrences and trends as typically evidenced in the ISP, PBSP, PNMT, and/or ISPAs (or the incident did not involve any prior occurrences or trends). This was excellent progress and improvement for the facility and its incident management department. IMRT oversight of the incident management system, as observed by the Monitoring Team throughout the onsite week, was also very good. This was not the case during the morning unit meeting at Garden Ridge. That meeting was not as well organized as the daily IMRT.

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

Summary: Although improvements are needed, the facility showed continued progress and improved scoring on this indicator over the past reviews. Moreover, the facility self-identified a need for improvement and was attending to it. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	468	440	491	212	411	25	127	17	110
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	82% 9/11	0/1	0/1	1/1	1/1	1/1	2/2	2/2	1/1	1/1

Comments:
2. The Monitoring Team rated nine of the 11 investigations as being reported correctly. All were discussed with the facility Incident Management Coordinator while onsite. This discussion, along with additional information provided to the Monitoring Team, informed the scoring of this indicator. Those not meeting criterion are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

- For Individual #468 UIR 16-277, the UIR noted this is a late report. It was unclear if the IMC determined that the anonymous reporter was likely aware of the suspicious injury and should have reported earlier. This was a discovered injury, in an area of the body not generally vulnerable to trauma, and the individual was not a reliable reporter. Therefore, a non-serious injury investigation should have been initiated, but wasn't.
- For Individual #440 UIR 16-179, the DFPS report showed that the alleged incident occurred at 9:26 am and was reported at 10:43 am (more than 1 hour). The UIR, however, showed that the incident occurred at 10:35 am and was reported at 11:01 am. The UIR stated that this was not a late report. The UIR should have addressed the circumstances associated with these apparent discrepancies.

To its credit, Denton SSLC's IMC and the department's staff attempted to identify, for each incident, whether or not proper reporting procedures were followed. In doing so, they also attempted to identify the source of any late report (not by name but by category, e.g., family, staff, individual, spurious reporter). This was an excellent practice. These data were tracked and reported at the facility QAQI Council meetings. Having these data and conducted these reviews resulted in facility self-identification of their systemic problem with late reporting. At the QAQI Council meeting observed by the Monitoring Team discussion occurred and campus wide training on reporting procedures was noted as having been developed and scheduled to start soon. Because timely reporting is so fundamental to an effective incident management system, it was good to see the depth of the review, maintenance of data, review of data, and development of responses to improve performance.

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: Indicator 3 showed improvement from past reviews while indicator 4 showed some decline. Indicator 5 was at 100% for this review and the past two reviews and, therefore, will be moved to the category of requiring less oversight. The other two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	468	440	491	212	411	25	127	17	110
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	82% 9/11	0/1	1/1	1/1	1/1	0/1	2/2	2/2	1/1	1/1

5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 11/11	1/1	1/1	1/1	1/1	1/1	2/2	2/2	1/1	1/1

Comments:
3. Because indicator 1 was met for all nine individuals, this indicator was not scored for them. Even so, the facility maintained it's administrative system for regular competency checks with staff. This was good to see. Also, during the onsite week, the Monitoring Team had reviewed the typical questions with four staff, all of whom answered all of the questions correctly.

4. For the two individuals for whom criteria were not met, there was no reference to that the typical information was provided to the individual or LAR.

In the homes on campus, the required poster (that contained reporting information) was present and, therefore, that sub-indicator's criterion was met. However, for some homes, it was in the kitchen area, but not entirely visible when the kitchen door was open. The Monitoring Team understands the importance to maintaining a home-style setting, but the facility should determine if there might be alternate/additional suitable locations for their placement that also do not compete with the home-style atmosphere.

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

Summary: Denton SSLC showed 100% performance on this indicator during this review and the last review, as well as improvement of already high scores from March 2015. Given this sustained performance, this indicator will move to the category of requiring less oversight

#	Indicator	Overall Score	Individuals: 468	440	491	212	411	25	127	17	110
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 11/11	1/1	1/1	1/1	1/1	1/1	2/2	2/2	1/1	1/1

Comments:

Outcome 5– Staff cooperate with investigations.

Summary: In this review and the previous two reviews, one or more investigations found a problem with staff cooperation with the investigation. Therefore, this indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 468	440	491	212	411	25	127	17	110
7	Facility staff cooperated with the investigation.	91% 10/11	0/1	1/1	1/1	1/1	1/1	2/2	2/2	1/1	1/1

Comments:
7. Generally, facility staff cooperated with investigation, that is, in all but one case during this review. For Individual #468 UIR 16-277,

the UIR noted a lack of cooperation by one staff in the facility investigation and also noted that unit was to address this concern. There was no indication that this occurred.

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.

Summary: Investigations by DFPS and by the facility contained all of the required elements and were in the proper format for this review and the previous two reviews. Therefore, indicator 8 will be moved to the category of requiring less oversight. That being said, attention needs to continue to be paid to whether incidents that should be investigated for abuse/neglect were instead referred back to the facility for investigation. Improved performance for indicators 9 and 10 might result in those two indicators also moving to the category of requiring less oversight after the next review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 468	440	491	212	411	25	127	17	110
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 11/11	1/1	1/1	1/1	1/1	1/1	2/2	2/2	1/1	1/1
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	91% 10/11	1/1	1/1	1/1	1/1	1/1	2/2	2/2	1/1	0/1
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	91% 10/11	1/1	1/1	1/1	1/1	1/1	2/2	2/2	1/1	0/1

Comments:

8. Criteria were met for all investigations, however, for Individual #468 UIR 16-277, the allegation to DFPS was that an unknown alleged perpetrator neglected the individual, which resulted in bruises. DFPS concluded that, because the injuries appeared to be from an unknown origin, that it was not the result of neglect. The source for this conclusion was limited to reviewing the client injury report (which may or may not have had complete and accurate data). Based on the nature of the allegation, DFPS probably should have conducted a regular investigation. The facility instead did its own follow-up investigation (which met criteria for this indicator).

9-10. For Individual #110 UIR 16-183, the DFPS conclusion was inconclusive because there was insufficient evidence to determine that the staff's verbalization/comments were meant as a threat or as intimidation. There was no indication that the DFPS investigator reviewed the emotional assessment done by a facility psychologist immediately after the incident, or interviewed the facility psychologist most familiar with Individual #110 to gain insight as to the effect of the alleged perpetrator's alleged verbal remarks. This may have produced enough additional information/evidence to make a finding of confirm or unconfirmed. Without having considered this, not all relevant evidence was collected, weighed, analyzed, and reconciled.

Outcome 7– Investigations are conducted and reviewed as required.

Summary: The facility maintained 100% performance for indicator 11 for this and the previous two reviews. Therefore, this indicator will be moved to the category of requiring less oversight. Performance was slightly lower on indicators 12 and 13 since the last review. For DFPS investigations, attention needs to be paid to the initiation of witness interviews as well as completion within the required 10 days. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 468	440	491	212	411	25	127	17	110
11	Commenced within 24 hours of being reported.	100% 11/11	1/1	1/1	1/1	1/1	1/1	2/2	2/2	1/1	1/1
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	82% 9/11	1/1	0/1	1/1	1/1	1/1	1/2	2/2	1/1	1/1
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	91% 10/11	1/1	1/1	1/1	1/1	1/1	2/2	2/2	1/1	0/1

Comments:

12. Two investigations did not meet criterion for timely completion. Individual #440 UIR 16-179 had extension requests that indicated that witnesses had not been available for interview, however, the first attempt by DFPS to interview staff was not until day seven, thereby, almost guaranteeing a need for an extension. DFPS needs to begin staff interviews earlier within the 10 days. This did not meet acceptable extraordinary circumstances. In its response to the draft report, the State reported that it was only one staff member who had not been interviewed by day 10 due to flu illness. Even so, there was no reason provided as to why a phone interview could not have been done earlier. Moreover, video review did not occur until day 12. The investigation was completed on day 14.

Individual #25 UIR 16-144 had an extension request with the reason being that DFPS was still reviewing documentation. This also did not represent an extraordinary circumstance.

13. One investigation, Individual #110 UIR 16-183, did not meet criteria for this indicator; the issues described in indicator 9 should have been identified during the facility review. 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: Denton SSLC showed 100% performance on these indicators during the last two reviews, with 100% on this review for indicator 14, and one absence of a non-serious injury investigation for indicator 15. Given this sustained performance and the presence of a good system, these two indicators will move to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	468	440	491	212	411	25	127	17	110
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	75% 3/4	0/1	N/A	N/A	1/1	1/1	1/1	N/A	N/A	N/A

Comments:

15. For Individual #468, no non-serious injury investigations were done, however, in reviewing the injury list, one should have been conducted for an injury on 6/3/16. This was first thought to be a witnessed injury, but the client injury report showed it as a discovered injury.

This indicator is predicated on a review of non-serious injuries to determine whether or not an NSI needs to be done (discovered versus witnessed, body part, and several other criteria). These determinations are made in the morning unit meeting reviews with IMRT oversight. Occasionally, these decisions are made with incomplete, incorrect, or conflicting data that's on the client injury report. To minimize, the facility has had (for a number of years) an excellent process for reviewing all client injury reports. That is, there is an appointed client injury specialist whose responsibility is to do a quality assurance check of each and every client injury report and reconcile any conflicting or missing information. The experienced specialist was on leave for a period of time that included the Monitoring Team's review period. Other staff filled in for him, which may have accounted for the miss in indicator 15.

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.	
Summary: Denton SSLC had an excellent system for tracking and managing UIR recommendations. This had been the case for some time now. Indicator 16 scored 100% on this review and the last review, as well as 90% on the review before that. Although one investigation did not meet criteria with indicators 17 and 18, the others did and, furthermore, the facility scored 100% on these two indicators at the	Individuals:

last two reviews, too. Moreover, there was an exemplary system of managing UIR recommendations. Thus, all three indicators will move to the category of requiring less oversight.											
#	Indicator	Overall Score	468	440	491	212	411	25	127	17	110
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 10/10	1/1	1/1	1/1	1/1	1/1	2/2	2/2	1/1	N/A
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	80% 4/5	0/1	1/1	N/A	N/A	N/A	2/2	N/A	1/1	N/A
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	88% 7/8	0/1	N/A	1/1	1/1	1/1	1/1	2/2	1/1	N/A
Comments: 16-18. Denton SSLC had an exemplary system for tracking UIR recommendations. They collected documentation to validate completion for each UIR recommendation and included it in the file for each specific UIR. Then, after recommended actions were reported to have been concluded, these information and relevant data were sent to the facility's assistant independent ombudsman to independently verify completion. He also attempted to validate the effectiveness of the planned/completed action. The three indicators of this outcome address whether recommendations were made and, if so, whether they occurred and were timely. The facility is commended for taking the extra step to assess the effectiveness of the planned action. The investigation for Individual #468 UIR 16-277 did not meet criteria for either indicator 17 or 18 because the facility could not produce any evidence that staff lack of cooperation with an investigation was addressed (17) or that staff checked the trampoline each week (18).											

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
Summary: This outcome consists of facility indicators. Data are collected, but more work needed in the creation of plans and data to assess plans. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes									
20	Over the past two quarters, the facility's trend analyses contained the required content.	Yes									
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	Yes									

22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No									
23	Action plans were appropriately developed, implemented, and tracked to completion.	No									

Comments:
19-21. The Monitoring Team reviewed QAQI Council information and documentation and observed the Council in its monthly meeting during the onsite review week. Content included the quarterly review of incident management data. Necessary data were presented and discussed. Appropriate conclusions and recommendations occurred, including the identification of systemic problem with timely reporting of incidents and initiated corrective action.

22-23. For the one corrective action plan in incident management, documentation did not show data that would demonstrate the effect of the plan and whether or not it needed modification.

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/4	0/1	N/A	0/1	N/A	0/1	0/1	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. Although the Center had a policy (i.e., IV Sedation – DS 24, dated 8/1/11) that listed five criteria for the use of TIVA, these criteria often were not measurable criteria, and were not consistent with those included in the Dental Audit Tool [i.e., the following procedures must be anticipated: Deep Cleaning (D4341/D4342), Restorative (D2140-D2999), Endodontics (D3110-D3999), and Extractions (D7111-D7999). There are some procedures, such as pulling wisdom teeth or deep scaling that people in the community would expect some form of sedation. For other procedures, three failed attempts must occur first before TIVA is used. If the individual met this criterion before and has another dental need, then only one failed attempt would be necessary, utilizing any desensitization or other strategies developed for the individual. The dentist should describe in detail what issues were observed during the trials. The only exceptions to this would be emergencies. Even if there are failed attempts, teams should document discussion of the need for programmatic interventions to increase cooperation in the future.]. The Center should modify its policy to be consistent with these guidelines.

Additionally, the Medical Department should have policies and procedures that describe which individuals are medically appropriate for TIVA/GA on campus or require dental treatment in a hospital setting. Additionally, there should be a medical policy related to comprehensive perioperative management of individuals who will have TIVA/general anesthesia. Perioperative management includes the process of preoperative evaluation. The Dental policies indicated a history and physical form would be sent to the provider, but there was no procedure associated with the form that described the criteria for completing diagnostics such as lab work and EKG. There are numerous tools published by professional organizations that provide guidance on the requirements for perioperative evaluations.

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

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

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: During this review and the last one, the Center showed improvement with this indicator. The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	100% 5/5	4/4	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
Comments: Of note, Individual #491 was administered general anesthesia for completion of a pap/pelvic exam. From the documentation provided, it was unclear whether or not the IDT had ensured the benefit outweighed the risk.											

Outcome 1 - Individuals' need for pretreatment chemical restraint (PTCR) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTCR.											
Summary: It was good to see that IDTs were attending to PTCR needs of individuals and talking about plans and/or support from the specialty on-campus clinic. But even so, plans were not being implemented. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	41	468	491	25					
1	IDT identifies the need for PTCR and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	100% 4/4	1/1	1/1	1/1	1/1					
2	If PTCR was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTCR, or (b)	100% 4/4	1/1	1/1	1/1	1/1					

	determined that any actions to reduce the use of PTCR would be counter-therapeutic for the individual.										
3	If treatments or strategies were developed to minimize or eliminate the need for PTCR, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTCR, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	25% 1/4	0/1	0/1	0/1	1/1					
4	Action plans were implemented.	0% 0/4	0/1	0/1	0/1	0/1					
5	If implemented, progress was monitored.	N/A	N/A	N/A	N/A	N/A					
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A	N/A	N/A	N/A	N/A					

Comments:
1-5. The IDTs for four individuals (Individual #41, Individual #468, Individual #491, Individual #25) had identified the need for PTCR. Each IDT had approved this need in the ISP. A Medical Restraint Plan (MRP) had been developed for one of the four individuals (Individual #25). Individual #41 had an action plan in her ISP that indicated familiar staff would provide support and, when available, her mother would attend appointments. It was not evident that this action plan had been implemented.

The IDTs indicated that three individuals (Individual #468, Individual #491, Individual #25) would be referred to the Behavior Analysis Resource Center (BARC) for possible participation in their dental desensitization clinic. Evidence of these referrals having been made was as follows: BARC documented that a referral had been made for Individual #468 on 10/6/15 at which time he was denied participation due to a lack of documentation of required dental sedations; Individual #491's ISP indicated that the referral had been completed on 12/17/14 nearly a full year before her ISP meeting – this is most likely a typographical error as the clinic was not operating at that time; and Individual #25's MRP indicated that he was on the wait list for the clinic. At the time of the onsite visit, none of these individuals were participating in the dental desensitization program.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	14	298	286	642	48				
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	100% 5/5	1/1	1/1	1/1	1/1	1/1				

	completed within 14 days of the clinical death review.										
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1	N/A				

Comments: a. Since the last review, 12 individuals died. The Monitoring Team reviewed five deaths. Causes of death were listed as:

- On 1/23/16, Individual #560 died at the age of 60 with causes of death listed as aspiration pneumonia, respiratory failure, hypertension, and diabetes mellitus;
- On 3/4/16, Individual #14 died at the age of 68 with causes of death listed as chronic obstructive pulmonary disease, and Alzheimer's disease;
- On 3/18/16, Individual #298 died at the age of 43 with causes of death listed as sepsis, pneumonia, and acute respiratory failure;
- On 4/29/16, Individual #286 died at the age of 64 with causes of death listed as recurrent urinary tract infections (UTIs), sepsis, Alzheimer's dementia, and protein calorie malnutrition;
- On 6/5/16, Individual #642 died at the age of 59 with causes of death listed as cardiopulmonary failure, anoxic encephalopathy, acute respiratory failure, and sepsis;
- On 6/9/16, Individual #48 died at the age of 68 with causes of death listed as acute respiratory failure, severe dehydration and shock, UTI, hypernatremia, and metabolic encephalopathy;
- On 7/12/16, Individual #42 died at the age of 52 with causes of death listed as acute on chronic respiratory failure, and pseudomonas pneumonia;
- On 8/16/16, Individual #98 died at the age of 61 with causes of death listed as cardiac arrest, ventricular arrhythmia, and myocardial infarction;
- On 9/5/16, Individual #653 died at the age of 56 with causes of death listed as cardiopulmonary arrest;
- On 9/10/16, Individual #637 died at the age of 64 with causes of death listed as respiratory failure, aspiration pneumonia, and dysphagia;
- On 9/13/16, Individual #272 died at the age of 67 with causes of death pending; and
- On 9/19/16, Individual #252 died at the age of 69 with causes of death pending.

b. through d. Some of the concerns with regard to recommendations included:

- Evidence was not submitted to show the Facility conducted thorough reviews of nursing care, or an analysis of medical/nursing

reviews to determine additional steps that can be incorporated in the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews.

- For individuals reviewed, the Center submitted death reviews the RN Case Manager completed that included information regarding acute issues, diagnostics and labs, medical and dental consultations, diet and weight, changes for the quarter, seizure management, gastrointestinal, changes in status, and a section for summary/analysis/recommendations. Although these reviews included many lists of information (e.g., lab work, consultations, IPN events), there was no analysis of care, or nursing documentation, and as a result, the reviews failed to identify the lack of acute care plans initiated for acute issues, the inadequacies of individuals' IHCPs, and/or the lack of pertinent information in the IRRF. Often these death reviews resulted in no recommendations.
- The QA Nursing Services Review was a two-page checkbox report that provided minimal information such as diagnoses, dates of hospitalizations, and checked categories such as vital signs, consultations, and integrated progress notes under a section entitled Review of Medical Record. It appeared that if the individual had their vitals signs taken or had a consultation, for example, the category was checked. No information was provided about the categories checked. At best, the QA Nurse report provided minimal information, and offered no specific course of events or analysis of nursing care and services. Again, few, if any recommendations were generated from this review.

e. The recommendations generally were not written in a way that ensured that Center practice had improved. For example, a recommendation that read: "RN Case Managers will be asked to ensure all items with Medium or High risk ratings have an action plan" resulted in an email to RN Case Managers. On 7/28/16, the Center considered this recommendation closed. This in no way ensured that concerning practices changed. The recommendation should have been written in a manner that required monitoring to determine whether or not nursing action plans in IHCPs addressed individuals' medium and high-risk ratings. As findings in this report show, action plans continued to be non-existent for some medium and high-risk ratings, and the quality of the IHCPs was poor.

In addition, in many instances, there was a lack of documentation to substantiate that the recommendations were implemented as written. A couple examples of the concerns noted were:

- For Individual #14's mortality review, one of the recommendations was to "conduct roundtable in-service for providers on atypical aging process in Down syndrome." Although the Center indicated this was completed, no evidence was submitted to confirm its completion (e.g., roster of attendees of Medical Department staff, copy of hand out referenced, etc.).
- For Individual #298, a recommendation was for the Physical and Nutritional Management Committee to continue efforts related to research of best practice for stoma care. The Center indicated this was completed on 4/22/16. However, the submitted minutes did not address this, nor was information about best practice stoma care submitted.

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Twelve of these indicators, in psychiatry, psychology/behavioral health, medical, and skill acquisition had sustained high performance scores and will be moved the category of requiring less oversight.

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

Assessments

Overall, IDTs need to do a better job of ensuring that needed assessments are considered, arranged for, and obtained. There was some progress seen in the completion of monthly reviews by the QIDPs. That being said, IDTs did not meet as needed and individuals were not receiving the supports as identified in the ISP action plans.

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

Psychiatry comprehensive evaluations and annual psychiatry updates were done for each individual. There was need for improvement in the content of both types of assessment documents. Similarly, behavioral health services assessments needed to improve in timeliness and content.

For this review and the previous two reviews, Medical Department staff completed the medical assessments in a timely manner. As a result, the related indicators will be placed in the category of requiring less oversight.

The Center should focus on improving the quality of medical assessments. Moving forward, the Medical Department should focus on ensuring medical assessments, as appropriate, describe pre-natal histories, family history, social/smoking histories, and childhood illnesses.

It was good to see some progress with regard to the quality of dental exams and summaries. However, more work was needed, and the Facility should continue to focus on the timeliness of dental exams and summaries as well.

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

The PNMT often was not providing needed reviews and/or assessments for individuals with physical and nutritional management-related needs that met criteria for referral to and/or review by the PNMT. For the one individual reviewed that the PNMT had completed an assessment, it was completed timely and included most of the required components, but it was missing key recommendations to allow the PNMT and IDT to measure whether or not supports were working and quickly intervene if they were not.

Some progress was seen with regard to the timeliness of OT/PT assessments. The Center should focus on improving the quality of OT/PT assessments.

With regard to communication assessments, some individuals reviewed who should have had comprehensive assessments or updates did not have them. A number of problems were noted with the updates that were completed, and the Center should focus on improving their quality.

Individualized Support Plans

Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The development of these types of personal goals across the six different ISP areas was not yet near criteria, but progress was evident. Three ISPs, for instance, included one or two goals that met criteria.

Action plans are the steps and activities to be taken to achieve personal goals. The various criteria included in the set of indicators in ISP outcome 3 were not met, except in a handful of cases. A focus area for the facility's QIDP department is to ensure the actions plans meet these various items.

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

The facility's psychiatry staff had begun to author goals regarding reductions in psychiatric symptoms. However, the goals were not specifically measurable and did not include psychiatric indicators. Psychiatrists attended and participated in ISP meetings,

though their participation was not well documented in the ISP document; it should be. Behavioral health services developed individualized measurable goals. The PBSPs themselves, however, needed improvement in content.

In addition to staff frequently not following the PNMPs, safe mealtimes were compromised due to the fact that PNMPs were becoming less comprehensive with fewer strategies for staff to follow. In the documentation reviewed, justification was not provided for removing strategies or falling back on vague language within PNMPs. Based on the Monitoring Team member's discussion with the Habilitation Therapies Director, many of the strategies were removed because they were considered to be standards of care. However, as the Monitor discussed with the Facility Director, if an individual requires a strategy to address a specific need, such as strategies to address taking big bites or eating too quickly, then the strategy should be included in the PNMP. It should not be left up to direct support professionals to determine which strategies should be employed with which individuals.

There were SAPs for all individuals and they were measurable, however, many were not meaningful or functional for the individual.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: The development of individualized, meaningful personal goals in six different areas, based on the individual's preferences, strengths, and needs was not yet at criteria, but progress was evident as described below. Three ISPs, for instance, included one or two goals that met criteria, which was progress since the last review. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	41	491	411	212	151	410			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	0/6	0/6	1/6	0/6	2/6	1/6			
2	The personal goals are measurable.	0% 0/6	0/6	0/6	1/6	0/6	2/6	1/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #41, Individual #491, Individual #411, Individual #212, Individual #151, Individual #410). The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Denton SSLC campus.											

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

None of the six individuals had individualized goals in all areas, therefore, none had a comprehensive set of goals that met criterion. There was little discernible improvement, overall, in the individualization and measurability of personal goals. Outcomes for the six ISPs remained very broadly stated and general in nature and/or were very limited in scope. Examples of fairly generic goals found in these ISPs included:

- Have more control over his environment.
- Gain employment in community.
- Increase independence in making choices.
- Increase participation in activities.
- Be provided with information about community living options.

On initial review, Individual #491's goals appeared to hold promise in that they seemed to reflect aspiration, a level of community participation and integration, and creativity on the part of the IDT. These goals included, for example, to participate in a 2K by 2017, to get a job in the community as a housekeeper by 2018, and to join a community group with her sister (who also lived at Denton SSLC) by 2017. Upon deeper review and staff interview, however, these goals had little to do with her personal preferences or aptitudes and were going to be replaced with different goals as reflected in the ISP preparation meeting held in July 2016. Related action plans minimally supported their achievement, in any event.

Across these ISPs, however, four personal goals met criterion. These were:

- Living options goals for Individual #411, Individual #151, and Individual #410 reflected their personal preferences.
- Individual #151 also had an independence goal for doing his own laundry.

2. Overall, personal goals for the ISPs did not meet the criterion described above in indicator 1. When a personal goal does not meet criterion, there can be no basis for assessing compliance with measurability or the individual's progress towards its achievement. The presence of a personal goal that meets criterion is a prerequisite to this process. Of the four personal goals that met criterion for Indicator 1, each also met criterion for measurability.

3. Most personal goals did not meet criterion, therefore, there was no basis for assessing whether reliable and valid data were available to determine if the individual met, or was making progress towards achieving, his/her overall personal goals. For the four personal goals that met criterion in indicator 1, none had reliable and valid data, due in large part to a lack of implementation and consistent documentation.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: When considering the full set of ISP action plans, the various criteria included in the set of indicators in this outcome were not met, but in a handful of cases. A focus area for the facility's QIDP department is to ensure the actions plans meet these various items. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	41	491	411	212	151	410			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	1/6	0/6	1/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
Comments: Once Denton SSLC develops more individualized personal goals, it is likely that actions plans will be developed to support											

the achievement of those personal goals and, thus, the facility can achieve compliance with this outcome and its indicators.

8. Most personal goals did not meet criterion in the ISPs reviewed as described above in indicator 1, therefore, action plans could not be evaluated in this context. A personal goal that meets criterion is a prerequisite for such an evaluation. Action plans are evaluated further below in terms of how they may address other requirements of the ISP process. For the four personal goals that did meet criterion under indicator 1, two met criterion for this indicator:

- Individual #411's action plans, including IDT members acting to obtain information of citizenship and guardianship, would support the living options goal.
- The action plans for Individual #151's independence goal included skill acquisition that would support the goal of independence in laundry.

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

- Individual #41 had an action plan for making choices among activities, but the IDT had not developed an adequate basis to make this functional or meaningful. An ISP preparation action plan indicated the IDT needed help identifying activities that would be good for her, but no assessments included any new information beyond what was in the Preferences and Strengths Inventory (PSI). The PSI section for meaningful day activities was blank.
- For Individual #491, personal preferences included eating out in the community, but there were no action plans for community outings. She liked talking with her mom on the phone, but the only related action plan was to write a note to her mother. She also liked to visit with a preferred building coordinator, but there was no action plan to build on or facilitate this preference. Few other preferences were noted in the ISP and significant choice making was not integrated into her action plans.
- Individual #212's action plans included getting manicures quarterly and outings twice a month, which appeared to reflect her preferences. There were no service objective implementation plans provided for review that would allow for an evaluation of whether they were written in a manner that would promote choice.
- Individual #411 had minimal action plans to enhance his ability to communicate his choices and preferences independently, either through acquisition of additional English language skills or additional signs. An electronic translator action plan was created, but was not functional. No choice-making action plans were included in his ISP.

10. ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making for any of the six individuals. No action plans were identified that clearly supported decision-making skills.

11. Overall, action plans did not assertively promote enhanced independence for any of the individuals. Examples included:

- Individual #41 and Individual #491 did not have action plans to promote their independence in dining. Per the IRRF and the OT/PT assessment, Individual #41 took large bites and tried to eat quickly when feeding herself and needed staff supervision, but no action plan to enhance independence and safety when eating. There was also no action plan for Individual #491 to address her independence in dining, even though the OT/PT assessment indicated she would slow down and even put her spoon down between bites when prompted. This should have prompted the IDT to building on this potential strength to further enhance her independence.
- The ability to effectively communicate wants and needs and facilitate social interaction is fundamental to enhanced independence. Individual #151's communication goals did not focus on the acquisition or use of signs, but rather simply on

attendance at a sign language group. None of his signs were in his communication dictionary.

- Individual #212's stated independence goal was to return to routine supervision, but the action plan for this was to attend Human Sexuality classes, which was not ongoing. No service objective was found. The goal to purchase all of her own food would perhaps enhance independence, but there were no action plans for actually going shopping.

12. IDTs did not consistently integrate strategies to minimize risks in ISP action plans. Examples included:

- The Monitoring Team was concerned that falls risks were not assertively identified or proactively addressed. This was illustrated by a lack of assertive action plans and IDT action for Individual #411. He had experienced 27 falls in the year preceding his 2015 ISP, and had experienced 14 falls between 3/3/16 and 7/21/16, including a recent one that resulted in a serious injury. The IDT had not completed a thorough analysis of his falls in order to develop appropriate action plans.
- Individual #410 was reported to be short of breath when walking and should have had a walking program, but did not. He also was at risk for inappropriate sexual behavior with children, which had negatively impacted his opportunities for community living and employment, but there were no clear objectives to address this need. He attended counseling, but it was unclear how this issue was being addressed or what progress was being made. It was also not clear how this risk was being addressed on his weekly home visits.
- IRRFs did not consistently address risks in a comprehensive manner. Examples included:
  - Individual #212 was at medium risk for choking, but her IRRF contained no description of her risk or past history. The section for proposed recommendations and rationale was not filled in. The only final recommendations were to not let her overfill her mouth and to make sure her food was chopped. She was at medium risk for skin integrity, but the IRRF did not reference data regarding the non-healing wound on her right heel that required treatment by the wound care nurse. For the behavioral health risk assessment, there was no documentation the IDT discussed considerations for use of restraint. The IRRF stated she had experienced three restraints in 30 days over the last six months, but did not document the total number of restraints that had occurred over the past year or otherwise evaluate trends in this regard.
  - Individual #151's IRRF did not address his Stage III chronic kidney disease.

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

- For Individual #411, psychology progress notes suggested that staff should advocate for the use of a token economy and should attempt to identify the environmental variables related to an increase in peer-to-peer aggression. There was no evidence that these recommendations had been addressed.
- Individual #41 was at high risk for dental and resisted assistance at home and for care in the dental clinic. Desensitization to refusing of oral care and tooth brushing was not addressed.

14. Meaningful and substantial community integration was largely absent from the ISPs reviewed. There were few specific plans for community participation that would have promoted any meaningful integration for any individual.

- Individual #491 and Individual #411 had no action plans that integrated encouragement of community participation and integration.
- Data for Individual #491, Individual #411, and Individual #41 showed they had no community outings from 2/1/16 through

7/31/16.

- Individual #151 had some action plans for community participation, such as shopping once a week. This was good to see, however, the frequency of activity was either limited or not specified for other plans, such as monthly community excursions and opportunities to attend church off campus. None of the action plans promoted community integration, although church participation should have offered such an opportunity. Individual #151 was noted to enjoy going to church and enjoyed attending with his family, but was not a member of any congregation. One possibility was for a local church of the same faith of his family to be contacted and, over time, a local church family developed.

15. One of six ISPs considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Although the personal goal defined by the IDT for Individual #491 did not actually represent her preference, the IDT did make an effort to consider possible work opportunities in the community and met criterion. Examples of insufficient action plans included:

- Individual #212 had a preference to work in the community, but no action plan was developed other than a broad and generalized service objective calling for vocational exploration to be strongly encouraged throughout the upcoming year.
- The vocational assessment noted that Individual #151 was attending work on campus much less frequently and with reduced participation when he was there, even sleeping at times. This was attributed to lack of staffing to accompany him to work and to be available at the worksite to assist him. It was also noted that he was not making as much money as he would like. An action plan was recommended to send a referral to Supported Employment for a more active job, but no action had been noted.
- Individual #410 had a goal for community employment and had previous experience working in a community setting (rolling silverware at Chili's) that he liked. There was no action plan for looking for community employment. He also had indicated he was interested in working as an office assistant and eventually working at Sprint in data entry and with customers. His on campus work included working Thursday and Friday from 3:00-4:45 for the Respiratory Department filing and entering dates into spreadsheets, but there was no action plan related to using that experience to obtain similar work in the community. There was no clear plan for addressing all the barriers identified in the vocational assessment, particularly the 1:1 staffing required due to prior inappropriate sexual contact with a child.

16. None of six ISPs had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. For example:

- Individual #411 had an action plan for supported employment, which was positive to see. Skill acquisition to meet his needs and address his preferences was, however, otherwise limited. There was no vocational exploration for community employment and no community participation action plans.
- Many of Individual #41's action plans had no implementation plans. Community engagement was very infrequent. Her daily schedule was not specific and individualized to her needs and choice making was not integrated throughout her day.
- Individual #212 had a goal for purchasing her own food, but the only action plan was for staff to assist in making a shopping list. There was no action plan for actual participation in grocery shipping in place or projected.

17. Barriers to various outcomes were not consistently identified and addressed in the ISP. In particular, living options barriers were frequently not addressed with individualized and measurable action plans.

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

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
Summary: Criterion was met for some indicators for some individuals, but overall, more work was needed to ensure that all of the activities occurred related to supporting most integrated setting practices within the ISP. Primary areas of focus are reconciliation of team member recommendations for referral, and the identification actions to address obstacles to referral. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	41	491	411	212	151	410			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	67% 4/6	0/1	1/1	1/1	1/1	0/1	1/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	67% 4/6	1/1	1/1	0/1	1/1	1/1	0/1			
23	The determination was based on a thorough examination of living options.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	33% 2/6	0/1	0/1	0/1	1/1	1/1	0/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A			

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

Comments:

19. Four of six ISPs included a description of the individual's preference and how that was determined. Individual #41 and Individual #151 had minimal exposure to, or awareness of, community living options.

20. The Monitoring Team observed Individual #411's annual ISP meeting. His preference for where to live was described and this preference appeared to have been determined in an adequate manner.

21. The medical assessment for Individual #410 provided a good overview of the barriers to community living from discipline-specific perspective. This was positive to see and was important because it allows the IDT to consider the barriers and hopefully develop specific action plans to address them. Overall, however, none of six ISPs fully included the opinions and recommendation of the IDT's staff members. Current assessments by key staff members were sometimes not available at the time of the ISP or did not include recommendations. The IDT did not consistently make a statement and offer a recommendation regarding living options that was either consistent or independent.

Discipline assessments used to develop the ISP did not consistently include a statement and recommendation regarding the most integrated setting appropriate to the individual's needs. Examples included:

- For Individual #410, there was no recommendation from the Functional Skills Assessment (FSA) or the nursing assessment.
- For Individual #41, there were no recommendations from OT/PT, communication, and medical assessments. A current behavioral health assessment was not available. The nursing assessment stated transition was not recommended, but offered no rationale.

22. Four of six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR. Those that did not accurately reflect the basis for the decision included the determinations for Individual #411 and Individual #410.

23. One of the individuals (Individual #410) had a thorough examination of living options based upon their preferences, needs and strengths.

24. Two of six ISPs, for Individual #212 and Individual #151, identified a thorough and comprehensive list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed. Examples of those that did not meet criterion included:

- For Individual #41, the IDT identified LAR choice and lack of individual awareness, but did not identify a behavioral issue as needed.
- For Individual #411, funding was identified as the obstacle. The IDT indicated in the ISP narrative that awareness of living options was undetermined, but did not identify this as obstacle.

25. The Monitoring Team observed Individual #411's ISP annual meeting while onsite. The IDT did develop a comprehensive list of potential barriers.

26. None of six individuals had individualized, measurable action plans to address obstacles to referral.

27. The Monitoring Team observed Individual #411's annual ISP meeting. Action plans were not clearly spelled out at the end of this long and chaotic meeting. Much of IDT had left the meeting at this point, including the psychiatrist, PT, and, in particular, the Human Rights Officer who was the interpreter for much of the meeting, knew the family best, and had been working on the citizenship and guardianship issues. Some of the action plans were projected to be same as last year and the IDT did address individual awareness with a plan for tours, yet it was not specific to his learning needs. The IDT also referred to a possible barrier of a previous confirmed abuse allegation against mother, but did not develop a clear action plan to address.

28. See Indicator 26 above.

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

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

Summary: ISPs were developed in a timely manner, but not implemented in a timely manner. Most individuals participated in their ISP preparation and annual meetings, but not all IDT members participated in the important annual meeting. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 41	491	411	212	151	410			
30	The ISP was revised at least annually.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	83% 5/6	1/1	0/1	1/1	1/1	1/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

30. ISPs were developed on a timely basis.

32. Action plans were implemented on a timely basis for none of six individuals. Examples in which timeliness criteria were not met included:

- For Individual #491, a SAP for hand washing was not developed as required and the QIDP did not take action until 8/24/15, nine months later.
- Action plans related to Individual #41's relationship goal had not implemented. There were also no formal service objective implementation plans for many other action plans. No data were provided in the monthly review for selecting activity, participating in an activity, putting her cup in trash, and selecting clothing in July 2016, with the wrong SAPs still being implemented in August 2016.
- Individual #212 was supposed to have vocational exploration monthly, but none had been documented through July 2016.

33. Five of six individuals could be said to have participated in their ISP meetings. Individual #491 attended, but did not have her hearing aids because they were being repaired. The communication description at the beginning of the ISP narrative stated staff accompanying her should ensure she uses them.

34. Individuals did not consistently have an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. For example, the speech-language pathologist (SLP) did not attend ISPs for Individual #41, Individual #411, or Individual #151, but each of these individuals had significant communication needs.

Outcome 6: ISP assessments are completed as per the individuals' needs.

Summary: Ensuring that needed assessments are considered, arranged for, and obtained is a focus area for the Denton SSLC IDTs. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 41	491	411	212	151	410			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	33% 2/6	1/1	0/1	0/1	0/1	0/1	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting, for two of six individuals. Examples of those that did not meet criterion included:

- For Individual #151, the IDT did provide more detail than most about the specific questions and needs to be addressed in various assessments, which was positive to see. This was not scored as meeting criterion, however, because the IDT did not request an SLP assessment to detail and clarify his sign language vocabulary, which was not clear across various documents.

- For Individual #411, the IDT also detailed some specific questions and needs that should be addressed in assessments, particularly related to tentative goals, such as getting a pet dog. In a significant failure to identify needed assessments, however, the IDT did not identify a need for a comprehensive falls analysis either as a stand-alone or as a focus for the assessments.
- For the upcoming year, the ISP preparation document for Individual #491 did not request a communication or OT/PT assessment, but should have based on her needs.

36. IDTs did not consistently arrange for and obtain needed, relevant assessments prior to the IDT meeting. Individual #212, for whom needed, relevant assessments were available, was the sole exception. Examples for which this did not occur included:

- For Individual #41, there was no evaluation of dental desensitization as indicated as a need at the ISP preparation meeting. Her behavioral health and communication assessments were not provided timely. Her PSI was current, but not complete.
- For Individual #410, the FSA was not completed and behavioral health assessment was still in draft at the time of the monitoring visit.

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

Summary: There was some progress seen in the completion of monthly reviews by the QIDPs. That being said, IDTs did not meet as needed and individuals were not receiving the supports as identified in the ISP action plans. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	41	491	411	212	151	410			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

37. IDTs did not consistently meet to respond to various events, behavioral incidents, and medical issues, or to review progress or revise supports and services as needed. Reliable and valid data were seldom available to guide decision-making, in any event. Examples included:

- The respective IDTs for Individual #151 and Individual #410 did not hold any ISPA meetings, despite needs to review lack of implementation of action plans.
- Also for Individual #410, the IDT did not meet to review his swallow study in January 2016 after it showed flash penetration with nectar and thin liquids.
- For Individual #212, the IDT held only one ISPA meeting, in July 2016, to review her enhanced level of supervision. There were no ISPAs to review lack of implementation of various action plans, such as vocational exploration, which was to occur monthly, the lack of Human Sexuality training for many months with no alternate intervention, or regression in the use of coping skills

per data cited in QIDP monthly review.

38. Overall, QIDPs were completing monthly reviews on a timelier basis. Many action plans were not implemented on a timely basis, if at all, as described elsewhere in this report.

Outcome 1 – Individuals at-risk conditions are properly identified.											
Summary: In order to assign accurate risk ratings, IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings within no more than five days. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	The individual's risk rating is accurate.	6% 1/18	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	17% 3/18	0/2	0/2	0/2	0/2	0/2	0/2	2/2	0/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas [i.e., Individual #491 – dental, and fractures; Individual #411 – falls, and weight; Individual #731 – weight, and dental; Individual #365 – constipation/bowel obstruction, and fluid imbalance; Individual #151 – weight, and behavioral health in relation to communication; Individual #410 – constipation/bowel obstruction, and respiratory compromise; Individual #48 – urinary tract infections (UTIs), and falls; Individual #271 – constipation/bowel obstruction, and infections; and Individual #252– cardiac disease, and skin integrity].

a. The IDT that effectively used supporting clinical data, used the risk guidelines when determining a risk level, and as appropriate, provided clinical justification for exceptions to the guidelines was for Individual #491 - fractures.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The exceptions to this were: Individual #48 – UTIs, and falls. For this individual, the IDT documented discussion of the individual's changes of status, including review of their risk ratings.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.	
Summary: The facility psychiatry staff had begun to author goals regarding reductions in psychiatric symptoms. However, the goals were not specifically	Individuals:

measurable and did not include psychiatric indicators. The development of individualized psychiatric goals was being addressed by state office. Over the next few months, those activities should impact Denton SSLC's psychiatric goals and move them towards meeting criteria with these indicators. Some initial effects of this were seen, such as the psychiatrists somewhat following the examples provided by the state office discipline lead a few months ago. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	41	468	491	411	212	25	127	17	110
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
4-7. Psychiatry staff had begun to formulate goals related to psychiatric status. For example, in the ISP for two individuals, Individual #17 and Individual #110, there were goals such as "maintain stability of mood and psychotic symptoms…reduce impulsive aggression…improve total sleep hours." There was no mention of what the specific symptoms for monitoring were (i.e., what state office has come to call psychiatric indicators).

Measurement of goals for some individuals was per a facility derived Likert scale. Other individuals had psychiatry related goals included in psychiatric documentation, but these were not included in the ISP, or in the ISP sections of the IRRF, or in the IHCP. Goals, once developed, must be formulated in a manner that would make them measurable, based upon the individual's psychiatric assessment, and provide data so that the individual's status and progress can be determined. The data will allow the psychiatrist to make data driven decisions regarding the efficacy of psychotropic medications. It was apparent that psychiatric staff were thinking about treatment goals and beginning to author goals for individuals receiving psychiatric services. These goals must be integrated into the overall treatment plan for individuals.

Psychiatric progress notes documented review of data, however, there was documentation in some cases, such as Individual #212, that data were not accurate. In the case of Individual #25, it was noted that data were not being tracked.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.	
Summary: CPEs were done for each individual. This has been the case at Denton SSLC for some time now. Therefore indicator 12 will move to the category of	Individuals:

requiring less oversight. CPEs were formatted according to Appendix B, except for the older ones. Consideration should be given to updating these. There remained a need for improvement in CPE content. Indicator 15 will also move to the category of requiring less oversight; it had also been at high performance for this review and the past two reviews. With sustained performance, indicator 16 might move to the category of requiring less oversight after the next review. All indicators met criteria for two individuals. Indicators 13, 14, and 16 will remain in active monitoring.

#	Indicator	Overall Score	41	468	491	411	212	25	127	17	110
12	The individual has a CPE.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
13	CPE is formatted as per Appendix B	67% 6/9	1/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1	0/1
14	CPE content is comprehensive.	22% 2/9	0/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	100% 5/5	1/1	1/1	1/1	N/A	N/A	1/1	N/A	1/1	N/A
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

13. The Monitoring Team looks for 14 components in the CPE. One of the evaluations reviewed was performed in 2009 and two were performed in 2010. These evaluations were not in Appendix B format. Other evaluations, performed more recently, were formatted per Appendix B.

14. Of the six evaluations performed since 2013, four were missing one element. The remaining two evaluations, regarding Individual #468 and Individual #25, were not missing any elements. The most common missing elements were treatment recommendations, and the results of the physical examination and labs

15. For the five individuals admitted since 1/1/14, all had psychiatric evaluations performed within 30 days of admission. All individuals had a integrated progress note from the primary care provider and nursing documenting the admission assessment within the first business day after admission.

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

Summary: Psychiatric treatment documentation was updated within the past 12 months for all individuals, and the psychiatrist or a licensed member of the psychiatric team attended the ISP meetings for all, or almost all individuals. This was the case at Denton SSLC for this review and the last two reviews. Therefore, indicators 17 and 20 will be moved to the category of requiring less oversight. Areas of focus are the completeness of the documentation in the annual review and in the ISP (indicators 18 and 21). With sustained performance, indicator 19 might be moved to the category of requiring less oversight after the next review. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 41	468	491	411	212	25	127	17	110
17	Status and treatment document was updated within past 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	22% 2/9	0/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	22% 2/9	0/1	0/1	0/1	0/1	1/1	1/1	0/1	0/1	0/1

Comments:

17. The facility had transitioned to the Annual Psychiatric Treatment Plan in lieu of the annual Comprehensive Psychiatric Evaluation. Of the nine individuals, five had Annual Psychiatric Treatment Plans.

18. The Monitoring Team scores 16 aspects of the annual evaluation document. Two of the evaluations reviewed (one an annual CPE regarding Individual #468 and one an Annual Psychiatric Treatment Plan regarding Individual #212) included the required elements. Of the remaining seven evaluations, the most common missing element was the risk/benefit discussion for treatment with psychotropic medications. This information was missing in five of the evaluations.

21. There was a need for improvement with regard to the documentation of the ISP discussion to include the rationale for determining that the proposed psychiatric treatment represented the least intrusive and most positive interventions, the integration of behavioral and psychiatric approaches, the signs and symptoms monitored to ensure that the interventions are effective and the incorporation of data into the discussion that would support the conclusions of these discussions, and a discussion of both the potential and realized side effects of the medication in addition to the benefits. The Monitoring Team looks for the above noted aspects of psychiatry participation. In two of the examples, regarding Individual #212 and Individual #25, the required elements were included in the IRRF documentation.

This was good to see.

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

Summary: Denton SSLC PSPs met some, but not all, of the requirements for content. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 41	468	491	411	212	25	127	17	110
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
22. None of the individuals chosen by the Monitoring Team had a PSP. The Monitoring Team, therefore requested two PSPs and received them for Individual #631 and Individual #482. The PSPs met some of the requirements: staff instructions on how to respond and support the individual (both individuals), the purpose of the plan (Individual #482 only), and instructions on data recording (Individual #631 only). Neither individual's PSP adequately included psychiatric indicators or other measurements to be used.

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

Summary: All five indicators showed good improvement since the last review. With sustained performance, indicators 28, 29, and 32 might move to the category of requiring less oversight after the next review. All five will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 41	468	491	411	212	25	127	17	110
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
32	HRC review was obtained prior to implementation and annually.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
28-29. The facility had transitioned to the revised consent form. These consent forms included some side effect information. The facility also routinely provided the consenter with medication information sheets for review. These were attached to the consent forms.

30-31. The risk versus benefit discussion was not included in the consent form. Alternate and non-pharmacological interventions consisted of a checklist and were not individualized.

Psychology/behavioral health

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

Summary: Denton SSLC ensured that every individual who needed a PBSP had a PBSP and that the PBSPs had goals/objectives as per criteria. This had been the case at the facility for a number of consecutive reviews and, therefore, indicators 1 and 2 will move to the category of requiring less oversight. Ensuring that goals are measurable and based upon assessments, and that reliable and valid data are collected are areas in need of continued focus. Therefore, those three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 41	468	491	411	212	25	127	17	110
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 13/13	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1
4	The goals/objectives were based upon the individual's assessments.	78% 7/9	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

1. All nine of the individuals reviewed by the behavioral health Monitoring Team had PBSPs. Of the five other individuals reviewed by the physical health Monitoring Team, four (Individual #271, Individual #151, Individual #410, Individual #731) had PBSPs. Observation by the Monitoring Team suggested that all of those who needed PBSPs had them in place.

2. The nine individuals reviewed by the behavioral health Monitoring Team had goals related to behavioral health services. This

included goals for problem behaviors, replacement and/or alternative behaviors, and where appropriate, counseling needs.

3. Although all goals found in the individuals' PBSPs were observable and measurable, the counseling goals for Individual #17 and Individual #110 were not.

4. For seven of the nine individuals, the goals were based upon their functional assessments. One exception was Individual #468, whose assessment indicated that stripping was an observed problem behavior. This was not addressed in his PBSP. The other exception was Individual #25. His functional assessment noted that unauthorized departure would be discontinued and combined with running indoors and out into the street. This change was not evident in his PBSP.

5. The Monitoring Team determined that the data for none of the individuals were reliable. Data timeliness was not assessed. Further, only the progress notes for one individual, Individual #127, indicated that IOA was assessed monthly over a six-month period. However, this assessment was consistently for nonoccurrence of targeted problem behavior.

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

Summary: These indicators were at about the same scoring as during the last review (one slightly higher, two somewhat lower). At this point, these three indicators should be at high performance. Criteria for all three indicators were met for one individual. This assessment information can be very important to the treating behavioral health specialist, psychiatrist, and other members of the IDT. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	41	468	491	411	212	25	127	17	110
10	The individual has a current, and complete annual behavioral health update.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
11	The functional assessment is current (within the past 12 months).	78% 7/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
12	The functional assessment is complete.	33% 3/9	0/1	1/1	0/1	0/1	1/1	1/1	0/1	0/1	0/1

Comments:

10. The behavioral health assessment was current for six of the nine individuals. The exceptions were Individual #41, Individual #491, and Individual #110. However, due to a lack of information about the individual's medical/physical health over the previous 12 months, only one assessment (Individual #212) was considered complete.

11. For seven of the nine individuals, the functional assessment was current. The exceptions were Individual #41 and Individual #491.

12. Three of the functional assessments were considered complete (Individual #468, Individual #212, Individual #25). Each contained

indirect and descriptive assessments that were completed with the last 12 months. While other reports documented both forms of assessment, the dates of completion were not provided. It should be noted that Individual #468's functional assessment included a review of observations completed at school, during a weekend day, and during the third shift. This completion of multiple observations across multiple environments and times was very positive. Individual #25's functional assessment also reflected multiple observations. Staff are advised to revise the report date when assessments are completed after the date of the initial report (e.g., there were observations of Individual #25 conducted in May 2016, but the report was dated April 2016).

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

Summary: Indicators 13 and 14 improved since the last review, while indicator 15 remained at 0%. With focused efforts, indicator 15 should be able to meet criteria (or show good improvement) at the time of the next review. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 41	468	491	411	212	25	127	17	110
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	56% 5/9	1/1	0/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1
14	The PBSP was current (within the past 12 months).	78% 7/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

13. Five of the nine PBSPs were implemented within 14 days of required consents. Exceptions included Individual #468, Individual #212, and Individual #110 whose plans were implemented later than 14 days after consent was provided. In Individual #411's case, his PBSP was implemented before the facility director's consent was obtained.

14. The PBSP was current within the past 12 months for seven individuals. Individual #41's PBSP had been implemented 13 months previously, while Individual #491's PBSP had been implemented 20 months previously.

15. None of the PBSPs were considered complete. While most, if not all plans, included operational definitions of target and replacement behaviors, antecedent and consequent strategies, and data collection descriptions, they were missing key components. In particular, the PBSPs did not consistently apply individual-specific reinforcement contingencies, nor did they identify sufficient opportunities for replacement behaviors to occur.

During the onsite visit, the use of a respite house was discussed with the director of behavioral health services. Although this hadn't been used in the past six months with any of the individuals reviewed, it had been used, albeit infrequently, in the past. There are a number of considerations if this is to continue and the reader is referred to the Monitoring Team's report for Abilene SSLC for August 2016.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.												
Summary: Denton SSLC ensured that counseling was provided when called for by the IDT. This has been the case for quite some time and, therefore, indicator 24 will be moved to the category of requiring less oversight. Proper documentation, however, was not available to indicate that a treatment plan and progress monitoring were in place. Therefore, indicator 25 will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	41	468	491	411	212	25	127	17	110
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 3/3	N/A	N/A	N/A	N/A	N/A	N/A	1/1	1/1	1/1
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	0/1
Comments: 24. Three individuals had been referred by their IDTs to participate in counseling. Individual #110 was meeting with a community-based counselor weekly. Individual #17 had been meeting with the campus-based counselor, but this service was discontinued on 7/28/16, due to her behavior outburst. Although the counselor indicated in her progress note that a community-based counselor "…would have terminated sessions the first time she screamed at them or stormed out of an office making threats," it may be appropriate to consider alternative providers. Individual #127 was not yet enrolled in counseling, although the campus-based counselor continued to interact with him in the hopes of initiating this service. 25. A counseling plan had not yet been developed for Individual #127. Although Individual #17's plan and progress notes included most of the required components, it did not identify treatment goals. Individual #110's plan did not include the required indicators.											

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely medical assessments (Round 9 – 78%, Round 10 – 78%, and Round 11 -100%), Indicators a and b will move to the category of requiring less oversight. The remaining indicator for this Outcome will be assessed once the ISPs reviewed integrate the revised periodic assessment process.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	For an individual that is newly admitted, the individual receives a	100%	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A

	medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	1/1									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	Not Rated (N/R)									

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

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

Summary: The Center should continue to focus on the quality of medical assessments. Given that over the last two review periods and during this review, individuals reviewed had diagnoses justified by appropriate criteria (Round 9 – 100% for Indicator 2.e, Round 10 – 100% for Indicator 2.e, and Round 11 - 100% for Indicator 3.b), Indicator b will move to the category of requiring less oversight. The remaining indicator for this Outcome will be assessed once the ISPs reviewed integrate the revised periodic assessment process.

Individuals:

#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	Individual receives quality AMA.	22% 2/9	0/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	N/R									

Comments: a. It was positive that the annual medical assessments for Individual #365 and Individual #48 included all of the necessary components to assess and set forth medical plans to address their individualized needs. Problems varied across the remaining medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed past medical histories, complete interval histories, lists of medications with dosages at the time of the AMA, and pertinent laboratory information. Most, but not all included allergies or severe side effects of medications, complete physical exams with vital signs, updated active problem lists, and plans of care for each active medical problem, when appropriate. Moving forward, the Medical Department should focus on ensuring medical assessments, as appropriate, describe pre-natal histories, family history, social/smoking histories, and childhood illnesses.

b. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. It was good to see that clinical justification was present for the diagnoses reviewed.

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

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

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

#	Indicator	Overall Score	Individuals: 491	411	731	365	151	410	48	271	252
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.	17% 3/18	1/2	0/2	0/2	1/2	0/2	0/2	1/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #491 – respiratory compromise, and cardiac disease; Individual #411 – cardiac disease, and seizures; Individual #731 – gastrointestinal (GI) problems, and weight; Individual #365 – respiratory compromise, and GI problems; Individual #151 – cardiac disease, and falls; Individual #410 – respiratory compromise, and constipation/bowel obstruction; Individual #48 – cardiac disease, and constipation/bowel obstruction; Individual #271 – urinary track infections (UTIs), and seizures; and Individual #252 – respiratory compromise, and GI problems].

The IHCPs that addressed individuals' chronic or at-risk conditions in accordance with applicable standards of practice were those for Individual #491 – respiratory compromise, Individual #365 – GI problems, and Individual #48 – constipation/bowel obstruction.

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

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.

Summary: It was good to see some progress with regard to the quality of dental exams and summaries. However, more work was needed, and the Facility should

Individuals:

continue to focus on the timeliness as well as the quality of dental exams and summaries.											
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	50% 4/8	1/1	1/1	0/1	1/1	1/1	0/1	N/A	0/1	0/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	63% 5/8	1/1	1/1	1/1	0/1	1/1	1/1	N/A	0/1	0/1
b.	Individual receives a comprehensive dental examination.	44% 4/9	0/1	0/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	67% 6/9	1/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1

Comments: a. For Individual #48, on 7/17/15, the dentist attempted to complete an exam, but it was unsuccessful. No further attempts were noted. She was scheduled to have an exam under TIVA on 3/7/16, but she had a stroke one day before her scheduled appointment.

b. It was positive that four individuals' dental examinations met the requirements. Problems varied across the remaining exams. Most, but not all included:

- An accurate description of the individual's cooperation;
- An oral cancer screening;
- An oral hygiene rating completed prior to treatment;
- Information regarding last x-ray(s) and type of x-ray, including the date;
- Periodontal charting;
- A description of periodontal condition;
- An odontogram;
- Caries risk; and
- Periodontal risk.

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

- A summary of the number of teeth present/missing.

c. It was good to find that six of the dental summaries reviewed met the requirements. Problems varied across the remaining dental summaries. Most, but not all included:

- Recommendations related to the need for desensitization or other plan;
- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health; and

- Recommendations for the risk level for the IRRF.

Moving forward the Facility should focus on ensuring dental summaries include:

- A summary of the number of teeth present/missing, which is important due to the fact that odontograms might be difficult for IDTs to interpret.

Nursing

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

Summary: These indicators require continued focus to ensure nurses complete timely annual and quarterly reviews, nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice.

#	Indicator	Overall Score	Individuals: 491	411	731	365	151	410	48	271	252
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.	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	67% 6/9	1/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/16	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/1

Comments: a. With regard to the timely completion of annual comprehensive nursing reviews and physical assessments, and quarterly nursing record reviews and physical assessments, the following problems were noted:

- For Individual #731, the annual nursing review contained so little information throughout each section that it was not considered complete. The months of October and November 2015 were not included in either quarterly review provided.
- The Center provided only one quarterly review for Individual #365.

- For Individual #271, the quarterly reviews were not considered complete. Dates in the quarterly reviews did not make sense for the months being reviewed. The Summary Section for one Quarterly that was supposed to contain a review of the individual's risk areas only noted: "Hospitalized again d/t [due to] not eating."
- For Individual #252, the date on the annual review was the same date as the individual's ISP meeting.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #491 – dental, and fractures; Individual #411 – falls, and weight; Individual #731 – weight, and dental; Individual #365 – constipation/bowel obstruction, and fluid imbalance; Individual #151 – weight, and behavioral health in relation to communication; Individual #410 – constipation/bowel obstruction, and respiratory compromise; Individual #48 – UTIs, and falls; Individual #271 – constipation/bowel obstruction, and infections; and Individual #252– cardiac disease, and skin integrity).

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

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

- On 1/15/16, Individual #491 experienced a fracture of her knee, but no preventative nursing assessments were added to her IHCP.
- Since Individual #411's ISP meeting on 10/21/15, he had at least 19 additional falls. However, his IHCP included no proactive nursing assessments related to falls.
- For Individual #731, the weight graph included in the IRRF for the 9/28/15 ISP noted he was 136.8 pounds in October 2014 and gradually increased over each month. His weight in June 2015 was 147 pounds and in July 2015 was 162.4 pounds. The IRRF contained few specifics, and no mention was made of the 15-pound increase in one month. The medium rating was not accurate, and it appeared that the IDT did not recognize this weight increase as a significant health issue. In August 2015 he weighed 160.1 pounds, no weight was documented for September 2015, and then in October 2015 his weight was down to 145.8 (a 14.3-pound weight loss), and in subsequent months, he continued to lose weight from146.8 in March 2016 to 138.4 pounds in May 2016. So he had weight gain and loss significantly in both directions. However, no proactive nursing assessments were implemented in response to these weight changes.
- A 7/1/16 IPN noted Individual #151 broke a window at the dental clinic. The IPN documenting the assessment did not indicate which hand the nurse assessed. The nurse included no specific information in the IPN regarding the individual's mental status (i.e., "alert and awake"). Nursing quarterly reviews did not note any injuries from SIB or aggressive behaviors. The IHCP included no nursing assessments for mood, sleep, appetite, or attention span to monitor any changes.
- After Individual #410's hospitalization in February 2016 with a diagnosis of constipation/bowel obstruction and removal of a fecal ball, no nursing assessments were added to the IHCP. Similarly, after episodes of asthma and pneumonia during the year, no nursing assessments were added to the IHCP or implemented.

- After Individual #48's hospitalization for a UTI from E coli, no nursing assessments were implemented in the IHCP.
- Individual #271 had a fecal impaction and subsequent episodes of constipation. However, nursing staff did not implement assessments in the IHCP to proactively monitor for constipation.
- For Individual #252, the IDT did not update the IRRF regarding a pressure wound to his neck, cellulitis of the left breast, and/or excoriation to groin. No regular nursing assessments were implemented. The IHCP included an action step for daily skin checks during bathing with direct support professional staff and the floor nurse. However, no documentation was found indicating that these checks were conducted.

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

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

#	Indicator	Overall Score	Individuals: 491	411	731	365	151	410	48	271	252
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.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	2/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	2/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	2/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	2/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	2/2

Comments: a. through f. The IHCPs that met the criteria for a number of these indicators were those for Individual #252– cardiac disease, and skin integrity. Unfortunately, documentation was not found to show they were implemented.

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
Summary: The PNMT was not consistently providing needed reviews and/or assessments for individuals with physical and nutritional management-related needs that met criteria for referral to and/or review by the PNMT. For the one individual reviewed that the PNMT had completed an assessment, it was completed timely and included most of the required components, but it was missing key recommendations to allow the PNMT and IDT to measure whether or not supports were working and quickly intervene if they were not. Scores during this review showed some regression from the last review. All of these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	50% 3/6	0/1	N/A	N/A	0/1	N/A	0/1	1/1	1/1	1/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	17% 1/6	0/1			0/1		0/1	0/1	1/1	0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	17% 1/6	0/1			0/1		0/1	0/1	1/1	0/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	17% 1/6	0/1			0/1		0/1	0/1	1/1	0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	50% 3/6	0/1			0/1		0/1	1/1	1/1	1/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	17% 1/6	0/1			0/1		0/1	0/1	1/1	0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and	0% 0/1	N/A			N/A		0/1	N/A	N/A	N/A

	• Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.										
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/6	0/1			0/1		0/1	0/1	0/1	0/1

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

- In July 2015, Individual #491 was diagnosed with aspiration pneumonia. She had three diagnoses of aspiration pneumonia, including one in March 2015, one in April 2015, and one in July 2015. The PNMT should have assessed her, but did not. This lack of assessment negatively impacted her IDT's ability to develop her ISP, dated 11/17/15, (i.e., her most recent ISP) in a manner that met her needs and addressed her high risk for aspiration pneumonia.
- Individual #365 was diagnosed with pneumonia on 10/3/15 and 10/24/15, but the PNMT did not review and/or assess her. Although she was in hospice care, PNMT review was necessary to determine whether or not changes were needed to her plan to mitigate recurrence to the extent possible. After hospitalizations for her two pneumonias in October 2015, evidence was not found of RN post-hospitalization reviews with PNMT discussion.
- According to Individual #410's IRRF, on 2/29/16, he was diagnosed with aspiration pneumonia. Although he was referred to the PNMT, according to PNMT minutes, it was not until 3/24/16 that the PNMT completed its review. The individual experienced multiple episodes of emesis, vomiting, and coughing from September 2015 to April 2016. The PNMT review lacked needed components, and the PNMT RN assessment lacked review and exploration as did PNMT minutes of the aspiration/pneumonia event. For example, the PNMT did not review the individual's swallowing after the incidence of pneumonia, despite a history of flash penetration with nectar and thin liquids, according to a modified barium swallow study (MBSS) report, dated 1/7/16.
- On 3/5/16, Individual #48 had a massive CVA that impacted all areas of functioning (e.g., eating, activities of daily living, etc.). Although it appeared from the PNMT minutes that they discussed her, no review/assessment was provided.
- It was good to see that Individual #271's referral to the PNMT for hypothermia was timely, the PNMT conducted a review and assessment timely, and included the disciplines necessary to address his issues. The RN post-hospitalization was timely and the PNMT reviewed it. The quality of the PNMT assessment is discussed below.
- Between November 2015 and May 2016, Individual #252 had six pneumonias (i.e., 11/2/15, 1/3/16, 1/28/16, 3/4/16, 5/6/16, and 5/16/16), but the PNMT never completed a comprehensive assessment. When the threshold for PNMT referral was met, the PNMT and IDT did meet, but the reviews the PNMT conducted lacked the necessary components (e.g., lack of review of areas potentially impacted, and/or identification of root cause). There was no evidence of direct observation or assessment. In December 2015, a new Head-of-Bed Evaluation (HOBE) was recommended according to the PNMT minutes, but there was no evidence this was completed. The only HOBE assessment noted was in May 2015, which was prior to the significant health change.

h. As noted above, for five of the six individuals that the PNMT should have conducted comprehensive assessments, they did not. For Individual #271, the PNMT assessment included review and analysis of the individual's relevant medications and their potential or realized side effects, relevant medical diagnoses, and behaviors. The assessment report showed that the PNMT had reviewed and made recommendations, as appropriate, to make changes to his relevant risk ratings. The PNMT also conducted relevant observations. The

PNMT assessed his current physical status, and reviewed the effectiveness and appropriateness of current supports. Potential causes of his hypothermia were identified in the assessment report. The PNMT offered recommendations with rationales for physical and nutritional interventions. All of this was positive. However, the key components that were missing from the assessment were recommendations for clinically relevant and measurable goals/objectives, clinical indicators, and/or thresholds for PNMT re-referral. These are necessary to allow the PNMT and IDT to measure the effectiveness of the recommended treatment and supports (i.e., to know whether or not the individual is doing better or worse, or maintain his current status), and to ensure the PNMT and IDT identify early signs and symptoms of problems and reconvene, when necessary.

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

Summary: Minimal improvement was seen with regard to these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs.

#	Indicator	Overall Score	Individuals: 491	411	731	365	151	410	48	271	252
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).	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	1/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	12% 2/17	1/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2	1/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	10% 1/10	1/2	0/1	0/2	0/1	N/A	0/1	0/1	0/1	0/1
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	22% 4/18	0/2	1/2	0/2	0/2	0/2	1/2	0/2	0/2	2/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: choking, and aspiration for Individual #491; choking, and weight for Individual #411; aspiration, and choking for Individual #731; weight, and aspiration for Individual #365; behavioral health in relation to communication, and fractures for Individual #151; GI problems, and aspiration for Individual #410; aspiration, and other: cardiovascular accident (CVA) for Individual #48; aspiration, and hypothermia for Individual #271; and skin integrity, and aspiration for Individual #252.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP. The exceptions were the IHCPs for other: CVA for Individual #48, and skin integrity for Individual #252.

b. The IHCP that included preventative physical and nutritional management interventions to minimize the individual's risk was for skin integrity for Individual #252.

c. All individuals reviewed had PNMPs and/or Dining Plans. Problems varied across the PNMPs and/or Dining Plans. Although the PNMPs generally identified individuals' risks, the levels of risk were not included on any of the PNMPs reviewed. Neither of the PNMPs for Individual #365 or Individual #151 included their risks for aspiration. The following provide a few examples of other problems noted:

- Individual #491's PNMP was not updated to reflect the need to "Add gravy or thick sauce to meats." It also did not include: "slow down and put spoon down" as listed in OT/PT assessment. The dining plan section of her PNMP did not match the Dining Plan. The communication section also lacked detail regarding her use of sign language, and did not reference her Communication Dictionary for additional information.
- Individual #411's PNMP did not provide photos of wheelchair positioning. It also did not contain information regarding the electronic translator, nor did it include the communication strategy to provide one- to two-step directions and use short sentences.
- Individual #731's PNMP did not include photos of wheelchair positioning, or custom inserts or shoes. The PNMP indicated he was "generally independent" with regard to transfers, but provided no definition of what this meant. The OT/PT assessment stated he was independent with staff to stand by to assist. The assessment also stated that Individual #731 did better with chairs with arms, but this was not included in PNMP. The PNMP did not mention decreased tolerance to tooth brushing. The object-symbol card was listed under adaptive equipment, but the Communication section of the PNMP did not describe how staff should assist the individual to use it.

In addition to staff frequently not following the PNMPs, safe mealtimes were compromised due to the fact that PNMPs were becoming less comprehensive with fewer strategies for staff to follow. In the documentation reviewed, justification was not provided for removing strategies or falling back on vague language within PNMPs. Based on the Monitoring Team member's discussion with the Habilitation Therapies Director, many of the strategies were removed because they were considered to be standards of care. However, as the Monitor discussed with the Facility Director, if an individual requires a strategy to address a specific need, such as strategies to address taking big bites or eating too quickly, then the strategy should be included in the PNMP. It should not be left up to direct support professionals to determine which strategies should be employed with which individuals.

d. The IHCPs reviewed generally did not include the action steps necessary to meet the identified objectives listed in a measurable goal/objective. The exception was the IHCP for skin integrity for Individual #252.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for choking for Individual #491, and skin integrity for Individual #252.

f. The IHCP that identified triggers and actions to take should they occur was for choking for Individual #491. Sometimes PNMPs

identified relevant triggers, but the corresponding IHCPs did not.

g. The IHCPs reviewed that identified the frequency of monitoring were those for weight for Individual #411; GI problems for Individual #410; and skin integrity, and aspiration for Individual #252.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: Since the last review, the Center had made progress with this outcome.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	100% 3/3	N/A	N/A	N/A	1/1	N/A	N/A	1/1	N/A	1/1
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.	N/A				N/A			N/A		N/A
Comments: a. Clinical justification for total or supplemental enteral nutrition was found in the IRRF and/or the ISP for the three individuals reviewed who were enterally nourished.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied. During the Round 9 review and this review, the Center scored at 89% with regard to timeliness, and 78% with regard to completing assessments in accordance with the needs of the individuals. However, during Round 10, the Center's score was 56% for both of these indicators. The quality of these assessments was an area that continued to require improvement. The Monitoring Team will continue to review these indicators, but it was encouraging to see some progress since the last review with regard to timeliness.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252

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.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	78% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
	Comments: a. and b. The following concerns were noted:										

- On 3/5/16, Individual #48 had a CVA. Due to the massive nature of the CVA, a full comprehensive OT/PT assessment was warranted, but was not provided. The assessment provided in the Infirmary did not meet standards of a comprehensive assessment.
- Individual #411 had multiple falls, including two in November 2015, three in December 2015, and five in February 2016. However, there was no evidence of an OT/PT consultation.

d. As noted above, due to the significant change in Individual #48's status, the OT/PT should have conducted a comprehensive assessment, but did not.

e. Unfortunately, some significant issues were noted with regard to the quality of the OT/PT updates. The following summarizes some examples of concerns noted with regard to the required components of OT/PT assessments:

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: All of the updates reviewed only stated that the individual had increased risk without including the level of risk;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: For a number of individuals, the updates only identified the cluster of medications prescribed and provided no discussion of the impact of medications on OT/PT supports, and failed to identify whether or not the individual experienced potential side effects. The only exceptions to this were Individual #491 and Individual #410;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day: Some examples of problems noted included a lack of discussion about the impact of vision problems on ambulation and mobility (e.g., Individual #491), assessments that included contradictory information about individuals' level of independence (e.g., Individual #411 in relation to ambulation, Individual #731 with regard to transfers, and Individual #151 regarding bathing and other ADLs), and failure to identify endurance issues that other IDT member identified (e.g., Individual #410). The only individuals reviewed for whom functional descriptions were accurate and complete were for Individual #365, Individual #271, and Individual #252;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale): Within the assessments of most individuals reviewed for whom this was applicable (i.e., six individuals), this component was complete and appeared accurate. However, for Individual #365, there was no evidence the HOBE was re-evaluated. The assessment stated that 20 degrees remained appropriate, but did not provide data to validate this conclusion;
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments: For most individuals reviewed, this component was complete and appeared accurate. However, this component was not fully addressed, for example, with regard to falls for Individual #491;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: For half of the individuals reviewed, this component of the updates did not include analysis of information to support findings that supports were effective (e.g., Individual #491 and Individual #411 in relation to falls, Individual #365 in relation to head-of-bed elevation, and Individual #271 in relation to leg exercises to address edema, and use of the assist bar in bed to promote independence). In order to analyze supports, data related to both implementation and outcomes needs to be reviewed and summarized. This was often confounded due to a lack of clinically relevant and measurable goals. Very few of

the assessments reviewed discussed monitoring findings;

- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services: Because a number of individuals did not have goals/objectives that were clinically relevant and measurable, the updates did not include evidence regarding progress, maintenance, or regression. In other instances, the justification provided for not developing OT/PT supports was not clinically sound (e.g., for Individual #365, bilateral upper extremity edema resulted in decreased range of motion. The OT/PT assessment stated that the OT considered a program to address it, but the individual showed signs of discomfort. No further options were explored except to accommodate the edema through support. No description of the individual's discomfort and distress was provided and these issues would be expected at least initially until the edema was reduced. Analysis was not provided regarding the risks associated with the increased edema versus an OT program); and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Most updates reviewed were missing recommendations to address strategies, interventions, and programs necessary to meet individuals' needs. The only exceptions were for Individual #731, Individual #271, and Individual #252.

On a positive note, all of the updates provided:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs; and
- The individual's preferences and strengths were used in the development of OT/PT supports and services.

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

Summary: Over the last two reviews and this one, the Center's scores for these indicators varied. It was good to see some improvement with regard to IDTs reviewing and making changes, as appropriate, to individuals' PNMPs and/or Positioning schedules at least annually. The Monitoring Team will continue to review these indicators.

#	Indicator	Overall Score	Individuals: 491	411	731	365	151	410	48	271	252
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	78% 7/9	1/1	0/1	0/1	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.	78% 7/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	46% 11/24	0/8	2/5	1/2	0/1	1/1	1/1	2/2	2/2	2/2

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.	27% 4/15	0/8	0/3	N/A	N/A	N/A	N/A	2/2	2/2	N/A
	Comments: a. Contradictions were found with regard to information included in the ISP and other documents about Individual #411's level of assistance for transfers, and Individual #731's diet texture. b. Individual #491's PNMP did not reflect the need for her to utilize a sleeve on her leg. No PT note or ISPA was found indicating the sleeve was no longer required. Individual #731's PNMP did not reflect the need for stand-by-assist as noted in the assessment. The PNMP stated "generally independent," but provided no functional definition. c. and d. Often, individuals' direct therapy goals had not been incorporated into their ISPs and/or an ISPA meeting was not held to gain the IDT's approval for the programs and ensure they were integrated with other supports.										

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: Continued work was needed with regard to the timeliness of communication assessments, and to ensure that assessments are completed in accordance with individuals' needs. The lack of quality of these assessments continued to be of considerable concern as well. The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/R	1/1	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	0% 0/1	N/A	N/A	N/A	N/A	N/A		0/1	N/A	N/A
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status	67% 4/6	1/1	1/1	1/1	0/1	1/1		N/A	0/1	N/A

	with regard to communication.										
b.	Individual receives assessment in accordance with their individualized needs related to communication.	63% 5/8	1/1	1/1	1/1	0/1	1/1		0/1	0/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	0% 0/1	N/A	N/A	N/A	N/A	N/A		0/1	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/1	N/A	N/A	N/A	N/A	N/A		0/1	N/A	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/6	0/1	0/1	0/1	0/1	0/1		N/A	0/1	N/A

Comments: a. and b. Individual #410 was able to communicate verbally with 100 percent intelligibility. Therefore, the communication outcomes and indicators were not assessed for him. The following provides information about problems noted:

- For Individual #48, the Speech Language Pathologist (SLP) only conducted a communication screening. The screening showed significant areas of deficit, and, therefore, should have resulted in a more thorough assessment. In addition, due to the CVA Individual #48 experienced in March 2016, another comprehensive communication assessment would have been warranted due to the massive impact on all areas of functioning.
- Individual #365's last communication assessment was completed in 2014, despite her having indirect communication supports in the form of a SAP to improve choice-making.
- Individual #271's last communication assessment was completed in 2013. Despite a decline in expressive language (i.e., he went from using full sentences to using short sentences), the IDT did not request further assessment. Some of his need areas included difficulty with two-step requests, perseverating on topics, and delayed speech.

c. Missing from Individual #48's screening were discussion regarding medications, exploration into AAC, and a recommendation for a comprehensive assessment.

d. As noted above, due to initial findings in the screening as well as the significant change in Individual #48's status, the SLP should have conducted a comprehensive assessment, but did not.

e. As noted above, Individual #365 and Individual #271 should have had updates completed, but did not. Problems varied across the remaining updates, but in each of the remaining updates three or more of the key components were insufficient to address the individual's strengths, needs, and preferences. The following summaries some examples of concerns noted with regard to the required components of communication assessments:

- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills: None of the updates reviewed met this criterion. Improvement was needed with regard to including actual comparisons from year to year that were based on assessment of the individual and data; and clear descriptions of individuals' expressive and receptive skills, including, as appropriate, their sign-language abilities;
- The effectiveness of current supports, including monitoring findings: The lack of monitoring/supervision findings to assist in the assessment of the effectiveness of current supports was a significant issue across most updates reviewed. The only exception was for Individual #731;
- Assessment of communication needs (including AAC, EC or language-based) in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services: With the exception of Individual #151's update, none of the other updates met this criterion. All three individuals had AAC devices. For Individual #411, his use of or the effectiveness of the English-Spanish translator were not explored. For all three individuals, assessments failed to explore other options, including ones that are more high-tech and might be more interesting to the individuals; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: None of the updates reviewed met this criterion. Some examples of problems included a lack of recommendations, when appropriate, to incorporate existing AAC into other goals/objectives to broaden the use of the device or system; lack of rationale for no recommendations to expand the use of AAC devices or systems (e.g., sign language) and/or to make changes to current AAC devices to improve their functionality; and lack of recommendations to build on existing communication skills.

On a positive note, all four updates reviewed included:

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

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	75% 6/8	0/1	1/1	1/1	1/1	0/1	N/R	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	25% 2/8	0/1	0/1	0/1	0/1	0/1		1/1	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.	38% 3/8	0/1	0/1	1/1	0/1	1/1		0/1	0/1	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: a. Neither Individual #491 nor Individual #151's ISPs provided sufficient details regarding their expressive language skills. For example, Individual #491's ISP stated that she uses communication cards and sign language, but provided no further details regarding content. Individual #151's ISP stated that he could use some signs, whereas the SLP assessment stated that he has a large vocabulary.

b. For many individuals reviewed, there was not evidence in the ISP that the IDT reviewed their Communication Dictionaries. In other instances, although the ISP stated a review was conducted, there was no indication whether or not the IDT determined the Communication Dictionary was effective (e.g., Individual #365 who had a Communication Dictionary dated 2015, and for whom no SLP was present at the meeting). The accuracy of Individual #151's was questionable, given that it did not reflect his large sign language vocabulary.

c. Problems varied, but some examples included no integration of communication strategies for training, lack of goal development, and lack of integration of specific strategies recommended in the assessment (e.g., picture cards).

Skill Acquisition and Engagement

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

Summary: Individuals had at least three skill acquisition plans and they were measurable. This was the case for this review and the previous two reviews. Therefore, these two indicators (1, 2) will move to the category of requiring less oversight. The other three indicators will remain in active monitoring. Ensuring that SAPs are based on assessment results (especially not a skill that the individual can already demonstrate); are practical, functional, and meaningful; and reliable and valid data are available are important areas of focus for the facility.

#	Indicator	Overall Score	Individuals: 41	468	491	411	212	25	127	17	110
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	100% 27/27	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3
3	The individual's SAPs were based on assessment results.	52% 14/27	3/3	3/3	1/3	0/3	2/3	2/3	0/3	2/3	1/3
4	SAPs are practical, functional, and meaningful.	33% 9/27	1/3	3/3	1/3	1/3	0/3	2/3	0/3	1/3	0/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/27	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3

Comments:

1. Each of the individuals reviewed had multiple SAPs. The Monitoring Team chooses three current SAPs for each individual for review.

2. All of the 27 SAPs were identified as measurable.

3. Fourteen of the 27 SAPs were based on assessments. Exceptions included skills that had been identified as mastered in the individual's functional assessment (Individual #491 – select soda; Individual #25 – running; and Individual #127 – continue working, complete chores, tell time using a digital clock). Others were skills that the individual was noted to do with verbal cues, yet the SAP included verbal cues (Individual #212 – traffic signs and Individual #110 – use a calculator). Finally, it was not clear that the skill had been assessed or that baseline measures had been collected to determine whether exposure to the task would result in the individual learning the skill (Individual #491 – identify colors; Individual #411 – sit up/meal, hand over mail, eat snack/meds; and Individual #17 – activities she cannot engage in with her boyfriend).

4. Nine of the 27 SAPs were considered to be practical, functional, and/or meaningful. Several of these were identified as skills the

individual already possessed. In other cases, the SAP did not address or contribute to the identified goal (Individual #41 – place cup in trash; Individual #491 – select soda and identify colors; and Individual #17 – activities she cannot do with her boyfriend). Individual #41 was to learn to engage in an activity, but the activity observed did not appear to be meaningful or interesting to her. Individual #212 and Individual #110 were both to learn about choosing/planning healthy snacks/meals, but it would be more functional to teach them to prepare healthy food that they preferred. Individual #17 was to learn to stay at work, but this was a compliance issue and not a new skill. Lastly, Individual #411 had three SAPs. Two of these (sit up at mealtime and eat a snack with your medications) addressed compliance issues. The third required him to learn to hand over mail using his right hand. As his right hand was impaired by right side hemiparesis and he could perform this task with his left hand, this SAP was deemed neither functional nor meaningful.

5. There was no evidence that any of the 27 SAPs had been monitored for data reliability over the previous six-month period.

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

Summary: Indicator 10 showed some decline compared to the previous two reviews whereas indicators 11 and 12 showed improvement. This outcome and its indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 41	468	491	411	212	25	127	17	110
10	The individual has a current FSA, PSI, and vocational assessment.	78% 7/9	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	78% 7/9	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1

Comments:

10. All of the individuals had current FSAs, PSIs, and when appropriate, vocational assessments. In lieu of a vocational assessment, a life skills assessment had been completed for Individual #41 who reportedly was not interested in working, and for Individual #468 and Individual #25 who were enrolled in school at the time of their ISPs. It would be appropriate to complete a vocational assessment for Individual #25 at this time because he no longer attends school. Although current, the PSI was incomplete for Individual #41 and Individual #212, resulting a zero score on this indicator.

11. Assessments were available to the IDT at least 10 days prior to the ISP for all, but two individuals. The exceptions were Individual #468 and Individual #491.

12. At least one SAP recommendation was included in the FSA or vocational assessment for all, but one individual. The exception was Individual #127 whose vocational assessment did not provide a SAP recommendation.

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

This domain contains 38 outcomes and 169 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Sixteen of these, in restraint, psychiatry, psychology/behavioral health, medical, and OT/PT had sustained high performance scores and will be moved the category of requiring less oversight. This included one outcomes: Outcome #12 in Psychiatry.

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

Goals/Objectives and Review of Progress

Denton SSLC regularly held reviews when there were three restraints within any rolling 30-day period. That being said, some of the important aspects of these reviews were not done.

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

In psychiatry, without measurable goals, progress could not be determined. Even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. Quarterly clinics were conducted as required, and the clinics observed by the Monitoring Team included the standard components. The review and management of polypharmacy met the criteria required. Content of the psychiatry clinic report needed improvement. PCP reviews of psychotropic medication side effects needs to occur more rapidly.

For behavioral health services, given the absence of good, reliable data, progress could not be determined for all of the individuals. Improvement was needed in progress notes and in the creation of useful graphs. Peer review was occurring regularly as required, which was good to see, but the minimum topic and follow-up requirements were not occurring.

Acute Illnesses/Occurrences

It was positive that for the individuals reviewed who required Emergency Department (ED) visits, hospitalizations, or Infirmary admissions, staff provided treatment and/or interventions for the acute illness. It was also good to see that for the individuals reviewed, upon their return to the Facility, 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.

The Center should focus on providers timely evaluating individuals prior to the transfer, or if unable to assess prior to transfer, within one business day, providing an IPN with a summary of events leading up to the acute event and the disposition; as appropriate, documenting a quality assessment in the IPN; and developing post-hospital ISPAs for individuals that address follow-up medical and healthcare supports to reduce risks and increase early recognition, as appropriate.

Overall, it was very troubling to find that a number of health issues found in the IPNs and nursing quarterly reviews did not have associated Acute Care Plans. The Acute Care Plan is a basic blueprint for guiding nursing staff in providing the needed care, assessments, and supports for the individuals that require more intensive and frequent care to address the acute health issue. This issue needs to be corrected quickly.

It was concerning that often IDTs did not refer individuals meeting criteria for PNMT review and/or assessment to the PNMT and/or that the PNMT did not self-refer these individuals.

Interim psychiatry clinics were available for all individuals, were provided, and there was documentation. When individuals were not making progress or deteriorating, behavioral health services took action for some, but not for all individuals.

Implementation of Plans

Staff training (and documentation) as well orienting float staff for their temporary assignment needed improvement.

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

Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. Although documentation often was found to show implementation of those action steps that IDTs assigned to the PCPs in IHCPs, the Monitoring Team will continue to review the related indicator until IHCPs include necessary action steps and they are implemented. The Center needs to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessments, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible. These treatments, interventions, and strategies need to be included in IHCPs, and PCPs need to implement them timely and thoroughly.

It was positive that over the last two review periods and during this review, for the non-Facility consultations reviewed, the PCP generally reviewed consultations and indicated agreement or disagreement, and as a result, the related indicator will move to the category of requiring less oversight. Improvement was noted with regard to PCPs writing IPNs related to consultations that

includes the necessary components. However, the Center needs to focus on ensuring PCPs conduct such reviews in a timely manner, order agreed-upon recommendations, refer consultation recommendations to IDTs, when appropriate, and that IDTs review the recommendations and document their decisions and plans in ISPAs.

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

With regard to dental care and treatment, over the last review and this one, the Center made progress in providing individuals with necessary prophylactic dental care, provision of x-rays, and the completion of restorative work, and extractions, when other options were exhausted. Two new indicators relate to the provision of fluoride treatment as appropriate, which required improvement, and treatment for periodontal disease, which was completed for most of the applicable individuals. For the individuals reviewed with missing teeth, some improvement was seen with regard to the dentist assessing the need for dentures. The Dental Department should focus on providing tooth-brushing instruction to individuals and/or their staff, and documenting it.

Adaptive equipment was generally clean and in good working order. The two related indicators will move to the category of requiring less oversight. Proper fit was sometimes still an issue.

Based on observations, there were still many instances (64% of 36 observations) in which staff were not implementing individuals' PNMPs and/or basic strategies to keep individual safe, or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Restraints

<table>
<tr><td colspan="2">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.</td></tr>
<tr><td>Summary: Denton SSLC met within 10 days of the occurrence of more than three restraints within any rolling 30-day period and each individual had a current PBSP and CIP. This had been the case at Denton SSLC for this review and the past two reviews. Therefore, indicators 18, 24, and 25 will be moved to the category of requiring less oversight. That being said, the other important protections required by this outcome were either not met for both individuals this review, or for those that did meet criteria for this review, had not yet sustained this across previous reviews. Therefore, these other indicators will remain in active monitoring.</td><td>Individuals:</td></tr>
</table>

#	Indicator	Overall Score	127	17							
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	100% 2/2	1/1	1/1							
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	50% 1/2	1/1	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.	50% 1/2	1/1	0/1							
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	50% 1/2	0/1	1/1							
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	50% 1/2	1/1	0/1							
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address 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.	100% 2/2	1/1	1/1							
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 2/2	1/1	1/1							
26	The PBSP was complete.	N/A	N/A	N/A							
27	The crisis intervention plan was complete.	50% 1/2	0/1	1/1							
28	The individual who was placed in crisis intervention restraint more	0%	0/1	0/1							

	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.	0/2									
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	100% 2/2	1/1	1/1							

Comments:

18. The restraints reviewed for outcome 7 occurred between 5/4/16 and 5/12/16 for Individual #127 and on 6/12/16 for Individual #17. In both cases, there was evidence that the individual's IDT met within 10 days of the fourth restraint.

19. There were a sufficient number of ISPAs for Individual #127. However, Individual #17 had been restrained more than three times in a rolling 30-day period four times over a six-month period (January 2016-June 2016). There was evidence that the IDT met to review the repeated restraints for only two occasions.

20. There was evidence that the IDTs for both Individual #127 and Individual #17 discussed the potential role of adaptive skills, and biological, medical, and psychosocial issues. While it was noted that Individual #17's restraints occurred in the early morning hours on weekends, there were no recommendations to observe staff during these times and provide re-training as necessary. It was also concerning that the team determined one application of restraint occurred when the event did not constitute a crisis. This should have triggered plans to retrain staff. ISPA minutes from July 2016 indicated that this same situation again resulted in an inappropriate use of restraint.

21. There was evidence of discussion of potential environmental antecedents. In Individual #127's case, it was hypothesized that problem behavior increased when he had not had sufficient sleep due to his staying up at night to play video games. There were no plans to address this issue.

22. There was evidence that the IDTs for both Individual #127 and Individual #17 discussed potential antecedents. In Individual #17's case it was noted that she was upset after losing her job at the greenhouse. There was no plan to explore her regaining employment in this setting or in some other area of interest.

23. Thee was evidence that the IDTs for both Individual #127 and Individual #17 discussed potential maintaining variables.

24-25. Both Individual #127 and Individual #17 had a PBSP and CIP.

26. A review of Individual #127 and Individual #17's PBSPs was provided in outcome 4 of the psychology/behavioral health section of this report.

27. Individual #127's CIP was considered complete. However, staff are advised to consider revision to this plan because one strategy was to prompt him to use a counseling replacement behavior, such as writing about the weather or planting plants. Neither of these is practical particularly when he is engaged or attempting to engage in an unauthorized departure. Individual #17's CIP was considered

incomplete. While it delineated the type of authorized restraint, specified the maximum restraint duration, and specified criteria for terminating restraint, it did not clearly specify the designated restraint situation. The CIP indicated that she could be restrained when she displayed physical aggression. Because physical aggression is addressed in her PBSP, this behavior alone does not constitute a crisis situation. It was also concerning that staff were advised not to laugh at Individual #17 during a crisis situation and that staff could inform her that a restraint may be necessary (threat). This latter point was discussed at an ISPA meeting held during the onsite visit, resulting in a revision to her CIP.

28. There was no evidence of objective assessment of treatment integrity for either Individual #127 or Individual #17.

29. There was evidence that the IDTs for both Individual #127 and Individual #17 reviewed their PBSPs. Individual #17 had a new PBSP implemented in August 2016.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.												
Summary: Denton SSLC routinely conducted Reiss screens for all individuals and had been doing so for a number of years. Therefore, indicator 1 will move to the category of requiring less oversight. Indicators 2 and 3 will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	365	252								
1	If not receiving psychiatric services, a Reiss was conducted.	100% 2/2	1/1	1/1								
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A	N/A	N/A								
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A	N/A	N/A								
Comments: 1. Of the 16 individuals reviewed by both Monitoring Teams, two individuals were not receiving psychiatric services. Both of these individuals were assessed utilizing the Reiss screen in March 2013. Unfortunately, it was not possible to determine if these were initial screening assessments or performed as a result of a change in status.												

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.	
Summary: Without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledges that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all	Individuals:

individuals. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	41	468	491	411	212	25	127	17	110
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 5/5	1/1	N/A	N/A	N/A	1/1	1/1	1/1	1/1	N/A
11	Activity and/or revisions to treatment were implemented.	100% 5/5	1/1	N/A	N/A	N/A	1/1	1/1	1/1	1/1	N/A
Comments: 8-9. Without measurable goals and objectives, progress could not be determined. Thus, the first two indicators are scored at 0%. 10-11. Despite the absence of measurable goals that were integrated into the overall treatment plan for an individual, it was apparent that when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments, suggestions for non-pharmacologic approaches) were developed and implemented.											

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary: Performance improved since the last review for indicator 23 and maintained for indicator 24. Updated PBSPs for two individuals would likely have set the occasion for 100% performance on both indicators for this review. Both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	41	468	491	411	212	25	127	17	110
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	78% 7/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	78% 7/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 23. There was reference to behavioral health identified target behaviors in psychiatric documentation and psychiatric data were included in the BSP. Two individuals, Individual #41 and Individual #491, did not have current PBSPs in place.											

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.											
Summary: Indicators 25 and 26 met criterion for this review period. If performance is sustained, it is likely these will move to the category of less oversight after the next review. Documentation of neurology requires some improvement. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	41	468	491	411	212	25	127	17	110
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	1/1	N/A	N/A
26	Frequency was at least annual.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	1/1	N/A	N/A
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	0% 0/2	N/A	N/A	N/A	N/A	0/1	N/A	0/1	N/A	N/A
Comments: 25-27. This outcome addresses the coordination between psychiatry and neurology. These indicators applied to two of the individuals. While there were detailed notes from psychiatry regarding neurological consultation, there was limited documentation from neurology. There were some individuals (e.g., Individual #468, Individual #491, Individual #411) who were prescribed antiepileptic medications and who were diagnosed with a seizure disorder and either a Bipolar Mood Disorder or Impulse Control Disorder. Per a discussion with facility psychiatric staff, these individuals had been reviewed and it was determined that the medication was not serving a dual purpose.											

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: Quarterly clinics were conducted quarterly, as required, at Denton SSLC for this review and for a number of years. Further, the clinics observed by the Monitoring Team included the standard components for this review and the last two reviews, too. Therefore, these two indicators (33, 35) will move to the category of requiring less oversight. Indicator 34 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	41	468	491	411	212	25	127	17	110
33	Quarterly reviews were completed quarterly.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
34	Quarterly reviews contained required content.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard	100%	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1

	components.	2/2									

Comments:
34. The Monitoring Team looks for nine components of the quarterly review. In general, reviews were missing one to four components; most commonly, a review of the implementation of non-pharmacological interventions and basic information, such as height and weight (or BMI) and vital signs.

35. Psychiatry clinic was observed for four individuals: Individual #41, Individual #110, and clinics for two individuals not part of the group of individuals reviewed by the Monitoring Team. Overall, the psychiatrists did a good job of reviewing all the information. There was also observed discussion of non-pharmacological interventions recommended for individuals. Data were presented during clinic, but the behavioral health services staff did not present the results of the data adequately, as such, they were not specifically utilized in decision making for medication adjustments.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: With sustained high performance, this indicator might move to the category of less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	41	468	491	411	212	25	127	17	110
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
36. Assessments and prescriber review were occurring in a timely manner, thereby meeting criteria for this indicator. In several cases, although the psychiatrist reviewed the document within the allotted time, the PCP review was delayed.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary: The availability, provision, and documentation of emergency/urgent and/or follow/up interim clinics met the criteria required for these indicators for a number of years. These three indicators will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	41	468	491	411	212	25	127	17	110
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 3/3	N/A	N/A	N/A	N/A	N/A	1/1	1/1	1/1	N/A
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 3/3	N/A	N/A	N/A	N/A	N/A	1/1	1/1	1/1	N/A
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 3/3	N/A	N/A	N/A	N/A	N/A	1/1	1/1	1/1	N/A

Comments:
37-39. Interim clinics were available for all individuals, were needed for three of these individuals, were provided, and there was documentation.

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

Summary: Indicators 40 and 41 met criteria during this review and the two previous reviews. All four important indicators, however, remain in active monitoring. Some may be considered for less oversight after the next review.

#	Indicator	Overall Score	Individuals: 41	468	491	411	212	25	127	17	110
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	78% 7/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
42. Two individuals, Individual #41 and Individual #491, did not have current PBSPs and were being treated with psychotropic medications.

43. The facility did not utilize PEMA.

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.

Summary: The review and management of polypharmacy met the criteria required for indicators 44 and 45 for a number of years. These two indicators will be moved to the category of requiring less oversight. Indicator 46 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 41	468	491	411	212	25	127	17	110
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 4/4	N/A	1/1	N/A	N/A	N/A	1/1	N/A	1/1	1/1
45	There is a tapering plan, or rationale for why not.	100%	N/A	1/1	N/A	N/A	N/A	1/1	N/A	1/1	1/1

		4/4									
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	50% 2/4	N/A	1/1	N/A	N/A	N/A	1/1	N/A	0/1	0/1

Comments:
44-45. These indicators applied to four individuals. Polypharmacy justification was appropriately documented in each case. In some cases, the documentation was located in psychiatry clinical documentation, in others, the information was located in the polypharmacy meeting minutes.

Although the other individuals did not meet criteria for polypharmacy, there were actions taken to reduce their medications and/or dosages, too.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for two of these four individuals. There was no documentation of a review for Individual #17 or Individual #110. It is possible that these reviews were done prior to the date of the document request.

The polypharmacy meeting was observed during the monitoring visit and was noted to be a good critical review of the polypharmacy regimens. The psychiatric clinicians were making valiant efforts to reduce polypharmacy, this was good to see.

Psychology/behavioral health

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

Summary: Given the absence of good, reliable data, progress could not be determined for all of the individuals. The Monitoring Team scored indicators 8 and 9 based upon the facility's report of progress/lack of progress as well as the ongoing exhibition of problem target behaviors. The indicators in this outcome will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 41	468	491	411	212	25	127	17	110
6	The individual is making expected progress	0% 0/9	0% 0/9	0% 0/9	0% 0/9	0% 0/9	0% 0/9	0% 0/9	0% 0/9	0% 0/9	0% 0/9
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	56% 5/9	1/1	0/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1
9	Activity and/or revisions to treatment were implemented.	40%	1/1	N/A	N/A	0/1	N/A	0/1	N/A	0/1	1/1

		2/5									

Comments:
6. Although graphs included in the progress notes indicated improvement for some problem behaviors identified for seven individuals (Individual #41, Individual #468, Individual #411, Individual #25, Individual #127, Individual #17, Individual #110), this indicator was rated as zero for all nine individuals due to the lack of reliable data. Further, the Monitoring Team had been asked to limit their contact with Individual #17 due to recent increases in her problem behavior. It was also reported that Individual #110 had been restrained once in September 2016. The use of a helmet with Individual #41 had recently been determined to be a protective mechanical restraint for self-injurious behavior by her IDT. More recently, this had been changed to a crisis intervention plan.

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

8-9. Recommendations were provided in the progress notes for five of the individuals (Individual #41, Individual #411, Individual #25, Individual #17, Individual #110).

- There was evidence that action steps had been taken to implement these recommendations for Individual #41 (i.e., her draft PBSP had been revised to address a newly observed behavior) and Individual #110 (i.e., a new PBSP had been implemented in August 2016).
- In Individual #411's case, progress notes suggested that staff should advocate for the use of a token economy and should attempt to identify the environmental variables related to an increase in peer-to-peer aggression. There was no evidence that these recommendations had been addressed. For Individual #25, it was repeatedly noted that the progress note should reflect the introduction of a new PBSP; no phase change lines were included in the graphs to indicate this change. Further, it was noted that dropping to the ground should be added to his PBSP. It did not appear that this had been completed at the time of the visit. In the progress note for Individual #17, monitoring the efficacy of her PBSP was recommended, but there was no evidence that this had occurred. In fact, her most recent progress note indicated that there was still evidence of measurement bias and observer reactivity. Although it was noted over a five-month period that data collection was too poor to speak to trends for Individual #468, no actions were recommended.

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

Summary: Staff training (and documentation) as well preparing float staff are areas of focus for Denton SSLC. It was good, however, to see that credentialed staff were available for the development and oversight of PBSPs. This had been the case for some time and, therefore, indicator 18 will be moved to the category of requiring less oversight. The other two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	41	468	491	411	212	25	127	17	110
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
17	There was a PBSP summary for float staff.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1

Comments:

16. Documents provided to the Monitoring Team did not reflect adequate training of staff on the PBSP for any of the nine individuals. When talking with the behavioral health services director, it was clear that training had occurred, but documentation was poor. Evidence could not be found of training of assigned staff for four individuals (Individual #41, Individual #491, Individual #411, Individual #17). For the other five individuals, documents suggested that 21% (Individual #212), 35% (Individual #127), 36% (Individual #468), 47% (Individual #25), and 63% (Individual #110) of the individual's assigned home staff had been trained.

17. The facility had not yet developed PBSP summaries for float staff. Staff reported that the PBSP Appendix C would be given to staff when they were assigned individual supervision. This is a multi-page document; it does not allow for a quick reference to the essential elements of the individual's PBSP.

18. The functional assessments and PBSPs for six of the individuals had been written or signed by a BCBA. For Individual #491 and Individual #17, the author was either enrolled in coursework or ready to sit for the exam. The only exception was Individual #212 whose reports were signed by an individual who was not a BCBA and who was no longer listed on the staff roster.

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

Summary: More focus is needed for progress reviews, that is, in progress notes and creation of useful graphs. Peer review was occurring regularly as required, which was good to see, but more focus also needs to be paid to the minimum topic requirements and follow-up. With sustained performance, indicator 23 might move to the category of requiring less oversight after the next review. All five indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 41	468	491	411	212	25	127	17	110
19	The individual's progress note comments on the progress of the individual.	67% 6/9	0/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The graphs are useful for making data based treatment decisions.	11% 1/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	67% 2/3	1/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	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.	0% 0/6	N/A	0/1	N/A	0/1	0/1	0/1	N/A	0/1	0/1
23	This indicator is for the facility: Internal peer reviewed occurred at	100%									

	least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.		

Comments:

19. The progress notes for six individuals commented on the individual's progress. The exceptions were Individual #41, Individual #468, and Individual #491 whose progress notes reflected inconsistent analysis of progress across a six-month period. In Individual #468's case, it was repeatedly noted that progress could not be determined due to poor data collection.

20. Only the graphs found in Individual #41's progress notes were useful for making data based decisions. In progress reports for others, graphs depicted too many measures (Individual #468, Individual #212, Individual #411, Individual #25, Individual #17) or they were very small (Individual #127, Individual #110) making it difficult to interpret the data. Phase change lines were not consistently utilized to depict new PBSP implementation, hospitalization, or other major life events.

21. An observation was conducted of the psychiatric clinic for two individuals (Individual #41, Individual #110). In both cases, the behavior health specialist or BCBA presented data, including measures collected for the current month. Although the focus of the ISPA meeting for Individual #468 was the re-introduction of a sensory diet to support positive behavior change, a review of his PBSP data did not occur.

22. There was evidence that six individuals had been reviewed in internal and/or external peer review meetings. Minutes from external peer review revealed a review of documents using the Settlement Agreement Cross-Referenced with ICF-MR Standards. This resulted in a completed checklist for Individual #468, Individual #212, Individual #411, and Individual #25, but did not include substantive comments or feedback regarding assessments and PBSPs. Internal peer review had provided feedback for two individuals. The recommendation for Individual #17 was to increase the consistency of program implementation, but there were no data on assessment of treatment integrity. The review for Individual #110 included revisions to the PBSP, but the document provided to the Monitoring Team was the PBSP implemented in January 2016. Progress notes indicated a new plan was implemented in August 2016.

23. There was evidence that internal and external peer review meetings occurred at the required frequency over a six-month period. The external peer reviewer was often in attendance at meetings of the Behavior Support Committee and internal peer review.

Outcome 8 – Data are collected correctly and reliably.											
Summary: The behavioral health data collection systems at Denton SSLC met the many criteria required by indicators 26 and 27 for this review and the previous two reviews, too. However, given the recently implemented changes with the state's electronic health record, the Monitoring Team will monitor these indicators at the next review, too. To meet all of the indicators in this outcome, measures and goals need to be established and maintained.			Individuals:								
#	Indicator	Overall Score	41	468	491	411	212	25	127	17	110

26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 9/9	1/1	1/1	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% 0/9	0/1	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).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

26. For all of the individuals reviewed, data collection as described in the PBSP was considered adequate. Staff are advised to check objectives, data collection descriptions, and graphs included in the progress reports to ensure there is correspondence across measurement systems in all documents. For example, in Individual #25's PBSP a frequency measure is suggested in all treatment objectives, but the data collection suggests a partial interval measure.

27. For all of the individuals, data collection as described in the PBSP was considered adequate for replacement/alternative behaviors. As noted above, staff are advised to check objectives, data collection descriptions, and graphs included in the progress reports to ensure there is correspondence across measurement systems in all documents. For example, Individual #110's objective for coping skills suggested a percent of opportunities, but a frequency measure was utilized.

28-29. Based upon the documents provided and discussion with the director of the behavioral health services department, it was determined that the facility had not established acceptable measures of data collection timeliness, IOA, or treatment integrity. Similarly, goal frequencies and levels had not been identified.

30. Although progress reports noted the percentage of data sheets that were completed, there was no report of data timeliness. IOA was consistently reported in the progress reports for Individual #127 only, but this was reported on nonoccurrence of targeted behaviors. When comments were made regarding treatment integrity, these were subjective statements, such as stating that the PBSP was implemented accurately and consistently. No objective assessment of treatment integrity was evident.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.	
Summary: For individuals reviewed, IDTs generally did not have a way to measure outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.	Individuals:

#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	17% 3/18	1/2	0/2	0/2	0/2	0/2	0/2	1/2	1/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	17% 3/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	1/2	1/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #491 – respiratory compromise, and cardiac disease; Individual #411 – cardiac disease, and seizures; Individual #731 – GI problems, and weight; Individual #365 – respiratory compromise, and GI problems; Individual #151 – cardiac disease, and falls; Individual #410 – respiratory compromise, and constipation/bowel obstruction; Individual #48 – cardiac disease, and constipation/bowel obstruction; Individual #271 – UTIs, and seizures; and Individual #252 – respiratory compromise, and GI problems).

From a medical perspective, the goal/objective that was clinically relevant, achievable, and measurable was for: Individual #271 – seizures. The goals/objectives that were clinically relevant, but not measurable were for Individual #48 – constipation/bowel obstruction, and Individual #491 – respiratory compromise.

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #151 – falls, and Individual #252 – respiratory compromise.

c. through e. At times, QIDPs included information about the health risk in the monthly ISP reviews, but without a relevant and measurable goal, the IDT could not use the information meaningfully. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Individual #271 had made progress with regard to seizures, but he did not have a clinically relevant, achievable, and measurable goal/objective related to UTIs. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of medical supports and services to these nine individuals.

Outcome 4 – Individuals receive preventative care.	
Summary: Seven of the nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to preventative care can be assessed	Individuals:

and are deemed to meet the requirements of the Settlement Agreement. In addition, the Facility needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.											
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	Individual receives timely preventative care:										
	i. Immunizations	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
	ii. Colorectal cancer screening	100% 6/6	1/1	N/A	1/1	N/A	N/A	1/1	1/1	1/1	1/1
	iii. Breast cancer screening	50% 1/2	1/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
	vii. Cervical cancer screening	100% 3/3	1/1	N/A	N/A	1/1	N/A	N/A	1/1	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

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

- For Individual #48, on 7/9/13, attempts to complete mammograms were unsuccessful, but it was unclear what plan the IDT developed and implemented to successfully complete the preventative test. She had also refused mammograms in 2003, 2008, and 2010. No sedation was given for the mammogram completed on 4/9/12, according to the sedation list provided in the annual medical assessment. It did not appear further attempts at mammograms were made after the failed attempt on 7/9/13.
- Documentation was not found to show Individual #271 received the zoster vaccine, and/or the reason for it not being administered.

b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence

needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. This was generally not seen in the documents submitted. For example, at times, QDRRs identified anticholinergic burdens that placed individuals at risk, but the PCP had not addressed how potential side effects (e.g., constipation, memory loss, drowsiness, tachycardia, etc.) would be monitored, and/or whether applicable medications were considered for reduction or elimination and/or their use was justified. Similarly, for some individuals reviewed, QDRRs identified metabolic syndrome risk, but AMAs did not provide the PCPs' analysis of the information or provide a plan/orders to address metabolic syndrome for those individuals who had it, such as by increasing the individuals' physical activity. An exception to this was Individual #491, for whom the PCP provided a good succinct review of metabolic syndrome and a corresponding plan. Unfortunately, the same was not true for this individual's anticholinergic burden. For Individual #48, there was a quality review of polypharmacy, but there was no mention of the metabolic syndrome risks reviewed in the QDRR nor the anticholinergic risk and the clinical application to the individual.

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: State Office is in the process of revising its policy with regard to DNR Orders. The Monitoring Team will continue to review this indicator.

#	Indicator	Overall Score	Individuals: 491	411	731	365	151	410	48	271	252
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	100% 2/2	N/A	N/A	N/A	1/1	N/A	N/A	1/1	N/A	N/A

Comments: None.

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

Summary: Given that over the last two review periods and during this review, prior to the transfer to the hospital or ED, individuals reviewed received timely treatment and/or interventions for the acute illness requiring out-of-home care (Round 9 – 100% for Indicator 4.e, Round 10 – 100% for Indicator 4.e, and Round 11 - 100% for Indicator 6.e), Indicator e will move to the category requiring less oversight. The Monitoring Team will continue to review the remaining indicators.

#	Indicator	Overall Score	Individuals: 491	411	731	365	151	410	48	271	252
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.	50% 7/14	1/2	1/2	1/1	2/2	N/A	1/2	0/2	1/2	0/1
b.	If the individual receives treatment for the acute medical issue at the	50%	2/2	0/2	0/1	0/1		1/1	1/1	N/A	N/A

	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.	4/8									
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.	64% 9/14	1/1	0/1	0/2	2/2	N/A	2/2	0/2	2/2	2/2
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	67% 4/6	1/1	N/A	0/2	1/1		N/A	N/A	1/1	1/1
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.	100% 14/14	1/1	1/1	2/2	2/2		2/2	2/2	2/2	2/2
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	64% 7/11	N/A	0/1	N/A	2/2		0/2	1/2	2/2	2/2
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	70% 7/10	N/A	N/A	2/2	2/2		N/A	0/2	2/2	1/2
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	93% 13/14	1/1	1/1	2/2	2/2		2/2	1/2	2/2	2/2

Comments: a. and b. For eight of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 14 acute illnesses addressed at the Center, including the following with dates of occurrence: Individual #491 (pneumonia on 2/10/16, and cough on 4/4/16), Individual #411 (left heel discoloration on 2/22/16, and coughing and vomiting on 7/29/16), Individual #731 (bruise on 5/24/16), Individual #365 (conjunctivitis on 6/26/16, and anemia on 6/9/16), Individual #410 (asthma on 7/6/16, and emesis on 6/27/16), Individual #48 [gastrostomy tube (G-tube) leaking on 5/6/16, and scratch on 4/26/16], Individual #271 (hypothermia on 5/7/16, and behavioral issues on 7/7/16), and Individual #252 (cellulitis on 4/25/16).

The acute illnesses for which documentation was present to show that medical providers assessed the individuals according to accepted clinical practice were for Individual #491 (pneumonia on 2/10/16), Individual #411 (coughing and vomiting on 7/29/16), Individual #731 (bruise on 5/24/16), Individual #365 (conjunctivitis on 6/26/16, and anemia on 6/9/16), Individual #410 (asthma on 7/6/16), and Individual #271 (behavioral issues on 7/7/16). For many of the remaining acute illnesses treated at the Facility that the Monitoring Team reviewed, medical providers did not cite the source of the information (e.g., nursing, activities/workshop staff, PT, OT, etc.) in assessing them. No documentation from the PCP was found to show the individual's relevant history was reviewed for Individual #271 (hypothermia on 5/7/16).

The acute illnesses/occurrences reviewed for which follow-up was needed, and documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized included those for Individual #491 (pneumonia on 2/10/16, and cough on 4/4/16), Individual #410 (asthma on 7/6/16), and Individual #48 (scratch on 4/26/16).

For eight of the nine individuals reviewed, the Monitoring Team reviewed 14 acute illnesses requiring hospital admission, Infirmary admission, or ED visit, including the following with dates of occurrence: Individual #491 (Infirmary admission for fever/hypoxia on 3/30/16), Individual #411 (ED visit for laceration on 6/3/16), Individual #731 (Infirmary admission for dehydration on 4/6/16, and Infirmary admission for dehydration on 4/13/16), Individual #365 [hospitalization for dislodgement of gastrostomy-jejunostomy tube (G/J-tube) on 5/31/16, and G/J-tube dislodgement on 2/27/16], Individual #410 (ED visit for possible pneumonia on 3/24/16, and ED visit for hypoxia and tachycardia on 3/26/16), Individual #48 (hospitalization due to abnormal blood chemistries on 5/31/16, and hospitalization due to G-tube leakage on 5/7/16), Individual #271 (hospitalization for distended bladder on 4/1/16, and hospitalization due to lethargy on 4/13/16), and Individual #252 (hospitalization for congestion on 5/16/16, and hospitalization for respiratory issues on 4/1/16).

c. The acute issues for which prior to the transfer, the PCP or a provider evaluated the individual timely, or if unable to assess prior to transfer, within one business day, the PCP or a provider provided an IPN with a summary of events leading up to the acute event and the disposition were for Individual #491 (Infirmary admission for fever/hypoxia on 3/30/16), Individual #365 (hospitalization for dislodgement of G/J-tube on 5/31/16, and G/J-tube dislodgement on 2/27/16), Individual #410 (ED visit for possible pneumonia on 3/24/16, and ED visit for hypoxia and tachycardia on 3/26/16), Individual #271 (hospitalization for distended bladder on 4/1/16, and hospitalization due to lethargy on 4/13/16), and Individual #252 (hospitalization for congestion on 5/16/16, and hospitalization for respiratory issues on 4/1/16).

d. Seven of the acute illnesses reviewed occurred after hours or on a weekend/holiday, and one required immediate transport to the ED.

For two acute illnesses, notes were not found to show that the PCP or a provider conducted an assessment.

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

g. For the acute illnesses for which this indicator was not met, IDTs did not hold and/or document post-hospitalization ISPA meetings.

h. For the individuals reviewed, upon their return to the Center, there was generally evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of the acute illness. The exception was Individual #48's hospitalization on 5/31/16, for which no PCP IPN was found upon her return on 6/6/16. She returned to the hospital and died a couple of days later.

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

Summary: Given that over the last two review periods and during this review, for the consultations reviewed, the PCP generally reviewed consultations and indicated agreement or disagreement (Round 9 – 100%, Round 10 – 100%, and Round 11 – 100%), Indicator a will move to the category of requiring less oversight. Improvement was seen over the last review and this one with regard to PCPs writing IPNs that included necessary components (Round 9 – 69%, Round 10 – 100%, and Round 11 – 94%). During the next review, should the Center sustain its progress in this area, Indicator c likely will move to the category requiring less oversight. The Facility needs to focus on ensuring PCPs conduct timely reviews, order agreed-upon recommendations, refer consultation recommendations to IDTs, when appropriate, and IDTs need to review the recommendations and document their decisions and plans in ISPAs.

#	Indicator	Overall Score	Individuals: 491	411	731	365	151	410	48	271	252
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	67% 12/18	1/2	2/2	2/2	1/2	2/2	0/2	1/2	1/2	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	94% 17/18	2/2	2/2	2/2	2/2	2/2	2/2	1/2	2/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence	75%	1/1	2/2	2/2	1/1	2/2	1/2	1/2	1/2	1/2

	it was ordered.	12/16									
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/2	N/A	N/A	N/A	N/A	N/A	0/1	0/1	N/A	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 18 consultations. The consultations reviewed included those for Individual #491 for neurology on 4/6/16, and immunology on 5/9/16; Individual #411 for neurology on 3/30/16, and urology on 7/1/16; Individual #731 for ophthalmology on 2/25/16, and neurology on 3/16/16; Individual #365 for ophthalmology on 3/15/16, and podiatry on 6/15/16; Individual #151 for neurology on 4/13/16, and ophthalmology on 2/16/16; Individual #410 for pulmonology on 2/8/16, and oncology on 2/18/16; Individual #48 for oncology on 1/8/16, and neurology on 5/11/16; Individual #271 for neurology on 6/22/16, and urology on 7/6/16; and Individual #252 for pulmonology on 6/13/16, and neurology on 5/11/16.

a. and b. It was positive that PCPs reviewed and initialed the consultation reports reviewed, and indicated agreement or disagreement with the recommendations. However, a number of these reviews did not occur timely, including those for Individual #491 for immunology on 5/9/16; Individual #365 for podiatry on 6/15/16; Individual #410 for pulmonology on 2/8/16, and oncology on 2/18/16; Individual #48 for oncology on 1/8/16; and Individual #271 for neurology on 6/22/16.

c. No PCP IPN was submitted related to Individual #48's neurology consultation on 5/11/16.

d. When PCPs agreed with consultation recommendations, evidence was not submitted to show orders were written for all relevant recommendations, including follow-up appointments, for the following: Individual #410 for oncology on 2/18/16, Individual #48 for neurology on 5/11/16, Individual #271 for neurology on 6/22/16, and Individual #252 for neurology on 5/11/16.

e. Based on Individual #410's oncology consultation on 2/18/16, he was to receive intravenous (IV) medications for three days, but no evidence was submitted of an IDT meeting. As noted above, for Individual #48, no IPN was found regarding whether or not a referral to the IDT was needed to discuss results of the oncology consultation on 1/8/16.

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

Summary: The Center needs to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessment, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible.

Individuals:

#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	33% 6/18	1/2	0/2	0/2	2/2	0/2	1/2	1/2	1/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #491 – respiratory compromise, and cardiac disease; Individual #411 – cardiac disease, and seizures; Individual #731 – GI problems, and weight; Individual #365 – respiratory compromise, and GI problems; Individual #151 – cardiac disease, and falls; Individual #410 – respiratory compromise, and constipation/bowel obstruction; Individual #48 – cardiac disease, and constipation/bowel obstruction; Individual #271 – UTIs, and seizures; and Individual #252 – respiratory compromise, and GI problems).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #491 – respiratory compromise; Individual #365 – respiratory compromise, and GI problems; Individual #410 – constipation/bowel obstruction; Individual #48 – constipation/bowel obstruction; and Individual #271 – seizures. The following provide a few examples of concerns noted regarding medical assessment, tests, and evaluations, as well as treatment plans:

- Individual #48 had a history of atrial fibrillation and also bradycardia, requiring a pacemaker. It was not clear from the documentation submitted if the atrial fibrillation was intermittent or continuous. There was also a notation that she was too high risk for anticoagulation therapy, but the reason for high-risk status was not clear. This was translated into no blood thinner, but also no aspirin. She subsequently had at least two strokes, and was placed on Coumadin after the second stroke. Her international normalized ratio (INR) (i.e., a way of reporting blood coagulation results) varied greatly, and at one time was over eight. She developed drainage from the G-tube ostomy, characterized as feculent, but might have been old blood, as her INR was elevated at the time of transfer to the ED. When she returned, she was placed on monitoring every two weeks, but she again began to have INRs that were supra-therapeutic. During her final hospitalization prior to her death, her INR was above the therapeutic range at 4.1. There might need to be a review of the Center's protocol for INR monitoring, including monitoring at increased frequency and for prolonged periods following dosage changes.

- Individual #151 had a fracture of his lower extremity, presumably associated with falling while outside in the rain. No other information was available concerning the details of the event, and there was no information to determine if the causes for fall risk had been assessed and carried forward in the AMA (e.g., monitoring footwear; appropriate length of trousers; problems of balance or gait; vertigo; startle reflex; hyperammonemia, which was documented as having occurred at least once in the past, but might have been inaccurate if the specimen had not been collected appropriately; visual field testing; etc.). His fracture healing was uneventful. The medical record was difficult to track concerning a possible femur infarct, which might have been ruled out. The consultant did not further treat this concern. Although radiographic findings suggested osteopenia, a DEXA scan indicated healthy bone density. He was noted to have a neck posture that had evolved over several years. There was no orthopedic involvement necessary. His Vitamin D level was monitored. He was treated adequately for bone health.

- Individual #252 had a long history of pulmonary challenges due to scoliosis, sleep apnea, carbon dioxide retention, tracheostomy placement, and frequent aspiration pneumonias. His pulmonary condition continued to require hospitalization at intervals for pneumonia. A pulmonary consultant followed him. There were recent tracheostomy dislodgements, as well as an attempt at weaning him from the tracheostomy. The contribution of allergies and asthma was not clarified in the submitted documentation. If extensive evaluation or allergy testing had been completed, ensuring this is carried forward in the Past Medical History section of the AMA would be important. Suction tooth brushing was ordered, but there were no data

concerning whether it was being done. This information was requested, but the Center's response was: "No data collected on suction tooth brushing as it is a Basic Standard of Care." The PCP needs to be assured oral health is maintained daily, bacterial burden is minimized in saliva, and that aspiration does not occur during tooth brushing. A monitoring system should be implemented to track this aspect of care. The reasons for the tracheal dislodgements were not further clarified, and documentation submitted did not illustrate steps taken to prevent recurrence. On a positive note, medication and respiratory therapy treatments were appropriate and timely.

- Since 1991, Individual #252 has had a G-tube. In 2010, gastritis and a hiatal hernia were noted. A recent esophagogastroduodenoscopy (EGD) indicated peptic stricture in the distal esophagus with extensive esophagitis. Positioning was appropriate as well as medication treatment. The lack of residuals indicated gastroparesis was not a contributing factor. The long-term sequelae and potential complications of reflux remained problematic, especially in the context of recurrent aspiration pneumonia. The severity of gastroesophageal reflux disease (GERD), with possible aspiration and complicating pneumonitis, was not determined. Submitted documentation did not include a discussion or evidence of consideration of additional steps to reduce reflux and sequelae of reflux.

- Individual #271 had a diagnosis of repeated UTIs leading to sepsis and hypothermia. He had bilateral kidney stones. A second neurologist was consulted to provide guidance for this individual with a number of complex issues. Topiramate was discontinued due to his kidney stone formation. There was concern about urinary retention, although there was no information submitted concerning post-void residuals. There was the presumed correlation of hypothermia and UTIs. The individual was prescribed Risperdal, which might aggravate both urinary retention and hypothermia. The anticholinergic effect of Risperdal was mentioned in the Quarterly Drug Regimen Review (QDRR), as well as the "disruption in ability to regulate body temperature." However, given the problems of UTIs and hypothermia, there was no recommendation to consider changing this medication. The side effect list in the QDRR was written so that such important considerations specific to this high risk in the individual were not highlighted and brought to the attention of the PCP. There was no submitted documentation of interdepartmental discussion involving pharmacy, psychiatry, and medical staff concerning alternatives to Risperdal. Extracorporeal shock wave lithotripsy had been successful in reducing the number of stones. There was no information submitted indicating the type of stone (if a stone was collected in the past and sent to the lab for identification). Urology followed him and prescribed Tamsulosin. Evaluation of the medication side effect profile needed further review and/or documentation of review. Evaluation of potential urinary retention was not included in the submitted documentation.

- Individual #731 had a history of severe reflux esophagitis and Barrett's esophagus. The most recent EGD, dated 10/18/12, did not mention evidence of Barrett's esophagus. Moderate chronic inflammation consistent with atrophic gastritis was found. Most recently, in approximately April 2016, there were several days/weeks when his oral intake dropped and he became dehydrated, requiring admission to the Infirmary twice. He had a drop in weight, but evidence of a review of common causes of anorexia in the elderly was lacking in the submitted documentation. The dietitian was consulted, but there was some failure of communication between departments, as supplements the dietician recommended on 4/26/16 did not occur initially. On 5/19/16, the lack of follow-through was identified. On 6/20/16, the IDT made adjustments to his PNMP. In June 2016, his weight stabilized at about 138 pounds from a prior weight of 146.8 pounds. Staff observed that he was more compliant with eating when familiar staff were with him, and that he preferred foods with a sweet taste and staff adapted food preparation

	based on this knowledge. There was no information concerning medical evaluation to determine etiology of his anorexia causing dehydration, such as the need to evaluate for worsening gastritis, gastric or esophageal ulcers, and/or recurrence/status of Barrett's esophagus or gastroparesis. As a result, there was the risk that episodes of dehydration and/or anorexia could occur again in the future.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. Although documentation often was found to show implementation of those action steps that IDTs assigned to the PCPs in IHCPs, the Monitoring Team will continue to review this indicator until IHCPs include necessary action steps and they are implemented.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	88% 14/16	1/2	2/2	2/2	2/2	2/2	1/1	1/2	1/1	2/2
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that IDTs had identified for the individuals reviewed generally were implemented. The exceptions were monitoring of the results of a lipid panel every six months for Individual #491, and "encouraging exercise," for Individual #48, which did not appear to be completed through an order or referral for an exercise program.											

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
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	N/A	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	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s);	0%	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	and	0/8									
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. Individual #411 was at low risk for dental, so a goal/objective was not necessary. The Monitoring Team reviewed eight individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, progress reports on existing goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For these eight individuals, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services. For Individual #411, a full review was completed because he was part of the core group.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: These are new indicators, which the Monitoring Team will continue to review.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	Individuals have no diagnosed or untreated dental caries.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
b.	Since the last exam:										
	i. If the individual had gingivitis (i.e., the mildest form of periodontal disease), improvement occurred, or the disease did not worsen.	N/A							N/A		
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	86% 6/7	N/R	1/1	1/1	1/1	1/1	0/1	N/A	1/1	1/1
c.	Since the last exam, the individual's fair or good oral hygiene score was maintained or improved.	N/R									

Comments: c. As indicated in the dental audit tool, This indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will not be rated. At the time of the review, State Office had not yet developed a process to ensure inter-rater reliability with the Centers.

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: Although some improvement was seen during this review, the Center's compliance with these indicators has varied. All of the indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	88% 7/8	1/1	1/1	1/1	0/1	1/1	1/1	N/A	1/1	1/1
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	63% 5/8	0/1	1/1	0/1	1/1	0/1	1/1	N/A	1/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	43% 3/7	0/1	1/1	0/1	0/1	0/1	1/1	N/A	1/1	N/A
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	88% 7/8	1/1	1/1	0/1	1/1	1/1	1/1	N/A	1/1	1/1
f.	If the individual has need for restorative work, it is completed in a timely manner.	100% 3/3	1/1	1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A
Comments: None.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: For the last two reviews, the individuals reviewed did not have dental emergencies, or necessary information was not available to conduct a review. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 1/1							1/1		

c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A							N/A		
Comments: None.											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: All of these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	50% 2/4	N/A	N/A	0/1	1/1	N/A	N/A	0/1	N/A	1/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	25% 1/4			0/1	1/1			0/1		0/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	25% 1/4			0/1	1/1			0/1		0/1
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/4			0/1	0/1			0/1		0/1
Comments: None.											

Outcome 9 – Individuals who need them have dentures.											
Summary: Some improvement was seen with regard to the dentist's assessment of the need for dentures for individuals with missing teeth.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	71% 5/7	1/1	0/1	1/1	N/A	1/1	N/A	0/1	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: None.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Overall, it was very troubling to find that a number of health issues found in the IPNs and nursing quarterlies reviews did not have associated Acute Care Plans. The Acute Care Plan is a basic blueprint for guiding nursing staff in providing the needed care, assessments, and supports for the individuals that require more intensive and frequent care to address the acute health issue. This issue needs to be corrected quickly. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0% 0/13	0/2	0/2	0/2	0/2	N/A	0/1	0/1	0/1	0/2
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% 0/13	0/2	0/2	0/2	0/2		0/1	0/1	0/1	0/2
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/13	0/2	0/2	0/2	0/2		0/1	0/1	0/1	0/2
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0% 0/10	0/2	0/2	0/2	N/A		0/1	N/A	0/1	0/2
e.	The individual has an acute care plan that meets his/her needs.	0% 0/13	0/2	0/2	0/2	0/2		0/1	0/1	0/1	0/2
f.	The individual's acute care plan is implemented.	0% 0/13	0/2	0/2	0/2	0/2		0/1	0/1	0/1	0/2
Comments: a. through f. The Monitoring Team reviewed the following acute illnesses for Individual #365 (conjunctivitis on 2/2/16, and conjunctivitis on 6/22/16), and Individual #271 (Otis media on 4/11/16). For a number of individuals, acute care plan should have been developed, but were not. This included for: Individual #491 (i.e., two episodes of pneumonia on 2/10/16 and 3/30/16, listed in the quarterly reviews), Individual #411 (i.e., for a UTI on 2/22/16, and a laceration to his face requiring six sutures), Individual #731 (i.e., who had multiple issues requiring initiation of acute care plans, such as conjunctivitis on 2/2/16, diarrhea and dehydration with IV fluids at the Infirmary on 4/6/16, swollen right foot on 5/23/16, etc., for whom the document request indicated "Acute Care Plans unable to locate"), Individual #410 (i.e., in response to the document request for acute care plans, the Center indicated "none," despite a											

hospitalization for a bowel obstruction during which a ball of feces had to be disimpacted), Individual #48 (i.e., in response to the document request for acute care plans, the Center indicated "none," despite the fact she had a cardiovascular accident, and had a G-tube placed while in the hospital), and Individual #252 (i.e., for pneumonia on 3/6/16, cellulitis to the left breast on 4/25/16, and pulmonary congestion on 5/16/16). A maximum of two acute illnesses are scored for each individual, but it was concerning that many acute care plans were not available for the individuals reviewed.

Overall, it was very troubling to find that a number of health issues found in the IPNs and nursing quarterlies reviews did not have associated Acute Care Plans. The Acute Care Plan is a document that nurses should review to plan and prioritize activities throughout their shifts for individuals that experience acute health events. It is a basic blueprint for guiding nursing staff in providing the needed care, assessments, and supports for the individuals that require more intensive and frequent care to address the acute health issue. In order to develop appropriate acute nursing care plans, information from the nursing protocols needs to be individualized specifically for the individual the acute care plan is addressing. Simply using the generic nursing protocols as acute nursing care plans renders them meaningless in providing appropriate direction to staff caring for the individual. Acute Care Plans need to accurately reflect what nursing is assessing (including the specific assessment criteria), how frequently, where it will be documented, how often it will be reviewed, what is being done to address prevention, health maintenance, and health promotion for the individuals. The Acute Care Plans need to be individual-specific and include appropriate measurable goals and specific interventions. Unfortunately, the lack of Acute Care Plans that were initiated for the acute health issues individuals reviewed experienced indicated that nursing staff do not see the Acute Care Plans as a guide for providing consistent clinical care. For individuals for whom Acute Care Plans were not initiated when they should have been, the overall score was zero for these indicators.

In addition to the overriding concern related to the lack of acute plans for acute illnesses and occurrences, the following provide some examples of other concerns noted:

- On 2/24/16 at 8:20 a.m., an IPN indicated Individual #410 had an episode of emesis. There was no indication the nurse checked the bowel movement log. The PCP note at 11:55 a.m. noted nursing staff reported emesis and abdominal pain. No indication was found in nursing documentation that Individual #410 expressed any pain prior to PCP seeing him. The PCP note indicated the individual had a hard bowel movement that morning and was bending over "like it really hurt." The note also indicated "likely constipation." The PCP note also stated that "because [Individual #410] has presented in mild distress for very serious conditions in the past," the PCP ordered a stat x-ray, lab work, and Magnesium Citrate. The fact that he presents in mild distress for very serious conditions should be included in his IHCP, so that staff do not discount any complaints from him. In addition to no acute care plan, documented nursing assessments did not include fluid intake, activity level, appetite, mental status, if flatus was present, any relief after vomiting, and/or what relieved the pain. As noted above, on 2/25/16 after pain got intense and bowel sounds were absent, Individual #410 was hospitalized for a bowel obstruction during which a ball of feces had to be disimpacted. After his hospitalization, the IPNs provided no indication about his bowel patterns, fluid intake, appetite, activity level, or what could have caused the fecal ball obstruction. Nothing appeared to have been put in place to prevent this from happening again (e.g., an ISPA).
- For Individual #48, on 4/24/16 at 1:05 p.m., an initial IPN noted her face was red. No further nursing assessment of her face was included in the IPNs. Given that this individual recently had a CVA (i.e., on 3/21/16) and was prescribed anticoagulation therapy (blood thinner), nursing staff should have reported to the PCP when her face was first noted to be red. On 4/25/16, an IPN noted redness to her face, nose, and around the eyes. The PCP was notified, and, on 4/26/16, the PCP saw her and

diagnosed cellulitis of her face and prescribed an antibiotic. Nursing staff did not initiate an acute care plan for this, or for the CVA or G-tube placement. As a result of a lack of criteria for ongoing nursing assessments of her face, the healing process was difficult to follow in the IPNs.

- While on site, the nursing member of the Monitoring Team met with Individual #271's nurse case manager regarding the individual's significant change in status. The RN Case Manager could not produce specific intake values after the individual's hospitalization for a UTI or specific data addressing the change of status he reported he was tracking. The Monitoring Team also discussed with the CNE problems with nursing documentation for this individual in terms of the annual nursing review, quarterly reviews, and IPNs. She indicated that she was aware that there was a problem. This issue was very concerning in that the nursing documentation did not accurately reflect the individual's status, especially given that direct support professionals clearly articulated a significant change of status for Individual #271.

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

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

#	Indicator	Overall Score	Individuals: 491	411	731	365	151	410	48	271	252
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	11% 2/18	1/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #491 –dental, and fractures; Individual #411 – falls, and weight; Individual #731 – weight, and dental; Individual #365 – constipation/bowel obstruction, and fluid imbalance; Individual #151 – weight, and behavioral health in relation to communication; Individual #410 – constipation/bowel obstruction, and respiratory compromise; Individual #48 – UTIs, and falls; Individual #271 – constipation/bowel obstruction, and infections; and Individual #252– cardiac disease, and skin integrity).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #491 – fractures; and Individual #151 – behavioral health in relation to communication.

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

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.

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

Individuals:

#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	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).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

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

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

Summary: During the last review, as well as this review, the Center did well with the indicators related to administering medications according to the nine rights (c), documenting the use of the PRN medications (e, and previously d), and following infections control practices (g, and previously f). However, given the importance of these indicators to individuals' health and safety and the variability in a number of scores over the last two reviews and this one, the Monitoring Team will continue to

Individuals:

review them until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will remain in active oversight as well.											
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	Individual receives prescribed medications in accordance with applicable standards of care.	94% 15/16	2/2	2/2	2/2	1/2	2/2	2/2	1/1	2/2	1/1
b.	Medications that are not administered or the individual does not accept are explained.	89% 8/9	N/A	1/1	2/2	0/1	1/1	N/A	1/1	2/2	1/1
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	N/A
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	0% 0/3	N/A	N/A	N/A	0/1	N/A	0/1	N/A	N/A	0/1
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	0% 0/4	0/1	N/A	N/A	0/2	N/A	N/A	N/A	N/A	0/1
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
f.	Individual's PNMP plan is followed during medication administration.	57% 4/7	1/1	1/1	0/1	0/1	1/1	1/1	N/A	0/1	N/A
g.	Infection Control Practices are followed before, during, and after the	86%	0/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	N/A

	administration of the individual's medications.	6/7									
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/A									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	75% 3/4	N/A	1/1	N/A	0/1	N/A	1/1	1/1	N/A	N/A
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.	67% 2/3	N/A	N/A	N/A	0/1	N/A	1/1	1/1	N/A	N/A

Comments: The Monitoring Team conducted record reviews for nine individuals and observations of eight individuals, including Individual #491, Individual #411, Individual #731, Individual #365, Individual #151, Individual #410, Individual #48 (deceased so no observation), Individual #271, and Individual #252 (deceased so no observation).

a. and b. Problems noted included:

- Although this did not negatively impact scoring, the Monitoring Team discussed the following concerns with the Facility Director during the onsite review. During the medication administration observations for two individuals in the same building, staff engaged in behavior that disrupted the environment, which should be as calm as possible during medication pass. Individual #411 began crying while he was waiting for the medication nurse to set up his medications. One staff member told him that he would be able to call his mother if he took his medications, which caused him to cry more intensely. The QIDP and nurse tried to comfort him. Then, another staff member made the comment that maybe he would not be able to call his mother if he did not take his medication. During this time, there was considerable noise and chaos in the area. A different direct support professional began speaking from the other side of the privacy curtain, which prevented him for seeing Individual #411 was upset, telling him to take his medications and then saying: "hurry up and swallow the medications; you're cutting into my active treatment time." Although this direct support professional was pressuring Individual #411 to take his medication, the nursing staff tending to the individual's needs at the time appropriately continued to focus on the individual until he was ready to take his medications.
- The Medication Administration Records (MARs) for Individual #365 showed omissions and/or MAR blanks for which variance forms were not provided.

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

d. Problems noted included:

- Individual #491 coughed and had nasal drainage throughout the medication pass. The nurse listened to lung sounds before medication pass, but had to be prompted to listen afterwards.
- The nurse listened to Individual #365's lungs before administering medications, but had to be prompted to do the same afterwards. The RN Case Manager stated that Individual #365 had a tracheal diversion. The Monitoring Team member pointed out that the individual was on hospice due to respiratory issues and was prescribed morphine, which depresses the respiratory system, so obtaining an additional assessment would be clinically prudent. No lung sound assessment was included in the IHCP.
- Individual #410 was at high risk for respiratory issues, but the IDT did not include nursing assessments in the IHCP to address his respiratory status. The same was true for Individual #252.

e. For the most part for the individuals reviewed, nursing staff documented the reason, route, and/or the individual's reaction or the effectiveness of the PRN or STAT medication.

f. During onsite observations, the following concerns were noted with regard to PNMP implementation during medication pass:

- For Individual #731, the medication nurse was not at eye level with the individual. Also, a direct support professional was holding his arms while the nurse was holding his head to give him his medications. Nursing staff should consult with Habilitation Therapies and Behavioral Health Services regarding safe and appropriate strategies to administer medications to Individual #731 due to challenges with him pushing and pulling during medication administration. Staff essentially restrained him during medication pass. The nursing member of the Monitoring Team spoke with Chief Nurse Executive (CNE) about staff holding him during the observation.
- For Individual #365, the nurse had to be prompted to use the PNMP, including the picture of the individual.
- For Individual #271, the nurse did not check the position of the wheelchair to ensure it was at the correction position and did not look at PNMP picture until prompted.

g. With one exception, for the individuals observed, nursing staff followed infection control practices. The exception was for Individual #491, for whom the nurse put the medication cup the individual had spit in back on the medication cart.

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

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

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

l. and m. As noted above, for Individual #365, MAR blanks were not reconciled and reported;

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Overall, IDTs and/or the PNMT did not have a way to measure outcomes related to individuals' physical and nutritional management at-risk conditions. In addition, it was concerning that often IDTs did not refer individuals meeting criteria for PNMT review and/or assessment to the PNMT and/or that the PNMT did not self-refer these individuals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	8% 1/12	0/1	0/2	0/2	1/1	0/2	0/1	0/1	0/1	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	58% 7/12	1/1	0/2	2/2	0/1	2/2	1/1	0/1	0/1	1/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/12	0/1	0/2	0/2	0/1	0/2	0/1	0/1	0/1	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/12	0/1	0/2	0/2	0/1	0/2	0/1	0/1	0/1	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/12	0/1	0/2	0/2	0/1	0/2	0/1	0/1	0/1	0/1
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	50% 3/6	0/1	N/A	N/A	0/1	N/A	1/1	0/1	1/1	1/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	0/1			0/1		0/1	0/1	0/1	0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	17% 1/6	0/1			0/1		0/1	0/1	0/1	1/1
	iv. Integrated ISP progress reports include specific data	0%	0/1			0/1		0/1	0/1	0/1	0/1

	reflective of the measurable goal/objective;	0/6									
	v. Individual has made progress on his/her goal/objective; and	0% 0/6	0/1			0/1		0/1	0/1	0/1	0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/1			0/1		0/1	0/1	0/1	0/1

Comments: The Monitoring Team reviewed 12 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: choking for Individual #491; choking, and weight for Individual #411; aspiration, and choking for Individual #731; weight for Individual #365; behavioral health in relation to communication, and fractures for Individual #151; GI problems for Individual #410; aspiration for Individual #48; aspiration for Individual #271; and skin integrity for Individual #252.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable goals/objectives. The goal/objective that was clinically relevant was the one for weight for Individual #365. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: choking for Individual #491; aspiration, and choking for Individual #731; behavioral health in relation to communication, and fractures for Individual #151; GI problems for Individual #410; and skin integrity for Individual #252.

b.i. The Monitoring Team reviewed six areas of need for six individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: aspiration for Individual #491; aspiration for Individual #365; aspiration for Individual #410, other: cardiovascular accident (CVA) for Individual #48, hypothermia for Individual #271, and aspiration for Individual #252.

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

- In July 2015, which was shortly before her most recent ISP meeting on 11/17/15, Individual #491 was diagnosed with aspiration pneumonia, but no referral or PNMT review was documented. This was the third aspiration pneumonia with two others occurring in March and April of 2015.
- Individual #365 was diagnosed with pneumonia on 10/3/15 and 10/24/15, but the PNMT did not review and/or assess her. Although she was in hospice services, PNMT review was necessary to determine whether or not changes were needed to her plan to mitigate recurrence to the extent possible.
- On 3/5/16, Individual #48 had a massive CVA that impacted all areas of functioning (e.g., eating, activities of daily living, etc.). Although it appeared from the PNMT minutes that they discussed her, no referral for a review/assessment was made.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT did not develop clinically relevant, achievable, and measurable goals/objectives for individuals reviewed. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: aspiration for Individual #252.

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of measurable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result of the lack of data, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took

necessary action. Due to the inability to measure clinically relevant outcomes for individuals, the Monitoring Team conducted full reviews of all nine individuals' PNM supports.

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
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.	11% 2/18	0/2	0/2	0/2	1/2	1/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	9% 1/11	0/1	0/1	N/A	0/2	0/1	0/2	0/2	1/1	0/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	N/A									

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, the IHCPs for which documentation was found to confirm the implementation of the PNM action steps that were included were those for weight for Individual #365, and fractures for Individual #151.

b. Individual #271's IDT took immediate action when he experienced a change in status in relation to hypothermia. The following are examples of some of the concerns related to IDTs' responses to changes in individuals' PNM status:

- Individual #365's weight dropped from 132 pounds in December 2015 to 111 pounds in May 2015, which would be considered significant, but there was no evidence the IDT took any action other than to note the change.
- For Individual #151, no evidence was found of a gait assessment/mobility assessment in response to a fall resulting in a fracture.
- Individual #410 experienced multiple episodes of emesis, vomiting, and coughing from September 2015 to April 2016, with an aspiration pneumonia event in March 2016. Prior to referral to the PNMT, evidence was not present to show the IDT took action.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.	
Summary: During numerous observations, staff failed to implement individuals' PNMPs as written, or in a manner that ensured individuals' safety. As noted with regard to Outcome #3, based on conversations with the Habilitation Therapy Director and the Facility Director, some strategies were removed from PNMPs	

because they were considered to be standards of care. As discussed on site, direct support professionals should not be responsible for making decisions about which strategies/standards of care should be applied to which individuals. In addition, PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	36% 13/36
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.	40% 2/5
Comments: a. The Monitoring Team conducted 36 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during five out of 21 observations (24%). Staff followed individuals' dining plans during seven out of 14 mealtime observations (50%). Transfers were completed correctly one out of one times (100%).		

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: None.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.	
Summary: It was good to see that a number of OT/PT goals/objectives developed for individuals reviewed were clinically relevant, and measurable. However, problems continued with regard to the measurability of a number of	Individuals:

goals/objectives, analysis in ISP monthly reviews of data collected, and IDTs responses to late implementation and/or lack of progress. These indicators will remain in active oversight.											
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	79% 19/24	8/8	4/5	1/2	0/1	0/1	0/1	2/2	2/2	2/2
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	50% 12/24	6/8	2/5	1/2	0/1	0/1	0/1	1/2	0/2	2/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	17% 4/24	0/8	1/5	1/2	0/1	0/1	0/1	0/2	0/2	2/2
d.	Individual has made progress on his/her OT/PT goal.	4% 1/24	0/8	1/5	0/2	0/1	0/1	0/1	0/2	0/2	0/2
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/24	0/8	0/5	0/2	0/1	0/1	0/1	0/2	0/2	0/2

Comments: a. and b. The goals/objectives that were clinically relevant and achievable, as well as measurable were those for Individual #491 (i.e., perform sit to stand, standing transfers, walk 500 feet with wheeled walker, walk through ramps and curbs, ascend/descend step, and flex knee at 90 degree angle), Individual #411 (i.e., sitting up after taking a bite of food), Individual #731 (i.e., putting on a shirt), Individual #48 (i.e., washing hands), and Individual #252 (i.e., select preferred items, and lifting foot to assist with putting on socks).

The goals/objectives that were clinically relevant, but not measurable were for Individual #491 (i.e., perform step up/down, forward/backwards, and sideways; and performing upper extremity activities), Individual #411 (i.e., increase range of motion in thumbs and wrist, and alternate positioning for fingers, and educating staff), Individual #48 (i.e., maintain right and left upper extremity range of motion), and Individual #271 (i.e., shoulder strength, and cross midline and hold left arm).

The goal/objective that was measurable, but not clinically relevant was for Individual #411 (i.e., using his right hand to deliver mail, given he has right hemiparesis).

c. through e. Although it was positive that some individuals had clinically relevant and achievable goals, a number of problems made it difficult for IDTs to determine whether or not individuals were making progress with goals/objectives, and to take action when progress was made or criteria were achieved. Some of these concerns included:

- Some goals/objectives still were not clinically relevant, and many were not measurable.
- Integrated ISP progress reports often did not include analysis of the data, which therapists sometimes were maintaining.
- Individual #411 met his SAP to sit up after taking a bite of food, which was a clinically relevant and measurable goal, and his ISP monthly reviews analyzed relevant data. However, his IDT had not met to determine whether or not to develop a new SAP.
- Individual #731 had a clinically relevant and measurable goal to put on his shirt. ISP reviews showed high variability in the

successful completion of trials. However, there was no evidence the IDT investigated/analyzed why this variability occurred.

- For Individual #48's goal related to washing her hands, the ISP reviews did not provide analysis of data.
- Individual #252 had clinically relevant, and measurable OT/PT goals. However, they were not implemented until five months after the IDT approved them, and success was inconsistent, but the IDT did not meet to discuss the possible reasons or discuss alternatives.

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

Summary: Although more work was needed, it was good to see some improvement from the last review with the Center's scores related to implementation of OT/PT supports. The Monitoring Team will continue to review them.

#	Indicator	Overall Score	Individuals: 491	411	731	365	151	410	48	271	252
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	48% 10/21	4/8	2/5	1/2	N/A	N/A	N/A	1/2	2/2	0/2
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/10	0/8	N/A	N/A	N/A	N/A	N/A	N/A	0/2	N/A

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

- The Center did not submit notes to demonstrate implementation of the following goals for Individual #491: ascend/descent step; perform step up/down, forward/backwards, and sideways; perform upper extremity activities; and flex knee at 90 degree angle. In May 2016, all of these goals had been revised.
- For Individual #411, monthly notes did not summarize the status of following goals as documented in IPNs from the OT: increase range of motion in thumbs and wrist, alternate positioning for fingers, and educating staff.
- For Individual #731, there was no evidence of implementation of the hand-washing goal that the OT recommended.
- In July 2015, Individual #48's hand-washing goal was agreed-upon, yet the SAP was not implemented for two months, and then the QIDP's reviews only stated to continue the objective with no review of data or analysis until March 2016, when the training was put on hold due to her CVA.
- Five months elapsed before staff implemented Individual #252's goals/objectives related to selecting preferred items, and lifting foot to assist with putting on socks.

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

Summary: Given that during the Round 9 review and during this review, individuals observed generally had clean adaptive equipment (Round 9 – 97%, Round 10 – not rated, and Round 11 - 91%) that was in working order (Round 9 – 100%, Round 10 – not rated, and Round 11 - 91%), Indicators a and b will move to the category of

requiring less oversight. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's varying scores (Round 9 – 91%, Round 10 – not rated, and Round 11 - 84%), this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	85	347	362	308	186	713	361	283	503
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	91% 29/32	1/1	1/1	1/1	1/1	3/3	1/1	1/1	1/1	1/2
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	91% 29/32	1/1	1/1	1/1	1/1	3/3	1/1	1/1	0/1	2/2
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	84% 26/31	1/1	1/1	1/1	0/1	2/3	0/1	1/1	0/1	2/2
		Individuals:									
#	Indicator		695	612	360	207	268	566	755	396	586
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1	2/2
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	2/2
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	2/2
		Individuals:									
#	Indicator		411	731	326	214	424	567	613	786	485
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	1/1	1/1	2/2	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		0/1	1/1	1/1	1/1	1/1	1/1	2/2	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	1/1	2/2	1/1	1/1
Comments: a. The Monitoring Team conducted observations of 32 pieces of adaptive equipment (i.e., some individuals had multiple pieces of adaptive equipment, and each was assessed separately). The individuals the Monitoring Team observed generally had clean											

adaptive equipment, which was good to see. The exceptions were: Individual #503's wheelchair, particularly the foot posts; Individual #207's lap tray; and Individual #566's wheelchair, particularly the sides and foot rests.

b. Individual #283's wheelchair seat was in poor repair and appeared to be splitting. Individual #360's footrest on her wheelchair was ripped. Individual #411's ankle foot orthosis was cracked.

c. Based on observation of Individual #308, Individual #186, Individual #713, Individual #283, and Individual #360 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.

Upon observation, Individual #586 was in a wheelchair that was too small for him, which resulted in pressure on his left arm and shoulder. Staff informed the Monitoring Team that a new wheelchair was in the process of being provided. The Monitoring Team member observed the new wheelchair, and the fit was much improved. As a result, the corresponding indicator was scored positively.

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

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition. None of the indicators had sustained high performance scores to be moved the category of requiring less oversight.

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

Given that most ISPs did not yet contain personal goals and action plans that met the various criteria, the indicators related to progress were also not met.

The Monitoring Team observed SAP implementation for five individuals. In no case was the SAP implemented as written. Inadequate data collection and implementation resulted in an inability to determine progress.

A positive observation was that most of the individuals were engaged in activities when observed by the Monitoring Team. This showed continued progress from the last two reviews. Community outings and community SAP training occurred for some individuals, but did not meet criteria.

Denton SSLC appeared to have a good relationship with the public school. Some, but not all, of the components required for this indicator were met.

IDTs did not have a way to measure clinically relevant outcomes with regard to individuals' communication skills. In addition, the Center is encouraged to focus on ensuring individuals' AAC/EC devices are available in all appropriate settings, and individuals use them functionally.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Given that goals were not yet individualized and did not meet criterion with ISP indicators 1-3, the indicators of this outcome also did not meet criteria. The handful of goals that were developed did not have data to allow progress to be assessed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	41	491	411	212	151	410			

4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

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

4-7. Overall, personal goals did not meet criterion as described above, therefore there was no basis for assessing progress in these areas. See Outcome 7, Indicator 37 for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans. For the four personal goals that met criterion, there was no evidence that progress was being made because reliable and valid data were not available.

Outcome 8 – ISPs are implemented correctly and as often as required.

Summary: These indicators will remain in active monitoring.

			Individuals:								
#	Indicator	Overall Score	41	491	411	212	151	410			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
39. Staff knowledge regarding individuals' ISPs was insufficient to ensure the implementation of the ISP, based on observations, interviews, and lack of consistent implementation. Monitoring Team observations included the following:

- Individual #41's Life Skills staff were not familiar with her SAP and did not implement or record SAP data correctly.
- Individual #491's staff were not aware of the need to add sauces and gravy per her PNMP and were not knowledgeable of her personal communication dictionary and how to use it.
- Individual #411's staff were not knowledgeable of his psychiatric symptoms. His observed medication pass was not consistent with staff instructions.

40. Action steps were not consistently implemented for any individuals as documented above. For Individual #151 and Individual #411, staff reported that staffing availability was a significant issue in consistent implementation.

Skill Acquisition and Engagement

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

Summary: Inadequate data collection, implementation, and/or monthly reviews resulted in an inability to determine progress. Whether SAPs were deemed progressing or not progressing by the facility, actions were not taken as required. It was, however, good to see that IDTs were using whatever data they did have to help inform decision making about their SAP programming. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 41	468	491	411	212	25	127	17	110
6	The individual is progressing on his/her SAPS	0% 0/27	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/4	N/A	N/A	N/A	0/3	N/A	N/A	0/1	N/A	N/A
8	If the individual was not making progress, actions were taken.	0% 0/10	N/A	0/2	0/3	N/A	0/3	N/A	0/2	N/A	N/A
9	Decisions to continue, discontinue, or modify SAPs were data based.	63% 17/27	0/3	3/3	3/3	3/3	3/3	2/3	3/3	0/3	0/3

Comments:

6. An individual's progress on his/her SAPs could not be determined. In some cases, the monthly review did not include a report of progress. This included all of the SAPs for Individual #41, Individual #17, and Individual #110. In Individual #25's case, it was too early to assess progress because his SAPs had just been introduced. For the remaining five individuals, the data were not reliable and, therefore, progress could not be determined. It should be noted that the data provided suggested progress on at least one SAP for Individual #468 (washing hands), Individual #491 (select soda), Individual #411 (sit up at meals, hand over the mail), and Individual #127 (continue working).

7. The monthly reviews indicated that Individual #411 had mastered his three SAPs and Individual #127 had mastered his continue working SAP. There was no evidence of a new or updated goal for either of these individuals.

8. There was no evidence of action taken when an individual was not making progress on his/her SAP.

9. In 17 of 27 SAPs, there was evidence that decisions regarding the plans were data-based. The exceptions were the three individuals whose SAPs were not reviewed (Individual #41, Individual #17, Individual #110) and the vending machine SAP for Individual #25 which also was not reviewed.

Outcome 4- All individuals have SAPs that contain the required components.												
Summary: SAPs were missing many components; none had all of the required components, including the absence of clear instructions for staff as to how to implement the plan as well as positive consequences for correct responding. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	41	468	491	411	212	25	127	17	110
13	The individual's SAPs are complete.	0% 0/27	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3

Comments:
13. None of the 27 SAPs included all the required components. Elements that were more consistently found were task analyses, when appropriate, relevant discriminative stimuli, guidelines following incorrect responding, and documentation methodology. The most consistent problems were the lack of clear behavioral objectives, specific instructions for teaching the skill, teaching schedules that identified the number of expected trials, and individual-specific reinforcement for correct responding. Behavioral objectives often omitted the number of monthly trials that were expected at the established mastery criterion. Instructions often referenced the most effective way to communicate with the individual. While this is an important consideration, it did not indicate how to present the task. The expected number of trials on training days were not identified. Lastly, only three SAPs identified reinforcers other than praise for correct responding. These were for Individual #491 (select soda) and Individual #127 (continue working and complete chores). Reinforcers were access to the soda, a break from working, and token reinforcement respectively.

Outcome 5- SAPs are implemented with integrity.												
Summary: Integrity of SAP implementation was not being monitored, so it was not surprising that the quality of SAP implementation was also poor. None of the SAPs observed were implemented correctly. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	41	468	491	411	212	25	127	17	110
14	SAPs are implemented as written.	0% 0/5	0/1	N/A	N/A	0/1	0/1	0/1	N/A	N/A	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% 0/27	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3

Comments:
14. The Monitoring Team was able to observe SAP implementation for five individuals, Individual #41, Individual #212, Individual #411, Individual #25, and Individual #110. In no case was the SAP implemented as written.

- With Individual #41, the staff member provided the correct discriminative stimulus and used a physical prompt to guide her hand towards the activation button. However, when Individual #41 did not respond, the staff member did not follow the

guidelines identified in the SAP.

- For Individual #212, the SAP was implemented better than written. Rather than verbally prompting each step in filling out a check, the staff member used a model that allowed Individual #212 to respond fairly independently.
- Although a completed SAP could not be observed because Individual #411 pushed away from the table after being told to sit up, the staff member did not provide the discriminative stimulus identified in the SAP.
- Individual #25 was expected to make a pizza. The materials were not out on the counter as indicated in the SAP, he was told to complete each step as it occurred, although only the initial verbal instruction is identified, and he was told to place the pizza in the oven, not a step in the SAP.
- Individual #110 was completing far more than what was identified in his SAP. He actually had two checklists that he independently checked to ensure that he completed necessary tasks in the greenhouse.

15. As explained by facility staff, assessment of SAP integrity had been initiated in August 2016. Each month, a QA staff member was to observe 14 residential SAPs and the external BCBA was to observe four program SAPs. As discussed with these same staff, the expectation is for each SAP to be monitored a minimum of one time within a six-month period. Documents provided indicated that none of the 27 SAPs had been monitored over the previous six months.

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

Summary: These two indicators received similar scores on the previous review. More work needs to be one to attend to these activities. Furthermore, given that the indicators related to SAP data and SAP implementation integrity were far from meeting criteria, these two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 41	468	491	411	212	25	127	17	110
16	There is evidence that SAPs are reviewed monthly.	63% 17/27	0/3	3/3	3/3	3/3	3/3	2/3	3/3	0/3	0/3
17	SAP outcomes are graphed.	59% 16/27	0/3	3/3	3/3	2/3	3/3	2/3	3/3	0/3	0/3

Comments:

16. There was evidence that data-based reviews of 17 of 27 SAPs had occurred monthly. A review of the most recent monthly reviews, provided in the document request, indicated that the following SAPs had not been reviewed: activity participation, placing the cup in the trash, and selecting clothing for Individual #41; vending machine use for Individual #25; fill out a ledger, stay at work, and activities not allowed with her boyfriend for Individual #17; and choosing work tasks, using a calculator, and planning a meal for Individual #110.

17. Graphic displays of data were found for 16 SAPs. Missing were the SAPs identified in indicator 16 above and the SAP for Individual #411 that required him to eat a snack while taking his medications. It should be noted that additional graphs were included in his monthly review, however, these were not labeled.

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.												
Summary: Most of the individuals were engaged in activities when observed by the Monitoring Team. This showed continued progress from the last two reviews, too. Further, the facility had set an engagement goal for all sites at the facility. That being said, the facility was measuring engagement at times, but not as often as required and goals were not met for those sites where engagement was measured. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	41	468	491	411	212	25	127	17	110
18	The individual is meaningfully engaged in residential and treatment sites.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

18. The Monitoring Team directly observed all nine individuals at least once during the onsite visit. Active engagement was observed for all, but Individual #41. In particular, individuals observed in their work environments, including Individual #491, Individual #212, Individual #127, Individual #17, and Individual #110, were consistently engaged.

19. Although the facility's policy indicated that engagement should be assessed each month, this was not evident for any of the individuals. For eight individuals, engagement in the home was assessed between two and five times over a six-month period. The exception was Individual #110 as no measures of engagement were documented in his home. For four individuals only (Individual #491, Individual #212, Individual #127, Individual #17) was there evidence of assessment of engagement twice in six months in their day programs.

20. The facility indicated that the goal for all sites was established at 65% engagement.

21. When assessed, engagement levels were not consistently met in the homes and day programs of the individuals reviewed.

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

in active monitoring.											
#	Indicator	Overall Score	41	468	491	411	212	25	127	17	110
22	For the individual, goal frequencies of community recreational activities are established and achieved.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

22. One individual, Individual #127, had goal frequencies for community recreational activities that had been achieved over a six-month period. While Individual #17 and Individual #110 experienced multiple trips to the community, their ISPs indicated this would occur monthly. The data provided indicated that there were one (Individual #17) to two (Individual #110) months over a six-month period when this had not occurred. Neither Individual #491 nor Individual #411 had goal frequencies established in their ISPs.

23. Although the document provided indicates that seven individuals (Individual #468, Individual #491, Individual #212, Individual #25, Individual #127, Individual #17, Individual #110) had at least one occurrence of SAP training in the community, none of the ISPs included established goal frequencies for community-based training. Staff are advised to check all data for correspondence. For example, it was noted that Individual #25 had only had two community outings, yet community-based training occurred 11 times. These may have occurred while he was attending school. Consideration should also be given to the appropriateness of community-based training on a private matter with Individual #17 (activities she cannot engage in with her boyfriend).

24. There were no plans developed to address barriers to community-based activities for any of the six individuals who had goals in their ISPs.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
Summary: Denton SSLC appeared to have a good relationship with the public school. Some, but not all, of the components required for this indicator were met. With additional attention, they likely can be. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	468								
25	The student receives educational services that are integrated with the ISP.	0% 0/1	0/1								

Comments:

25. One of the individuals, Individual #468, was enrolled in school at the time of the visit. The QIDP reported that he attended the

annual IEP meeting, but there were not regularly scheduled meetings with school personnel. Information about his participation was minimally addressed in his ISP and his monthly progress report commented on his performance at school. There were no action plans in the ISP that supported his IEP.

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A									
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									
Comments: For the nine individuals reviewed, these indicators did not appear applicable.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: The Center's scores during this review showed some regression. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/7	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	29% 2/7	0/1	0/1	0/1	1/1	1/1		0/1	0/1	
c.	Integrated ISP progress reports include specific data reflective of the	0%	0/1	0/1	0/1	0/1	0/1		0/1	0/1	

	measurable goal(s)/objective(s).	0/7									
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/7	0/1	0/1	0/1	0/1	0/1		0/1	0/1	
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/7	0/1	0/1	0/1	0/1	0/1		0/1	0/1	

Comments: a. and b. Individual #410 was able to communicate verbally with 100 percent intelligibility. Therefore, the communication outcomes and indicators were not assessed for him. Other individuals' communication needs (e.g., Individual #491, Individual #411, Individual #731, Individual #48, and Individual #271) were not met, no goals/objectives were developed, and IDTs provided no clinical justification for not developing programs to expand these individuals' communication skills.

Individual #252 participated in SAP training in the past focused on the use of Environmental Control with no progress. Alternative types of EC were trialed with no progress noted. Informal strategies had been identified to help his receptive understanding. Therefore, a formal goal/objective was not necessary.

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: to choose a dress for Individual #365, and to participate in sign class for Individual #151.

c. through e. For seven individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals. Individual #252 did not require a goal/objective, but he had communication needs. A full review was conducted for him as well.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	491	411	731	365	151	410	48	271	252
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	14% 1/7	0/1	0/1	0/1	0/1	1/1	N/R	0/1	0/1	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									

Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. For most individuals reviewed, evidence was not present to show that the strategies were implemented.

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
Summary: Minimal improvement was noted with the Center's performance with these indicators. The Center is encouraged to focus on ensuring individuals' AAC/EC devices are available in all appropriate settings, and individuals use them functionally. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "Overall Score."]			Individuals:								
#	Indicator	Overall Score	151	491	283	469	302	32	165	153	757
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	40% 4/10	0/1	0/1	0/1	1/2	0/1	1/1	1/1	0/1	1/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	30% 3/10	0/1	0/1	0/1	1/2	0/1	1/1	0/1	0/1	1/1
Comments: a. and b. It was concerning that often individuals' AAC devices often were not present or readily accessible, and that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them. Two scores were calculated for Individual #469, who had a Big Mac (present and used) and Object Symbols.											

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

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

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

Although a number of supports in the CLDP reviewed were measurable, more work was needed in this area. Although IDTs included a number of important pre- and post-move supports, which represented progress from the last review, a number of essential supports were missing from the CLDPs reviewed, and this should be a focus for Center staff.

It was positive that the Post-Move Monitor conducted timely monitoring for the individuals reviewed. The Center should focus on IDTs following up in a timely and thorough manner when the Post-Move Monitor notes problems with the provision of supports.

Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of some components of transition assessments. Although Center staff provided training to community provider staff, the CLDPs did not define the training well, and the training did not appear to meet the individual's needs.

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

#	Indicator	Overall Score	123	774							
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: 1. The respective IDTs developed 17 pre-move supports for Individual #123 and 16 pre-move supports for Individual #774. For both individuals, pre-move supports primarily focused on exchange of information, in-service training, transportation, and ensuring that equipment requirements were in place. While it was positive the IDT developed several supports for training of provider staff, these did not include any descriptions of the training methodologies or competency demonstration criteria specified for the training supports. The IDT also did not specify how direct support staff would receive training on health care needs or physical and nutritional management requirements. These two supports called only for nursing and administrative staff to receive the training.

The respective IDTs developed 53 post-move supports for Individual #123 and 52 post-move supports for Individual #774. Many of these supports were measurable. It was also positive that in many supports additional detail was provided to further explain the expectations. While the Monitoring Team noted improvement in the identification and detailed nature of transition supports, a number of supports did not provide the Post-Move Monitor with measurable criteria or indicators that could be used to ensure supports were being provided as needed. Supports that did not meet criterion included the following:

- For Individual #123:
    - A support, for monitoring blood sugar prior to administration of metformin provided specificity about how often monitoring should occur, and required staff to notify the agency's RN if numbers were outside of a specified acceptable range. It did not specify whether medication should be withheld until after the RN was notified.
    - A support called for monitoring for noted changes in behavior such as repeated refusals to get up and decreased intake when she has an infection. The required evidence was to interview staff regarding any urinary tract or ear infections and to review of nursing notes. It was unclear how the interviewing staff about urinary tract or ear infections would measure staff knowledge about the need to monitor for the specified changes in behavior or why this was important as an early indicator of possible infection.
- There were two supports for Individual #774 to be monitored for signs of hypoglycemia, hyperglycemia, and macrocytic anemia. While there was a good description of these signs and symptoms, the supports only called for staff to monitor and did not include any detail as to how often (e.g. continuously) or on what schedule. As noted above, there was no training support for these, so it was unclear how staff were expected to have gained this knowledge.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for this indicator to be scored as meeting criterion. The Center had identified many supports for these two individuals and it was positive they had made a diligent effort to address their needs. Despite these efforts, neither of these CLDPs comprehensively addressed support needs and did not meet criterion, as described below:

a. Past history, and recent and current behavioral and psychiatric problems: For both individuals, supports called for pre-move training related to behavioral needs, but did not specify the training methodologies or competency demonstration criteria. Supports did not sufficiently reflect the individual's past history, and recent and current behavioral and psychiatric problems in a consistent manner. Examples included:
    - For Individual #123:
        - The psychiatric assessment noted Individual #123 experienced some difficulties with changing medications. It further recommended that if Individual #123 were to exhibit a sudden change in behaviors, a consultation with a Psychiatrist, RN, and/or behavior analyst should be obtained to rule out medical causes before considering any major change in psychotropic medications. The IDT did not identify a related support.
        - The CLDP narrative indicated residential staff needed to be trained on self-injurious behavior, but there was no detail provided in the narrative as to the nature of this behavior or any specific support developed.
        - The QIDP summary recommended it was essential to have consistency and structure for implementation of the PBSP. This was to include staff that could verbalize the treatment plan and implement with consistency and accuracy as well as frequent input from psychological services. The behavioral support developed called for the provider to implement the Positive Behavior Support Plan (PBSP) into the plan of care upon Individual #123's transition and for the Post-Move Monitor to interview staff about target behaviors and staff instructions, but there were no specific staff knowledge or competencies defined. The support for psychological intervention called only for Individual #123 to be seen within 14 days of transition, but specified no additional follow-up.
        - The behavioral assessment indicated Individual #123 was making progress in dental desensitization and should not be referred until this was complete. The CLDP contained no further discussion in this regard.
    - For Individual #774, it was positive that the IDT considered her history of unsuccessful attempts at community living and increased behavioral issues after such moves, and developed a transition process that took this into account. Post-move supports were not as well constructed for her specific needs or individualized as they were the same as those for Individual #123. The behavioral support called for the provider to implement the PBSP into the plan of care upon transition and for the Post-Move Monitor to interview staff about target behaviors and staff instructions, but there were no specific staff knowledge or competencies defined. The support for psychological intervention called only for her to be seen within 14 days of transition, but specified no additional follow-up.

b. Safety, medical, healthcare, therapeutic, risk, and supervision needs: For both individuals, the IDT developed many supports related to safety, medical, healthcare, therapeutic and risk needs that were addressed across settings. It was positive a support had been developed for the Registered Dietitian to participate in the 45-Day PMM visit for Individual #123, given her needs related to weight and diabetes. Overall, the Monitoring Team noted improvement in this area from the previous monitoring visit, but this was not yet consistent. Training supports for these areas did not include specific methodology or specific competency demonstration and there was no specific support for training direct support staff. No supports were defined that specified the level of nursing care, monitoring and oversight required, or for routine staff monitoring for possible unwanted side effects from psychotropic medications as recommended in each PBSP. For Individual #123, the IDT did not define supports for OT/PT on a consultative basis, as recommended in her assessment in this area. It also did not define the supervision/staffing level required. A pre-move support indicated 24-hour awake staff was required to monitor health and safety, but did not define whether one awake staff would be sufficient or under what circumstances. In the profile section of

the CLDP, required level of supervision is documented only as "no." For Individual #774, there was no indication found in the CLDP of supervision or staffing level required to meet her needs other than a notation in the profile that her required level was "routine."

c. What was important to the individual:

- For Individual #123:
  - The vision statement in her ISP indicated she wanted to move to a small group home in the community, get a job at a grocery store rolling silverware, make a friend at her new apartment, learn to purchase a Dr. Pepper at a supermarket, and learn to operate a radio and wash her hands. Only the move to the group home was addressed in her supports.
  - The CLDP narrative identified other outcomes important to the individual, including maintaining best physical health possible and remaining psychiatrically and behaviorally stable. These appeared to be addressed with a number of specific supports.
  - Other outcomes, including becoming more independent with daily living skills and going on an increased number of community outings, were not addressed in any meaningful way. There was only one support related to daily living skills, calling for Individual #123 to have weekly opportunities to increase her independence through working on a list of suggested activities. This approach would not seem to be sufficient to meet the intent of increasing her independence. Another support called for her to be afforded opportunities to participate in nine social activities, but only two of these, "community activities/vehicle rides" and going to restaurants, were related to community outings. This did not appear to meet the intent of increased community outings and was not written in a manner to be able to determine whether having a weekly opportunity to watch TV or relax in her recliner would be considered to have been sufficient to demonstrate the support was in place.
- For Individual #774, the CLDP incorporated a number of things that were important to her, including writing letters and shopping. One of her favorite things, popcorn, was included in a long list of items and activities that she might engage in on a weekly basis and received no prioritization for being regularly and frequently available. The CLDP also indicated outcomes important to her were to be more independent with daily living skills, to go on an increased number of community outings, to maintain the best physical health and remain psychiatrically and behaviorally stable. These appeared to perhaps be boilerplate outcomes, as they were the same as those for Individual #123. The Monitoring Team cautioned transition staff about over-reliance on such statements without taking the time to ensure they reflect individualized needs and preferences.

d. Need/desire for employment, and/or other meaningful day activities:

- For Individual #123, the vision statement in her ISP indicated she wanted to work in a grocery store and the Life Skills summary noted she wanted to work in a restaurant. The only support in the CLDP was for her to begin day habilitation

within 14 days. The CLDP included no work-related support. The IDT also did not identify any specific meaningful day activities that could occur in integrated community settings, even though the Preferences and Strengths Inventory (PSI) suggested participation in a Red Hat Club or a coffee club as an integrated activity that reflected her preferences.

- For Individual #774, the only support identified was to begin day habilitation within 14 days. The IDT did not identify any work-related support or any support for specific meaningful day activities in integrated community settings.

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

- For Individual #123, the IDT incorporated some positive reinforcement in a support related to communication. Supports did not incorporate specific positive reinforcement techniques and preferences found in assessments, including positive reinforcement of sugar free tea, coffee, diet Dr. Pepper, cheerios, sugar-free gum, candy, and cookies. The behavioral health assessment also stated to be sure to praise Individual #123 when she completed a task or appropriately communicated "no," but these were not reflected.

- For Individual #774, many of her preferences were listed in a single support that called for her to be afforded opportunities to participate weekly in social activities and other activities of her choice. Evidence was to include documentation and interviews of both staff and the individual about the opportunities afforded, their frequency, and her compliance. It was not clear what frequency was expected and, for example, whether participation once a week in one of the listed activities, such as sitting on the patio or waking up early, would be sufficient to meet the intent of the support. The PBSP documented that she loves and is very reinforced by popcorn and loves staff attention. Popcorn was included in the list of items, but given no prioritization. There was no support related to staff attention.

f. Teaching, maintenance, participation, and acquisition of specific skills: The respective IDTs developed few supports related to teaching, maintenance, participation, and acquisition of specific skills.

- For Individual #123:
  - The IDT developed no specific supports for learning to purchase a Dr. Pepper at a supermarket, operate a radio, or wash her hands, as indicated in her ISP vision statement.
  - The ISP indicated she had learned to make her own coffee, but there was no support to provide her with opportunity to continue to do so.
  - The independence goal in her ISP was to learn to make her own snacks and meals, but the CLDP did not reflect this was considered as a support.
- For Individual #774, there was a support for ensuring she would brush teeth twice a day. There was also one support related to daily living skills more generally, calling for weekly opportunities to increase her independence by working on a list of activities. This support was not written in a manner to be able to determine whether having a weekly opportunity to participate in any one of the listed activities in a week would be considered to have been sufficient to demonstrate the support was in place. The expectation was not clear that she would engage in any of these specifically.

g. All recommendations from assessments are included, or if not, there is a rationale provided: Recommendations from assessments were not consistently addressed. Examples included:

- For Individual #123:
  - The IDT did not develop a support for the recommended OT/PT on a consultative basis. It also did not define a support related to the psychiatrist recommendation to obtain consultation to rule out medical causes before considering major change in psychotropic medications. No justifications were provided for either of these.
  - The nursing assessment provided a discussion of weight gain related to stealing Ensure and Boost and noted a lock box had been requested at the Center. The assessment went on to provide a recommendation for how this could be addressed in community setting, but the IDT did not address this in the CLDP.
  - The IDT did not fully discuss or develop a specific support for a recommendation from the social work assessment that Individual #123 have plenty of opportunity to make new friend in community.
  - Per the CLDP narrative, a dental recommendation was for her to see a dentist every six months for prophylaxis with IV sedation due to behavior; however, due to a dental cap in HCS program this would not be possible. The IDT did not develop a support for her to be seen on any specific schedule, only that the provider would have her seen by a dentist that does IV sedation within six months. This was also concerning in light of the lack of resolution regarding the behavioral assessment that indicated she was making progress in dental desensitization and should not be referred until this was complete.
- For Individual #774, the speech-language pathologist (SLP) assessment indicated she would need access to SLP for intermittent caregiver training in communication strategies, but this was not addressed in the CLDP. The nutrition assessment called for access to a registered dietitian for an annual assessment at a minimum, but also reassessment as needed. There was no clarification as to the annual need; rather, the support called only for an evaluation within 90 days of transition.

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

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

Individuals:

#	Indicator	Overall Score	123	774							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	100% 2/2	1/1	1/1							
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1							
5	Based on information the Post Move Monitor collected, the individual	0%	0/1	0/1							

	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.	0/2									
6	The PMM's scoring is correct based on the evidence.	0% 0/2	1/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, the IDT/Facility implemented corrective actions in a timely manner.	0% 0/2	0/1	0/1							
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	0% 0/1	0/1	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/R	N/R	N/A							

Comments: 3. Post-move monitoring was completed at required intervals for both individuals. Each of these post-move monitoring visits were within the required timeframes, included all locations where the individual lived or worked, were done in the proper format, and included comments regarding the provision of every support.

4. Reliable and valid data availability was improved from the previous site visit, but was still not consistent. Examples included:

- For Individual #123:
    - The provider was to monitor for noted changes in behavior such as repeated refusals to get up and decreased intake when she has an infection. Evidence cited did not indicate staff were aware of repeated refusals to get up.
    - The provider was to ensure she received all current medications and treatments until seen by the new PCP, but the only evidence provided indicated day program staff were aware of three medications she was to receive there and review of documentation showed no changes in medications. The MAR was missing at the day program, so it was unclear how this could have been substantiated.
- For Individual #774, provider staff were not consistently taking and/or recording data as required:
    - Blood pressure readings were not being routinely recorded as indicated at the 7-Day and 90-Day PMM visits.
    - Blood-sugar readings were not being recorded following the prescribed schedule at the 90-Day PMM visit.
    - Provider staff were not aware of signs and symptoms of hypoglycemia, hyperglycemia, and macrocytic anemia, so reliable monitoring was not possible.

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

- Individual #123 was not consistently receiving supports as listed and/or described in the CLDP. Examples included:
  - For the 7-Day PMM visit, all of the following were not available: sample menu; communication dictionary; blood sugar log; flow sheet to monitor meal/fluid intake; bowel movement log; breast exam chart; and, behavioral data sheets. Staff were not knowledgeable of supports for blood sugar testing; signs of hypo and hyperglycemia; bowel management plan; needed protocol in the event of seizure; dining equipment; PBSP implementation and data collection; and, communication techniques. Required documentation not available at that time included the medication administration record (MAR) at the day program as well as the logs and behavioral data as indicated above. The Social Security application to be the representative payee was due within seven business days, but was not completed timely.
  - Supports not in place as required at the time of the 45-Day PMM visit included staff knowledge of protocol in the event of a seizure; behavioral data to have been shared with the RN, psychiatrist and behavior analyst; staff knowledge to provide her with prune juice at breakfast; staff knowledge of the need to remain upright for one hour after meals; home staff knowledge of any training related to independence; and, the behavior tracking sheets at her home for the month of August. She was also not seen by a psychiatrist within the prescribed timeframe.
- Individual #774 was not consistently receiving supports as listed and/or described in the CLDP. Examples included:
  - At the 7-Day PMM visit, all of the following were not being provided as required: evidence that the MAR was properly completed; staff knowledge of seizure diagnosis and protocol; bowel movement tracking sheet at home and day habilitation; staff knowledge of blood pressure and blood sugar thresholds; daily vital signs being taken; staff knowledge of signs and symptoms of hypoglycemia, hyperglycemia and macrocytic anemia; staff knowledge of diabetic foot care plan; staff knowledge of mobility instructions; staff knowledge of how long to stay upright after meals; and, staff tracking of behavioral data.
  - Supports not in place as required at the 45-Day and 90-Day PMM visits included some of the same issues as found at the 7-Day visit. In addition, the behavior analyst from Denton SSLC did not complete the 45-day visit in a timely manner.

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

- For Individual #123:
  - The Social Security application was supposed to have been completed within seven business days, but was not completed until 12 business days. This was scored as present.
  - The provider was to ensure she received all current medications and treatments until seen by the new primary care practitioner (PCP), but the only evidence provided for the affirmative score indicated day program staff were aware of the three medications she was to receive there and that a review of documentation showed no changes in medications. The MAR was missing at the day program, so it was unclear how this could have been substantiated.
  - The provider was to monitor for noted changes in behavior such as repeated refusals to get up and decreased intake when she has an infection. Evidence cited did not indicate staff were aware of repeated refusals to get up, but the

support was scored as present.

- Staff required re-training by the Post-Move Monitor as to the protocol if a seizure occurred, but this support was scored as present.

- The provider was to ensure behavioral documentation was shared between the psychiatrist, RN, and behavior analyst. This support was scored affirmatively based on a notation that the provider was aware of this protocol, but there was no evidence behavioral documentation had been shared as required. Behavioral tracking logs were not available in any event.

- Incorrect scorings were less frequent at the time of the 45-Day PMM, although some did occur. These included continuing to affirmatively score the support for sharing behavioral data when that had not occurred, and continuing to affirmatively score the support for proper protocol in the event a seizure occurred when staff were still not able to state she would need to be seen immediately in the ER.

- For Individual #774:

  - A support called for her to have weekly opportunities to increase her independence to work on the following "such as but not limited to pedestrian safety skills, money management, choosing a perfume or lotion to wear and brushing her teeth." Provider staff reported they worked on various other independence skills, but typically none of the above. The only exception was that tooth brushing was noted as included at the 90-Day PMM visit. There were no data required or taken to measure whether she was indeed more independent with living skills. This support was marked as present for every PMM visit, without any rationale provided as to why the indicated skills were not included.

  - There was likewise no way to quantify whether she was going on an increased number of community outings, but it was also concerning that no shopping was listed as something she had taken part in.

  - The provider was to have Individual #774 seen by a BCBA within 14 days of transition. The Post-Move Monitor marked this support as present, but the only documentation was dated 5/8/16 and indicated the Post-Move Monitor obtained it on 6/09/16, both well after the 14-day prescribed timeframe.

7. It could not be reliably determined the IDT/Facility consistently implemented, for either individual, corrective actions in a timely manner for the many supports that were not being provided as needed. It was positive the Post-Move Monitor typically documented he re-trained provider staff at the time deficiencies were identified. It was not clear the Post-Move Monitor had sufficient expertise to provide re-training in all areas for which supports were not being met or to determine whether further action might be needed. There were no post-move ISPA meetings held for the IDTs to review and consider whether any additional corrective action was necessary. Follow-up documentation for re-training was routinely requested, but was not always received in a timely basis for Individual #774. Many of her numerous supports involving staff knowledge that were absent at the time of the 7-Day PMM visit on 3/31/16 were still outstanding up until early June.

8. The Post-Move Monitor was diligent in his efforts, but there were issues that should have been more assertively addressed. Examples included:

- For Individual #123, issues identified at the time of the 7-Day and 45-Day visits were routinely followed up and resolved within a week, in that the provider made requested documentation available within that timeframe. The concern remained as to whether the Post-Move Monitor's receipt of re-training documentation was sufficient to ensure the support was in place as required, given the IDT was not involved in making those determinations. It was also concerning that re-training documentation for some supports was provided following the 7-Day PMM visit, but did not have a positive outcome, as these same supports continued to be missing at the 45-Day visit. This should have been a red flag to have the IDT convene to consider what additional action might be needed. Instead, the provider was again asked to submit evidence of re-training.

- For Individual #774, many of the numerous supports involving staff knowledge that were absent at the time of the 7-Day PMM visit on 3/31/16 were still outstanding up until early June. At least one support, for Glucerna availability, was not documented as resolved. The Post-Move Monitor should have called upon the IDT and/or the LIDDA to assist in resolving these issues on a timely basis.

9. On 9/26/16, the Monitor accompanied the Post-Move Monitor on the 90-day post-move monitoring visits for Individual #123. On a positive note, the Post-Move Monitor clearly had established a good rapport with community provider staff, as well as individuals in the settings visited. In addition, the Post-Move Monitor's made noticeable efforts to ask open-ended questions (as opposed to leading questions), which was a significant improvement from the last review. Although the Post-Move Monitor reviewed a number of the CLDP supports thoroughly, based on observation, there were a number for which it did not appear the Post-Move Monitor conducted a review and/or a thorough review. For example:

- At times, it appeared the Post-Move Monitor relied on interview as opposed to confirming staff report through documentation review. For example, the CLDP listed documentation as well as interview for supports related to affording Individual #123 with opportunities to participate in social activities, but the Post-Move Monitor did not appear to request/review related documentation.
- During the review, the Post-Move Monitor did not interview a nurse and/or ask questions about a number of medical/nursing supports. For example, a nurse was to complete monitoring for psychotropic side effects, which was due two days after the onsite visit. The CLDP required review of documentation and interview with a nurse. However, during the Monitor's observations, neither of these activities occurred.
- It was unclear whether or how the Post-Move Monitor confirmed that some medical appointments that should already have been scheduled and/or occurred were scheduled and/or completed (e.g., DEXA scan, podiatry, EKG, endocrinologist, cardiologist, and dermatologist).
- Similarly, it was unclear whether or how the Post-Move Monitor confirmed that a psychiatrist had seen Individual #123, and/or that the provider maintained required documentation to share with the psychiatrist.
- Other than through staff interview, it was unclear how the Post-Move Monitor confirmed Individual #123 received a 1200-calorie diet.

10. The Monitor inadvertently forgot to ask for a copy of the completed post-move monitoring checklist, so this indicator could not be rated.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of preventable negative events following transition into the community.											
Summary: Neither individual had experienced a PDCT.			Individuals:								
#	Indicator	Overall Score	123	774							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	100% 2/2	1/1	1/1							
Comments: 11. Neither individual had experienced a PDCT.											

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.											
Summary: Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of some components of transition assessments. Although Center staff provided training to community provider staff, the CLDPs did not define the training well, and the training did not appear to meet the individual's needs. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	123	774							
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	100% 2/2	1/1	1/1							

	regarding the supports and services to be provided at the new setting.										
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	50% 1/2	0/1	1/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	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.	0% 0/2	0/1	0/1							
18	The APC and transition department staff collaborates with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition.	50% 1/2	1/1	0/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

Comments: 12. Assessments did not consistently meet criterion for this indicator. The Monitoring Team considers four sub-indicators when evaluating compliance.

- Assessments updated with 45 days of transition: The Center did not review or update the IRRF for either of the individuals, but should have, or should have indicated that the IRRF was reviewed and no updates were required. The IRRF section of the ISP typically contains a great amount of information. The Admissions Placement Coordinator (APC) should ensure that the IDTs review the status of the IRRF as part of the transition assessment process. For Individual #123, not only was the IRRF not updated, it was incomplete, with very limited data provided. It was missing various ratings and some recommendation sections were not filled out. Other examples included:
  - For Individual #123, the nursing assessment was not updated within 45 days prior to her transition.
  - For Individual #774, the Integrated Behavioral Health Assessment/Positive Behavior Support Plan (IBHA/PBSP) provided data only through 3/27/15, even though it cited an assessment date of 2/29/16. The speech assessment provided was from 5/5/14, with the only exception being the recommendations.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: For Individual #123, the IRRF was the only assessment that did not provide a reasonable summary of stay. For Individual #774, in addition to the outdated speech assessment and IBHA, which did not include current data, only the dental assessment did not meet criterion.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: For both individuals, training recommendations were not consistently specific to current individual needs.
- Assessments specifically address/focus on the new community home and day/work settings: There was significant improvement for this

indicator. Assessments generally provided at least some recommendations that focused on the new community home and day/work settings. The dental assessments were the primary exception.

13. Criterion was met for this indicator. 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. The Transition Specialist logs, which provided much detail about the transition process, were particularly valuable in making this evaluation.

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: Supports for the provision of training for community settings were very broad and non-specific and did not typically provide for adequate testing of staff knowledge or competence. For both individuals, Denton SSLC delegated most training for direct support staff to the provider and had no evidence of their competence to provide those supports as required prior to the transition. The only staff Denton SSLC trained for health care and physical and nutritional management needs were the directors of the residential and day programs and no competency testing was required. Some training for behavioral supports was completed by phone. Overall, the documented outcome of a significant lack of staff knowledge at the time of PMM visits would indicate training of community provider staff was not sufficient to meet the needs of these individuals.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: A doctor-to-doctor collaboration was completed for both individuals and this was considered to meet criterion for Individual #774, based on her assessed needs. For Individual #123, the psychiatrist expressed a specific concern about making psychotropic medication changes, but there was no support for collaboration with the identified community psychiatrist.

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. Documentation for both individuals indicated a Denton SSLC Occupational Therapist (OT) participated in community visits to prospective providers and provided an assessment of these settings as well as useful recommendations.

17. The CLDP should provide a specific statement about the types and level of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences. Examples include provider direct support staff spending time at the Center, Center direct support staff spending time with the individual in the community, and Center and provider direct support staff meeting to discuss the individual's needs. The CLDPs for Individual #123 and Individual #774 did not include such a statement. As noted in Indicator 14, training activities based on the needs of the individual also did not meet criterion.

18. Criterion was met for Individual #123. The LIDDA participated in both CLDPs. For Individual #774, the LIDDA also participated in a meeting related to a behavioral spike post transition. It was positive to see this type of collaboration occurring; however, Denton SSLC should have followed up with the LIDDA to assist in obtaining important documentation of provider staff in-service following the 7-Day PMM visit, as documented with regard to Indicator #7.

19. The language in the Pre-Move Site Reviews was equivocal as to whether the Post-Move Monitor actually observed certain supports at the provider sites. It stated only that he received and reviewed several documents that had been "provided to provider." During interview, the Post-Move Monitor indicated it had been his practice to review these documents off-site. The findings at the subsequent 7-day PMM visit illustrated why this practice was not sufficient to confirm pre-move supports were actually present, as various health care logs, sample menus, and behavioral data sheets could not be located at the time of the 7-Day visit.

Outcome 5 – Individuals have timely transition planning and implementation.

Summary: It was positive that for the individuals reviewed documentation was present to show justifiable reasons for the delays in their transitions. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. This indicator will remain in active oversight.

Individuals:

#	Indicator	Overall Score	123	774							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	100% 2/2	1/1	1/1							

Comments: For both individuals, transition exceeded 180 days. For Individual #123, the referral date was 10/20/15, and transition occurred on 6/28/16. No ISPA were provided, but the Transition Specialist log offered detailed justification, particularly regarding the IDT's responsiveness to the family's desire for a thorough exploration of community living options.

For Individual #774, referral took place in 2014 with a transition date of 3/28/16. Transition Specialist notes indicated her transition was delayed due to hospitalization and health instability for some months. These notes further indicated a 180-day and post-180-day monthly ISPA meetings were held, but documentation of these was not provided.

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

- Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
- In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic);
- Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
- In the past six months, individuals with dental emergencies;
- Individuals with Do Not Resuscitate Orders, including qualifying condition; and
- In the past six months, individuals with adverse drug reactions, including date of discovery.

- Lists of:
  - Crisis intervention restraints.
  - Medical restraints.
  - Protective devices.
  - Any injuries to individuals that occurred during restraint.
  - DFPS cases.
  - All serious injuries.
  - All injuries from individual-to-individual aggression.
  - All serious incidents other than ANE and serious injuries.
  - Non-serious Injury Investigations (NSIs).
  - Lists of individuals who:
    - Have a PBSP
    - Have a crisis intervention plan
    - Have had more than three restraints in a rolling 30 days
    - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
    - Were reviewed by external peer review
    - Were reviewed by internal peer review
    - Were under age 22
  - Individuals who receive psychiatry services and their medications, diagnoses, etc.

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

c. Medical
d. Nursing
e. Dental

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

The individual-specific documents listed below:

- ISP document, including ISP Action Plan pages
- IRRF, including revisions since the ISP meeting
- IHCP
- PNMP, including dining plans, positioning plans, etc. with all supporting photographs used for staff implementation of the PNMP
- Most recent Annual Medical Assessment, including problem list(s)
- Active Problem List
- ISPAs for the last six months
- QIDP monthly reviews/reports, and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request
- QDRRs: last two, including the Medication Profile
- Any ISPAs related to lack of progress on ISP Action Plans, including IHCP action plans
- PNMT assessment, if any
- Nutrition Assessment(s) and consults within the last 12 months
- IPNs for last six months, including as applicable Hospitalization/ER/LTAC related records, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, Restraint Checklists Pre- and Post-Sedation, etc.
- ED transfer sheets, if any
- Any ED reports (i.e., not just the patient instruction sheet)

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

- When there is a recommendation in patient intervention or a QDRR requiring a change to an order, the order showing the change was made
- Adverse Drug Reaction Forms and follow-up documentation
- PCP post-hospital IPNs, if any
- Post-hospital ISPAs, if any
- Medication Patient Profile form from Pharmacy
- Current 90/180-day orders, and any subsequent medication orders
- Any additional physician orders for last six months
- Consultation reports for the last six months
- For consultation reports for which PCPs indicate agreement, orders or other documentation to show follow-through
- Any ISPAs related to consultation reports in the last six months
- Lab reports for the last one-year period
- Most recent colonoscopy report, if applicable
- Most recent mammogram report, if applicable
- For eligible women, the Pap smear report
- DEXA scan reports, if applicable
- EGD, GES, and/or pH study reports, if applicable
- Most recent ophthalmology/optometry report
- The most recent EKG
- Most recent audiology report
- Clinical justification for Do Not Resuscitate Order, if applicable
- For individuals requiring suction tooth brushing, last two months of data showing implementation
- PNMT referral form, if applicable
- PNMT minutes related to individual identified for the last 12 months, if applicable
- PNMT Nurse Post-hospitalization assessment, if applicable
- Dysphagia assessment and consults (past 12 months)
- IPNs related to PNMT for the last 12 months
- ISPAs related to PNMT assessment and/or interventions, if applicable
- Communication screening, if applicable
- Most recent Communication assessment, and all updates since that assessment
- Speech consultations, if applicable
- Any other speech/communication assessment if not mentioned above, if any within the last 12 months
- ISPAs related to communication
- Skill Acquisition Programs related to communication, including teaching strategies
- Direct communication therapy plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to communication
- Communication dictionary
- IPNs related to speech therapy/communication goals and objectives
- Discharge documentation for speech/communication therapy, if applicable

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

The individual-specific documents listed below:

- ISP document
- IRRF, including any revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment
- Active Problem List
- All ISPAs for past six months
- QIDP monthly reviews/reports (and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request)
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- These annual ISP assessments: nursing, habilitation, dental, rights
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment
- Functional Skills Assessment and FSA Summary
- PSI
- QIDP data regarding submission of assessments prior to annual ISP meeting
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained

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

For specific individuals who have moved to the community:

- ISP document (including ISP action plan pages)
- IRRF

- IHCP
- PSI
- ISPAs
- CLDP
- Discharge assessments
- Day of move checklist
- Post move monitoring reports
- PDCT reports
- Any other documentation about the individual's transition and/or post move incidents.

APPENDIX B - List of Acronyms Used in This Report

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

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

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