United States v. State of Texas

Monitoring Team Report

Denton State Supported Living Center

Dates of Onsite Review: January 7th through 11th, 2019

Date of Report: April 3, 2019

Submitted By:	Maria Laurence, MPA Alan Harchik, Ph.D., BCBA-D Independent Monitors
Monitoring Team:	James M. Bailey, MCD-CCC-SLP Daphne Glindmeyer, M.D. Marlenia Overholt, B.S., R.N. Susan Thibadeau, Ph.D., BCBA-D Teri Towe, B.S. Scott Umbreit, M.S. Rebecca Wright, MSW Wayne Zwick, MD

Table of Contents

Background

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

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

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

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

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

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

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

Methodology

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

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

Organization of Report

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

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

Executive Summary

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

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at 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. At the time of the last review, 12 of these indicators, including three entire outcomes, had sustained high performance scores and moved to the category requiring less oversight. Presently, one additional indicator will move to the category of less oversight, which represents the entirety of Outcome 5 in the area of abuse, neglect, and incident management.

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

Denton SSLC continued to have a low usage of crisis intervention restraint. Census-adjusted, it was the third lowest rate in the state, with recent declines concurrent with the implementation of SUR (and elimination of horizontal restraints). Restraint durations also decreased. Some attention should be put towards cleaning up aspects of the restraint-related data systems: injury counts, and usage of pre-treatment sedation.

For the third consecutive review, crisis intervention chemical restraints were not handled and documented correctly. Even though crisis intervention chemical restraint was an infrequent occurrence at the Center, it needs to be implemented correctly when it is utilized and not utilized when it is not warranted.

Staff were able to correctly answer the Monitoring Team's questions about restraint practices.

There were errors/omissions in some of the restraint documentation, such as the IRIS form not including the entry for whether or not the individual was checked for injury by a nurse, and/or dates and times on the IRIS form that should match but did not. This suggests there should be more intense Center self-review to ensure all data are entered correctly and are consistent from one part of the form(s) to another.

It was positive that for all restraints reviewed, nursing staff initiated assessments/monitoring timely. It was also positive that with one exception, nursing staff documented vital signs in accordance with applicable standards of care. Some of the areas on which nursing staff need to focus with regard to restraint monitoring include: monitoring individuals for potential side effects of chemical restraints in accordance with applicable standards; providing follow-up for abnormalities identified as a result of

assessments; and providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline.

Abuse, Neglect, and Incident Management

Denton SSLC had a new Incident Management Coordinator (IMC) who had a solid background for this assignment. She was a long-term Center employee who had been a unit director, QIDP, Center investigator, and SAC. She was in this role for just two weeks at the time of the onsite visit.

Supports were generally in place to reduce future likelihood of incidents occurring (e.g., PBSPs, PNMPs, staff checks). APS and SSLC requirements regarding individuals who received streamlined investigations were being followed.

Most allegations met the reporting requirements (11 of 13). Additional exploration and explanation of the circumstances around the incident and the reporting might have cleared up any confusion. Staff who regularly work with the individual were knowledgeable about ANE and incident reporting. The past year's occurrences and trends of allegations and discovered/witnessed injuries should be reviewed at the ISP meeting and documented in the final ISP document

Denton SSLC's UIRs were comprehensive and contained relevant information presented in an easy-to-understand manner.

One investigation was for an allegation referred back to the Center under the clinical referral and investigation protocol. It was conducted by the State Office medical discipline coordinator. The investigation activities were conducted as required and the written report was easy to follow.

Most but not all investigations were completed timely; and about two-thirds of investigations had thorough reviews completed. This latter point requires improvement. That is, The Center's own review of investigations was not identifying the same issues that the Monitoring Team identified (e.g., alleged perpetrator late re-assignment, late reporting).

Follow-up tracking of investigation recommendations continued to be well done. Using the Assistant Ombudsman to track and document completion dates continued to be an excellent practice.

Other

Denton SSLC IDTs were discussing some of the content regarding pre-treatment sedation needs. Recently-updated State Office protocols should help set the occasion for this, and further progress, to occur in this area.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.												
Summary: Denton SSLC continued to have a low usage of crisis intervention restraint. Census-adjusted, it was the third lowest rate in the state, with recent declines concurrent with the implementation of SUR (and elimination of horizontal restraints). Restraint durations also decreased. Some attention should be put towards cleaning up aspects of the restraint-related data systems: injury counts, and usage of pretreatment sedation. These indicators remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	83% 10/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (March 2018 through November 2018) were reviewed. Overall, crisis intervention restraint was infrequently used when census-adjusted compared with the other SSLCs. Denton SSLC's rate across the nine-month period was the third lowest in the state. When looking over the past six nine-month periods, one can see that (a) the rate is slightly ascending over the past four of the six periods (however, overall, low), (b) the trend was decreasing across the nine months of this review period, and (c) the last three months were the lowest of the nine months and coincided with the implementation of SUR (and its elimination of horizontal restraints).

The usage of crisis intervention physical restraint paralleled the overall use of crisis intervention restraint because most crisis intervention restraints were crisis intervention physical restraints. The average duration of a crisis intervention restraint was about three minutes, which was about one minute lower than at the last review.

There were few instances of crisis intervention chemical restraint (two). One turned out to be an improper classification of a medication administration as a crisis intervention chemical restraint. It was for Individual #10 9/26/18. It was a planned administration of an IM Ativan contingent on her refusal of oral benzodiazepine medication. This should have more appropriately been handled via a medical treatment plan. As State Office suggested: It would have been good to have an ISPA to discuss possible regression due to medication refusals, dangers of benzodiazepine withdrawal, and least-to-most restrictive approaches. IM medication would be considered one of the more restrictive approaches and, as a result, would have led to the process of medical treatment plan, IDT approval, and, possibly, the need for consent.

There were four instances of crisis intervention mechanical restraint. Two were implemented as part of one individual's crisis intervention plan (Individual #41), one turned out to be an improper use of a toilet belt (which was confirmed as an abuse by HHSC PI), and one occurred prior to the data in the tier 1 document request.

The data showed an increase in injuries that occurred during implementation of restraint (all were deemed to be non-serious, e.g., abrasions, scratches), from zero to five per month from zero to two per month at the last review. The Center said that more restraints were occurring outside and, as a result, abrasions occurred. Further, when there was an injury during a series of multiple consecutive restraints, the Center scored each of those as having an injury, even if it was just one scratch, for instance. The Monitoring Team recommends that the Center get guidance from State Office on how to handle this, so that the data can be more valid and also be consistent with what other Centers are doing.

The number of individuals who had one or more crisis intervention restraints each month showed a decreasing trend. The number of individuals who had protective mechanical restraint for self-injurious behavior (PMR-SIB), however, increased to four (one was an individual admitted from the Lufkin SSLC during the review period).

There was little usage of non-chemical restraints for medical or dental procedures (three times in nine months). There was little/stable usage of pretreatment sedation for medical procedures (about 10 times per month) and a sharply decreasing trend in usage of pretreatment sedation for dental procedures (from 11 times per month to zero times per month). This led to some discussion with the Monitoring Team as to whether individuals, instead of pretreatment sedation for dental procedures were getting more intrusive intervention (e.g., TIVA/GA) or needed less intrusive intervention (e.g., go with a preferred staff). The Center also said that some individuals now go to a community clinic/hospital for treatment and they weren't sure if pretreatment sedations for those individuals were even in their data set. Thus, some attention needs to be paid to sorting this out so that the Center has accurate information about the Center-wide usage of pretreatment sedation. TIVA usage remained stable at about 20 individuals per month.

Thus, facility data showed low/zero usage and/or decreases in 10 of the 12 facility-wide measures (overall use of crisis intervention restraint; use of crisis intervention physical, chemical, and mechanical restraint; duration of physical restraint; number of individuals who had crisis intervention restraint; non-chemical restraint, pretreatment sedation, and TIVA for medical and dental procedures).

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

Ukeru: The Center implemented the statewide Ukeru program since the last review. The behavioral health services department reported that, overall, implementation was going well. They do video review and discussion if implementation was captured on video. They also reported that individuals seemed accepting of the procedures and related equipment and that there had been no negative comments from individuals, advocates, or regulator. The Monitoring Team found this to be the case, too, but with one notable exception: one individual in the review group (Individual #219) expressed fear of the Ukeru pads after being hit with them by either a peer or a staff member (noted in an ISPA in early December 2018). An investigation by Health and Human Services Commission Provider Investigations (HHSC PI) was currently being conducted. While a follow-up observation by behavioral health staff suggested no observed or reported fear, staff are advised to continue to observe and assess individual responses to this intervention.

PMR-SIB: Four individuals had a PMR-SIB plan at the time of the onsite visit. One of these individuals, Individual #303, was reviewed in detail. PBSPs and progress notes were requested for the other three individuals: Individual #315, Individual #173, and Individual #674. While Individual #173's BHA and PBSP were completed by a staff member from BARC who worked onsite, the BHAs and PBSPs for Individual #315 and Individual #674 were developed by a BCBA who served as the external peer reviewer for behavioral health services. When asked for information regarding this arrangement, the Center reported that this was a temporary measure put in place while the department experienced staff vacancies. This BCBA was not on the Denton SSLC staff and, therefore, he did not have day to day responsibilities that would allow for adequate training and supervision of staff who were working with Individual #315 and Individual #674. In fact, one progress note for Individual #674 noted that the external BCBA would no longer have professional responsibility for the plan because there were concerns with the accuracy of reporting and the fidelity of intervention. Staff were directed to speak with the behavioral health assistant or the director of behavioral health services.

- For all four individuals, evidence indicated inconsistent assessment of treatment integrity. In some cases, integrity was assessed via interview. IOA and data timeliness were not consistently assessed for any of the four individuals with a PMR-SIB.
- The fading plan for Individual #303 did not provide clear criteria for reducing the time out of restraint. Staff are advised to meet at a minimum once each month to review and revise, when appropriate, the effectiveness of all fading plans.

2. Five of the individuals selected for review by the Monitoring Team were subject to restraint. Of these five individuals, three received crisis intervention physical restraints (Individual #227, Individual #592, Individual #219), received crisis intervention chemical restraint (Individual #10), and one received PMR-SIB (Individual #303). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for all four of the individuals who had crisis intervention restraint. Data also showed a decreasing trend in the usage of PMR-SIB (however, see paragraph immediately below). The other four individuals selected by the Monitoring Team had no restraints making a total of eight of the nine individuals meeting the criteria for this indicator.

Upon further review of Individual #303's data, the decrease in usage was not clinically significant, that is, the reduction was about 12 hours per month (about 15 minutes per day). The plan for fading usage was not well developed (see comments in indicator 1 above). The Monitoring Team acknowledges that the Center took various actions over the review 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: There was some regression in six of the indicators of this outcome. For the third consecutive review, crisis intervention chemical restraints were not handled and documented correctly. Even though crisis intervention chemical restraint is an infrequent occurrence at the Center, it needs to be implemented correctly when it is utilized and not utilized when it is not warranted. Indicators 5-11 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	227	592	303	219	10				

3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The restraint was a method approved in facility policy.										
5	The individual posed an immediate and serious risk of harm to him/herself or others.	88% 7/8	2/2	2/2	1/1	2/2	0/1				
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 6/6	2/2	2/2		2/2					
7	There was no injury to the individual as a result of implementation of the restraint.	38% 3/8	0/2	0/2	1/1	1/2	1/1				
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	88% 7/8	2/2	2/2	1/1	2/2	0/1				
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated				
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	63% 5/8	1/2	2/2	0/1	2/2	0/1				
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	88% 7/8	2/2	2/2	1/1	2/2	0/1				

Comments:

The Monitoring Team chose to review eight restraint incidents that occurred for five different individuals (Individual #227, Individual #592, Individual #303, Individual #219, Individual #10). Of these, six were crisis intervention physical restraints, one was a crisis intervention chemical restraint, one was a PMR-SIB. 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.

3-4, 8, and 10. The crisis intervention chemical restraint for Individual #10 had many problems associated with it. First, it was implemented because she persistent refusal of medications. Although refusal of medications put her at risk, it was not made clear that a crisis intervention chemical restraint was warranted. Second, it was not identified until the day after implementation. Third, proper documentation was not completed. Fourth, it was not reviewed properly. Thus, criteria for these four indicators were not met. After further discussion between the Monitor and the Center and State Office, this administration of medication would have been more appropriate to have been handled and classified as a medical treatment plan.

Furthermore, the Monitoring Team has found problems with Denton SSLC's implementation of crisis intervention restraint for consecutive reviews. Even though crisis intervention chemical restraint is an infrequent occurrence at the Center, it needs to be implemented correctly when it is utilized.

7. Five restraint incidents did not meet criteria for showing that there were no injuries. For two of these five, the nurse entry regarding injury was blank. For the other three, the nurse indicated non-serious injuries.

9. When criterion for indicator 2 is met, this indicator is not scored. That was the case for all of the individuals during the week of the onsite review. In the weeks following the onsite visit, the Monitor determined that one individual did not meet criterion for indicator 2, however, at that point this indicator could not be rated.

10. In addition to the problems with the restraint for Individual #10 described above in this outcome, two other restraint occurrences did not meet criteria with this indicator. For Individual #227 8/2/18, pre-restraint strategies were not implemented. For Individual #303, his PMR-SIB plan had not been updated in more than a year.

11. For Individual #10, the AMA noted that she had osteopenia and that there should be safeguards put in place minimize risk. This was good to see, however, there was no further elaboration or direct instruction for staff.

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

Summary: It was good to see that staff were able to correctly answer the Monitoring Team's questions about restraint practices. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	227	592	303	219	10				
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 5/5	1/1	1/1	1/1	1/1	1/1				

Comments:

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

Summary: For two restraints, face-to-face assessment was not done as required. For the PMR-SIB, however, opportunities for release were done correctly and documented. With sustained high performance, this indicator (14) might be moved to the category of requiring less oversight after the next review. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	227	592	303	219	10				
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	71% 5/7	1/2	2/2		2/2	0/1				
14	There was evidence that the individual was offered opportunities to	100%			1/1						

	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.	1/1										

Comments:
13. For Individual #227 8/2/18, the restraint monitor arrived about half an hour after the restraint initiation. For Individual #10, the crisis intervention chemical restraint was identified the next day and documentation was incorrect.

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

Summary: It was positive that for all restraints reviewed, nursing staff initiated assessments/monitoring timely. It was also positive that with one exception, nursing staff documented vital signs in accordance with applicable standards of care. Some of the areas on which nursing staff need to focus with regard to restraint monitoring include: monitoring individuals for potential side effects of chemical restraints in accordance with applicable standards; providing follow-up for abnormalities identified as a result of assessments; and providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	227	592	303	19	10				
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	25% 2/8	1/2	1/2	0/1	0/2	0/1				
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	63% 5/8	1/2	2/2	0/1	2/2	0/1				
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	25% 2/8	1/2	0/2	0/1	1/2	0/1				

Comments: The restraints reviewed included those for: Individual #227 on 7/2/18 at 1:35 p.m., and 8/2/18 at 1:03 p.m.; Individual #592 on 7/22/18 at 12:50 p.m., and 10/22/18 at 8:04 p.m.; Individual #303 from 11/3/18 to 11/9/18 (for PMR-SIB); Individual #19 on 8/11/18 at 7:29 p.m., and 10/2/18 at 10:54 p.m.; and Individual #10 on 9/26/18 at 6:05 p.m. (chemical).

a. through c. Some positive included:

- For Individual #227's restraint on 7/2/18 at 1:35 p.m., nurses performed physical assessments, documented whether there were any restraint-related injuries or other negative health effects, and took action, as needed to meet the needs of the individual.
- In addition to the one restraint listed in the paragraph above, for the following restraints, the nurses documented whether or not the individuals sustained restraint-related injuries or other negative health effects: Individual #592 on 7/22/18 at 12:50 p.m., and 10/22/18 at 8:04 p.m.; and Individual #19 on 8/11/18 at 7:29 p.m., and 10/2/18 at 10:54 p.m.

- It was positive that for all restraints reviewed, nursing staff initiated assessments/monitoring timely.
- It was also positive that with one exception (i.e., Individual #10's chemical restraint on 9/26/18 at 6:05 p.m.), nursing staff documented vital signs in accordance with applicable standards of care.

The following provide examples of problems noted:

- A significant ongoing problem was nurses' descriptions of individuals' mental status. As discussed in numerous previous reports, descriptions such as "alert and awake" did not provide specific comparisons to individuals' baselines.
- For Individual #592, in an IPN, dated 7/22/18, at 1:24 p.m., the nurse that conducted the initial assessment documented the location and measurements of his skin integrity injuries, including those on his right arm, right mid-back, and right knee. However, follow-up assessments consistent with applicable standards were not found. The next IPN, dated 7/23/18, at 1:39 a.m., did not provide measurements to determine if the injuries were healing or not.
- For Individual #592's restraint on 10/22/18 at 8:04 p.m., the nurse's initial assessment revealed a high pulse rate of 105. No follow-up assessment was found. In addition, the description of his behavior requiring restraint included head butting the Campus Coordinator. Nurses should have conducted neurological checks and/or initiated the head injury protocol, but did not conduct and/or document any such assessments.
- For Individual #303's PMR-SIB, entries did not consistently include the helmet's condition, whether or not he was wearing it according to the plan, and/or circulation/skin integrity checks, including descriptions. In addition, abnormalities in vital signs were noted without follow-up (e.g., low temperatures).
- Similarly, on 10/2/18, Individual #19's temperature was low when the nurse assessed her after the restraint, but no documentation of follow-up was found.
- For Individual #10, on 9/26/18, at 6:05 p.m., a nurse administered Ativan. Five nursing IPNs indicated that the individual refused vital signs, but the nurse did not document respiratory rates, which do not require the individual's cooperation. IView documentation included some respiratory rates, but not at the frequency required after administration of a chemical restraint (i.e., every 15 minutes for one hour, and then, every 30 minutes for an hour).

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

Summary: Three restraints had incomplete information in the documentation. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	227	592	303	219	10				
15	Restraint was documented in compliance with Appendix A.	63% 5/8	0/2	0/2	1/1	2/2	0/1				

Comments:
15. Missing from both of Individual #227's restraint documentation was the injury assessment information and/or the correct date/time of the restraint. The restraint for Individual #10 was missing a lot of the typical information (e.g., description of circumstances leading up to restraint, description of interventions/actions taken by staff prior to implementing restraint).

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.												
Summary: Three restraints did not meet criteria with indicator 16. One was due to an incorrect date on the form, and one was done a day past the deadline. The third, however, did not occur at all. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	227	592	303	219	10					
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	57% 4/7	1/2	2/2		1/2	0/1					
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments: 16. Three restraints did not show proper review. For Individual #227 8/2/18, IMRT review had an incorrect date. For Individual #219 10/2/18, IMRT review occurred on the fourth day (requirement is by the third day). For Individual #10, there was no action to address (i.e., administratively) how a crisis intervention chemical restraint was implemented without typical protocols implemented (e.g., communication with behavioral health services), or how the crisis intervention chemical restraint addressed her medication refusals. A complete post-restraint ISPA meeting and document might have answered some of these questions.												

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 few occurrences of crisis intervention restraint at Denton SSLC. The requirements of these indicators were met for the one administration that was chosen for review by the Monitor. There were a number of questions about the classification of this administration (i.e., whether or not it was crisis intervention restraint). Given this, these indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	10									
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 1/1	1/1									
48	Multiple medications were not used during chemical restraint.	100% 1/1	1/1									
49	Psychiatry follow-up occurred following chemical restraint.	100% 1/1	1/1									
Comments:												

47-48. The above indicators applied to a chemical restraint regarding Individual #10. The Administration of Chemical Restraint: Consult and Review form was completed the day following the chemical restraint and there was documentation of psychiatric follow-up. This restraint event did not follow the typical pattern of a restraint, such as an exacerbation of symptoms with resultant danger to self or others from a physical perspective. This chemical restraint was precipitated due to significant medical concerns, (e.g., refusal to eat or drink leading to an elevated/toxic lithium level, prescription of high doses of Klonopin in an individual refusing to take medication which could lead to life threatening withdrawal). While the need for treatment with medication is apparent, this medication administration is not typically classified as a chemical restraint, but rather is addressed via a medical treatment plan.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.

Summary: Supports were generally in place to reduce future likelihood of incidents occurring (e.g., PBSPs, PNMPs, staff checks). Specifically, criteria were met for all investigations for eight of the nine individuals. APS and SSLC requirements regarding individuals who received streamlined investigations were being followed. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 456	227	592	303	219	154	194	605	327
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	85% 11/13	2/2	2/2	1/1	1/1	1/3	1/1	1/1	1/1	1/1

Comments:

The Monitoring Team reviewed 13 investigations that occurred for nine individuals. Of these 13 investigations, eight were HHSC PI investigations of abuse-neglect allegations (two confirmed, four unconfirmed, no inconclusive, one unfounded/streamlined, one referred back to Center for clinical review). The other five were for facility investigations of serious injuries (fractures/laceration of ankle, hand, face, eye), and unauthorized departure. 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 #456, UIR 18-297, HHSC PI 4724747, unfounded allegation of physical and sexual abuse, streamlined investigation, 7/17/18
- Individual #456, UIR 18-335, HHSC PI 47386571, 47387572, 47387587, 47388306; unconfirmed allegations of physical and verbal/emotional abuse, 8/9/18
- Individual #227, UIR 18-322, HHSC PI 47358370, confirmed and unconfirmed allegations of physical abuse class 2, 7/31/18
- Individual #227, UIR 19-001, HHSC PI 47418451, confirmed allegations of physical and emotional abuse, 9/2/18
- Individual #592, UIR 19-022, HHSC PI 47447078, unconfirmed allegation of physical abuse, 9/23/18
- Individual #303, UIR 18-266, serious injury, laceration, face, witnessed, 6/19/18

- Individual #219, UIR 18-340, serious injury, witnessed, fracture, hand, 8/11/18
- Individual #219, UIR 18-341, HHSC PI 47389826, unconfirmed allegations of physical, verbal/emotional, sexual abuse, 8/11/18 (related to UIR 18-340 above)
- Individual #219, UIR 19-070, unauthorized departure, 11/1/18
- Individual #154, UIR 19-009, HHSC PI 47431780, unconfirmed allegation of physical abuse, 9/12/18
- Individual #194, UIR 19-010, serious injury, fracture, ankle, 9/13/18
- Individual #605, UIR 18-350, HHSC PI 47404280, clinical referral of an allegation of neglect, 8/23/18
- Individual #327, UIR 19-053, serious injury, laceration, eye, discovered, 10/24/18

1. For all 13 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes (a) the occurrence of staff criminal background checks and signing of duty to report forms, (b) facility and IDT review of trends of prior incidents and related occurrences, and the (c) development, implementation, and (d) revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator and other facility staff met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

For all 13, background checks and signing of 1020 forms were done (i.e., item a). For eight investigations, the content of the allegation was about alleged staff behavior, so there were no individual-related trends or history for the team to examine. For the other five, there was evidence of IDT reviewed trends for all five (item b). For three of the five, the IDT also implemented plans (e.g., PBSP, PNMP) and reviewed/modified them as needed (items c and d). For the other two, the investigations found confusion among staff about how to implement her plan, no actions taken to address this, and/or lack of regular correct implementation of the PBSP (Individual #219 UIR 18-340, Individual #219 UIR 19-070).

Nine individuals at Denton SSLC were designated by HHSC PI for streamlined investigations due to their making frequent calls that proved to be unfounded and that met APS's various criteria for inclusion on this list. This was the same number as at the time of the last review. The Monitoring Team looked to see if the APS and SSLC policies and protocols were being followed. Two individuals were chosen for review: Individual #456 and Individual #227. APS had done quarterly reviews as required. This was an improvement from the last review. Moreover, the documentation list showed that some individuals were removed and some were added to the list since the last review. This also showed that APS and the Center were actively looking at individuals' appropriateness for inclusion. The Center was meetings its responsibilities in that strategies were included in each individual's PBSP for reducing the likelihood of future false allegations.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.											
Summary: Performance scoring remained about the same as at the last three reviews. Two allegations did not meet the reporting requirements, though additional exploration and explanation of the circumstances around the incident and the reporting might have cleared up any confusion. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall	456	227	592	303	219	154	194	605	327

		Score									
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	85% 11/13	2/2	2/2	1/1	1/1	2/3	0/1	1/1	1/1	1/1

Comments:

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

Those not meeting 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.

- Individual #219 UIR 18-340: The UIR, on page 4, showed that the incident occurred at 7:25 pm. The time the injury was coded as serious was left blank. The time reported to Center showed 9:49 pm and notification of the facility director/designee was noted as 9:59 pm, more than two hours after the incident.
- Individual #154 UIR 19-009: For this allegation, the reporting sequence was unclear. The HHSCI PI report showed that intake received the allegation at 4:09 pm. The UIR showed that the incident was reported to the facility director/designee at 3:10 pm and that the alleged perpetrator was reassigned at 3:50 pm. The UIR also stated that the individual was the reporter. The UIR needed to have more explanation of these circumstances.

During the onsite week, Individual #456 made an allegation during her ISP meeting. Later in the day, the Monitoring Team explored whether the allegation was reported, and it had been reported by staff.

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: High performance was demonstrated for indicators 3 and 4 and with sustained high performance, these two indicators might be moved to the category of requiring less oversight after the next review. The Monitor has two comments, however, regarding indicator 4. They are to ensure that the past year's occurrences and trends of allegations and discovered/witnessed injuries are, at least minimally, reviewed at the ISP meeting and documented in the final ISP document. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	456	227	592	303	219	154	194	605	327
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting.	100% 1/1					1/1				
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	reporting.											
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										

Comments:
3. Because indicator #1 was met for eight of the individuals, this indicator was not scored for them. The indicator was scored for the other individual and criteria were met, that is, staff members who worked with this individual were able to correctly answer all of the Monitoring Team's relevant questions.

4. The ISP documentation showed that comprehensive and useful information was provided to the individual and LAR. In addition, reporting posters were posted in each location as required. For sub-indicator 2, the IDT should do a more thorough job of delineating between witnessed and discovered injuries, and discussing/analyzing any trends. Criterion for sub-indicator 2 were scored as being met, however, some improvement to this is warranted.

Individual #456 was scored as not meeting criteria for this indicator because at her ISP that was observed by the Monitoring Team there was no discussion of the past year's history/trend of injuries or allegations.

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

Outcome 5 – Staff cooperate with investigations.												
Summary: The Center sustained high performance. Therefore, indicator 7 will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	456	227	592	303	219	154	194	605	327
7	Facility staff cooperated with the investigation.	92% 12/13	2/2	1/2	1/1	1/1	3/3	1/1	1/1	1/1	1/1

Comments:
7. For Individual #227 UIR 19-001, one collateral witness failed to show for three scheduled interviews. The employee was dismissed from employment.

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
Summary: Denton SSLC's UIRs were comprehensive and contained relevant information presented in an easy to understand manner. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	456	227	592	303	219	154	194	605	327
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 13/13	2/2	2/2	1/1	1/1	3/3	1/1	1/1	1/1	1/1
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	100% 13/13	2/2	2/2	1/1	1/1	3/3	1/1	1/1	1/1	1/1
Comments: 9-10. Denton SSLC's UIRs, for the most part, were very good, that is, the information in the UIRs was relevant and comprehensive, and the flow/sequence of the content presented the investigation in an easy to understand manner. The clinical referral investigation (Individual #605 UIR 18-350) contained the standard required components of an investigation, too.											

Outcome 7– Investigations are conducted and reviewed as required.											
Summary: Performance remained about the same as at the last review. That is, most but not all investigations were completed timely; and about two-thirds of investigations had thorough reviews completed. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	456	227	592	303	219	154	194	605	327
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	85% 11/13	2/2	2/2	1/1	1/1	1/3	1/1	1/1	0/1	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	69% 9/13	1/2	2/2	1/1	1/1	2/3	0/1	1/1	0/1	1/1

	accurate, complete, and coherent.										

Comments:
12. For Individual #219 UIR 18-341, an extension was provided, but the first staff interview did not occur until day eight, making it almost impossible to complete the investigation in 10 days. For Individual #605 UIR 18-350, the report was finalized 12/6/18. There was a request earlier, that is, for 9/7/18, but nothing after that. In a comment on the draft version of this report, HHSC PI wrote that their office will work with field staff to ensure that cases are being worked on in a timely manner.

13. 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.

Four incidents did not meet criterion with this indicator. Three were because the Center's review did not identify the investigation problem with time of alleged perpetrator reassignment, or lateness of first interview of a witness. The fourth was because the clinical referral investigation folder did not include any validation of the Center director's review of the final report of the state medical discipline coordinator (who conducted the investigation).

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.											
Summary:			Individuals:								
#	Indicator	Overall Score									
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.										
Comments:											

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
Summary:			Individuals:								
#	Indicator	Overall Score									
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									

17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	

Comments:
17. There were six investigations at Denton SSLC that included confirmations of physical abuse category 2. In all of the cases, the employees' employment was not maintained.

17-18. Denton SSLC continued its excellent practice of having the Assistant Independent Ombudsman track and validate completion of investigation recommendations.

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 were collected and trended. Some corrective actions were developed. Also see the quality assurance and improvement section of this report. 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.	No									
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No									
23	Action plans were appropriately developed, implemented, and tracked to completion.	No									

Comments:
19. All seven data sets were being tracked and trended.

20. The tracking and trend analysis met the requirements of quarterly conduct, contained the minimum data elements, and provided a narrative description of results and conclusions.

21-23. There was evidence of formal CAPs and the tracking of planned actions. CAPs should have expected outcomes that are more measurable, using baseline data and a targeted improvement goal, such as decrease injuries by 20% from date to date, rather than a general statement that the intended outcome was to see a decrease in injuries. Along the same lines, in the Q4 Trend Report (page 25), it was noted that 13% of falls were caused by environment. There was no further detail about what these were, or any planned action to address environmental causes of falls.

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.

Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	50% 2/4	N/A	1/1	N/A	N/A	N/A	0/1	N/A	0/1	1/1
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. As discussed in the last report, the Center had a policy on medical clearance for TIVA. This document entitled: "TIVA Criteria List Used by Dental Anesthesiologists" listed numerous high-risk conditions for which current data was requested before the anesthesiologist could medically clear the individual for TIVA. According to the policy, the PCPs were expected to provide additional information for individuals who had specific diagnoses outlined on this list in order for the anesthesiologist to determine medical clearance. Additionally, the PCP needed to provide the dental anesthesiologist with an updated physical exam and medical history within 30 days of the use of TIVA.

- Individual #459 was scheduled for TIVA on 5/15/18, but refused. The information the PCP provided, dated 5/14/18, was out-of-date, when she received TIVA on 6/18/18.
- For Individual #276, the PCP submitted an interval medical review, dated 6/25/18, but it did not include the required physical exam.

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

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

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									
Comments: a. Based on the documentation provided, during the six months prior to the review, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation for medical procedures.											

Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
Summary: Denton SSLC IDTs were meeting some of the requirements of this outcome. IDTs need to documentation discussion/review of all of the required components of indicator 1. Recently updated state protocols should help set the occasion for this, and further progress, to occur in this area. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	227	592	303	219	10	194	681		
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	43% 3/7	0/1	0/1	1/1	1/1	0/1	0/1	1/1		
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	86% 6/7	1/1	1/1	1/1	1/1	0/1	1/1	1/1		
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	67% 4/6	1/1	1/1	0/1		0/1	1/1	1/1		
4	Action plans were implemented.	17% 1/6	0/1	1/1	0/1		0/1	0/1	0/1		
5	If implemented, progress was monitored.	67% 4/6	1/1	1/1	0/1		0/1	1/1	1/1		
6	If implemented, the individual made progress or, if not, changes were	0%	0/1	0/1	0/1		0/1	0/1	0/1		

	made if no progress occurred.	0/6									

Comments:

1. Based upon the documentation provided, it was determined that seven of the nine individuals reviewed by the behavioral health Monitoring Team had required pretreatment sedation over the previous 12-month period. For five individuals (Individual #227, Individual #592, Individual #303, Individual #194, Individual #681), there was evidence of the following: discussion of the usage and effectiveness of PTS, behaviors observed during procedures, other supports that could be provided in the future, and the risk/benefit of using PTS. For all, but two (Individual #227, Individual #592), of these individuals, the use of PTS was identified as a rights restriction in their ISPs. Consent from both the Human Rights Committee and the LAR/facility director were evident for all, but Individual #592 and Individual #10.

Individual #219 also received PTS in the past 12-month period. Evidence of the team's determination for the need of PTS for the extraction of two teeth was found in her IRRF related to her current ISP that occurred approximately eight months after the procedure. There was evidence of consent.

2. For six of the seven individuals, the IDT developed a plan to reduce the usage of PTS. The exception was Individual #10 for whom there were no plans developed. In Individual #219's case, the plan was to maintain good home care and six-month checkups with the dentist. For the remaining individuals, plans included developing tooth brushing SAPs, ensuring that familiar staff accompanied the individual to appointments, and/or referring the individual to the Behavior Analysis Resource Center (BARC) for desensitization.

3. For Individual #227, Individual #592, Individual #194, and Individual #681, there was a SAP for tooth brushing in their ISPs. For these same individuals, with the exception of Individual #592, the ISP also indicated that a referral would be made to BARC for desensitization. There was no evidence that training in tooth brushing was addressed in Individual #303's ISP either as a SAP or service objective.

4. While there was evidence that tooth brushing plans had been implemented for the four individuals who had this identified as a SAP, there was no evidence that a referral had been made to BARC, or if it had, no evidence of the status of the plan.

5-6. Tooth brushing SAPs were monitored for the four identified individuals, Individual #227, Individual #592, Individual #194, and Individual #681. However, data presented in the QIDP monthly report indicated that these were not being implemented at the scheduled frequency.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	243	78	90	176					

a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 4/4	1/1	1/1	1/1	1/1					
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	50% 2/4	0/1	1/1	1/1	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.	50% 2/4	0/1	1/1	1/1	0/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	25% 1/4	0/1	0/1	1/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/2	0/1	0/1	N/A	N/A					

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

- On 4/13/18, Individual #492 died at the age of 75 with cause of death listed as complications of aspiration pneumonia.
- On 5/21/18, Individual #39 died at the age of 82 with cause of death listed as complications of end stage renal disease.
- On 5/22/18, Individual #636 died at the age of 59 with causes of death listed as small bowel obstruction, and respiratory failure.
- On 6/26/18, Individual #243 died at the age of 67 with cause of death listed as sepsis.
- On 8/22/18, Individual #78 died at the age of 57 with cause of death listed as metastatic bladder cancer.
- On 11/9/18, Individual #90 died at the age of 66 with cause of death listed as gallbladder cancer.
- On 12/4/18, Individual #176 died at the age of 41 with causes of death pending.

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

- Individual #243's mortality review was missing a review of the documentation of the progression of dementia, including signs, and symptoms. In addition, review of the tests, and treatments that the PCP and psychiatrist/neurologist considered was warranted.
- Individual #176's mortality review would have benefitted from a review of the potential pharmacological causes of the individual's weight loss (e.g., Topomax).
- For Individual #176, the nursing review stated: "it was determined that her weight loss was due to an improper implementation of her diet plan and scarce documentation that she received her supplement and nurse being notified." However, the QA nurse review concluded that: "it appears that there are no potential nursing contributing factors that led to

the death."

- At times, recommendations included in the nursing reviews were not captured in either the administrative or clinical death reviews.

e. At the time of the Monitoring Team's review, some of the recommendations related to Individual #90 and Individual #176's deaths were not yet due, and/or enough time had not elapsed to assess their completion/effectiveness.

As has been discussed in several previous reports, the recommendations generally were still not written in a way that ensured that Center practice had improved.

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the time of the last review, 20 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, seven additional indicators will move to the category requiring less oversight in the areas of ISP development, behavioral health, dental, physical and nutritional management, Occupational and Physical Therapy (OT/PT), and communication.

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

For the most part, the QIDPs and direct support staff were knowledgeable about the needs and preferences of the individuals they served.

For many, but not all, individuals, the IDTs considered and determined what assessments were needed. But then, for most individuals, they were not all obtained prior to the ISP meeting.

Overall, the Center should have a greater focus on providing opportunities for individuals to experience a normal life, including having private rooms, comfortable beds, a greater selection of clothing and meals, access to more activities outside of the work day, participation in community activities, etc.

In psychiatry, the annual evaluations contained all of the required elements. All individuals reviewed requiring an annual comprehensive psychiatric evaluation (CPE) had one completed prior to the annual ISP meeting.

Behavioral assessments continued to be incomplete or not current or updated. Not all functional assessments were current or updated or complete. One individual who did not have a PBSP should have had one.

About half of the individuals reviewed had current Functional Skills Assessments (FSAs), Preference and Strengths Inventories (PSIs), and vocational assessments. And about half of these assessments included recommendations for skill acquisition.

Even so, individuals continued to have skill acquisition programs (SAPs) and that they were written in measurable terminology. Less than half, however, were based on assessment results (though this was an improvement from the last review). Many SAPs

addressed skills the individual already demonstrated, or they included prompting levels that were identified in baseline or current level of performance.

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

Three of the nine individuals had quality annual medical assessments that included the necessary components and addressed individuals' needs. Moving forward, the Medical Department should continue to improve the quality of the medical assessments, and specifically, improve the plans of care for active medical problems.

For the individuals reviewed, the Dental Department completed timely dental exams and summaries. As a result of the Center's sustained performance in this area, two related indicators will move to the category requiring less oversight. During this review, all nine individuals' dental exams and dental summaries also met criteria for quality, which was very good to see.

It was good to see that all of the individuals reviewed had timely annual nursing reviews and physical assessments, and quarterly record reviews, and physical assessments. With regard to quality, 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.

It was good to see that in some instances, when individuals experienced changes of status, nurses completed assessments in accordance with current standards of practice, but this is also an area in which improvements are still needed.

It was positive that for the most part, a timely Registered Nurse (RN) Post-Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results. Due to consistent performance for the past few reviews, the related indicator will move to the category of less oversight.

Significant improvements were needed, though, with regard to IDTs making timely referrals to the Physical and Nutritional Management Team (PNMT) or the PNMT making self-referrals, as well as the PNMT completing comprehensive assessments that addressed individuals' needs. For the four individuals who needed comprehensive assessments, the PNMT completed no assessment for two individuals, and completed substantially late assessments for the other two individuals. Moreover, the assessments reviewed provided incomplete evaluation information, and lacked thorough analyses of the potential causes of the

individuals' physical and nutritional management issues. As a result, the PNMT likely did not offer full sets of recommendations to the individuals' IDTs.

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, but during this review declined, particularly with regard to assessments to address individuals' changes in status. The quality of OT/PT assessments continues to be an area on which Center staff should focus.

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

Of note, as part of the onsite review week, the Monitoring Team appreciated the Habilitation Therapy Director's willingness to conduct an objective review of one individual's OT/PT and communication assessments, review the findings with the Center therapists, and then, discuss her findings openly with the members of the Monitoring Team and State Office staff. This effort showed Center staff's ability to identify strengths, as well as weaknesses in the assessments, as well as to identify potential solutions to the significant improvements that are needed with regard to the assessments. The Monitoring Team is hopeful that the Habilitation Therapy Director's ongoing auditing of assessments with feedback provided to therapists will assist in improving the quality of the assessments.

Individualized Support Plans

In ISPs, Denton SSLC continued to make progress in identifying and defining more individualized, aspirational, meaningful goals (19 compared with 16 at the last review) and written in measurable terminology (10 compared with six at the last review).

Even so, there was a lack of action plans that would lead to the accomplishment of goals. And, ISP action plans were not regularly implemented for any of the individuals. In addition, reliable data (or any data) were not collected for most of the goals and their action plans.

QIDP monthly reviews were routinely submitted on time and included a cursory review of all services. Some QIDP monthly reviews included data for some action plans, but rarely included an analysis of those data to determine what specific progress had been made towards achievement of goals.

In psychiatry, the providers at the Center were in their current positions for several years. The ancillary staff was also consistent. This sets the stage for continued progress towards meeting the criteria of the various outcomes and indicators. The psychiatry department staff's work over the past nine months was evident in their documentation and treatment planning.

In psychiatry, Denton SSLC made progress in that for all individuals in the review group, psychiatric indicators for reduction were identified in one or more documents, indicators were consistently identified, and were defined in observable terminology. Regarding indicators for increase, these indicators were identified, but there was a need for the relationship to the individual's diagnosis to be documented (and/or perhaps creation of additional indicators for increase that are more aligned with the diagnosis).

The benefit of the psychiatric participation in the ISP meeting was noted. There was documentation of the ISP discussion in the IRRF regarding behavioral health and psychiatry. All of the required elements were addressed. This was good to see, and the first time the Monitoring Team has seen this level of performance at any of the Centers (Indicator 21).

In behavioral health, the PBSPs for about half of the individuals were current. None of the PBSPs were considered complete, but several sub-indicators were present in the majority of plans.

The obtaining/collection of reliable data in behavioral health/psychiatry, however, remained a challenge and problem for Denton SSLC, even though there was some improvement since the last review. This is a pivotal activity and should be a priority for the behavioral health services department.

Of the 27 SAPs, there was evidence that two SAPs had been monitored for data reliability over a six-month period.

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.

Since the last review, some good improvement occurred with regard to IDTs defining in IHCPs the frequency of interval medical reviews. However, in most cases, IDTs included action steps for PCPs to complete interval medical reviews every six months. Given the severity of some individuals' level of risk, this frequency was not sufficient to meet their needs.

It was positive that ISPs reviewed included descriptions of how individuals communicate, and how others should communicate with them. As a result of the Center's sustained performance in this area, the related indicator will move to the category requiring less oversight.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: Denton SSLC continued to make progress in identifying and defining more individualized, aspirational, meaningful goals (19 compared with 16 at the last review) and written in measurable terminology (10 compared with 6 at the last review). Even so, reliable data (or any data) were not collected for any of the goals or their action plans. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	456	303	219	194	538	459			
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	4/6	1/6	4/6	3/6	3/6	4/6			
2	The personal goals are measurable.	0% 0/6	0/6	0/6	1/6	3/6	3/6	3/6			
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 #303, Individual #194, Individual #219, Individual #456, Individual #538, and Individual #459. 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. The ISP relies on the development personal goals as a foundation. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish.

Although not part of the criteria for this indicator, personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

The IDTs continued to work toward developing individualized, aspirational personal goals. For this review period, none of the six ISPs contained individualized goals in all areas, therefore, none had a comprehensive set of goals that met criterion. However, each of the ISPs contained an individualized goal in two or three different areas.

Nineteen personal goals met criterion as aspirational statements of outcomes, based on an expectation that individuals will learn new skills and have opportunities to try new things that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. This was an improvement from the previous monitoring visit, when 16 goals met criterion.

The personal goals that met criterion were:

- Leisure goals for Individual #194, Individual #219, Individual #456, and Individual #459.
- Relationship goals for Individual #194 and Individual #538.
- Work goals for Individual #194, Individual #219, Individual #456, Individual #538, and Individual #459.
- Independence goal for Individual #219, Individual #456, Individual #538, and Individual #459.
- Living options goals for Individual #303, Individual #219, Individual #456, and Individual #459.

IDTs had created the above goals (that were more individualized and based on known preferences), however, although not rated for indicator 1, few had specific teaching strategies to ensure staff were implementing them and measuring success consistently, and few had been fully implemented. Thus, individuals did not have person-centered ISPs that were really leading them towards achieving their personal goals. The facility needs to focus on barriers that are preventing individuals from achieving their goals and develop plans to address those barriers.

In a comment on the draft version of this report, the State wrote that the preferred transition of Individual #194 remained to live with her volunteer, but that it was now delayed for nine more years. Given the individual lived at the Center since she was six years old, and given she had been on the referral list since 2012 (indicating that her team identified community transition as an important goal), it seemed reasonable to explore other living options other than solely overnight stays with her volunteer.

2. Of the 19 personal goals that met criterion for indicator 1, 10 also met criterion for measurability. This was also an increase from the six personal goals that met criteria the previous review. Those that did not meet criteria were:

- Individual #303's living option goal. Although the goal was aspirational, the IDT did not project a timeline for completion.
- Individual #219's recreational goal to form and/or participate in a basketball team did not clearly state completion criteria for her goal. Her work and greater independence goals did not include a timeline for completion.
- Individual #456's goals did not include a timeline for completion.
- Individual #538's greater independence goal did not clearly state criteria for completion or include a timeline.
- For Individual #459's recreation goal does not include a timeline for completion nor does it include a measurable objective. IDTs should avoid terms such as facilitate, attend, operate, and participate because those, as is, are not measurable.

When personal goals for the ISPs did not meet the criterion described above in indicator 1, 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.

3. None of the goals had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals.

As noted throughout this report, for all of the other goals, it was not possible to determine if ISP supports and services were being regularly implemented or to determine the status of goals because of the lack of reliable data and documentation provided by the Center. While there were some data collected showing implementation of some action plans, there was not enough information documented to clearly determine the status of goals.

Individual #456's annual ISP meeting was observed. All team members were present at the meeting and contributed to the discussion. Although Individual #456 was vocal regarding what she would like to achieve during the upcoming year, the team was hesitant to write goals based on her preferences. They struggled (i.e., were unable) to develop action plans that would support her progress and ensure that she would meet her goals. It was difficult to see how Individual #456 would learn new skills and achieve her goals given the lack of a concrete plan to support her.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.

Summary: This set of indicators speaks directly to the overall quality of the ISP and to score these indicators, the Monitoring Team looks across the entire ISP. Six indicators improved slightly from the last review, that is, from 0% to either 17% or 33%. This shows that Denton SSLC has the capacity to make improvements across all ISPs.

#	Indicator	Overall Score	Individuals: 456	303	219	194	538	459			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	33% 2/6	0/1	1/1	0/1	0/1	1/1	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.	33% 2/6	0/1	0/1	0/1	1/1	1/1	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	1/1	0/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	17% 1/6	1/1	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:

8. Nineteen of the personal goals met criterion in the ISPs, as described above in indicator 1, therefore, those action plans could be evaluated in this context (i.e., for this indicator). 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.

IDTs still needed to focus on laying out a clear path of assertive action plans to meet each goal. Some goals had no action plans that were clearly related. None of the goals in the six ISPs met criterion.

Skill acquisition programs did not include enough information to ensure that staff could consistently implement them and determine what progress was made. Most of the action plans were written as service objectives and did not include staff instructions or implementation strategies that would ensure staff could consistently teach a new skill or accurately collect data on progress. Many action plans stated what staff would do, but not what action the individual would take to show progress towards accomplishing his/her goal thus data often indicated how many times staff had implemented the plan instead of measuring specific progress towards the goal.

9. One of the ISPs (Individual #538) had action plans that integrated preferences and opportunities for choice. For the most part, goals and action plans were based on individual preferences, however, opportunities for making choices were limited. Opportunities for work based on preferences was particularly limited. For example,

- Individual #219's ISP indicated that she was unhappy with her current work program. Action plans were not aggressively addressing finding other employment that she might have enjoyed more.
- Individual #456 had action plans to attend the computer center to download music. She indicated throughout the ISP year that she did not want to miss work to go to the computer center. She stated this again at her ISP meeting, observed by the Monitoring Team. The IDT did not consider giving her internet access outside of her scheduled work day to download her music.
- Individual #459 had a goal to cook macaroni and cheese. The IDT missed an opportunity to support her in making choices by choosing an item to cook. She had a goal to work part-time in the community, however, it was not clear that she had been offered opportunities to identify her work preferences.

IDTs were generally not identifying preferences in a way that might guide the development of activities that would offer opportunities

to learn new skills and build on developing a plan for meaningful days. For the most part, ISPs listed general preferences related to food, music, television, and activities routinely offered at the facility.

Opportunities to make meaningful choices were limited, for the most part. Expanding choices may result in discovering new preferences.

10. One of the ISPs clearly addressed strengths, needs, and barriers related to informed decision-making. A basis to making informed decisions is offering individuals exposure to a variety of new experiences and opportunities to make choices throughout their day. These opportunities were rarely included in action plans in any substantial way. Individual #538 had action plans related to his money management goal that gave him opportunities to have more control over his budget.

11. Two of the ISPs met criterion for this indicator to support the individual's overall independence. These were:
- Individual #303 had action plans to independently play his CD, buckle his seat belt, wash his hands, and wipe his mouth.
- Individual #538 had money management action plans that supported him to use a debit card to budget his money.

Assessments and interviews indicated that many of the action plans were compliance plans written for skills that the individual could already complete independently.

12. None of the ISPs integrated strategies to minimize risks in ISP action plans. While risks were addressed through action plans included in the IHCP, supports were not routinely integrated into other action plans when relevant, and risks were not always identified by the IDT. Rarely were SAPs written to provide staff with strategies for implementing plans and, when SAPs were written, they did not include specific mobility, behavioral, and safe eating supports.

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 ISPs. In most cases, supports were fragmented, with little evidence that IDT members were sharing data and collaborating on developing supports. Some examples of this lack of integrated supports included:
- Individual #303's action plans did not integrate communication strategies. Although, the IDT acknowledged that his lack of communication skills contributed to his self-injurious behaviors, the ISP only offered support staff limited strategies for increasing his communication.
- Individual #194's ISP did not integrate communication strategies into other action plans. Her skill acquisition plans instructed staff to give her verbal prompts even though she has no functional hearing according to her communication assessment.

14. Two of the ISP included action plans to support meaningful integration into the community.
- Individual #194 had goals to work, volunteer, and live in the community. Although her action plans had not been implemented, if implemented, they would support integration in the community.
- Individual #538 had action plans to support shopping, banking, and attending church in the community.

Individuals made frequent trips into the community, but were rarely given opportunities to utilize community resources that might support them to be more independent and integrated into the community. Individuals generally did not have goals for banking,

volunteering, getting haircuts, joining a church, or joining a gym in the community. Outings were limited to specific events, such as eating out, going to the movies, or attending a sporting event. While these types of activities support community exposure, they are unlikely to lead to meaningful integration.

15. One ISP (Individual #456) included action plans to support opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Day and work opportunities were particularly limited for most individuals. Vocational training was not focused on building skills that might lead towards employment in a more integrated setting. Individual #194 and Individual #538 had goals to work in the community, however, their action plans were unlikely to lead towards community employment.

Training opportunities were limited and rarely individualized. Individuals had few opportunities to learn new skills and experience new things.

16. For the most part, ISPs did not support substantial opportunities for functional engagement described with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Overall, the ISPs provided limited opportunities for learning and functional skill development. During observations, activities were rarely functional and did not provide opportunities to experience new things and learn new skills. IDTs need to expand the preference assessment to offer more opportunities to try new things and identify new interests.

- Individual #456 had action plans to learn new skills that might support her desire to work in the community.
- Individual #303 had two action plans (turn on CD player and choose a sensory item). It is unlikely that either of these skills will lead towards a more meaningful day/work opportunities. During observations, he was rarely engaged in meaningful activities.
- Individual #194's IDT did consider community employment, however, action plans did not support skill building opportunities.
- Individual #219 was routinely refusing to go to work because she did not like her job. It was not evident that the IDT had offered work exploration activities to determine her preferences and skills needed to obtain a job that she likes.
- Individual #538 had one SAP to sign in for work. He wanted to work in the community, however, the IDT had not identified skills that he would need for his preferred job.
- Similarly, Individual #459's IDT has not identified her work preference and job skills that would be beneficial to learn.

17. ISPs did not adequately address barriers to achieving goals and learning new skills. Goals were not consistently implemented, and IDTs did not address barriers to implementation. A review of ISP preparation documents indicated that some goals that either had not been implemented or the individual failed to make progress were continued from the previous ISP without addressing barriers. None of the ISPs addressed identified barriers to community transition.

18. Action plans did not describe detail about data collection and review, in almost all cases. Overall, ISPs did not usually include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action plans were broadly stated, not individualized, and, in most cases, skill acquisition plans were not developed when needed to ensure consistent training strategies were implemented.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
Summary: Denton SSLC ISPs included statements of the decision of the entire IDT. This has been the case for all individuals for three consecutive reviews. Therefore, indicator 22 will be moved to the category of requiring less oversight. For the other indicators, there was some, albeit very small progress. That is, five indicators scored higher than at the last review, but not yet at a high-performance level. Two indicators had slightly lower scores, and two others remained at zero. Other than indicator 22, this set of indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	456	303	219	194	538	459			
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).	83% 5/6	1/1	1/1	1/1	0/1	1/1	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	1/1								
21	The ISP included the opinions and recommendation of the IDT's staff members.	50% 3/6	1/1	0/1	0/1	0/1	1/1	1/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	67% 4/6	1/1	1/1	0/1	0/1	1/1	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).	67% 4/6	1/1	1/1	0/1	0/1	1/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	0% 0/1	0/1								
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	67% 4/6	1/1	0/1	0/1	1/1	1/1	1/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 0/1	0/1								

28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/2		0/1		0/1					
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A									

Comments:

19. Five ISPs included a description of the individual's preference for where to live and how that preference was determined by the IDT.
    - Individual #194 lived at the Center since 1971. Her ISP noted that she had little exposure to community living options. The IDT stated that she would like to live in the community with her advocate/friend. She should be given opportunities for greater exposure to other living options, too, because living with her advocate/friend is not a possibility right now.

20. Individual #456's ISP was observed. She clearly stated her preference for where to live.

21. Four ISPs included the opinions and recommendation of the IDT's staff members. For those that did not meet criteria, relevant assessments were not submitted prior to the ISP meeting for review by the IDT.

22. All ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.

23. Four of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths. Individual #194 and Individual #219's ISPs did not document a discussion of available settings that might meet individual's needs.

24. Four ISPs identified a list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed. Individual #194 and Individual #219's ISPs did not clearly define obstacles to referral.

26. Four of the individuals had individualized, measurable action plans to address obstacles to referral, or were referred if obstacles were not identified. Individual #219 and Individual #303 had general action plans to address obstacles with no measurable outcomes to ensure progress.

25 and 27. Individual #456's ISP meeting was observed. The IDT did not clearly define obstacles to referral or develop measurable action plans to address any obstacles.

28. Individuals did not have individualized and measurable action plans to educate the individual and/or LAR on living options that might be available to support their needs. This was not scored for Individual #219, Individual #456, Individual #538, or Individual #459 because the IDT did not identify a need for further education either for them or their LARs.

29. None of the individuals had been referred to the community.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.												
Summary: Ensuring full attendance from IDT members and then implementing the action plans remain areas for focus by the IDT, clinicians, and residential and day departments. Those two indicators (32, 34) will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	456	303	219	194	538	459				
30	The ISP was revised at least annually.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.											
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).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
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:

32. Documentation was not submitted that showed that action plans were implemented within a timely basis for any of the individuals.

34. Four of the individuals had an appropriately constituted IDT based on the individual's strengths, needs, and preferences, who participated in the planning process.

- The speech therapist did not attend Individual #303's ISP meeting. He has significant communication needs.
- The IDT failed to assess Individual #219's work preferences and skills prior to her IDT meeting.

Outcome 6: ISP assessments are completed as per the individuals' needs.												
Summary: For many, but not all, individuals, the IDT considered and determined what assessments were needed (same score from last review). But then, they were not all obtained prior to the ISP meeting for most individuals. These two indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	456	303	219	194	538	459				
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.	67% 4/6	1/1	0/1	1/1	1/1	1/1	0/1				
36	The team arranged for and obtained the needed, relevant	17%	1/1	0/1	0/1	0/1	0/1	0/1				

	assessments prior to the IDT meeting.	1/6									

Comments:

35. For four individuals, IDTs considered what 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 the other two:
    - Individual #303's ISP Preparation document indicated a vocational assessment was not requested. His ISP noted the need for an assessment.
    - Individual #459's IDT did not consider the need for an updated OT/PT assessment prior to her ISP meeting.

36. Five IDTs did not arrange for and obtain all needed, relevant assessments prior to the IDT meeting.
    - Individual #303's psychiatry assessment was submitted late.
    - Individual #194's FSA, annual medical exam, and behavioral assessment were submitted late.
    - Individual #219's FSA was not completed prior to her ISP meeting.
    - Individual #538's FSA and psychiatry assessment were submitted late.
    - Individual #459's FSA was not submitted timely.

Without relevant assessments for the IDT to review, it is unlikely that comprehensive supports and services were developed, and all risks were addressed.

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

Summary: Progress was not adequately being reviewed by QIDPs and IDTs. Consequently, actions were not developed or taken. These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	456	303	219	194	538	459			
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. The IDT reviewed supports, services, and serious incidents. This was good to see, however, IDTs did not routinely revise supports or goals or address barriers when progress was not evident.

38. Consistent implementation and monitoring of ISP action steps remained areas of concern. ISP action plans were not regularly implemented for any of the individuals.

For the most part, monthly reviews were routinely submitted on time and included a cursory review of all services. The consistent

completion of the QIDP monthly reviews was good to see, however, they included little meaningful information regarding progress towards goals and efficacy of supports. When additional assessments were recommended throughout the ISP year, it was often not apparent that the IDT obtained those assessments, reviewed any resulting recommendations, and/or implemented changes to supports when recommended.

Some QIDP monthly reviews included data for some action plans, but rarely include an analysis of those data to determine what specific progress had been made towards achievement of goals. Information regarding behavioral supports, habilitation therapy, and medical supports was inserted in the monthly reviews without a summary of status, statement on the efficacy of supports, or efforts made to follow-up on outstanding issues. There was little documentation of follow-up when plans were not implemented or not effective. This practice places individuals at significant risk for harm when the IDT cannot determine if supports to address risks are consistently implemented or effective.

Going forward, the QIDPs will need to be sure that they are gathering data for the month, summarizing progress, and revising the ISP as needed, particularly when goals are not consistently implemented.

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	194	303	538	149	315	459	201	276	781
a.	The individual's risk rating is accurate.	6% 1/18	0/2	0/2	0/2	1/2	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.	50% 9/18	1/2	2/2	2/2	1/2	0/2	2/2	0/2	1/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #194 – constipation/bowel obstruction, and fractures; Individual #303 – cardiac disease, and falls; Individual #538 – circulatory, and skin integrity; Individual #149 – choking, and urinary tract infections (UTIs); Individual #315 – respiratory compromise, and constipation/bowel obstruction; Individual #459 – dental, and weight; Individual #201 – aspiration, and gastrointestinal (GI) problems; Individual #276 – diabetes, and infections; and Individual #781 – seizures, and falls].

a. The IDT that effectively used supporting clinical data, and used the risk guidelines when determining a risk level was for: Individual #149 – choking.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs completed IRRFs for individuals within 30 days of

admission and updated the IRRFs at least annually. It was positive that when Individual #194 experienced a fracture, in September 2018, her IDT reviewed/revised the IRRF. However, it was concerning that when changes of status occurred for other individuals that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #303 – cardiac disease, and falls; Individual #538 – circulatory, and skin integrity; Individual #149 – choking; Individual #459 – dental, and weight; and Individual #276 – diabetes.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.

Summary: At Denton SSLC, there was progress in many of the sub-indicators of each of the indicators in this outcome. The psychiatry department staff's work over the past nine months was evident in their documentation and treatment planning. Specifically, Denton SSLC made progress in that for all individuals in the review group, psychiatric indicators for reduction were identified in one or more documents, indicators were consistently identified, and were defined in observable terminology. Regarding indicators for increase (i.e., positive/desirable behaviors that indicate the individual's condition, or ability to manage the condition is improving), these indicators were identified, but there was a need for the relationship to the individual's diagnosis to be documented (and/or perhaps creation of additional indicators for increase that are more aligned with the diagnosis). These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	89% 8/9	2/2	2/2	2/2	2/2	2/2	1/2	2/2	2/2	2/2
5	The individual has goals related to psychiatric status.	78% 7/9	2/2	2/2	0/2	1/2	2/2	2/2	2/2	2/2	2/2
6	Psychiatry goals are documented correctly.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

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

At Denton SSLC, there was progress in many of the sub-indicators.

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

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

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

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

The Monitoring Team looks for:

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

Denton SSLC showed progress in this area as all individuals in the review group had one or more indicators related to the reduction of psychiatric symptoms, the indicators related to their psychiatric diagnosis or diagnoses, and the indicators were described in observable terminology. For example, Individual #227 had diagnoses that included Bipolar Mood Disorder, Type 1. One identified indicator was acute mood symptoms (depressive/manic symptoms), which were described in observational terminology for her.

All of the individuals in the review group also had psychiatric indicators for increase in positive/desirable actions identified. These indicators were identical to the replacement behaviors identified by behavioral health. The Center psychiatrists had begun to document their rationale of how the positive/desirable action related to the diagnosis when the action was not immediately evident (although this was not specifically located in all examples, inferences could be made). PBSP replacement behaviors may not always make sense to also

be psychiatric indicators for increase. Indeed, for one of the nine individuals (Individual #154), it was not evident that the replacement behavior of asking for a break was related to the diagnoses of anti-social personality disorder. Therefore, it was good to see that the Center was looking at each of these more closely.

Thus, criteria were met for all three sub-indicators (a, b, c) for psychiatric indicators for reduction for all individuals in the review group and for all but one of the individuals for psychiatric indicators for increase.

5. Psychiatric goals:
The Monitoring Team looks for:

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

At Denton SSLC, there were acceptable goals written regarding psychiatric indicators for reduction for eight of the individuals (all but Individual #592). Goals included the psychiatric indicator and a criterion (sub-indicator d). Because the psychiatric indicators for increase were identical to the replacement behaviors identified by behavioral health, there were goals authored for seven individuals that were acceptable (all but Individual #592 and Individual #303), with data to be collected in care tracker regarding the individual's use of the specific replacement behavior. Again, as noted above, PBSP replacement behaviors may, or may not, be good choices for psychiatric indicators because they may, or may not, be related to the individual's diagnoses.

There were notations indicating that data would be collected via a psychiatric symptom Likert scale that was developed by the Center. These seemed reasonable and did meet the criteria for this sub-indicator (sub-indicator e). Again though, because the purpose of the psychiatric indicator is to determine an individual's symptom experience, a mixture of indicators could be considered:

- individually-defined indicators (Denton SSLC's Likert-scales),
- individually-defined indicators (data from direct observations by staff of psychiatric indicators), and
- the collection of data utilizing rating scales normed for this population.

Thus, both sub-indicators were met for eight of the individuals for goals for reduction and for seven of the individuals for goals for increase.

6. Documentation:
The Monitoring Team looks for:

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

At Denton SSLC, psychiatric indicators/goals for reduction were incorporated into the Center's overall documentation system, the IHCP. In five examples, the goals were in the IHCP section of the ISP and included metrics and duration. In all examples, however, the goals were noted as met, although psychiatric documentation did not support this statement.

Similarly, goals for increase were incorporated into the IHCP in four examples, and included metrics and duration. Again, in all examples, the goals were noted as met, although psychiatric documentation did not support this statement.

It seemed odd that a goal entered into the new year's ISP/IHCP would say it was already met. If so, then one would expect a different goal. It may be that the psychiatrist wanted to keep the same goal from the previous year. That is, an individual might have met a goal for no occurrences of psychiatric indicators (for reduction). The psychiatrist might feel it appropriate to keep the same goal and target for the upcoming year (not uncommon in psychiatry practice). If so, it might be better to indicate this logic rather than inserting statement that the goal was already met.

Regarding sub-indicator 6g., per conversations with the Center's psychiatry staff, goals are entered into the IHCP annually, but there was no mechanism for the goals to be updated other than on an annual basis. It is often appropriate to update and change goals (and perhaps also psychiatric indicators, observable definitions, data collection, etc.) during the course of the year. This can be documented in an ISPA, psychiatry note (e.g., quarterly clinic), or an updated IHCP. The Center might work with State Office discipline coordinators in psychiatry and ISPs regarding this.

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

At Denton SSLC, data were reported for psychiatric indicators for the nine individuals reviewed. Unfortunately, these data were generally stale and of limited utility due to the lack of reliability. The collection and presentation of reliable data is an area of focus for the psychiatry department. Likely, maintaining this will require ongoing collaborative work between psychiatry, behavioral health, residential services, day/vocational services, and the Center's ADOP. This will be the case as Denton SSLC moves towards further individualizing psychiatric indicators for decrease and increase that may not be identical to what is already being measured by the PBSP as target behaviors/replacement behaviors.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
Summary: CPE content met criteria for about half of the evaluations. Most that did not meet criteria were three or four years old. Some attention to diagnostic consistency across the record is also needed. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681
12	The individual has a CPE.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B										

14	CPE content is comprehensive.	44% 4/9	1/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1
15	If admitted within two years prior to the onsite review, and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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.	33% 3/9	1/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1

Comments:
14. The Monitoring Team looks for 14 components in the CPE. Four of the CPEs included the required components. The remaining evaluations were missing one to two elements. Four evaluations were missing one element and one evaluation was missing two elements. The most common deficient element was the inclusion of information regarding the results of the physical examination. This was missing in three examples. The bio-psycho-social formulation was incomplete in two examples. The CPEs that did not meet criteria were written in 2018 (Individual #592), 2017 (Individual #219), and 2015 (Individual #303, Individual #10, Individual #194).

16. There were six individuals whose documentation revealed inconsistent diagnoses across disciplines, Individual #592, Individual #303, Individual #219, Individual #154, Individual #10, and Individual #681.

Outcome 5 – Individuals' status and treatment are reviewed annually.											
Summary: All indicators were met for all individuals for this review. The efforts of the psychiatrists and the psychiatry staff were evident and show in the resultant scores. With sustained high 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.			Individuals:								
#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681
17	Status and treatment document was updated within past 12 months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	100% 8/8	1/1	1/1		1/1	1/1	1/1	1/1	1/1	1/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	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	Due to the Center's sustained performance, this indicator was moved to the									

	individual's ISP meeting.	category of requiring less oversight.									
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
18. The Monitoring Team scores 16 aspects of the annual evaluation document. The annual evaluations contained all of the required elements. This was good to see.

19. All individuals requiring an annual CPE had one completed prior to the annual ISP meeting. One individual, Individual #592, was a new admission, and the initial CPE was completed prior to the initial ISP meeting.

21. The benefit of the psychiatric participation in the ISP meeting was noted with regard to the documentation of the ISP discussion in the IRRF regarding behavioral health and psychiatry. All of the required elements were addressed. This was good to see, and the first time the Monitoring Team has seen this level of performance at any of the Centers.

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

Summary: Two PSPs were reviewed. Some aspects of one were not in place. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	50% 1/2									0/1

Comments:
22. PSP documents regarding Individual #681 and Individual #247 were reviewed. The PSPs were detailed and contained a large amount of information. One example, regarding Individual #681, did not include a specific purpose for the PSP, but more of a statement regarding long-term goals. Unfortunately, Individual #681 had diagnoses including dementia and, as such, there needs to be a focus on maintaining his activities of daily living as this condition progresses. Otherwise, both examples included a description of the psychiatric symptoms for monitoring and recommendations for staff regarding how to respond to and support the individual.

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

Summary: Both indicators met criteria for all individuals. With sustained high performance, indicator 30 might be moved to the category of requiring less oversight after the next review. It is also possible for the same for indicator 31, too. Both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681
28	There was a signed consent form for each psychiatric medication, and	Due to the Center's sustained performance, these indicators were moved to the									

	each was dated within prior 12 months.	category of requiring less oversight.										
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.											
30	A risk versus benefit discussion is in the consent documentation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
32	HRC review was obtained prior to implementation and annually.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										

Comments:
30. The risk versus benefit discussion was included in the consent forms in the nine examples. Although brief, these were individualized and adequate. This was good to see.

31. The consent forms for the individuals in the review group did not include alternate, individualized, non-pharmacological interventions. The forms did include a statement that indicated alternatives of "clinical supports, environmental supports, vocational/education services, and skill acquisition plans."

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: One individual who did not have a PBSP should have had one (Individual #276, indicator 1). Behavioral health goals and objectives were based upon assessments. Due to this sustained high performance, indicator 4 will be moved to the category of requiring less oversight. The obtaining/collection of reliable data for these goals, however, remained a challenge and problem for Denton SSLC, even though there was some improvement since the last review. This is a pivotal activity and should be a priority for the behavioral health services department. This indicator (5) will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the										

	reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.										
3	The psychological/behavioral goals/objectives are measurable.										
4	The goals/objectives were based upon the individual's assessments.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	

Comments:

1. Eight of the nine individuals reviewed by the behavioral health monitoring team had a Positive Behavior Support Plan (PBSP). The exception was Individual #681 who had a Psychiatric Support Plan. These supports were determined to be appropriate. Additionally, five of the seven individuals reviewed by the physical health monitoring team had PBSPs. This included Individual #538, Individual #459, Individual #315, Individual #149, and Individual #781. After meeting the individuals and talking with staff, this was determined to be appropriate, with one exception. Behavioral Health Services staff are advised to complete a functional behavior assessment for Individual #276 because direct support staff reported that she exhibited both aggressive and self-injurious behavior when demands were placed on her, particularly when awoken and during medication administration. Nursing staff also reported difficulty during medication administration. Behavioral health service staff are advised to meet with nursing staff and schedule repeated observations during identified difficult times.

4. The identified goals/objectives for all eight individuals were measurable and based upon assessments.

5. Reliable and valid data were not available to assess individual progress or the lack thereof. Correcting this problem should be a focus of the Center and the behavioral health services department.

Data timeliness was not consistently reported, although paper data sheets had been introduced in May 2018. Information provided by the Center indicated that data timeliness was calculated as the percentage of data sheets completed each month, however, to assess timeliness it will be necessary to ensure that data are recorded within two hours of behavioral occurrence.

Onsite checks were made by the Monitoring Team, when possible, of data recording within a two-hour period. Between 5:00 and 5:15, on two separate evenings, a check of PBSP data sheets for Individual #456, Individual #227, Individual #154, and Individual #303 revealed no data recorded since 2:00. Similarly, a check of Individual #194's data sheet at 11:00 in workshop revealed no data recorded for that day. Positively, however, when Individual #154 was visited in his home one morning at 8:30, data were recorded up to 8:00. Similarly, data were recorded up to 11:00 when Individual #456's PBSP data sheet was checked at 11:10 in workshop. Behavioral health services staff are advised to check data sheets when visiting homes and day programs and provide immediate feedback to staff.

For three of the eight individuals (Individual #303, Individual #219, Individual #10), inter-observer agreement (IOA) was not assessed each month as expected per facility policy. Additionally, during the onsite visit, Individual #303 was observed engaging in repeated self-injurious behavior when his helmet was removed during snack. While the Monitoring Team recorded 10 hits, a check of his

completed data sheet showed two occurrences of this behavior recorded during this time period (i.e., 20% IOA).

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

Summary: Performance remained about the same now for four consecutive reviews. Behavioral assessments continued to be incomplete or not current or updated. Not all functional assessments were current or updated or complete. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 456	227	592	303	219	154	10	194	681
10	The individual has a current, and complete annual behavioral health update.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
11	The functional assessment is current (within the past 12 months).	63% 5/8	1/1	1/1	1/1	0/1	0/1	1/1	1/1	0/1	
12	The functional assessment is complete.	38% 3/8	0/1	1/1	1/1	0/1	0/1	1/1	0/1	0/1	

Comments:

10. Six of the individuals had a current behavioral health assessment (BHA). The assessments for Individual #303, Individual #219, and Individual #194 were completed in 2017 (i.e., more than a year old).

Furthermore, none of the assessments were rated as being current because there was no review of the individuals' physical health over the previous 12 months. Additionally, there was no review of an assessment of Individual #592's cognitive abilities.

While not part of the criteria for this indicator, about half of the nine assessments were available to the individual's interdisciplinary team 10 days prior to the annual ISP meeting. The exceptions were the BHAs for Individual #592, Individual #303, Individual #219, and Individual #154. The Center provided an updated BHA/PBSP for Individual #303 while the Monitoring Team was onsite.

11. The functional behavior assessments were current for five of the individuals. The exceptions were Individual #303, Individual #219, and Individual #194. Dates of the assessment were not clearly identified for Individual #303, and observations were completed in 2017 for Individual #219 and Individual #194. This was particularly concerning for Individual #303 and Individual #219 because both exhibited significantly risky behavior that should have triggered repeated observations to ensure adequate supports to effect positive behavior change.

12. Three of the functional behavior assessments were considered complete. These were the assessments for Individual #227, Individual #592, and Individual #154.

Staff are advised to update the FBA for Individual #592 because this was completed shortly after his admission to the Center. A modified functional analysis had been completed on identified precursor behaviors, but direct observation was warranted now that he has had time to become acclimated to his new living situation. For Individual #456 and Individual #194, repeated observations were

completed, but no target problem behaviors were observed. No explanation was provided as to why additional observations did not occur.

It was positive that a referral had been made to the Behavioral Analysis Resource Center (BARC) for further assessment of the function of Individual #303's self-injurious behavior. The intake date was June 2018, with a discharge date five months later. Four observations, between 15 and 20 minutes each, had been conducted in the first 10 days, but the functional analysis was not completed until October 2018. In light of the severity of this behavior necessitating a helmet with face guard, it is suggested that greater urgency was advised.

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

Summary: Performance did not maintain for indicators 13 and 14. These semi-clerical tasks should be occurring regularly. PBSPs continued to have many, but not all of the required components. Comments regarding other content are provided below. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 456	227	592	303	219	154	10	194	681
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	63% 5/8	1/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1	
14	The PBSP was current (within the past 12 months).	63% 5/8	1/1	1/1	1/1	0/1	0/1	1/1	1/1	0/1	
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	

Comments:

13. Based upon the consent tracking information provided by the facility, five of the PBSPs had been implemented within 14 business days of all consents. The exceptions were Individual #154 whose plan was implemented before the facility director had provided consent, and Individual #10 and Individual #194 whose plans were implemented almost three months and one month, respectively, after the last consent.

14. The PBSPs for five of the individuals were current. The exceptions were Individual #303, Individual #219, and Individual #194. Although each of these plans had implementation dates in 2018, the plans were part of the older BHAs with objectives to be met by October, September, and November of 2018, respectively. An updated PBSP was provided for Individual #303 while the Monitoring Team was onsite.

BHS staff are advised to ensure that current plans are available to staff in both homes and day program sites. A check of the book at Ceramics revealed plans from 2017 for Individual #538 and Individual #781. The book at Individual #154's home contained no PBSP.

15. Although none of the PBSPs were considered complete, several sub-indicators were met in the majority of plans. This included the following: operational definitions of both targeted and replacement behaviors, antecedent and consequent strategies, training/reinforcement of replacement behaviors, and treatment objectives.

Missing elements from the majority of plans included the use of reinforcement in a manner that was likely to result in positive behavior change, and

sufficient opportunities for reinforcement of identified replacement behaviors.

Individual-specific comments are outlined below.

- As has been noted in previous reports, staff are advised to stop using the term "junk" and "annoying" behavior. This term was found in the BHAs and/or PBSPs for Individual #456, Individual #227, and Individual #219. This term displays a lack of respect for the individual, particularly because any behavior that an individual exhibits probably serves an important function. The term also does not provide operational definitions of behaviors that should be ignored. This could result in staff interpreting this guideline differently and, consequently, implementing the plan inconsistently.
- Several PBSPs addressed suicidal threats and gestures. In the plans for Individual #227, Individual #592, Individual #219, and Individual #154, the operational definitions of these behaviors were reversed. Staff are advised to update PBSPs so that suicidal threats are defined as statements to harm oneself, while suicidal gestures are defined as actions taken to harm oneself.
- In the PBSPs for Individual #227 and Individual #219, guidelines for reinforcing replacement behaviors indicated that staff should honor appropriate communication as long as the individual was not engaging in targeted problem behavior. However, descriptors included behaviors that were included in the operational definitions of targeted problem behaviors. For example, staff were to reinforce Individual #227's request for escape when she was upset or agitated, but one of the descriptors included cursing at others which is part of her disruptive behavior.
- Individual #303 had a revised PBSP implemented in January 2019 that included a replacement behavior of choice making. When this was observed in his day program, staff presented two options, a toy and a rock. As staff explained, this was to teach Individual #303 to choose a preferred item versus a non-preferred item. Individual #303 did not choose either of the presented items, rather he reached past these into a bin from which he obtained a snack packet. Furthermore, staff are advised to reconsider the use of a rock as a non-preferred item because this could potentially be used by Individual #303 to either harm himself or others. It was, however, positive to read guidelines for intervening when he exhibits wrist flapping because this had been identified by BARC staff as a precursor to self-injurious behavior. Staff had also separated head hitting from head banging, although the first behavior was to be measured using a partial interval recording (one-hour intervals). Staff are advised to review the latest PBSP to ensure that other recommendations (e.g., conducting frequent preference assessments, providing multiple activities, ensuring consistent implementation) made by BARC staff are addressed.

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

Summary: Not all individuals who needed counseling services were receiving them. This was also noted at the last review. Because it seemed that activities/counseling programs were at initial stages of provision for some individuals (and likely to be for others in the near future), the Monitor will leave indicator in the category of requiring less oversight. This should be corrected if indicator 24 is to remain in this category after the next review. The one individual in the review group who was receiving counseling did not yet have a treatment plan or progress notes. Indicator 25 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681

24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	0% 0/1					0/1				

Comments:

24. A community-based professional was providing counseling services to nine men at the Center (i.e., three from the review group plus six others). In addition, four BCBAs had received training in Acceptance and Commitment Therapy. At the time of the visit, two of the nine individuals were identified to receive counseling from one of these BCBAs. Individual #592 had not yet begun receiving this service; staff reported that he was seeing the chaplain for counseling. Individual #219 was to begin ACT counseling the week of the onsite visit. Individual #456 had been referred repeatedly for counseling, but at the time of the visit, she was not participating in this service.

Given the many individuals with personality disorder diagnoses (e.g., borderline personality disorder), specialized therapies may be needed and should be explored by the Center for these individuals, such as DBT, CBT, ACT, and anger management. Along these lines, four BCBAs recently participated in a four-day training on Acceptance and Commitment Therapy. These staff were expected to begin providing counseling services to identified individuals.

25. There was no counseling plan for Individual #219. As this service was just beginning, it is anticipated that a plan will be developed that will allow for data-based review of progress.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Although some improvement was noted with regard to individuals' ISPs/IHCPs defining the frequency of interval medical reviews, the IDTs' decisions did not always address individuals' specific needs. In addition, even when the IHCPs correctly defined the frequency, PCPs often had not conducted required interval medical reviews. Indicator c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
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.										
c.	Individual has timely periodic medical reviews, based on their	22%	0/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1

	individualized needs, but no less than every six months	2/9									

Comments: c. The IHCPs reviewed defined the frequency of medical review. However, for Individual #149 – aspiration, and GI problems, and Individual #315 – respiratory compromise, IDTs defined the frequency as six months, but given the severity of these individuals' level of risk, this frequency was not sufficient to meet their needs.

In addition, for a number of individuals, PCPs did not complete the required interval medical reviews.

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

Summary: Center staff should continue to improve the quality of the medical assessments, and specifically, improve the plans of care for active medical problems. Indicators a and c will remain in active oversight.

#	Indicator	Overall Score	Individuals: 194	303	538	149	315	459	201	276	781
a.	Individual receives quality AMA.	33% 3/9	0/1	0/1	0/1	0/1	1/1	1/1	0/1	1/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	22% 4/18	0/2	2/2	2/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. It was positive that three individuals' AMAs (i.e., Individual #315, Individual #459, and Individual #276) included all of the necessary components, and addressed the selected chronic diagnoses or at-risk conditions with thorough plans of care. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, family history, social/smoking histories, childhood illnesses, past medical histories, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, pertinent laboratory information, and updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments include quality plans of care for each active medical problem, when appropriate.

c. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions [i.e., Individual #194 – weight, and fractures; Individual #303 – other: pica, and osteoporosis; Individual #538 – cardiac disease, and other: sleep apnea; Individual #149 – aspiration, and gastrointestinal (GI) problems; Individual #315 – respiratory compromise, and circulatory; Individual #459 – constipation/bowel obstruction, and weight; Individual #201 – aspiration, and GI problems; Individual #276 – fluid imbalance, and GI problems; and Individual #781 – seizures, and weight].

The individuals for whom the ISPs/IHCPs defined the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines, and PCPs had completed quality medical reviews were: Individual #303 – other: pica, and osteoporosis; Individual #538 – cardiac disease, and other: sleep apnea.

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
Summary: Since the last review, some good improvement occurred with regard to IDTs defining in IHCPs the frequency of interval medical reviews. However, in most cases, IDTs required interval medical reviews every six months, but given the severity of some individuals' level of risk, this frequency was not sufficient to meet their needs. As indicated in the last several reports, overall, much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
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.	22% 4/18	0/2	0/2	0/2	0/2	2/2	0/2	2/2	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.	83% 15/18	2/2	2/2	2/2	0/2	1/2	2/2	2/2	2/2	2/2

Comments: a. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions (i.e., Individual #194 – weight, and fractures; Individual #303 – other: pica, and osteoporosis; Individual #538 – cardiac disease, and other: sleep apnea; Individual #149 – aspiration, and GI problems; Individual #315 – respiratory compromise, and circulatory; Individual #459 – constipation/bowel obstruction, and weight; Individual #201 – aspiration, and GI problems; Individual #276 – fluid imbalance, and GI problems; and Individual #781 – seizures, and weight).

The following IHCPs included action steps to sufficiently address the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations: Individual #315 – respiratory compromise, and circulatory; and Individual #201 – aspiration, and GI problems.

b. The ISPs/IHCPs reviewed often defined the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. Although the following individuals' ISPs/IHCPs defined the frequency as six months, given the severity of the individuals' level of risk, this frequency was not sufficient to meet their needs: Individual #149 – aspiration, and GI problems, and Individual #315 – respiratory compromise.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: Given that over the last two review periods and during this review, annual dental examinations (Round 12 – 88%, Round 13 – 100%, and Round 14 - 100%), and summaries (Round 12 – 100%, Round 13 – 100%, and Round 14 - 100%) generally were completed timely for the individuals reviewed, Indicators a.ii and a.iii will move to the category requiring less oversight. Since the last review, the quality of the dental exams showed continued improvement. Over this review and the last one, the Dental Department sustained improvements with regard to the quality of annual dental summaries. If the Center continues to sustain this progress, after the next review, Indicator c might move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
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.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments: a. It was good to see that individuals reviewed had timely dental exams and summaries

b. It was positive that for the nine individuals reviewed, the dental exams included all of the required components:

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

- Caries risk;
- Periodontal risk;
- An oral cancer screening;
- Information regarding the last x-ray(s) and type of x-ray, including the date;
- Sedation use;
- A summary of the number of teeth present/missing;
- Treatment provided/completed;
- An odontogram;
- A treatment plan; and
- Periodontal charting, updated within the last year, or a justification for not completing it with a plan to complete it.

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

- Effectiveness of pre-treatment sedation;
- Recommendation of need for desensitization or another plan;
- A description of the treatment provided (i.e., treatment completed);
- The number of teeth present/missing;
- Dental care recommendations;
- Dental conditions that could cause systemic health issues or are caused by systemic health issues;
- Treatment plan, including the recall frequency;
- Provision of written oral hygiene instructions; and
- Recommendations for the risk level for the IRRF.

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.											
Summary: For all nine individuals reviewed, nurses completed timely annual or new-admission nursing reviews and physical assessments, as well as quarterly nursing record reviews and physical assessments. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1

	10 days prior to the ISP meeting.										
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: a.i. and a.ii. It was good to see that all of the individuals reviewed had timely annual comprehensive nursing reviews and physical assessments, and quarterly record reviews, and physical assessments.											

Outcome 4 – Individuals have quality nursing assessments to inform care planning.											
Summary: Work was needed to ensure that nurses completed annual and quarterly physical assessments that addressed the necessary components. Work is also needed to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to individuals' at-risk conditions. It was good to see that in some instances, when individuals experienced changes of status, nurses completed assessments in accordance with current standards of practice, but this is also an area in which improvements are still needed. All of these indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	Individual receives a quality annual nursing record review.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual receives quality annual nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	33% 3/9	0/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1
c.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual receives a quality quarterly nursing record review.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality quarterly nursing physical assessment,	33%	0/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1

	including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	3/9									
f.	On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
g.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	44% 4/9	1/2	N/A	N/A	0/1	1/1	N/A	0/2	1/1	1/2

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

- Consultation summary; and
- Tertiary care.

Most, but not all included:

- Active problem and diagnoses list updated at time of annual nursing assessment (ANA);
- Social/smoking/drug/alcohol history;
- Immunizations; and
- Lab and diagnostic testing requiring review and/or intervention.

The components on which Center staff should focus include:

- Family history;
- Procedure history;
- List of medications with dosages at time of ANA; and
- Allergies or severe side effects to medication.

b. For three individuals reviewed, nurses completed annual physical assessments that addressed the necessary components. Some of the problems noted with the remaining physical assessments included a lack of follow-up for abnormal findings, missing assessments for some body systems, and incomplete descriptions of individuals' mental status.

c. and f. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #194 – constipation/bowel obstruction, and fractures; Individual #303 – cardiac disease, and falls; Individual #538 – circulatory, and skin integrity; Individual #149 – choking, and UTIs; Individual #315 – respiratory compromise, and constipation/bowel obstruction; Individual #459 – dental, and weight; Individual #201 – aspiration, and GI problems; Individual #276 – diabetes, and infections; and

Individual #781 – seizures, and falls).

Overall, none of the annual comprehensive nursing or quarterly assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Nurses often had not included status updates in annual assessments, including relevant clinical data; analyzed this information, including comparisons with the previous quarter or year; and/or made recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

d. It was positive that all of the quarterly nursing record reviews the Monitoring Team reviewed included the following:

- Consultation summary.

Most, but not all included:

- Active problem and diagnoses list updated at time of the quarterly assessment;
- Procedure history;
- Social/smoking/drug/alcohol history;
- List of medications with dosages at time of quarterly nursing assessment;
- Immunizations;
- Lab and diagnostic testing requiring review and/or intervention; and
- Tertiary care.

The components on which Center staff should focus include:

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

e. For three individuals reviewed, nurses completed quarterly physical assessments that addressed the necessary components. Some of the problems noted with the remaining physical assessments included a lack of follow-up for abnormal findings, missing assessments for some body systems, and incomplete descriptions of individuals' mental status.

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

- On 9/22/18, at 7:20 p.m., an IView entry indicated Individual #194 required the administration of Biscodyl for constipation. An IPN, dated 9/28/18, at 11:28 p.m., noted it was a medication administration follow-up, and the medication effective box stated: "Yes." It provided no further information regarding a nursing assessment. The next IPN, dated 9/23/18, at 7:20 a.m., related to her pain medication. Based on the documentation submitted, nurses did not follow applicable nursing guidelines for assessment of constipation, including, for example, abdominal assessments, or review of her intake/output prior to or post the administration. This was particularly problematic given that as a result of her fracture, she was taking pain medication that placed her at higher risk for constipation.
- On 9/13/18, when Individual #194 fell and sustained an injury, it was positive that the nurse conducted an assessment in accordance with the applicable nursing guideline. This included notifying the PCP. The individual was sent to the ED, and treated for a fracture.
- On 10/8/18, Individual #149 went to the ED due to an elevated white blood cell count, and on 10/12/18, she was discharged

with a diagnosis of a UTI. Upon her return to the Center, nurses did not conduct assessments in accordance with applicable standards of care, including, for example, assessments of the individual's urine for color, odor, etc.

- On 6/18/18, at 9:50 p.m., Individual #315 experienced respiratory distress. The RN conducted an assessment consistent with applicable standards of care, which was good to see. The nurse activated the emergency system (i.e., 3333), notified the PCP, and the individual was sent to the ED. Given the individual's emergent needs, nursing staff were prudent in their action to activate the emergency system.
- For Individual #201, on 8/4/18, an ER/Hospitalization Medical Transfer Screen indicated he went to the hospital for respiratory distress, GJ-tube migration, and black bleeding from the stoma. Based on the documents submitted, a nurse did not write a corresponding IPN documenting the individual's signs and symptoms, and/or an assessment of the individual. Prior to this, on 8/3/18, at 8:40 p.m., an IView entry noted that the individual had an elevated heart rate, and "GJ tube migration excessive drainage for ga…" with the remainder of the words cut off. The nurse noted that the physician was notified and orders were received. On 8/4/18, at 9:10 p.m., an IView entry noted the individual had an elevated pulse and respiratory rate, and that the nurse administered oxygen 2 liters (L), and notified the physician who ordered transfer to the ED. No corresponding IPN was found. The individual was admitted to the hospital with a diagnosis of aspiration pneumonia. Due to the lack of an IPN with a description of the event(s) prior to the transfer, the Monitoring Team could not confirm that nursing staff followed standards of care based on the individual's signs and symptoms.
- On 9/26/18, nursing IPN and IView entries indicated that staff reported Individual #276 experienced emesis, and each time, she had a congested cough before the emesis. Based on the individual's signs and symptoms, lack of cooperation with the assessment process, and decreasing oxygen saturation rates, which required oxygen support, the nurse correctly followed the standards of care, including physician notification. The physician ordered transfer to the ED.
- On 9/23/18, Individual #781 required the administration of Ativan for more than five seizures in 24 hours. The IView documentation did not show that nurses completed a full head-to-toe assessment in that it did not include an abdominal assessment to check for constipation.
- On 11/29/18, while getting into the shower, Individual #781 fell. According to staff who witnessed the fall, she slipped onto her buttocks and hit her right hand on the shower chair. The nurse conducted an assessment that was in alignment with the nursing protocol for falls, which was good to see.

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

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

#	Indicator	Overall Score	Individuals: 194	303	538	149	315	459	201	276	781
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	preventative interventions to minimize the chronic/at-risk condition.	0/18									
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. through f. Significant work is needed to improve the nursing components of individuals' IHCPs.											

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: Given that over the last two review periods and during this review, for the most part, a timely Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results (Round 12 – 100%, Round 13 – 100%, and Round 14 - 83%), Indicator e will move to the category requiring less oversight. Significant improvements were needed, though, with regard to IDTs making timely referrals to the PNMT or the PNMT making self-referrals, as well as the PNMT completing comprehensive assessments that addressed individuals' needs. For the four individuals who needed comprehensive assessments, the PNMT completed no assessment for two individuals, and completed substantially late assessments for the other two individuals. Moreover, the assessments reviewed provided incomplete evaluation information, and lacked thorough analyses of the potential causes of the individuals' physical and nutritional management issues. As a result, the PNMT likely did not offer full sets of recommendations to the individuals' IDTs. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	Individual is referred to the PNMT within five days of the	50%	1/1	N/A	N/A	0/1	1/1	N/A	1/1	0/1	0/1

	identification of a qualifying event/threshold identified by the team or PNMT.	3/6									
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	50% 3/6	1/1			0/1	1/1		1/1	0/1	0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/4	N/A			0/1	N/A		0/1	0/1	0/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	33% 2/6	1/1			0/1	1/1		0/1	0/1	0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	83% 5/6	0/1			1/1	1/1		1/1	1/1	1/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/6	0/1			0/1	0/1		0/1	0/1	0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/2	0/1			N/A	0/1		N/A	N/A	N/A
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4	N/A			0/1	N/A		0/1	0/1	0/1

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

- On 9/13/18, Individual #194 fell and sustained a fracture of her left ankle and distal fibula. On the day following the event, this fracture of a long bone resulted in an automatic referral to the PNMT. On the same day as the referral, the PNMT conducted a review. With regard to the quality of the PNMT review, the PNMT included the presenting problem, as well as the individual's medical history and pertinent diagnoses, which was positive. However, the PNMT only listed applicable risk areas as falls, osteoporosis, and fractures. Other risk areas that the fracture potentially impacted due to individual's decreased mobility included skin issues, GERD, and behavior. In addition, the PNMT limited its discussion of current health and physical status to just a few sentences, and the review lacked information regarding the fracture's impact on all areas of physical and nutritional management. The PNMT review stated that the individual had fallen only once, but according to the latest ISP, over the past year, she fell three times.
- In March 2018, and again, in September 2018, Individual #149 was diagnosed with aspiration pneumonia. In response to her diagnosis of aspiration pneumonia, on 9/13/18, no evidence was found in the IPNs or PNMT assessment of a PNMT review or

assessment. In December 2017, and March 2018, her IDT referred her to the PNMT in response to episodes of emesis. Despite the individual's ongoing issues with emesis (i.e., 12/9/17, 12/14/17, 12/25/17, 3/6/18, and 3/7/18), low oxygen (i.e., 2/18/18), and aspiration pneumonia (i.e., 3/6/18, and 9/14/18), the PNMT did not conduct a comprehensive assessment.

- On 6/18/18, Individual #315 was diagnosed with aspiration pneumonia. On 6/26/18, the PNMT initiated a referral, and on 6/27/18, the PNMT conducted a review. With regard to the quality of the review, it contained little assessment information. The PNMT reviewed the individual's history, and concluded that the "root cause" of the aspiration was the individual's inability to control her secretions. However, although the PNMT indicated that monitoring was needed, it did not complete monitoring to observe with individual's secretion management or positioning. In addition, the PNMT did not provide an analysis of the impact of the aspiration pneumonia on the individual's other PNM-related risks.
- Since January 2017, Individual #201 averaged roughly one aspiration pneumonia every two to three months. Most recently, on 2/1/18, 7/4/18, 8/4/18, and 9/23/18, he was diagnosed with aspiration pneumonia. The PNMT did not initiate an assessment until after the 9/23/18 aspiration pneumonia, which was the fourth in nine months. The PNMT had conducted reviews, but they lacked analysis to determine the root cause(s), which often consisted of a single statement that the PNMT had not supported with monitoring or other data. For example, the review, dated 7/19/18, concluded that the "root cause" of the aspiration pneumonia was emesis due to increased gastric volume, but the PNMT had not explored previous residuals or determined the cause of the increased volume.
- In response to Individual #276's 5/20/18 vomiting episode that required an ED visit, the IDT did not make a referral to the PNMT, and the PNMT did not make a self-referral. At least a review was warranted due to her recent history of unresolved emesis. More specifically, she had emesis on 2/21/18, 2/24/18, 3/3/18 x2, and 4/12/18 x3. On 4/26/18, the PNMT conducted a review. Given that the vomiting remained unresolved, after the ED visit in May, the PNMT should have conducted another review. In addition, no evidence was submitted of a referral, or a review or assessment after her aspiration pneumonia diagnosis on 9/26/18. The PNMT noted that they could not see her due to her immediate return to the hospital, but there was no evidence that since the hospitalization, on 10/3/18, the PNMT completed a review/assessment. Based upon her history of unresolved emesis, PNMT observations/assessment of a number of areas was warranted. To address the emesis, the PNMT should have reassessed her HOBE. PNMT members also should have collaborated with Behavioral Health Services staff regarding pica behavior and mealtime issues, but the Monitoring Team found no evidence that this occurred. In its comments on the draft report, the State stated the following: "Please refer to TX-DE-1901-II.05.o., individual #276 does not have a diagnosis of PICA." Based on the Tier I Document #TX-DE-1901-III.10, on 5/17/18, Individual #276 returned from the ED with a diagnosis of pica.

  In April 2018, the PNMT recommended an EGD. In an ISPA, dated 5/21/18, the IDT also stated they felt strongly there was a need for an EGD. However, based on the ISPA documentation submitted, the IDT did not meet to discuss EGD results, or to provide a rationale for not completing an EGD. Beyond the 4/26/18 review, the PNMT did not document any notes/minutes or reviews. On 10/10/18, the IDT held a change-of-status meeting, but the ISPA did not reflect results from observations of PNM-related supports or analysis of PNM-related data.
- Individual #781's IDT made timely referrals to the PNMT for falls in October 2017 and January 2018, and again in August 2018, for weight gain. However, despite 22 falls (four in March 2018, three in April 2018, six in May 2018, and nine in June 2018), it was not until 8/24/18, that the PNMT completed an assessment. On 5/18/18, the PNMT conducted a review related to weight, but made no mention of falls.

f. As the Monitoring Team has discussed with State Office, without signature pages that include dates, it is not possible to determine which members of the PNMT participated in the PNMT assessments. Currently, PNMT documents include a list of "participants" within the document. Given that PNMT members are licensed clinicians, the Center needs to have a mechanism to verify the participation of each clinician in the PNMT assessment process. The author or person entering information could potentially populate the list of "participants" without those clinicians having any role in the process or even knowing that they are listed as "participants." Other entries in IRIS provide a "signature" of sorts, because the system identifies the author of each entry as the user that entered the system using a password. Such entries are also time-stamped. Given the ongoing challenges with IRIS related to the inability to have more than one user "sign" a document, the State should propose a mechanism to allow this verification (i.e., allowing one user to simply include the names of "team members" at the bottom of the report does not suffice).

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

- On 9/13/18, Individual #194 returned from the hospital, but a RN post-hospital review was not completed until 9/17/18. The PNMT's review, dated 9/14/18, did not provide an explanation.

h. As noted above, two individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #149, and Individual #276). As discussed above, Individual #201 and Individual #781 should have had comprehensive assessments sooner. However, to provide the Center with feedback regarding the quality of the assessments the PNMT completed, the following summarizes some of the findings for these two assessments:

- On a positive note, for both individuals, the PNMT:
    - Identified the presenting problem;
    - Discussed the pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs; and
    - Showed evidence of observation of the individual's supports at his/her program areas.
- For Individual #201, the PNMT initiated an assessment after his aspiration pneumonia event on 9/23/18, but relied on a review of medications from August 2018, which needed updating given his change of status. The PNMT did not complete a reassessment of the appropriateness of his HOBE. The PNMT recommended a wheelchair assessment, and the OT/PT consultation, dated 12/3/18, included a brief note saying that one was completed. However, no evidence was found in the IPNs or consults/assessments of the completion of an actual wheelchair assessment. Although the PNMT identified a number of potential "root causes," data to support the conclusions were not consistently available and/or the PNMT did not make a plan to collect such data to rule in or out causes. Recommendations focused on correcting positioning issues. However, without complete analyses, the PNMT did not have the information with which to offer the IDT a complete set of recommendations.
- For Individual #781, the PNMT stated that: "behaviors may impact risk but no specific data available," but the PNMT did not develop/implement a plan to acquire this data. In January 2018, the PNMT conducted a review, and concluded the root cause of her falls was a medication, Onfi. However, in August 2018, the PNMT assessment indicated that medications did not appear to impact her fall risk. The PNMT offered no explanation for how/why this suspected "root case" was ruled out. The assessment focused primarily on transfers and gait. The PNMT discussed the individual's weight, which continued to increase (i.e., a roughly 15-pound increase between May 2018 and August 2018), but offered no recommendations for changes. The

	PNMT included no discussion of the potential impact on falls of the middle ear dysfunction and ringing (i.e., as noted in the Communication assessment from May 2018). Although the PNMT stated the individual had issues using adaptive equipment as well as with gait balance, they did not implement a monitoring/observation schedule to obtain data. Over the various reviews and the assessment, the PNMT identified differing potential "root causes," but data to support the conclusions were not consistently available and/or the PNMT did not make a plan to collect such data to rule in or out causes. Without complete analyses, the PNMT did not have the information with which to offer the IDT a complete set of recommendations.

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

Summary: Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. The plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps. In addition, many action steps were not measurable. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 194	303	538	149	315	459	201	276	781
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	6% 1/16	0/2	0/2	0/2	0/2	0/2	1/1	0/2	0/2	0/1
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	33% 3/9	0/1	0/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	11% 2/18	0/2	0/2	0/2	0/2	1/2	1/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	28% 5/18	1/2	0/2	0/2	0/2	0/2	2/2	0/2	1/2	1/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: Individual # - Individual #194 – choking, and falls; Individual #303 – choking, and aspiration; Individual #538 – GI problems, and aspiration; Individual #149 – aspiration, and GI problems; Individual #315 – GI problems, and aspiration; Individual #459 – skin integrity, and weight; Individual #201 – aspiration, and GI problems; Individual #276 – choking, and aspiration; and Individual #781 – falls, and weight.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP. The exception was: for Individual #459 – skin integrity.

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

The plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps (e.g., if behavior was a frequent cause of falls, measurable interventions to address the behaviors should be included; or if an individual was at increased risk of choking due to a fast eating pace or improper positioning during meals, then measurable action steps are needed to address these factors). In addition, many action steps were not measurable (e.g., "modify diet," "offer toileting," etc.).

c. All individuals reviewed had PNMPs and/or Dining Plans. It was positive that the PNMPs for Individual #538, Individual #149, and Individual #315 included the necessary components. Of note, Individual #459 did not require assistance in a number of areas, but the PNMP did not specify that no supports were needed, which would have been helpful. The PNMPs that did not meet criteria included many important supports, but some key supports were still missing.

- It was positive that all of the PNMPs, as applicable to the individuals' needs were reviewed and/or updated within the last 12 months, and included:
    - Descriptions of assistive/adaptive equipment;
    - Positioning instructions;
    - Mobility instructions;
    - Bathing instructions;
    - Toileting/personal care instructions;
    - Handling precautions or moving instructions;
    - Mealtime instructions;
    - Medication administration instructions; and
    - Oral hygiene instructions.
- As applicable to the individuals, most, but not all of the PNMPs reviewed included:
    - Pictures of all applicable adaptive equipment;
    - Transfer instructions; and
    - Complete communication strategies.
- The component of the PNMPs on which the Center should focus on making improvements is that:
    - Most PNMPs/Dining Plans were missing relevant risk areas.

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

d. The IHCPs reviewed did not include the steps necessary to meet the goal/objective.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for: Individual #315 – aspiration, and Individual #459 – weight.

f. Even though, at times, PNMPs identified relevant triggers, the IHCPs reviewed did not include triggers and actions to take should they occur.

g. Often, the IHCPs reviewed did not include the frequency of PNMP monitoring. Those that did were for: Individual #194 – choking; Individual #459 – skin integrity, and weight; Individual #276 – choking; and Individual #781 – weight.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
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.	33% 1/3	N/A	N/A	N/A	N/A	0/1	N/A	1/1	0/1	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/2					N/A		0/1	0/1	

Comments: a. and b. Although Individual #315's IRRF described her current status, it did not describe the underlying reason that she required enteral nutrition (i.e., the clinical justification).

Individual #201's PNMT assessment, dated 11/26/18, stated that he had a G-tube secondary to decreased intake. In the past, he resumed oral intake, but then went through a period of time of unsafe refusals. In July 2012, a Modified Barium Swallow Study (MBSS) documented that he had the ability to eat safely. Pleasure feedings were provided, but discontinued due to the individual's refusals. Since 2014, no evidence was found that the IDT had revisited trials of by-mouth intake.

For Individual #276, the IDT had not provided a rationale in the IRRF for providing medication via G-tube when the individual ate all meals by mouth and received a regular texture diet with thin liquids. The IDT had not put a plan in place to trial oral medications, or provided a justification for not doing so. In addition, the IDT did not document the frequency of supplemental feedings to determine the individual's status in comparison with the previous year, or the potential for improvement.

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, but during this review declined. The quality of OT/PT assessments continues to be an area on which Center staff should focus. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	55% 5/9	0/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	55% 5/9	0/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1
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;	N/A									

	• Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/5	0/1	N/A	N/A	0/1	0/1	N/A	0/1	0/1	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/4	N/A	0/1	0/1	N/A	N/A	0/1	N/A	N/A	0/1

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

- For Individual #194, who experienced a fracture, it was positive the OT/PT provided a consultation immediately post-fracture and provided a comprehensive assessment in time for her annual ISP meeting. However, the OT/PT did not provide another needed assessment based on a change of healthcare status. Another comprehensive assessment was warranted, but not completed, to help determine if prior functioning had fully returned when she returned to ambulation, since many supports had changed.
- In the draft report, the Monitoring Team included the following finding: Individual #459's last assessment was in September 2017. The summary of that assessment stated an annual assessment was needed, but none was completed in 2018. In its comments on the draft report, the State provided clarification and stated: "Please refer to TX-DE-1901-III.12.ii.m. pages 16-21 for the 2018 assessment for individual #459." The State did not explain in its comments that it did not include this assessment in response to the Monitoring Team's request for: "Most recent OT/PT comprehensive assessment, and all updates since that assessment," but rather provided it in response to a request from the Monitoring Team member who reviews ISPs. However, the Monitor reviewed the information and modified the scores related to timeliness. The quality of this assessment was problematic.
- For Individual #201, a comprehensive assessment was completed in time for the ISP meeting, but the Center did not provide evidence that the OT/PT completed a needed wheelchair assessment. The OT/PT did not complete an assessment of head-of-bed elevation (HOBE) in response to episodes of emesis occurring in bed (i.e., 7/4/18, 9/14/18, 9/15/18, and 9/23/18). In addition, Center staff did not assess whether the volume of enteral feeding should be decreased, despite signs of discomfort (pulling out tubes) and repeated emesis, until the PNMT completed an assessment in November 2018.
- Individual #276 had experienced multiple unresolved episodes of emesis, but did not receive a comprehensive assessment to identify possible causes. The IDT did not make a referral for, or otherwise obtain assessments for HOBE appropriateness, to determine if mealtime behavior was contributing to increased emesis, or to determine the potential impact of pica behavior on emesis.
- On 2/16/18, the PT requested that Individual #781 accompany the PT to a medical supply store to trial and choose a walker. This trip was not completed until 4/30/18, with no justification for this significant delay.

d. None of the five comprehensive assessments met criteria for a quality assessment. It was positive that all five comprehensive assessments reviewed met criteria, as applicable, with regard to:

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

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

- The individual's preferences and strengths were used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;

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

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale;
- 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;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

e. As discussed above, Individual #459 should have had an update, but did not. It was positive that all of the three updates reviewed met criteria, as applicable, with regard to:

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

Most, but not all, included, as appropriate:

- The individual's preferences and strengths are used in the development of OT/PT supports and services; and
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports.

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

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- 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;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including 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; 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.

Of note, as part of the onsite review week, the Monitoring Team appreciated the Habilitation Therapy Director's willingness to conduct an objective review of one individual's OT/PT and communication assessments, review the findings with the Center therapists, and then discuss her findings openly with the members of the Monitoring Team and State Office staff. This effort showed Center staff's ability to identify strengths, as well as weaknesses in the assessments, as well as to identify potential solutions to the significant improvements that are needed with regard to the assessments. The Monitoring Team is hopeful that the Habilitation Therapy Director's ongoing auditing of assessments with feedback provided to therapists will assist in improving the quality of the assessments.

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

Summary: IDTs need to include in ISPs concise, but thorough descriptions of individuals' OT/PT functional statuses. Over the previous two review periods and for this review, the IDTs of individuals reviewed had generally reviewed, modified, as needed, and approved PNMPs/positioning schedules as part of the ISP process, including providing a brief summary of any changes made/needed (Round 12 – 100%, Round 13 – 100%), and Round 14 - 89%). As a result, Indicator b will move to the category requiring less oversight. IDTs also included OT/PT interventions, strategies, and programs in individuals' ISPs, but due to problems with assessments, IDTs did not have comprehensive sets of recommendations to consider. The remaining indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 194	303	538	149	315	459	201	276	781
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	44% 4/9	1/1	0/1	1/1	1/1	0/1	1/1	0/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	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.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification	67% 2/3	1/1	N/A	N/A	N/A	N/A	N/A	1/1	0/1	N/A

	or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.										

Comments: a. Four of nine ISPs reviewed included concise, but thorough descriptions of individuals' OT/PT functional statuses. The remaining five ISPs did not contain a clear description of overall OT/PT status. Pertinent information was segmented and scattered throughout the ISP. Therapists should work with QIDPs to make improvements.

b. It was positive that eight of nine ISPs met criteria for IDT review and update of the PNMP/Positioning Schedule at least annually, or as the individual's needs dictated. For Individual #276, the ISP reflected such a review as part of the annual ISP, but updates to the PNMP did not appear to have IDT approval and/or review.

c. It was positive that eight of nine ISPs met criteria for inclusion of strategies, interventions, and programs recommended in the OT/PT assessment. Still, it remained concerning that those OT/PT assessments often did not include recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need. For Individual #459, the IDT did not have a current assessment and recommendations available to use in planning those strategies, interventions and programs. OT/PT clinicians did not complete a 2018 assessment and the assessment completed in 2017 was more than a year old.

d. For two of three individuals, an ISPA meeting was held to discuss and approve implementation of new OT/PT services or supports initiated outside of an annual ISP meeting or when a modification or revision to a service was indicated. For Individual #276, the Center did not provide any evidence of an ISPA meeting to discuss her new wheelchair.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: Significant work continued to be needed to improve the quality of communication assessments and updates in order to ensure that SLPs provide IDTs with clear understandings of individuals' functional communication status; AAC options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports is objectively evaluated. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	Individual receives timely communication screening and/or assessment:										

	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	88% 7/8	1/1	1/1	1/1	1/1	N/A	0/1	1/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: • Vision, hearing, and other sensory input; • Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: a. and b. The following provides information about problems noted: • Individual #315's assessment, which was not completed until 12/4/18, was not available for use by the IDT in development of her ISP at the meeting held on 8/30/18.											

d. None of eight comprehensive assessments reviewed met criteria, as applicable, with regard to any single indicator. Most, but not all met criteria, as applicable, with regard to:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services; and
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated.

Overall, the communication updates were of poor quality. The Center should focus most on the following sub-indicators:

- The individual's preferences and strengths are used in the development of communication supports and services;
- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;
- A comparative analysis of current communication function with previous assessments;
- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

e. Individual #303's Communication Assessment of Current Status/Evaluation Update met criteria with regard to:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication; and
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services.

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

- The individual's preferences and strengths are used in the development of communication supports and services;
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;
- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs (including AAC, EC, or language-based) in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.	
Summary: t Given that over the previous two review periods and for this review, the	Individuals:

ISPs reviewed generally provided a description of how the individual communicates and how others should communicate with the individual (Round 12 – 100%, Round 13 – 89%), and Round 14 - 100%). As a result, Indicator a will move to the category requiring less oversight. The remaining indicators will continue in active oversight.											
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/6	0/1	0/1	N/A	0/1	0/1	N/A	0/1	0/1	N/A
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: b. For the six individuals who required a Communication Dictionary, based on their needs, none of their ISPs documented an IDT review; rather the narrative indicated only that the IDT approved it. Simply including a stock statement such as "Team reviewed and approved the Communication Dictionary" did not provide evidence of what the IDT reviewed, revised, and/or approved, and/or whether the current Communication Dictionary was effective at bridging the communication gap.

c. Overall, "It was positive that ISPs often included strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessments, but it remained a significant concern that the assessments upon which the IDTs relied often did not offer recommendations for goals and objectives to address individuals' identified needs, and expand or explore communication possibilities.

Individual #194's communication assessment stated she could not hear, but multiple goals within the ISP indicated staff would use verbal cues.

d. Per the ISP, Individual #194 had a service objective (SO) to be referred by 11/1/18 for participation in a signing class once per week as an action plan for her relationships personal goal, but did not describe any measurable objective to be achieved through that participation. Once the referral was completed, the IDT should have held an ISPA meeting to discuss and approve the purpose of participation, what was to be achieved and how that would be measured. The IDT had not held such an ISPA meeting.

Skill Acquisition and Engagement

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

Summary: It was good to see that individuals continued to have SAPs and that they were written in measurable terminology. Less than half were based on assessment results (though this was an improvement from the last review). Most, however, were not determined to be practical, functional, or meaningful; and almost all did not have reliable data. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 456	227	592	303	219	154	10	194	681
1	The individual has skill acquisition plans.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The SAPs are measurable.										
3	The individual's SAPs were based on assessment results.	41% 11/27	1/3	0/3	1/3	0/3	2/3	2/3	3/3	0/3	2/3
4	SAPs are practical, functional, and meaningful.	19% 5/27	0/3	0/3	0/3	2/3	0/3	1/3	1/3	0/3	1/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	7% 2/27	1/3	0/3	0/3	0/3	0/3	0/3	0/3	1/3	0/3

Comments:

3. Eleven of the 27 SAPs were based on assessments, primarily the identified current level of performance found in the SAP. These were the following SAPs: Individual #456 - clean work area; Individual #592 - choose clothing; Individual #219 - make list and peer interactions; Individual #154 - call job coach and calculate work; Individual #10 - address envelope, write check, and sweep floor; and Individual #681 - wash hands and make purchase.

Exceptions included:

- SAPs in which baseline assessment indicated the individual could perform the skill with the same level of prompting identified in the objective (Individual #456 - connect tablet and identify medication; Individual #227 - write name, brush teeth, and manage her ledger; Individual #592 - laundry; Individual #303 - hand washing; Individual #154 - make a purchase; Individual #194 - correct work, turn on television, and make a purchase; and Individual #681 - write name);
- a SAP in which baseline assessed a more complex skill (Individual #592 - weekly balance); a SAP in which baseline was not assessed (Individual #303 - play CD);
- a SAP in which baseline assessed a less complex skill (Individual #303 - choose activity); and
- a SAP that required a verbal response, but gestural prompting was identified as the current level of performance (Individual #219 - identify abbreviations).

4. Five of the 27 SAPs were considered to be practical, functional, and/or meaningful. These were the following: Individual #303's learning to operate a CD player and wash his hands; Individual #154 learning to calculate his work hours/earnings; Individual #10 learning to sweep the floor; and Individual #681 maintaining his hand washing skills.

Exceptions included:

- those SAPs in which the objective matched the current level of performance,
- SAPs that addressed skills identified as mastered in the Functional Skills Assessment (Individual #456 - clean work area; Individual #592 choose clothing; Individual #303 - choose activity; Individual #219 - make list; and Individual #154 - call job coach);
- SAPs that did not support the identified goal (Individual #219 - identify abbreviations; and Individual #681 - make a purchase);
- a SAP that did not teach a new skill (Individual #219 - peer interactions); and
- SAPs that did not teach the skill accurately or in total (Individual #10 - address envelope and write check).

5. Of the 27 SAPs, there was evidence that two SAPs had been monitored for data reliability over a six-month period. These were the clean work area SAP for Individual #456 and the correct work SAP for Individual #194. While Individual #303's choosing an activity SAP and Individual #681's write name SAP had been assessed for treatment integrity, there was no evidence that data reliability had been assessed.

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: Performance needs improvement in completing these important foundational assessments. Note, however, that four of the individuals (i.e., almost half) met criteria with all three indicators. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 456	227	592	303	219	154	10	194	681
10	The individual has a current FSA, PSI, and vocational assessment.	67% 6/9	1/1	1/1	0/1	0/1	1/1	1/1	0/1	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.	22% 2/9	0/1	0/1	0/1	1/1	1/1	0/1	0/1	0/1	0/1
12	These assessments included recommendations for skill acquisition.	56% 5/9	1/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1

Comments:

10. Six of the individuals had a current FSA, PSI, and vocational assessment. The exceptions included Individual #303 whose last full vocational assessment was completed in 2015, with an update completed in 2018. Although the IDT determined at that time that a full assessment was not warranted due to his disinterest in working, this indicator was rated zero. Individual #303 was a young man who may enjoy working should the right job be identified. In a comment on the draft version of this report, the State referred to its own

policy, which read "A comprehensive vocational assessment will be completed every three years for all individuals, unless the Personal Support Team (PST) determines that an assessment is not warranted. Justification for this decision will be filed in the individual's active record." The Monitoring Team concurs that the IDT followed this policy, but given his age, poor implementation of his current programming, and significant clinical challenges, a vocational assessment was an easy to conduct protocol that might have led the team to do some additional planning for him, even if work was not an option for him at this time.

Individual #592's vocational assessment was incomplete. Although Individual #10 had a PSI, the document provided was completed after the date of her ISP. When the PSI related to her latest ISP was requested onsite, the same PSI was identified. Therefore, it could not be determined that she had a PSI at the time of her ISP meeting.

11. Assessments for two of the individuals were available to the IDT 10 days prior to the ISP meeting. These were Individual #303 and Individual #219.

12. Recommendations for skill acquisition were provided in both the functional skills assessment and vocational assessment for four of the individuals. Additionally, recommendations were provided for Individual #681 in both his FSA and life skills assessment. (Individual #681 was of retirement age and the IDT determined that life skills provided a better opportunity for him to maintain his skills in consideration of his dementia diagnosis.)

SAP recommendations were not included in the vocational assessments/updates for Individual #592, Individual #303, Individual #219, and Individual #154. Additionally, Individual #219's FSA did not include SAP recommendations. Staff are again advised to use these assessments to identify a broad array of possible SAPs to ensure that habilitation services are provided to increase the individual's independence and quality of life.

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 clinical services, and implementation of plans by the various clinical disciplines. At the time of the last review, 22 of these indicators, including three entire outcomes, had sustained high performance scores and moved to the category requiring less oversight. Presently, three additional indicators will move to the category of less oversight in psychiatry, behavioral health, and dental.

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

Goals/Objectives and Review of Progress

In psychiatry, once Denton SSLC routinely obtains reliable data for psychiatric indicators, then progress can be assessed. Comparing the Center's psychiatry goal/indicator data with actual incidents may help ensure that the data being collected are valid, too. Psychiatry clinics were observed. They were well run and organized. Psychiatrists did a good job of reviewing the information, but the data were out of date, not reliable, and, therefore, not of much use to the psychiatrists.

In behavioral health, without data shown to be reliable, progress could not be validly determined. In behavioral health, external peer review was not occurring as a collaborative participatory activity as it should.

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

Acute Illnesses/Occurrences

When there were frequent restraints, IDTs met as often as required, but they were not discussing the content/topics as required by indicators 19-23. Also, Crisis Intervention Plans (CIPs) no longer contained all of the required components (Indicator 27).

When individuals were experiencing psychiatric distress or decompensation, psychiatry staff took action.

Nursing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis for acute illnesses/occurrences remain areas on which the Center needs to focus. Although nursing staff sometimes timely notified the practitioner/physician of signs and symptoms that required medical intervention in accordance with the nursing guidelines for notification, improvement is still needed in this area. The acute care plans reviewed needed significant improvement, particularly with regard to the

inclusion of interventions that address individuals' needs in a manner consistent with applicable nursing guidelines, and that define the frequency of interventions.

Some of the areas on which PCPs and providers need to focus with regard to acute care include assessing individuals with emergent health issues when they occur on campus (i.e., during regular business hours) and doing so in a timely manner, communicating necessary clinical information with hospital staff, and conducting follow-up for at least 48 hours after individuals return from the hospital.

When dental emergencies occurred for the individuals reviewed, the dentist saw the individuals timely, provided necessary treatment, and provided pain management, as needed. The indicator related to timely initiation of dental care for emergencies will move to the category requiring less oversight.

Implementation of Plans

In psychiatry, the Monitoring Team looks for nine components of the quarterly review. All were missing two to three components, most frequently references to side-effect assessments and review/discussion of non-pharmacological interventions.

In psychiatry, side effect monitoring assessments were completed and reviewed by the prescriber in a timely manner. Polypharmacy committee activities occurred regularly. There were well-written justifications for polypharmacy. More participatory discussion of medication regimens is suggested.

In behavioral health, based on the data that the Center did have, four individuals were reported to have met their goals, and six individuals had goals that were not making progress. Goals were not updated or created when reported to be met, and actions were not taken when goals were reported to not be making progress.

Denton SSLC did not show that the majority of staff were trained on individuals' PBSPs. There were also some questions about the way in which the PBSP trainers were themselves trained.

In behavioral health, paper data sheets had been introduced in May 2018 in an effort to improve documentation of both target problem and target replacement behaviors. There was some slight improvement, in that data collection systems for some target behaviors and some replacement behaviors met criteria. Furthermore, ensuring that data are reliable and recorded timely, and that treatment integrity is assessed are important aspects of behavioral health service provision that need 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.

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

For the consultations reviewed, the PCPs reviewed them and indicated agreement or disagreement, and generally did so in a timely manner. It was good to see continued improvement with regard to PCPs writing orders for agreed-upon recommendations.

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

The individuals reviewed received the dental treatment they needed, or for two individuals for whom hospital treatment was needed, plans were underway to obtain it. For those individuals needing suction tooth brushing, IDTs need to do a better job of including measurable objectives in ISPs/IHCPs, as well as measurable actions steps for monitoring. Staff also need to implement and document the provision of suction tooth brushing according to the agreed-upon schedules, and QIDPs need to summarize data, and refer concerns to the IDTs.

Proper fit of adaptive equipment was sometimes still an issue.

Overall, PNMP/Dining Plan implementation at Denton SSLC continued to need substantial improvement. Often, the errors that occurred (e.g., staff not intervening when individuals took large bites, or ate at an unsafe rate, and incorrect positioning) placed individuals at significant risk of harm. On a positive note, since the last review, Center staff identified one home in each unit with significant issues with regard to the implementation of PNMPs. Based on the Monitoring Team's review, some good improvement was noted in one of the homes, with problems persisting in the other home. As discussed with the Center Director and Assistant Director of Programs (ADOP), the Monitoring Team encourages Center staff to continue this corrective action process by rolling it out to other homes based on priority need, and at a pace that allows for sustained progress.

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: IDTs met as often as required, which was good to see (indicator 19). On the other hand, they were not discussing the content/topics as required by</td><td>Individuals:</td></tr>
</table>

indicators 19-23. These are regarding various variables that might be contributing to the occurrence of behaviors that lead to restraint. At this point, the Center should be regularly and consistently meeting these indicators. Also, CIPs no longer contained all of the required components (indicator 27). This should be corrected so that indicator 27 can remain in less oversight after the next review. The eight indicators that are in active monitoring will remain in active monitoring.											
#	Indicator	Overall Score	227	592	219						
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 3/3	1/1	1/1	1/1						
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/3	0/1	0/1	0/1						
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/3	0/1	0/1	0/1						
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	33% 1/3	0/1	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	0% 0/3	0/1	0/1	0/1						

	address them.										
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).										
26	The PBSP was complete.	N/A									
27	The crisis intervention plan was complete.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	67% 2/3	1/1	1/1	0/1						
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	33% 1/3	1/1	0/1	0/1						

Comments:

18-19. During the six months prior to the onsite visit, three of the nine individuals reviewed by the behavioral health monitoring team had experienced more than three restraints in a rolling 30-day period. These were Individual #227, Individual #592, and Individual #219. For each of these individuals, their IDT met within or before 10 business days. There were sufficient meetings held to address this issue.

20-23. In no case, however, were all of the potential variables discussed and/or adequately addressed by the individual's IDT, as required by these four indicators. Specific comments are below.

- Although Individual #227's team reviewed her adaptive skills, the review of her biological, medical, and psychosocial issues focused on historical information. Current variables were not discussed. One incident resulting in restraint occurred as Individual #227 waited for her mother to arrive on campus. When she was denied access to a phone to call her mother, she became upset. Staff responses were not clearly identified, so it was difficult to determine whether alternatives were provided to her (e.g., staff would place the call). A second incident involved staff using deception to obtain Individual #227's tablet, after which it was not returned to her. The only action indicated was to ask Individual #227's mother to not provide advanced notice regarding her visits.
- The IDT for Individual #592 discussed his preference for taking a bath versus showering. While it was decided that bubble bath would be purchased, there was no mention of purchasing a necessary plug for the tub. Further, he would be rewarded with an outing if he took three showers in one week. There was no clear action taken to honor his preference for baths.
- Individual #219's ISPA meeting minutes reflected a review of the restraints, but no variables related to these restraints. The only discussion in either of the ISPAs related to repeated restraint was regarding her attendance at work. No action plans were identified other than to provide a 30-day trial at the greenhouse. There were no actions identified to help her maintain good work attendance or to address her complaints about the heat.

27. At the time of repeated restraints, all three individuals had a current PBSP and CIP. One of the three CIPs was considered complete (i.e., 33%). While all CIPs included a description of a behavioral crisis, the approved type of restraint, and the maximum duration of restraint, only the plan for Individual #219 provided clear termination criteria. Individual #227's plan noted she should be calm, but this should be operationally defined. Individual #592's plan did not include criteria for terminating restraint following object retrieval.

28. There was evidence of monthly assessment of treatment integrity for both Individual #227 and Individual #592. Over the same six-month period, there were no reported assessments of treatment integrity for Individual #219.

29. There was evidence that the IDT for Individual #227 had reviewed her PBSP.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.												
Summary:			Individuals:									
#	Indicator	Overall Score										
1	If not receiving psychiatric services, a Reiss was conducted.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.											
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.											
Comments:												

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Once Denton SSLC routinely obtains reliable data for psychiatric indicators, then indicators 8 and 9 can be assessed by the Monitoring Team. Similarly, indicators 10 and 11 can then be assessed, too. Comparing the Center's psychiatry goal/indicator data with actual incidents may help ensure that the data being collected are valid, too. That being said, the Monitoring Team acknowledges the efforts of the psychiatry staff in taking action for individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681
8	The individual is making progress and/or maintaining stability.	0%	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2

		0/9									
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
11	Activity and/or revisions to treatment were implemented.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1

Comments:
8-9. Given the absence of data shown to be reliable (and perhaps valid) for psychiatric goals/indicators, progress could not be determined for goals for reduction or for increase. For instance, the Center reported that three individuals (Individual #456, Individual #154, Individual #194) were psychiatrically stable, but Individual #456 had required medication dosage adjustments and Individual #154 and Individual #194 continued to experience symptoms. In other words, if the Likert scale tool is showing the individual is doing well, but staff observations indicate otherwise, the validity of the tool might be questioned.

10-11. It was apparent that in general, when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (e.g., medication adjustments) were developed and implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.

Summary: Performance was slightly lower for both indicators compared with the last review. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 456	227	592	303	219	154	10	194	681
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.	67% 6/9	1/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	63% 5/8	1/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1	

Comments:
23. The psychiatric documentation referenced the behavioral health target behaviors for all individuals. The functional assessment discussed the role of the psychiatric disorder upon the presentation of the behaviors in six examples. The behavioral health documentation for Individual #219 and Individual #303 was out of date. The behavioral health documentation regarding Individual #154 did not include a discussion of the role of the psychiatric disorder upon the presentation of the target behaviors.

24. The documentation revealed evidence of psychiatric participation in the development of the PBSP for five individuals. The PBSP was out of date for two individuals, Individual #219 and Individual #303. The PBSP regarding Individual #154 did not include documentation of psychiatric participation.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.											
Summary:			Individuals:								
#	Indicator	Overall Score									
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
26	Frequency was at least annual.										
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.										
Comments:											

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: The inclusion of, primarily, one additional piece of information in the quarterly clinic notes should lead indicator 34 to positive scores. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681
33	Quarterly reviews were completed quarterly.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
34	Quarterly reviews contained required content.	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 components.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments: 34. The Monitoring Team looks for nine components of the quarterly review. None of the examples included all the necessary components, with examples missing two to three components, most frequently missing were references to side-effect assessments and review/discussion of non-pharmacological interventions. In a comment on the draft version of this report, the State wrote that non-pharmacological interventions were addressed via a checklist. The Monitor will accept this as meeting criterion for that sub-indicator for this review and for future reviews, too. For the other sub-indicator, regarding side-effect assessments, the date of the assessment needs to be added to the quarterly reviews. The State noted that IRIS did not automatically insert this. Other Centers have done so by manually adding in the date to the IRIS entry area (and then it also appears in the printout).											

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: Good performance across all the sub-indicators of indicator 36 was demonstrated. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 36. In general, assessments were completed and reviewed by the prescriber in a timely manner. In the review group, there was one assessment that was delayed. Individual #227 had an AIMS assessment 7/31/18 with the subsequent assessment dated 11/19/18. There should have been an assessment performed in October 2018.											

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

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: All four indicators remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681
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	1/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication	100%							1/1		

	administration (PEMA), the administration of the medication followed policy.	1/1									

Comments:
42. Two individuals, Individual #219 and Individual #303, did not have current behavioral support plans.

43. There was one instance of PEMA documented regarding Individual #10. This was appropriately documented. In this case, Individual #10 had experienced difficulty sleeping for several days and the psychiatrist added a medication on an emergency basis to assist with sleep in an effort to avoid an exacerbation of symptoms associated with sleeplessness.

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: Given sustained high performance over this and the previous two reviews, indicator 46 will be moved to the category of requiring less oversight. Polypharmacy committee activities occurred regularly. More participatory discussion of medication regimens is suggested.

Individuals:

#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
45	There is a tapering plan, or rationale for why not.										
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 7/7	1/1	1/1	1/1	1/1	1/1		1/1		1/1

Comments: These indicators applied to seven individuals. Polypharmacy justification was appropriately documented in all examples.

Note: Individual #154's medication regimen included Depakote (noted for dual purpose), as well as three other medications described as prescribed for seizure use (Vimpat, Keppra, Trileptal). He did not meet current criteria for requiring polypharmacy review.

46. Polypharmacy committee met regularly. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for all of the seven individuals meeting polypharmacy criteria.

The polypharmacy committee meeting was observed during the onsite visit. This was a formal, well-organized meeting attended by multiple disciplines including primary care, pharmacy, and nursing. The psychiatric providers did a good job of presenting the polypharmacy regimens and plans for future care. There was, however, a paucity of discussion and or challenge regarding the regimens.

In order to ensure that all regimens meeting criteria for polypharmacy were reviewed in a timely manner, the psychiatry clinic staff had made changes to the scheduling of polypharmacy review. Specifically, individuals were now being scheduled for review annually, or quarterly, if medication adjustments were made or if there was an active medication taper in progress.

Psychology/behavioral health

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

Summary: Without data shown to be reliable, progress could not be validly determined. Therefore, indicator 6 was scored 0 for all of the individuals. Even so, based on the data that the Center did have, four individuals were reported to have met their goals, and six individuals had goals that were not making progress. Goals were not updated or created when reported to be met, and actions were not taken when goals were reported to not be making progress. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 456	227	592	303	219	154	10	194	681
6	The individual is making expected progress	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/4	0/1		0/1	0/1		0/1			
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
9	Activity and/or revisions to treatment were implemented.	N/A									

Comments:

6. The most recent graphs depicting targeted problem and replacement behaviors for Individual #10 and Individual #194 suggested progress. For the remaining six individuals, progress was suggested for some, but not all, of the behaviors addressed in their PBSPs. This indicator was rated as zero for all individuals due to problems with data reliability (see indicator 5).

7. For four individuals (, Individual #592, Individual #303, Individual #154), goals for one to three of their targeted and/or replacement behaviors had been met according to the Center's own data. There was no evidence that new or updated goals had been developed.

8-9. There was no evidence that corrective actions had been taken to address the lack of progress for the identified six individuals. Because actions weren't developed, indicator 9 was scored N/A.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
Summary: Denton SSLC did not show that the majority of staff were trained on individuals' PBSPs. There were also some questions about the way in which the PBSP trainers were themselves trained. Summaries existed for one-quarter of the individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
17	There was a PBSP summary for float staff.	25% 2/8	0/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1	
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	75% 6/8	1/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1	

Comments:

16. Evidence provided by the Center indicated that, in no case, were the majority of assigned staff trained on the PBSP for the eight individuals. A comparison of staff rosters with training rosters indicated that 0% (Individual #592) to 73% (Individual #219) of assigned staff had been trained on the individual's current PBSP. The mean percentage of staff trained was 24%.

The Center reported that they were employing a total of eight behavior coaches who were assigned to cover two units throughout the day and evening. These staff received on the job training with Campus Coordinators and reported to the Lead Campus Coordinator. These staff did not report to the BHS department and apparently did not receive competency-based training on all PBSPs.

17. A PBSP summary was provided for seven of the individuals. The exception was Individual #592. Two of these summaries (Individual #219, Individual #194) were considered adequate. All others did not identify targeted problem behaviors and, in some cases, did not indicate the date to ensure that it corresponded to the current PBSP.

18. Six of the functional behavior assessments and PBSPs were either written by a BCBA or signed off on by a BCBA. The exceptions were the assessments and plans for Individual #303 and Individual #219.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.	
Summary: Progress notes each month contained comments on the individual's progress for all individuals for this review (with one exception for one individual, for one month) and for the previous two reviews, too. Therefore, indicator 19 will be moved to the category of requiring less oversight. Graphs, however, were not useful, data were not up to date for clinical review meetings, and peer review was not functioning correctly or as often as needed. In particular, external peer review	Individuals:

was not occurring as a collaborative participatory activity as it should. Indicators 20-23 will remain in active monitoring.											
#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681
19	The individual's progress note comments on the progress of the individual.	88% 7/8	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	
20	The graphs are useful for making data based treatment decisions.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	25% 1/4	0/1					0/1	0/1	1/1	0/1
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.	33% 1/3		0/1			0/1	1/1			
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0%									

Comments:

19. The monthly progress notes for seven of the individuals commented on the individual's progress. The exception was Individual #219 whose progress note from October 2018 through November 2018 did not include comments.

20. The graphs for all eight individuals were difficult to interpret due to the small size, and in some cases (e.g., Individual #456, Individual #219), too many data paths. In no case were changes in intervention or significant events consistently noted with phase change lines in the PBSP graphs. A check of the documented implementation date, noted in information regarding consent, did not correspond to the phase change lines indicated on the graphs for Individual #456, Individual #219, Individual #10, and Individual #194. Phase change lines were not included for PBSP implementation for Individual #227, Individual #592, Individual #303, and Individual #154. Other examples of significant events not identified with phase change lines included the following: the addition of a sensory diet with Individual #303; a reinforcement plan that had been used with Individual #592 to reduce unauthorized departures; medication changes for Individual #456, Individual #227, and Individual #592; and significant health issues for Individual #303 and Individual #194. The horizontal axis was not consistently/correctly labeled for Individual #592 and Individual #154.

21. An observation was conducted in the psychiatric clinics for three of the individuals in the review group. In the clinics for Individual #154 and Individual #681, presented data were not current. Individual #154's graphs were completed through 12/23/18, while Individual #681's graphs were completed through 1/1/19 or 1/2/19 (the behavior health specialist was not sure of the date). In Individual #194's clinic, the BCBA reported data through the previous day.

One concern raised during Individual #154's meeting was the measurement of psychiatric symptoms, particularly physical aggression

disproportionate to the antecedent. When the BCBA was asked to explain the criteria for determining a disproportionate response, he stated that he was able to identify what caused Individual #154 to be aggressive. But because he is not always present to observe antecedents, he was asked for further clarification. He then stated with confidence that he knew events that lead to this behavior. This was a subjective determination, without sufficient evidence and, therefore, staff are advised to re-examine psychiatric indicators.

22. There was evidence that over a six-month period, the Internal Peer Review Committee had reviewed the plans for Individual #227 and Individual #219. In the documents provided, there were no firm recommendations with expected follow-up by designated staff. In Individual #227's case, one BCBA presented a strategy he had employed with the individuals with whom he worked. The assigned BCBA noted that group contingencies might be considered, however the building coordinator was opposed to this. This same person noted that non-contingent behaviors could be beneficial, but the meaning of this statement was unclear. Lastly, it was suggested that the BCBA try to identify reinforcers that were of greater potency than those provided by the individual's family member. In Individual #219's case, variables were identified that might contribute to problem behaviors. These included too many restrictions placed on Individual #219, a busy home especially at night, a building coordinator who was at her wit's end, and staff who may not be a good fit with the individuals living in this home. The point here is that, while all of these were valid considerations, there were no plans identified to address them.

Evidence provided indicated that over this same six-month period, three of the individuals (Individual #227, Individual #219, Individual #154) had been reviewed by the External Peer Review Committee. The review consisted of one consulting BCBA providing a review of the individual's Behavioral Health Assessment and Positive Behavior Support Plan. Task Elements were identified and scored as either passing or not. Comments were often included when an identified element did not receive a passing score. The final determination indicated that the assessments and plans for Individual #227 and Individual #154 were approved pending corrections, while the assessment and plan for Individual #219 were disapproved.

23. The facility reported that the External Peer Review Committee met three to four times each month over a six-month period. However, documentation indicated that peer review consisted of feedback on BHAs, FBAs, and PBSPs by one BCBA, working alone, that is, not in any type of collaborative meeting with other clinicians. This does not meet the requirements or expectations of an External Peer Review Committee. The director of behavioral health services is advised to consider recruiting the state discipline coordinator of behavioral services and BCBAs at other facilities to serve as external peer reviewers. A committee of peers could then review cases that are particularly complex or those in which the individual is not making expected progress.

During this same time period, the Internal Peer Review Committee met one to four times each month. This did not meet the guidelines of the Settlement Agreement. Staff are advised to document all staff who participate in this peer review process.

Outcome 8 – Data are collected correctly and reliably.	
Summary: There was some slight improvement, in that data collection systems for some individuals for some target behaviors and some replacement behaviors met criteria. That being said, attention needs to be paid to those systems. Furthermore, ensuring that data are reliable and recorded timely, and that treatment integrity is assessed are important aspects of behavioral health service provision that need	Individuals:

improvement. This set of indicators will remain in active monitoring.											
#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	50% 4/8	0/1	1/1	0/1	0/1	1/1	0/1	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.	25% 2/8	0/1	0/1	0/1	0/1	1/1	0/1	1/1	0/1	
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	0% 0/8	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% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	

Comments:

26. A review of paper data sheets for the eight individuals who had PBSPs indicated that frequency measures were used to document all behaviors targeted for reduction. While this would be an appropriate data collection system, concerns were raised when the PBSP directions for recording behavioral occurrences were reviewed. These are outlined below.

- Individual #456's plan indicated that her disruptive behavior was defined as episodes separated by five minutes.
- Similarly, four of Individual #592's behaviors targeted for reduction (aggression, property destruction, self-injury, and laying in the road) were defined as episodes separated by 30 seconds.
- Individual #154 also had targeted problem behaviors that were defined as episodes separated by five minutes. This included verbally disruptive behavior, property destruction, aggression, and self-injury.
- Duration measures were defined for Individual #303's self-injurious behavior.

When episodes are reported as frequency, there is the risk that behavioral occurrences are under-reported. Similarly, under-reporting can occur when duration measures are reported as number of occurrences. Staff are advised to review all PBSPs to ensure that operational definitions, guidelines for documentation, data sheets, and graphs are consistent and make sense (i.e., are valid).

27. A review of paper data sheets for seven of the eight individuals who had PBSPs indicated that frequency measures were used to document replacement behaviors. The exception was Individual #194 whose replacement behavior was documented as occurring or not occurring within one-hour blocks of time. As noted above, inconsistencies were noted when reviewing the individuals' PBSPs, data sheets, and graphs. Specific examples are provided below.

- Replacement behaviors for Individual #456, Individual #303, and Individual #154 were graphed as count of intervals, yet their data sheets indicated the frequency of these behaviors should be recorded.
- Individual #227's PBSP indicated that her replacement behaviors should be recorded as percentage of opportunities, but her data sheet and graphs indicated that frequency would be documented.
- Individual #592's PBSP indicated a partial interval recording would be used to document his replacement behavior, yet the

data sheet and graph showed that these were frequency measures.
- Individual #194's PBSP indicated that percentage of opportunities would be documented, yet her data sheet and graph indicated a partial interval recording.

As noted above, consistency across PBSPs, data sheets, and graphs should be ensured.

28-29. While the Center had introduced paper data sheets in May 2018, there remained problems with the assessment of data timeliness. The sample data sheet provided to the Monitoring Team indicated that timeliness would be assessed by determining the percentage of data sheets completed each month. The staff are advised to develop a system to ensure that data are entered at a minimum of once every two hours.

Inter-observer agreement and treatment integrity were reportedly assessed via observation. However, in some cases, treatment integrity was reported based on staff interview. Every effort should be made to assess treatment integrity via observation. These assessments were to occur monthly with an acceptable level established at 80%.

30. Data timeliness was not reported for any of the eight individuals with PBSPs. For five of the eight individuals (, Individual #227, Individual #592, Individual #154, Individual #194), there was evidence that IOA was assessed each month over a six-month period.

Lastly, evidence provided indicated that treatment integrity was assessed each month over a six-month period for four individuals (, Individual #227, Individual #592, Individual #154). Because some reports indicated that treatment integrity was assessed via interview, staff are advised to make every effort to assess the fidelity of plan implementation via observation.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	6% 1/18	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #194 – weight, and fractures; Individual #303 – other: pica, and osteoporosis; Individual #538 – cardiac disease, and other: sleep apnea; Individual #149 – aspiration, and GI problems; Individual #315 – respiratory compromise, and circulatory; Individual #459 – constipation/bowel obstruction, and weight; Individual #201 – aspiration, and GI problems; Individual #276 – fluid imbalance, and GI problems; and Individual #781 – seizures, and weight).

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #194 – weight.

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

Outcome 4 – Individuals receive preventative care.

Summary: Seven of the nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, these indicators will continue in active oversight until the Center's quality assurance/improvement mechanisms related to preventative care can be assessed, and are deemed to meet the requirements of the Settlement Agreement. In addition, the Center needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

Individuals:

#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	Individual receives timely preventative care:										
	i. Immunizations	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 6/6	1/1	N/A	N/A	1/1	1/1	N/A	1/1	1/1	1/1
	iii. Breast cancer screening	100%	1/1	N/A	N/A	1/1	1/1	N/A	N/A	N/A	1/1

		4/4									
	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	80% 4/5	1/1	N/A	N/A	0/1	1/1	1/1	N/A	N/A	1/1
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	22% 2/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1

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

- Based on the initial documentation submitted, Individual #194's varicella status was unclear. The Monitoring Team could not determine if she was assumed to be immune due to her age, or if a titer had been completed. While on site, the Monitoring Team member requested further documentation. The Center submitted an order, dated 1/7/19, for a varicella zoster antibody. This order was placed during the onsite review week.
- In October 2012, Individual #149's last pap smear was completed with a notation of a history of a hysterectomy (no further information was noted in the consult documentation submitted or in the AMA as to the reason for procedure). The gynecological consultation included a recommendation for a repeat in five years. Evidence was not submitted to show the follow-up occurred.

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

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score									
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State	N/A									

	Office Guidelines.										
	Comments: a. None										

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Some of the areas on which PCPs and providers need to focus with regard to acute care include assessing individuals with emergent health issues when they occur on campus (i.e., during regular business hours) and doing so in a timely manner, communicating necessary clinical information with hospital staff, and conducting follow-up for at least 48 hours after individuals return from the hospital. All of the remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
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.	67% 6/9	N/A	N/A	2/2	N/A	1/2	1/1	N/A	1/2	1/2
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	100% 3/3			N/A		2/2	N/A		1/1	N/A
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	67% 8/12	0/1	2/2	1/1	1/2	2/2	N/A	0/2	2/2	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	57% 4/7	0/1	1/1	N/A	1/2	N/A		0/1	2/2	
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	58% 7/12	1/1	1/2	1/1	1/2	2/2		0/2	1/2	
g.	Individual has a post-hospital ISPA that addresses follow-up medical	50%	N/A	N/A	N/A	0/1	1/1		1/1	0/1	

	and healthcare supports to reduce risks and early recognition, as appropriate.	2/4									
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.	25% 1/4	N/A	N/A	N/A	0/1	1/1		0/1	0/1	

Comments: a. For five of the nine individuals reviewed, the Monitoring Team reviewed nine acute illnesses addressed at the Center, including: Individual #538 (toothache on 7/14/18, and toothache on 7/29/18), Individual #315 (bleeding toe on 9/11/18, and rash on shoulder and ear on 10/17/18), Individual #459 (injury to head on 11/28/18), Individual #276 (rash on back on 7/5/18, and emesis on 9/4/18), and Individual #781 (right neck pain on 8/21/18, and left ankle pain on 8/2/18).

PCPs assessed the following acute issues according to accepted clinical practice: Individual #538 (toothache on 7/14/18, and toothache on 7/29/18), Individual #315 (bleeding toe on 9/11/18), Individual #459 (injury to head on 11/28/18), Individual #276 (emesis on 9/4/18), and Individual #781 (right neck pain on 8/21/18).

b. For the acute issues addressed at the Center that the Monitoring Team reviewed, the PCPs 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.

The following provide examples of concerns noted:

- For Individual #276, a nursing IPN, dated 6/30/18, indicated staff noticed a rash on Individual #276's lower back. The nurse applied hydrocortisone cream. On 7/1/18, at 4:25 p.m., a nurse wrote an IPN indicating that the rash was getting better. A nursing IPN, dated 7/2/18, at 12:29 p.m., noted application of a treatment for a rash. In an IPN, dated 7/3/18, at 9:08 a.m., a nurse documented that the Nurse Practitioner saw the individual, the NP did not write a note. The nurse indicated that the Family Nurse Practitioner (FNP) stated: "these are petechiae," and indicated that on 7/5/18, the individual would go to the clinic. On 7/5/18, at 11:27 a.m., the PCP saw the individual, and diagnosed non-specific dermatitis, and made no change in treatment.
- For Individual #781's left ankle pain, the PCP did not complete a timely assessment. On Thursday, 8/2/18, at 11:22 a.m., a nurse documented the individual was on her way to the x-ray department, but the PCP did not evaluate her until Monday, 8/6/18.

c. For seven of the nine individuals reviewed, the Monitoring Team reviewed 12 acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #194 (ED visit for ankle fracture on 9/13/18), Individual #303 (ED visit for laceration on 11/16/18, and ED visit for laceration on 6/19/18), Individual #538 (ED visit for chest pain on 7/7/18), Individual #149 (hospitalization for elevated white blood cell count, altered mental status, and UTI on 10/8/18; and ED visit for pneumonia on 11/15/18), Individual #315 (hospitalization for respiratory distress and hypoxia on 6/18/18, and hospitalization for respiratory distress on 12/1/18), Individual #201 [hospitalization for aspiration pneumonia on 9/23/18, and ED visit for gastrostomy/ jejunostomy tube (GJ-tube) replacement on 11/1/18], and Individual #276 (hospitalization for repeated emesis on 9/26/18, and ED visit for abnormal labs on 10/3/18).

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

- It was positive to see that the following individuals displaying signs/symptoms of acute illness received timely acute medical care, and follow-up care: Individual #303 (ED visit for laceration on 11/16/18), Individual #538 (ED visit for chest pain on 7/7/18), Individual #315 (hospitalization for respiratory distress and hypoxia on 6/18/18, and hospitalization for respiratory distress on 12/1/18), and Individual #276 (ED visit for abnormal labs on 10/3/18).
- According to a nursing IPN, dated 9/13/18, at 12:00 p.m., Individual #194 was moving towards a trash bin, when she fell backwards onto her buttocks. She had left lower leg and ankle swelling. Although this was during business hours, the PCP did not see her, but rather at 1:30 p.m. reviewed x-ray findings, and ordered that she be sent to the ED. A PCP would be expected to see individuals with acute care issues during business hours while on site.
- On 10/8/18, Individual #149 went to the ED due to lethargy and leukocytosis. Her white blood cell count was elevated at 30.9. It was good to see that prior to her transfer, the PCP ordered stat testing, including a complete blood count (CBC), a comprehensive metabolic panel (CMP), and a chest x-ray, as well as oxygen by nasal cannula. The PCP contacted the ED. However, Center staff did not submit an ISPA to show that the IDT, including the PCP, met to discuss this hospitalization, as well as modifications to her IHCP, if any were needed. In addition, although a PCP note was found for an assessment after her return on 10/12/18, the PCP did not document follow-up assessments for a minimum of 48 hours.
- On 11/15/18, at 9:50 a.m., a nursing IPN indicated that Individual #149 was not acting herself, had refused breakfast, held medications in her mouth, and was coughing. Although this occurred during business hours, the PCP did not see her. At 11:35 a.m., she was transferred to the ED. No documentation was found to show that the PCP or nurse contacted the ED. Upon her return, she was admitted to the Infirmary with a respiratory infection, and the PCP ordered an antibiotic.
- On 9/23/18, staff transferred Individual #201 to the hospital, where he was diagnosed with aspiration pneumonia, as well as a UTI. Based on the documents submitted, the PCP did not write an IPN related to this transfer. An IPN(s) related to treatments or interventions prior to his transfer were not found. In addition, no IPN was found to show that a nurse or provider contacted the hospital to provide necessary clinical information.

  On 10/9/18, he returned to the SSLC. On 10/9/18, the PCP saw the individual, and noted he now had a low profile GJ-tube, the UTI resolved, and he had completed a course of intravenous (IV) vancomycin. The plan was to check the individual's Dilantin level, repeat the CBC, and continue the proton pump inhibitor (PPI). On 10/10/18, the IDT held an ISPA meeting to discuss the individual's diagnoses and treatments, which included the plans written in the PCP post-hospital IPN, as well as completion of a PNMT evaluation. It was not until 10/11/18, that the PCP/a provider saw the individual again in the Infirmary.
- On Thursday, 11/1/18, staff transferred Individual #201 to the ED due to a dislodged GJ-tube. Based on the documents submitted, the PCP did not write an IPN. Moreover, the transfer occurred during regular business hours, but the PCP did not see/assess the individual. No IPN was found to show that a nurse or provider contacted the hospital to provide necessary clinical information. Although this was not a hospitalization, which would have required a post-hospital ISPA, it was good to see that the IDT met, and discussed actions to prevent future dislodgements of the GJ-tube, including, for example, the use of an abdominal binder, use of two staff to check and change him, and use of two staff during transfers.
- On 9/26/18, the PCP saw Individual #276 in her room. Nursing reported that her oxygen saturation was 88%. Staff placed her on oxygen supplementation, and the PCP ordered staff to call an ambulance for transfer to the hospital. On 9/26/18, the PCP documented a complete assessment in an IPN. However, based on documentation submitted, a nurse or provider did not

contact the hospital to provide necessary clinical information. On 9/28/18, the individual returned from the hospital. On 10/1/18, the IDT held an ISPA meeting, but indicated they would need to reconvene, because the PNMT did not have an opportunity to review the individual's data and history. The PCP did not attend this 10/1/18 ISPA meeting. It was not until 10/3/18, that the PCP/provider saw the individual, and reviewed the hospital course, and tests. The PCP documented that the individual had a gastric outlet obstruction due to a migrating G-tube, which was replaced with a low-profile G-tube. The PCP indicated the individual would complete a 21-day course of antibiotics for pneumonia.

Later that day, the individual was transferred back to the ED for an abnormal lab, and returned the same day. Again, on 10/4/18, she was sent as a direct hospital admission for abnormal lab results, with discharge the following day. On 10/10/18, the IDT held an ISPA meeting, but the PCP did not attend.

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

Summary: During this review, for the consultations reviewed, the PCPs reviewed consultations and indicated agreement or disagreement, and generally did so in a timely manner. It was good to see continued improvement with regard to PCPs writing orders for agreed-upon recommendations. If the Center sustains this progress, after the next review, Indicator d might move to the category requiring less oversight. At this time, all of these indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 194	303	538	149	315	459	201	276	781
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.	83% 15/18	1/2	2/2	2/2	1/2	2/2	1/2	2/2	2/2	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	100% 15/15	2/2	2/2	1/1	1/1	1/1	2/2	2/2	2/2	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	N/A									

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 18 consultations. The consultations reviewed included those for: Individual #194 for neurology on 6/20/18, and orthopedics on 10/4/18; Individual #303 for neurology on 6/20/18, and neurology on 9/26/18; Individual #538 for eye clinic on 8/9/18, and podiatry on 11/16/18; Individual #149 for surgery on 6/7/18, and podiatry on 9/17/18; Individual #315 for pulmonary on 9/10/18, and neurology on 9/5/18; Individual #459 for podiatry

on 6/29/18, and podiatry on 11/7/18; Individual #201 for neurology on 8/1/18, and cardiology on 9/14/18; Individual #276 for nephrology on 7/24/18, and hematology on 10/30/18; and Individual #781 for neurology on 9/19/18, and gynecology on 10/29/18.

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

b. Three of these reviews did not occur timely, including those for: Individual #194 for neurology on 6/20/18, Individual #149 for surgery on 6/7/18, and Individual #459 for podiatry on 6/29/18.

c. It was positive that all of the PCP IPNs related to the consultations reviewed included all of the components State Office policy requires.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments.

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

Summary: Additional work was necessary to ensure that for individuals' chronic or at-risk conditions, PCPs completed medical assessment, tests, and evaluations consistent with current standards of care, and that PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.

#	Indicator	Overall Score	Individuals: 194	303	538	149	315	459	201	276	781
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.	44% 8/18	1/2	1/2	0/2	0/2	2/2	2/2	0/2	2/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #194 – weight, and fractures; Individual #303 – other: pica, and osteoporosis; Individual #538 – cardiac disease, and other: sleep apnea; Individual #149 – aspiration, and GI problems; Individual #315 – respiratory compromise, and circulatory; Individual #459 – constipation/bowel obstruction, and weight; Individual #201 – aspiration, and GI problems; Individual #276 – fluid imbalance, and GI problems; and Individual #781 – seizures, and weight).

a. For the following individuals' chronic or at-risk conditions, PCPs conducted medical assessment, tests, and evaluations consistent with current standards of care, and PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #194 – fractures; Individual #303 – osteoporosis; Individual #315 – respiratory compromise, and circulatory; Individual #459 – constipation/bowel obstruction, and weight; and Individual #276 – fluid imbalance, and GI problems. The following provide examples of concerns noted:

- Individual #194 had a diagnosis of obesity. She also had cerebral palsy with hemiparesis, limiting her mobility, as well as

hyperlipidemia. She was prescribed a 1200-calorie, low cholesterol diet. Every six months, the PCP obtained and reviewed lipid panels. On 9/2/18, her high-density lipoprotein (HDL) was 51, and triglycerides were 138. Her low-density lipoprotein (LDL) was slightly elevated above the optimal range. On 12/1/17, a hemoglobin (Hgb) A1C was 5.4, and on 6/8/18, it was 5.7. Her weight varied over time, and might have been inaccurate. From 6/4/18 through 8/1/18, she lost between 0.8 pounds and 3.4 pounds per month, and then in September 2018, she suddenly gained 6.8 pounds, followed in October 2018, by a five-pound weight loss. However, a nutrition services assessment, dated 10/4/18, indicated that she has not lost weight over the prior 12 months. The assessment noted that she drank two regular sodas daily, and encouraged replacement of one of these with alternative low-sugar drinks.

More recently, her weight loss efforts were complicated by her temporary sedentary state caused by a fractured ankle. On 11/2/18, her most recent weight showed she was 60.6 pounds over her estimated desired weight range (EDWR). There was no ISPA to address her obesity and/or to develop/revise a plan to encourage her to replace her regular drinks with low calorie alternatives. For example, her IHCP did not include a measurable action step, but rather indicated staff should "encourage" her to only drink one regular soda daily. "Encourage" was not defined, nor had the IDT determined who would implement such an action step, and/or where they would record implementation or the status. As her ankle fracture had healed, this was no longer a limiting factor for her physical activity, but based on the documentation submitted, her IDT did not implement a plan to increase her activity. The IDT also should have delineated steps to obtain accurate weights, given the considerable variation weights in the recorded weights, making it more difficult to track progress in weight loss.

- Individual #303 had pica listed on his active problem list. When interviewed, the PCP, did not know of any recent pica event(s) and believed it occurred prior to the individual's admission to Denton SSLC. When the member of the Monitoring Team pointed out that the nursing IPNs regularly screened and recorded an assessment to rule out pica or pica complications, the PCP was unaware of these assessments. If the individual did not demonstrate pica or pica attempts for several years, it was unclear why nursing staff were completing ongoing assessments. However, a behavioral health review included information showing that his pica was related to paper ingestion, with four occurrences of pica as well as four to six attempts of pica in the year prior to the report. Based on this information, the lack of the PCP's knowledge about the status of the pica was concerning. It was unclear where the communication breakdowns occurred. Ongoing PCP evaluation was incomplete, and it was unclear whether or not the IDT had implemented necessary safeguards, such as minimizing the accessibility to paper products within reach of the individual.

- Beginning in November 2015, Individual #588 had a history of obstructive sleep apnea. At that time, an overnight oxygen (O2) study indicated a low oxygen saturation of 82%. On 1/20/16, another sleep study indicated desaturation to 77.2%, at which time he was tried on continuous positive airway pressure (CPAP). It was reported he could not tolerate it. A 2/24/16 sleep study again confirmed moderate obstructive sleep apnea that responded to CPAP. He was to avoid sleeping supine. More recently, a nursing note documented that he was sleeping without CPAP in use. He stated that "it stops me from breathing." The AMA indicated the prior PCP asked the Registered Nurse Case Manager (RNCM) to speak with Behavioral Health Services staff to consider a desensitization program to improve his compliance with wearing the CPAP apparatus. The IHCP indicated this was done, but there was no further information to suggest it had occurred or was in progress. If it occurred, it was not successful in improving compliance with CPAP use. A nursing note, dated 10/25/18, indicated that the individual refused to

wear the CPAP at night for months and the order was discontinued. IPNs also indicated periodic headaches, which might be sequelae of sleep apnea. There was no information as to whether or not he returned to the sleep study center to determine whether there were issues related to the proper fit of the equipment or to determine what, if any, alternative steps could be taken, such as use of more recently available equipment. His last reported visit to the sleep study center/specialist was approximately three years ago. At the time of the Monitoring Team's review, he had moderate obstructive sleep apnea without treatment. His weight gain, which is discussed below, will additionally contribute to his sleep apnea.

- Individual #538 had metabolic syndrome (i.e., obesity, increased abdominal girth, low HDL, and high triglycerides). In 2013 and 2014, he lost weight, which resulted in resolution of his hypertension at that time. His PCP discontinued his hypertensive medications. Currently, his blood pressure remained within normal limits, although he was at risk for recurrence of hypertension due to his ongoing weight gain. His most recent Hgb A1C was 5.6. He was prescribed Lipitor for his dyslipidemia, as well as a low-cholesterol, low-calorie diet for weight control. He was diagnosed with hypothyroidism, and was prescribed replacement therapy. Follow-up thyroid testing values had been normal. The QIDP and RNCM reviewed his weight monthly. The AMA stated to "encourage healthy food choices and increase physical activity as tolerated," which was not measurable. There was no information about how staff or the individual should implement these steps. His weight remained in a narrow range (from 218 to 224.5 pounds) over several months, indicating no significant change in his body mass index (BMI). He continued to purchase additional snacks and meals, as reportedly he did not like the food provided at Denton SSLC.

  Along with his risk factors, he had chest pain, which resulted in ED visits on 12/9/15, 1/3/17 12/26/17, 1/22/18, and 7/11/18. Cardiac causes were ruled out. He was diagnosed with heartburn, made worse by behaviors, such as ingestion of highly caffeinated drinks, eating spicy food, and swallowing dip followed by smoking. He continued to smoke, but decreased how much he smoked (i.e., from one pack to five cigarettes per day). The IHCP indicated that staff discouraged him from smoking cigarette butts from the ground and this action step was marked "done," but the QIDP monthly reviews did not provide specific data or narrative to indicate how this occurred (i.e., frequency, which staff, etc.). The IHCP did not indicate any action plan for ongoing reinforcement to minimize his smoking habit. He has been placed on a proton pump inhibitor (PPI), with additional antacid as needed with good results. His electrocardiogram (EKG) remained unchanged. The submitted documents did not indicate a formal plan/action steps to guide him to healthy food choices, or for how the Central Kitchen choices could be enhanced to accommodate his preferences without changing diet restrictions. The IDT put no formal exercise program in place. Based on the documents submitted, Behavioral Health Services staff had not conducted an evaluation, nor had the IDT held an ISPA meeting to discuss motivation to adhere to a diet plan, benefits of weight loss, etc. The PCP had ensured appropriate testing and treatment of his metabolic syndrome and chest pain, but had not utilized an interdisciplinary approach to develop and implement a plan to assist the individual in achieving needed healthy goals.

- Individual #149 had a history of gastroesophageal reflux disease (GERD). On 6/15/11, she had an upper gastrointestinal (UGI) bleed. An esophagogastroduodenoscopy (EGD) showed severe reflux esophagitis and a hiatal hernia. She was treated with a PPI. On 4/7/14, she completed a barium swallow, which indicated decreased motility in the esophagus, as well as a large hiatal hernia with excessive GERD. On 11/5/15, a gastric emptying study was considered normal. On 5/5/17, an EGD showed only the hiatal hernia. A surgeon was consulted for consideration of surgical intervention (i.e., hiatal hernia repair, fundoplication), but the response was she was not a candidate. The reason for this conclusion was not listed. It might be

clinically accurate that she was not a surgical candidate, but the PCP did not know the reason. It might be helpful to the individual to pursue the reason(s) to determine whether or not the hernia could be repaired. If there are significant physiological risks associated with potential surgery, or significant anesthesia risk, then this should be documented in the IPNs and the AMA. Given that she had ongoing repeated aspiration pneumonias, pursuing high-risk surgery in a tertiary care/university setting where intensive monitoring and support can be arranged, and with a subspecialist surgeon with considerable experience in these procedures in high-risk patients might be an option that the IDT needs to consider and/or rule out. If the surgeon was concerned about post-operative care and complications, then the IDT should communicate with the surgeon to determine the post-operative requirements (e.g., one-to-one staffing, restraint use, pain management, etc.). The lack of follow-up regarding the reason for Individual #149 not being a surgical candidate was not helpful to the individual, or the guardian in making needed decisions.

- Individual #149 had a history of recurrent pneumonia (i.e., 7/14/16, 4/26/17, 7/21/17, 2/18/18, 3/10/18, 4/5/18, and 9/12/18). During her 2/18/18 to 3/1/18 hospital admission, she underwent a swallow study, in which she failed all consistencies. Again, during the 9/12/18 to 9/14/18 hospital admission, she completed a swallow study, and she failed all consistencies. The recommendation was for nothing-by-mouth (NPO) status. Based on documentation submitted, at the time of the February 2018 test, the IDT and guardian declined percutaneous endoscopic gastrostomy tube (PEG-tube) placement, but their reasons were not clearly stated. After the second test, an ISPA, dated 9/18/18, recorded that the State guardian along with the PCP favored PEG-tube placement, but that there was a lack of consensus from the IDT team. As the Monitoring Team discussed with the Center Director, this lack of consensus should have resulted in the IDT requesting an Administrative Review Team review, but none of the IDT members made the appropriate referral.

  On 9/27/18, Habilitation Therapy staff at Denton SSLC, completed a modified barium swallow study (MBSS), which indicated Individual #149 could tolerate a ground diet with thin liquids. The staff indicated the difference in results could be as a result of the test occurring in a familiar setting with familiar staff. She also had improved physically, which likely had an impact.

  Based on the Monitoring Team's discussion with the PCP, staff believed she would not tolerate a PEG-tube, and would pull it out. However, a PEG-tube had never been tried with her. The stated concern is a common concern when considering PEG-tube placement, but often individuals tolerate them well. Reportedly, the IDT also was concerned that her quality of life would greatly decrease, as eating was one of the only enjoyments currently available to her. However, enteral tube feeding does provide satiation. On the other hand, her quality of life was greatly compromised as a result of the repeated severe pneumonias requiring hospitalization. Although she "passed" the MBSS at Denton SSLC, it seemed that when she has a physiological stress, such as a urinary tract infection (UTI), she became systemically weak, and severe dysphagia developed. To allow by mouth (PO) intake when she was in such a weakened state, placed her at great risk of a poor outcome. It was not clear that the IDT understood that repeated pneumonias, with chronic scarring worsened her respiratory condition.

  Given the individual's ongoing and significant risk, the Lead Monitor and physician member of the Monitoring Team discussed this issue with the Center Director during the onsite review. The Center Director indicated that an Administrative Review Team review was indicated to thoroughly review the risks and benefits of the procedure the hospital recommended. The Monitoring Team appreciated the Center Director's attention to this issue, as well as the commitment to re-train PCPs on the

option of requesting an Administrative Review Team review when they had concerns, such as this, about the health and safety of an individual.

- Individual #201 had a long history of GERD. He was prescribed a PPI, and while in bed, his head-of-bed-elevation (HOBE) was 20 degrees. In 1999, a G-tube was inserted due to his refusal to eat and drink. In September 2012, when he resumed eating, it was removed, but in December 2012, it was placed again. Thereafter, he refused attempted pleasure feeding. On 10/24/14, he underwent placement of a GJ-tube. More recently, on 6/8/18, an EGD indicated extensive esophagitis of his entire esophagus (LA class D). He remained NPO for all nutrition and hydration. He continued with intermittent emesis.

  As of June 2018, his PCP ordered enteral feedings for 15 hours per day via the J-tube. At the time of his hospital discharge, on 7/16/18, the hospital nutritionist recommended continuous formula feeding at 55 milliliters (ml) per hour and free water at 30 ml per hr. A nursing post-hospital IPN, dated 7/17/18, indicated his rate rapidly increased to 80 ml formula per hour and 80 ml of free water per hour. This was based on the dietician's recommendations and PCP orders. During a hospitalization on 8/20/18, his GJ tube was replaced by a low-profile GJ tube, as the prior GJ tube migrated and caused a gastric outlet obstruction. In September 2018, he was subsequently hospitalized for a UTI. During that admission, the hospital nutritionist recommended a continuous rate (24 hours) at a low formula rate of 40 ml per hour, with a goal rate of 50 ml per hour to meet 100% of his nutritional needs. The hospital physician recommended water flushes at 15 ml per hour. He was subsequently transferred to a long-term acute care (LTAC) facility for post-hospital care, and during this stay, his formula rate was increased successfully to 50 ml per hour for 22 hours per day. When he returned to Denton SSLC, his PCP increased his rate without gradual titration (i.e., the PCP ordered feeding for 15 hours per day, with a formula rate of 80 ml per hour and free water at an additional 80 ml per hour). A PNMT assessment, dated 11/16/18, suggested a reduction in the formula rate to 75 ml per hour and free water rate of 70 ml per hour, at which time, the PNMT discharged him from its caseload.

  Given that he had periodic emesis over many months (i.e., 10 episodes from 11/4/17 to 10/30/18), associated at times with aspiration pneumonia, it appeared that the use of intermittent feeding needed further review. Formula feeding rates at the hospital and LTAC were maximal at 50 ml per hour with 15 ml per hour of water. The abrupt increase in formula and water rate to 160 ml per hour might have increased the jejunal cramping and reflux, with subsequent emesis. Further consultation is needed with the gastroenterologist to guide/clarify formula and free water rates via the J-tube, along with a review of the need for continuous (22 plus hours per day) versus intermittent feeding.

- In the past year, Individual #201 had several hospitalizations for aspiration pneumonia. He was hospitalized on 12/13/17, 2/2/18 (after emesis), 7/4/18 (after emesis, when his G-tube was used for feeding due to the malfunctioning J-tube), 8/4/18 (GJ migration), and 9/23/18 (after emesis). Based on documentation submitted, his IDT did not conduct a "root cause analysis" to review the potential causes of the repeated episodes of aspiration pneumonia. A number of factors appeared to impact his ongoing risk for aspiration, and the IDT needed to conduct a thorough review, using data to determine whether treatment was optimized for each, and to determine whether other factors were increasing his risk. For example:
  - As discussed in detail above, the rapid jejunal intermittent tube feeding rate was not consistent with the hospital discharge recommendations for flow rate.
  - He also had a long history of GERD. On 6/8/18, an EGD of indicated LA class D esophagitis.

- On 6/22/18, Habilitation Therapy Services staff reviewed his positioning in his wheelchair and bed.
- As also discussed above, during a hospitalization on 8/20/18, his GJ-tube was replaced by a low-profile GJ tube, as the prior GJ tube migrated and caused a gastric outlet obstruction.
- The 9/23/18 hospital admission was associated with an elevated Dilantin level.
- A PNMT assessment of 11/16/18 did analyze the periodic emesis and determined that episodes mainly occurred in the evening and usually in bed. This was at the end of his 15-hour feeding schedule. The PNMT determined that staff were not following special instructions for keeping him sitting up until the feeding was completed.
- The AMA, dated 5/30/18, and a post-hospital ISPA, dated 6/13/18, both mentioned possible evaluation for a Nissen fundoplication. Although his GERD remained severe and medical management did not resolve it, submitted documents did not reflect further progress with this consideration.
- His reactive airway disease was believed to be related to his aspirations. A pulmonary specialist followed him and treated him with Brovana, Pulmicort, and pro re nata (PRN, or "as needed") Duoneb treatments.

This individual was at increasing risk for health decline from recurrent aspiration pneumonia. As the Monitoring Team discussed with staff during the onsite review, his IDT, with the leadership of the PCP, needed to develop and implement plans to decrease his risk to the extent possible.

- Individual #781 had a history of metabolic syndrome (i.e., obesity, hyperlipidemia, and elevated blood sugar). More recently, her blood sugar improved, and the diagnosis of metabolic syndrome was removed. Her hyperlipidemia was treated with medication. Her weight was a significant challenge. She was currently prescribed a 1500-calorie, low-cholesterol diet with three snacks daily. The IDT was reluctant to reduce her caloric intake further due to a history of anorexia and bulimia. There was also the concern she would steal food if the diet was more limited. In June 2018, staff documented a SAP in which she was to make her own salad and go shopping for specific food items. She was "encouraged" to exercise more, with a goal of attending Texercise three times per month. She also had access to exercise DVDs in the home. The dietitian sent out reminders to staff and lists of food recommendations. Staff were to use these lists to assist her in making more healthy choices. Consistency in "encouraging" the correct food choices reportedly was challenging due to her having moved several times, with new staff unfamiliar with her diet restrictions. Staff also mailed her father a food list, due to his frequent visits.

  In June 2018, her weight was 201.6 pounds, and in January 2019, her weight was 231.2 pounds. Information from the QIDP indicated she had not attended Texercise, according to the documentation. An ISPA, dated 8/29/18, revised the system for her money management, and did away with vouchers, and allowed her to accumulate money for twice monthly outings. Although it appeared to have great promise, it has not impacted her ongoing weight gain. On 9/4/18, an IDT meeting indicated that weight gain was also associated with a decrease in participation in excursions with a result that she had increased spending money for excess snacks.

  The dietitian wrote several notes (i.e., on 6/6/18, 7/30/18, 11/2/18, 12/7/18, and 1/7/19). They all included similar recommendations: encourage physical activity, follow the shopping lists and food list, and continue to monitor weight. These interventions had little impact on her weight.

Individual #781 was at continued risk for complications of obesity, including the recurrence of prediabetes. She had obstructive sleep apnea. The IDT, with the participation of the PCP, needs to develop and implement formal interdisciplinary supports and strategies. Action steps written with terms such as "encourage" do not provide the needed details to allow implementation and measurement of implementation. Given her history, the IDT might need guidance from a specialist in eating disorders. Further input was needed from Habilitation Therapies staff concerning exercise programming that is sufficiently rigorous to affect weight change. Behavioral Health Services did not appear to have participated in creating a motivation plan to assist in improving her exercise participation or adherence to food lists, but this appeared necessary. Based on documentation, she regularly declined Central Kitchen selections and bought or obtained other food, but the dietician had not developed a plan for how her food preferences could be modified and offered as part of her routine low calorie menu. Given that the few interventions the IDT had attempted thus far had not resulted in weight loss, interdepartmental coordination was needed to create and implement a set of effective interventions.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. However, for six of the 18 IHCPs reviewed, documentation was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs/ISPs. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	33% 6/18	0/2	2/2	2/2	0/2	2/2	0/2	0/2	0/2	0/2
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, the action steps assigned to the PCPs were implemented for the following: Individual #303 – other: pica, and osteoporosis; Individual #538 – cardiac disease, and other: sleep apnea; and Individual #315 – respiratory compromise, and circulatory.											

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	194	303	538	149	315	459	201	276	781
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	and achievable to measure the efficacy of interventions;	0/9									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/9	0/1	0/1	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% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. None of the individuals reviewed had clinically relevant, achievable, and measurable goals/objectives related to dental.

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

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, integrated progress reports on existing goals with data and analysis of the data generally were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For all nine individuals, the Monitoring Team conducted full reviews of the processes related to the provision of dental supports and services.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	Not rated (N/R)									

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

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: The individuals reviewed received the dental treatment they needed, or for two individuals for whom hospital treatment was needed, plans were underway to obtain it. If the Center sustains its performance with regard to the provision of prophylactic care, tooth brushing instruction, and extractions, after the next review, Indicators a, b, and f might move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	100% 7/7	1/1	1/1	1/1	1/1	N/A	1/1	N/A	1/1	1/1
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	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.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
e.	If the individual has need for restorative work, it is completed in a timely manner.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
f.	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	N/A	N/A	1/1	N/A

Comments: a. through f. It was good to see that most individuals reviewed received the dental treatment they needed.

Individual #315 required hospital-based dental care. She was newly admitted, and efforts were underway to obtain the needed treatment. Because the treatment was not yet overdue, some of the indicators were scored as N/A.

Individual #201 was awaiting some treatment, but required general anesthesia to complete the work. The individual was on the hospital treatment plan list for scaling and root planning. On 1/9/19, he was supposed to have dental treatment in the hospital, but the appointment was canceled, because he was not medically cleared.

Outcome 7 – Individuals receive timely, complete emergency dental care.	
Summary: Based on the dental emergencies reviewed, the Dentists provided the individuals with timely dental assessment and care. Given that over at least three review periods, the Dentists initiated dental services within 24 hours for individuals	Individuals:

with dental emergencies (Round 11 – 100%, Round 12 – 100%, and Round 14 - 100%), Indicator a will move to the category requiring less oversight. If the Center sustains its performance, at the time of the next review, Indicator b might move to less oversight.											
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 5/5	N/A	N/A	2/2			2/2		1/1	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 5/5			2/2			2/2		N/A	1/1
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	100% 3/3			2/2			1/1		N/A	N/A
Comments: a. through c. through c. On 7/16/18, and 7/30/18, Individual #538 experienced dental emergencies (i.e., pain under a crown, and pain and swelling, respectively). In both instances, the Dentist saw him timely, provided necessary treatment, and prescribed pain medications. On 4/27/18, and 6/8/18, Individual #459 experienced dental emergencies (i.e., a tooth wiggling, and dental pain, respectively). In both instances, the Dentist saw her timely, provided necessary treatment, and on 6/18/18, prescribed pain medications. On 8/21/18, a nursing IPN indicated that Individual #276 complained of dental pain. The nurse emailed the Dental Clinic. On 8/22/18, the dentist saw the individual, who did not complain of pain at that time. No treatment or pain medication was needed. On 11/27/18, Individual #781 had a dentist appointment. When she arrived, the dental exam showed a broken bridge, and a tooth broken almost to the gum line. The Dentist started the procedures needed to replace the bridge. The dental progress note indicated the individual was not having pain.											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	0% 0/2	N/A	N/A	N/A	N/A	0/1	N/A	0/1	N/A	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/2					0/1		0/1		
c.	If individual receives suction tooth brushing, monitoring occurs	0%					0/1		0/1		

	periodically to ensure quality of the technique.	0/2									
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% 0/2					0/1		0/1		

Comments: a. For the two applicable individuals, IDTs did not include measurable suction tooth brushing strategies/plans in their ISPs/IHCPs. For both individuals, IHCPs included action steps for suction tooth brushing twice a day. To make them measurable, IDTs need to add the duration of suction tooth brushing that reflect the individual's needs and current tolerance (e.g., for 30 seconds, two minutes).

b. No suction tooth brushing data were submitted for Individual #315. The data for Individual #201 indicated that staff implemented it only once per day (i.e., the IHCP required twice per day) with some omissions. Although the IHCP did not define the duration, documentation most often showed two-minute sessions.

c. The Center provided no monitoring data for either individual. It is important as IDTs revise ISPs to include monitoring that they define the frequency of the monitoring. Specifically, the audit tool requires: "Frequency of monitoring should be identified in the individual's ISP/IHCP, and should reflect the clinical intensity necessary to reduce the individual's risk to the extent possible."

d. The QIDP reports did not include specific data related to suction tooth brushing. Moving forward, specific suction tooth brushing data is needed to summarize the frequency of sessions completed in comparison with the number anticipated (e.g., 60 out of 62 sessions). Additionally, a second data subset is needed on the number of such events during which the individual completed the expected duration of suction tooth brushing (e.g., of the 60 completed sessions, in 12 sessions the individual completed two minutes of suction tooth brushing).

Outcome 9 – Individuals who need them have dentures.

Summary: Given that over the last two review periods and during this review, the Dentists generally conducted and documented assessments of individuals with missing teeth to determine the appropriateness of dentures and offered clinically justified recommendations (Round 12 – 100%, Round 13 – 100%, and Round 14 - 89%), Indicator a will move to the category requiring less oversight. Indicator b will continue in active oversight.

			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									

Comments: a. For most of the individuals reviewed with missing teeth, the Dental Department provided clinical justification for not recommending dentures. For Individual #538, the Dentist had not addressed this concern.

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: Nursing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis for acute illnesses/occurrences remain areas on which the Center needs to focus. Although nursing staff sometimes timely notified the practitioner/physician of signs and symptoms that required medical intervention in accordance with the nursing guidelines for notification, improvement is still needed in this area. The acute care plans reviewed needed significant improvement, particularly with regard to the inclusion of interventions that address individuals' needs in a manner consistent with applicable nursing guidelines, and that define the frequency of interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	60% 3/5	1/1	0/1	N/A	1/1	N/A	N/A	0/1	1/1	N/A
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.	60% 3/5	1/1	1/1		0/1			0/1	1/1	
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	100% 1/1	N/A	N/A		N/A			N/A	1/1	
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0% 0/5	0/1	0/1		0/2			0/1	N/A	
e.	The individual has an acute care plan that meets his/her needs.	0% 0/6	0/1	0/1		0/1			0/1	0/1	
f.	The individual's acute care plan is implemented.	0% 0/6	0/1	0/1		0/1			0/1	0/1	
Comments: The Monitoring Team reviewed six acute illnesses and/or acute occurrences for five individuals, including Individual #194											

– ED visit for fall with left bi-malleolar ankle fracture on 9/3/18; Individual #303 – ED visit for laceration with seven sutures to the right eyebrow on 11/16/18; Individual #149 – hospitalization for sepsis, UTI, and Klebsiella pneumonia on 10/8/18, and ED visit for respiratory infection on 11/15/18; Individual #201 – hospitalization for acute respiratory failure with hypoxemia probably related to aspiration pneumonia with GJ-tube placement on 7/4/18; and Individual #276 – rash (adverse drug reaction) on 10/3/18.

a. The acute illnesses/occurrences for which nursing assessments (physical assessments) were performed were for Individual #194 – ED visit for fall with left bi-malleolar ankle fracture on 9/3/18, Individual #149 – ED visit for respiratory infection on 11/15/18, and Individual #276 – rash (adverse drug reaction) on 10/3/18.

b. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms in accordance with the SSLC nursing protocol entitled: "When contacting the PCP" were: Individual #194 – ED visit for fall with left bi-malleolar ankle fracture on 9/3/18, Individual #303 – ED visit for laceration with seven sutures to the right eyebrow on 11/16/18, and Individual #276 – rash (adverse drug reaction) on 10/3/18.

e. For each of the acute illnesses/occurrences reviewed, nursing staff had developed acute care plans. Common problems with the acute care plans that were submitted included a lack of: instructions regarding follow-up nursing assessments that were consistent with the individuals' needs; alignment with nursing guidelines/protocols; specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; clinical indicators nursing staff would measure; and the frequency with which monitoring should occur.

The following provide a few examples of findings related to this outcome:

- For Individual #194's fall with left bi-malleolar ankle fracture on 9/3/18, it was good to see that upon discovery of the injury, the nurse followed standards of care by performing a head-to-toe assessment, and pain assessment, and notifying the PCP. The individual received pain medication, and the PCP ordered an x-ray. The nurse reported the findings of the x-ray to the PCP, and the individual was transported to the ED. Problems with the quality of the acute care plan included, for example: many of the interventions did not identify the frequency, interventions were incomplete (e.g., given the severity of the injury, in addition to circulation checks, nurses also should have conducted sensation checks), and the individual was prescribed opioids, but no interventions were included to monitor for side effects, such as constipation. With regard to implementation, data were not present to show consistent implementation. In addition, without frequencies included in the interventions in the plan, it was difficult to determine whether or not staff implemented them at the necessary frequency. In some cases, nurses did not follow up on abnormalities (e.g., elevated blood pressure).
- On 10/8/18, Individual #149 went to the ED due to an elevated white blood cell count, and on 10/12/18, was discharged with a diagnosis of a UTI. The acute care plan included 10 interventions, five of which were assigned to direct support professional staff. A number of nursing interventions were missing. For example, the acute care plan did not require nurses to monitor the effects of antibiotic treatment, such as for signs and symptoms of side effects, or evaluate voiding, including, for example, a description of the urine, or whether or not it had an odor. As a result, follow-up assessments did not include this information. In addition, numerous entries noted abnormal vital signs of low temperatures, but nurses did not follow up. Nurses provided no information regarding her total intake over a 24-hour period.
- For Individual #149, an IPN, dated 11/14/18, at 8:30 p.m., indicated the Registered Nurse (RN) was called to re-assess the

Licensed Vocational Nurse's (LVN's) findings of abnormal lung sounds. The record indicated emesis might have occurred based on food particles found on the bed. The nurse administered PRN medication and notified the respiratory therapist. Although the nurse conducted this initial assessment in accordance with standards of practice, nursing staff did not reassess the individual until 11/15/18 at 12:53 a.m., at which time, her temperature was abnormal (i.e., 36.3 – low). On 11/14/18, nursing staff did not notify the PCP that the individual had emesis while in bed, was coughing and wheezing, and/or that she required a respiratory treatment. On 11/15/18, at 11:35 a.m., the individual was transported to the ED, and a few hours later, she was discharged with a diagnosis of a respiratory infection. On 11/15/18, in IView entries, at 3:35 p.m., the Center nurse noted a low temperature (i.e., 36), and breath sounds "diminished" in all lobes. In the printout, the details of the provider notification were cut off. It was not until 11/15/18, at 10:15 p.m. that the next IView entry indicated a nurse conducted a follow-up respiratory assessment. With regard to the quality of the acute care plan, the two nursing interventions did not include a frequency. They were to: 1) assess for lung sounds, skin color, and breathing pattern; and 2) take vital signs. Based on applicable nursing guidelines, the ACP was missing important interventions, including, for example, assessments related to antibiotic therapy, pain, and intake. For the interventions that were included, documentation was not present to show consistent implementation, and as noted above, nurses did not follow-up in a timely manner in response to findings such as low temperatures and diminished breath sounds.

- For Individual #201, documentation was missing to explain how his transfer to the hospital occurred on 7/4/18. On 7/17/18, he returned from the hospital. The acute care plan included four nursing interventions: 1) complete vital signs each shift for 72 hours; 2) assess lung sounds for 72 hours; 3) assess bowel sounds for 72 hours; and 4) notify PCP if individual has abnormal lung sounds, vital signs, or emesis. The acute care plan had significant omissions in that it did not recognize or include interventions to address the GJ-tube that was placed while he was in the hospital.

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

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

#	Indicator	Overall Score	Individuals: 194	303	538	149	315	459	201	276	781
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.	22% 4/18	1/2	0/2	1/2	0/2	1/2	0/2	0/2	1/2	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	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	takes necessary action.	0/18									

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #194 – constipation/bowel obstruction, and fractures; Individual #303 – cardiac disease, and falls; Individual #538 – circulatory, and skin integrity; Individual #149 – choking, and UTIs; Individual #315 – respiratory compromise, and constipation/bowel obstruction; Individual #459 – dental, and weight; Individual #201 – aspiration, and GI problems; Individual #276 – diabetes, and infections; and Individual #781 – seizures, and falls).

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #194 – constipation/bowel obstruction, Individual #538 – circulatory, Individual #315 – constipation/bowel obstruction, and Individual #276 – diabetes.

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

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

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

Individuals:

#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
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% 0/8	0/1	N/A	N/A	0/1	0/1	N/A	0/2	0/1	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

a. and c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. In addition, a number of interventions included were not measurable, because they did not define the expected frequency. Often, evidence was not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, or that nursing interventions were implemented thoroughly.

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

- From 10/8/18 to 10/12/18, Individual #149 was hospitalized for a UTI. The organism identified was E. coli. Based on the documentation submitted, the IDT did not hold a post-hospital ISPA meeting, but her annual ISP meeting was held on 10/16/18. The IDT did not develop an IHCP that met her needs with regard to infections. For example, the IHCP included only one relevant intervention for nursing staff. The intervention called for nursing staff to "Evaluate Vital signs, Output, SX [symptoms] of UTI, Pain While Urinating." This intervention was not measurable. Given the individual's history with UTIs (i.e., the IRRF indicated recurrent UTIs and two related hospitalizations in the previous ISP year) and the organism identified (i.e., E. coli can indicate a problem with proper cleansing), the interventions that defined residential staff' role were not sufficient to address her needs, and were not measurable (i.e., provide peri care, and provide skin incontinence care – wears briefs). Based on Document #TX-DE-1901-IV.1-20, on 12/12/18, Individual #149 was diagnosed with another UTI.
- From 6/18/18 to 6/26/18, Individual #315 was hospitalized for aspiration pneumonia. On 6/27/18, the IDT held an ISPA meeting. The IDT did not review the acute care plan or require that the RN Case Manager make improvements to it, and/or incorporate changes to nursing interventions into the IHCP. Only one of the 10 interventions for the respiratory/aspiration risk area was assigned to nursing staff, and it related to the administration of prescribed medications. The IDT had not assigned nursing staff with responsibility for ongoing nursing assessments to address this high-risk area, and even after the individual's hospitalization for aspiration pneumonia, the IDT did not revise the IHCP to include any ongoing nursing assessments.
- From 8/4/18 to 8/8/18, Individual #201 was hospitalized. Discharge diagnoses included aspiration pneumonia, and a malfunctioning GJ-tube, including replacement with a low-profile GJ-tube. On 8/14/18, the IDT held an ISPA meeting. The ISPA notes stated in part: "It was noted prior to his presentation that his GJ-tube appeared to have migrated the day before his admission." The record indicated the IDT agreed to the following recommendations: Continue feedings per jejunostomy tube and medications through gastrostomy tube, and GI consult. Based on the ISPA documentation, the IDT did not review the IRRF or IHCP using data to determine what supports were working or were not working. The IDT did not mention how much intake he would receive via his J-tube, including a timeline and a total amount of prescribed feeding/flushes in a 24-hour period. The IDT did not add needed nursing interventions that they had not included in the original IHCP (e.g., abdominal assessments, stoma site assessments). Despite the fact that he had been hospitalized for aspiration pneumonia and problems with his GJ-tube, the IDT concluded that the current supports were effective, and he did not require PNMT referral.
- On 9/4/18, Individual #276 went to the ED for a UTI. From 9/26/18 to 9/28/18, she was hospitalized for aspiration pneumonia. On 10/1/18, the IDT held an ISPA meeting. The only recommendations were: 1) referral to a nephrologist (without an explanation/rationale); 2) IDT to meet again with the PNMT; 3) no changes recommended at this time; and 4) IDT to meet again on 10/18/18 for her ISP meeting. The IDT did not review or revise the related IHCPs or IRRF in light of the two recent infections, and did not review or require improvements to the acute care plan.
- Based on information included in Document #TX-DE-1901-IV.1-20, Individual #781 had 174 seizures, as well as the administration of Ativan four times (i.e., the order was for Ativan administration for five or more seizures in a 24-hour period).

Based on documents provided, her IDT had not held ISPA meeting to discuss her frequent seizures.

- For Individual #781, the IDT met to discuss falls on 7/10/18, 10/30/18, and 11/6/18. According to Document #TX-DE-1901-IV.1-20, between June 2018 and December 2018, the individual fell 31 times. Some, but not all of these falls were the result of seizures. None of these ISPA meetings included a review of the IHCP to establish what, if any, interventions were working, or required changes, or to determine if additions were needed. Missing was analysis of the data to assist the IDT in determining the etiology(ies) of the falls, which in turn would assist the IDT in developing a comprehensive set of supports to address the falls and reduce the individual's risk to the extent possible.

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

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

#	Indicator	Overall Score	Individuals: 194	303	538	149	315	459	201	276	781
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R									
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 8/8	N/R	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	25% 1/4	N/A	N/A	N/A	0/1	0/1	N/A	1/1	0/1	N/A
	ii. If an individual was diagnosed with acute respiratory	17%	N/A	N/A	N/A	0/1	0/1	N/A	1/2	0/2	N/A

	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.	1/6									
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	100% 8/8		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	88% 7/8		1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of eight individuals, including Individual #303, Individual #538, Individual #149, Individual #315, Individual #459, Individual #201, Individual #276, and Individual #781.

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

d. The following concerns were noted:

- On 9/13/18, Individual #149 had aspiration pneumonia. Although the acute care plan developed when she returned from the hospital included assessment of lung sounds each shift for 72 hours, in her ISP/IHCP, dated 10/18/18, the IDT did not include regular respiratory assessments.
- On 6/18/18, Individual #315 was diagnosed with aspiration pneumonia. Her IHCP did not include regular respiratory assessments.
- Over the past year, Individual #201 experienced multiple episodes of aspiration pneumonia. His IHCP included a nursing intervention to conduct lung sound assessments before and after two medication passes daily. During the onsite observation, the medication nurse conducted a lung sound assessment, and appropriately, took necessary next steps when the results were coarse and raspy lung sounds with a pulse oximetry of 93%. Unfortunately, in reviewing documentation related to respiratory assessments, nursing staff had not completed them consistently according to the schedule required in the IHCP.

  In addition, a physician's order, dated 12/12/18, indicated: ""assess lungs before and after the 1200 and 1900 med pass x 6 months. If he is in the bed it is ok to assess his lung sounds anteriorly only." An ISPA was not found where the IDT discussed the risk/benefit for anterior breath sounds only, or to discuss/establish the clinical justification for this order.
- Individual #276's IHCP did not define respiratory assessments, but should have, given her high risk, and diagnosis of aspiration pneumonia on 9/28/18.

  Of note, during the Monitoring Team's observation, prior to the administration of medications, the individual was vocal, and pushing away staff. Staff reported that the individual often was uncooperative in accepting medications through her G-tube. The individual receives recreational meals, but no information was found in the records reviewed showing that the IDT discussed if she could take her medications orally, or if she had a related evaluation. She received medications via her G-tube six times every 24-hour period. The IDT should meet to discuss supports during her medication administration, regarding her behaviors and not wanting to accept medications via the tube.

f. It was good to see that nurses adhered to the individuals' PNMPs, including checking the position of the individuals prior to medication administration.

g. For the individuals observed, nursing staff generally followed infection control practices, which was good to see. The exception was that for Individual #315, the medication nurse did not follow aseptic techniques prior to and during medication observation, due to contact of the G-tube with other objects.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.	
Summary: It was good to see continued improvement with regard to individuals being referred to the PNMT, when needed. Overall, though, IDTs and/or the PNMT did not have a way to measure clinically relevant outcomes related to individuals'	Individuals:

physical and nutritional management at-risk conditions. These indicators will remain in active oversight.											
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9	0/1	0/2	0/2	N/A	0/1	0/2	N/A	0/1	N/A
	ii. Individual has a measurable goal/objective, including timeframes for completion;	44% 4/9	1/1	1/2	0/2		1/1	0/2		1/1	
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/9	0/1	0/2	0/2		0/1	0/2		0/1	
	iv. Individual has made progress on his/her goal/objective; and	0% 0/9	0/1	0/2	0/2		0/1	0/2		0/1	
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/9	0/1	0/2	0/2		0/1	0/2		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;	89% 8/9	1/1	N/A	N/A	2/2	1/1	N/A	2/2	0/1	2/2
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9	0/1			0/2	0/1		0/2	0/1	0/2
	iii. Individual has a measurable goal/objective, including timeframes for completion;	11% 1/9	0/1			0/2	0/1		1/2	0/1	0/2
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	11% 1/9	0/1			0/2	0/1		1/2	0/1	0/2
	v. Individual has made progress on his/her goal/objective; and	0% 0/9	0/1			0/2	0/1		0/2	0/1	0/2
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/9	0/1			0/2	0/1		0/2	0/1	0/2
Comments: The Monitoring Team reviewed nine goals/objectives related to PNM issues that six individuals' IDTs were responsible for											

developing. These included goals/objectives related to: Individual #194 – choking; Individual #303 – choking, and aspiration; Individual #538 – GI problems, and aspiration; Individual #315 – GI problems; Individual #459 – skin integrity, and weight; and Individual #276 - choking.

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #194 – choking; Individual #303 – choking, Individual #315 – GI problems, and Individual #276 - choking.

b.i. The Monitoring Team reviewed nine 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 goals/objectives were included. These areas of need included for: Individual #194 – falls; Individual #149 – aspiration, and GI problems; Individual #315 – aspiration; Individual #201 – aspiration, and GI problems; Individual #276 – aspiration; and Individual #781 – falls, and weight.

In response to Individual #276's 5/20/18 vomiting episode that required an ED visit, the IDT did not make a referral to the PNMT, and the PNMT did not make a self-referral. At least a review was warranted due to recent history of unresolved emesis. More specifically, she had emesis on 2/21/18, 2/24/18, 3/3/18 x2, and 4/12/18 x3. On 4/26/18, the PNMT conducted a review. Given that the vomiting remained unresolved, after the ED visit in May, the PNMT should have conducted another review. In addition, no evidence was submitted of a referral, or a review or assessment after her aspiration pneumonia diagnosis on 9/26/18. The PNMT noted that they could not see her due to her immediate return to the hospital, but there was no evidence that a review/assessment had been completed since the hospitalization on 10/3/18.

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

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #201 – GI problems (i.e., less than seven emesis, and less than three suppositories).

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

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.	
Summary: None of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Many of the PNM action steps that were included were not measurable, making it difficult to collect specific data. Substantially more work is needed to document that individuals receive the PNM supports they require. In	Individuals:

addition, in numerous instances, IDTs did not take immediate action, when individuals' PNM risk increased or they experienced changes of status. At this time, these indicators will remain in active oversight.											
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	0% 0/10	0/1	N/A	0/1	0/2	0/1	N/A	0/2	0/1	0/2
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	67% 4/6	0/1	N/A	N/A	1/2	1/1	N/A	N/A	N/A	2/2

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Monthly integrated reviews often only included statements such as "no aspiration pneumonia," or weight loss did not occur as planned, without providing specific information or data about the status of the implementation of the action steps.

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

- After Individual #194 sustained a fracture of her left ankle and distal fibula on 9/13/18, her IDT met and referred her to the OT/PT for a consultation in a timely manner. However, the OT/PT recommended a shoulder x-ray due to pain, but it did not appear that the x-ray was completed or that the IDT met to discuss the results.
- According to Individual #538's ISP monthly progress notes, emesis episodes were ongoing. From 9/14/17 to 12/12/17, he had eight episodes of emesis, and they continued more recently (i.e., 2/21/18 - 1, 3/17/18 - 1, 4/13/18 - 1, 5/9/18 - 1, 6/1/18 - 1, 6/4/18 - 1, and 7/11/18 - 1), and other data (i.e., from document #TX-DE-1901-IV.1-20) showed additional dates (i.e., 7/28/18 – 1, and 12/28/18 – 1). However, the IDT had not held an ISPA meeting to discuss the emesis, its potential etiology(ies), and possible changes to interventions. Although the IDT changed the goal, it did not review interventions.
- Based on review of ISPAs for Individual #149, the IDT did not take necessary actions in relation to her changes in status related to emesis and aspiration pneumonia. For example, the IDT did not recommend/complete OT/PT consults related to positioning or programs to address unsafe eating habits. In February 2018, an MBSS included a recommendation for the individual to move to NPO status. Although there appeared to be a difference in opinion among IDT members about the use of a feeding tube, the IDT did not seek assistance to resolve their differences. Although the IDT requested a second opinion about hiatal hernia repair, evidence was not found to show they met to discuss the results. In addition, the IDT did not develop and implement a program to ensure the individual's safety or improvement in her oral skills.
- In June 2018, in response to an aspiration pneumonia event, the PNMT recommended that Individual #315's IDT monitor for increased secretions and positioning. Based on review of the ISPAs, the IDT did not discuss and/or address this recommendation.

- As discussed above, on 2/1/18, 7/4/18, 8/4/18, and 9/23/18, Individual #201 was diagnosed with aspiration pneumonia. The PNMT did not initiate an assessment until after the 9/23/18 aspiration pneumonia, which was the fourth in nine months. Moreover, no evidence was found to show the OT/PT conduced a wheelchair assessment or HOBE evaluation in response to emesis occurring in bed. The caseload PT did not agree with multiple PNMT recommendations. For example, the PNMT recommended developing a positioning schedule and monitoring adherence to the positioning schedule. The PT stated that the individual would not follow a schedule, and as a result, there was nothing to monitor. However, in July 2018, a schedule was developed, so it was unclear whether or not a schedule was in use. The IDT did not document whether or not it accepted the PNMT's recommendation(s). In addition, no alternative intervention to address the concern was trialed or recommended. Despite reports that the individual pulled out his tube, which can be a sign of discomfort, the IDT did not document discussion regarding decreasing the volume of feeding or repeated emesis, until the PNMT assessment in November 2018.
- Despite at least 21 episodes of emesis between June 2018 and October 2018 (i.e., per document #TX-DE-1901-IV.1-20), Individual #276's IDT did not make a referral to the OT/PT to assess her HOBE to make sure it remained appropriate. The IDT also did not make a referral for a mealtime assessment to determine whether or not her mealtime behaviors might contribute to her increased emesis. Likewise, the IDT did not make a referral to Behavioral Health Services to review the potential impact of pica behavior. In April/May 2018, the IDT agreed with a PNMT recommendation to obtain an EGD, but no documentation was found to show the IDT met to discuss the results. From the documents provided, it was unclear if an EGD occurred, because an ISPA, dated 10/10/18, still referenced an EGD completed in 2017. It did not appear that the IDT further investigated the impact of a finding of slow gastric emptying noted in a study, dated 3/31/17.

c. In four of six instances, the PNMT met with IDTs and shared relevant discharge information. The problems included:

- After the PNMT conducted a review related to Individual #194's fracture, it did not appear the PNMT met with the IDT to discuss the results.
- The PNMT's meeting with Individual #149's IDT lacked comprehensive discussion regarding her PO status, and the MBSS findings from February 2018, which recommended a NPO status.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.	
Summary: Overall, PNMP/Dining Plan implementation at Denton SSLC continued to need substantial improvement. Often, the errors that occurred (e.g., staff not intervening when individuals took large bites, or ate at an unsafe rate, and incorrect positioning) placed individuals at significant risk of harm. On a positive note, since the last review, Center staff identified one home in each unit with significant issues with regard to the implementation of PNMPs. Based on the Monitoring Team's review, some good improvement was noted in one of the homes, with problems persisting in the other home. As discussed with the Center Director and ADOP, the Monitoring Team encourages Center staff to continue this corrective action process by rolling it out to other homes based on priority need, and at a pace that allows for sustained progress. These indicators will continue in active oversight.	

#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	38% 20/52	
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	75% 3/4	

Comments: a. The Monitoring Team conducted 52 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 12 out of 31 observations (39%). Staff followed individuals' dining plans during seven out of 19 mealtime observations (37%). Staff completed transfers correctly during one out of two observations (50%).

The following provides more specifics about the problems noted:

- With regard to Dining Plan implementation, the great majority of the errors related to staff not using correct techniques (e.g., cues for slowing, presentation of food and drink, prompting, etc.). Individuals were at increased risk due to staff's failure, for example, to intervene when they took large unsafe bites, ate at too fast a rate, or staff did not provide liquids in between bites. In one instance, staff failed to recognize that an individual was not swallowing in between multiple bites. It was good to see that with one exception, texture/consistency was correct, and that adaptive equipment was correct, and staff and the individuals observed were positioned correctly at mealtime.
- With regard to positioning, problems varied, but the most common problem was that individuals were not positioned correctly. Often, this was due to staff's failure to follow the positioning plan. In addition, in about 20% of the observations, necessary adaptive equipment/supports were not present, and in about 25% of the observations, staff had not used equipment correctly.
- For one of the two transfers observed, staff did not follow the PNMP instructions to use the gait belt.

On a positive note, since the last review, Center staff identified one home in each unit with significant issues with regard to the implementation of PNMPs. Based on the Monitoring Team's review of Home 523A, some good improvement was noted. More specifically, staff correctly implemented Dining Plans for three of the four individuals observed. The results in Home 509A were less successful. Problems were noted for both individuals observed. As discussed with the Center Director and ADOP, the Monitoring Team encourages Center staff to continue this corrective action process by rolling it out to other homes based on priority need, and at a pace that allows for sustained progress.

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	There is evidence that the measurable strategies and action plans	N/A					N/A		N/A	N/A	

	included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.										
Comments: a. None.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Most individuals reviewed did not have clinically relevant and measurable goals/objectives to address their needs for formal OT/PT services. In addition, QIDP interim reviews often did not include data and/or analysis related to existing goals/objectives. As a result, IDTs did not have information in an integrated format related to individuals' progress or lack thereof. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	38% 3/8	0/1	0/1	0/1	1/1	0/1	N/A	1/1	0/1	1/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	38% 3/8	0/1	0/1	0/1	1/1	0/1	N/A	1/1	0/1	1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/8	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/8	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1
Comments: a. and b. Three individuals had goals/objectives that were clinically relevant and achievable as well as measurable: Individual #149 (i.e., transferring with a gait belt); Individual #201 (i.e. self-propelling wheelchair); and Individual #781 (i.e., ambulation). Individual #459 did not have an apparent need for OT/PT services because she was independent with activities of daily living (ADLs,) and ambulated without difficulty, with a low risk for falls. The remaining five individuals had identifiable needs for OT/PT services, but did not have clinically relevant goals. The Monitoring Team conducted full reviews for all nine individuals, including Individual #459, because she lacked a 2018 assessment that might have revealed underlying concerns that needed to be addressed. c. through e. Progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether individuals were making progress on their											

goals/objectives, or that when progress was not occurring, the IDTs took necessary action. None of the three individuals who had clinically relevant and measurable goals also had integrated ISP progress reports that included specific data that reflected progress on the goal, and /or analysis of the data:

- ISP monthly progress notes for Individual #149 did not include a review of data and/or progress toward the OT/PT goals.
- For Individual #781, monthly notes provided raw data, but not analysis to document progress or regression, or potential reasons.
- While the Direct Therapy notes from the physical therapist (PT) did document data for Individual #201, the ISP monthly progress report provided no analysis to indicate regression or progress to prompt the IDT to take necessary action.

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

Summary: Overall, few individuals reviewed had measurable strategies and action plans included in their ISPs/ISPAs to address their OT/PT needs outside of their PNMPs. As a result, the score was potentially a false positive, because until individuals' ISPs include a full set of needed supports, assessment of this indicator is limited. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 194	303	538	149	315	459	201	276	781
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	67% 2/3	N/A	N/A	N/A	1/1	N/A	N/A	0/1	N/A	1/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. For Individual #201, consistent implementation of his wheelchair mobility goal was lacking. The goal was initiated in February 2018, and staff implemented it at the specified frequency during only one month out of the last nine months.

b. For Individual #194, the IDT did not hold an ISPA meeting to discuss major changes to her OT/PT supports, including, for example, changes in transfers, or the addition of a bed rail, and mesh cover due to a fractured leg. In its response to the draft report, the State offered the following clarification: "Please refer to TX-DE-1901-II.07.b. pages 2-8 for ISPA dated 9/25/18 & pages 10-11 ISPA dated 9/25/18. Both ISPAs discuss OT/PT supports." Even after reviewing the document the State referenced, the Monitoring Team did not find documentation of a meeting to discuss the addition of a bed rail or the use of the mesh cover. These changes occurred in October, and the meetings the State listed occurred before these changes.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: For many of the 33 individuals observed, adaptive equipment appeared to fit, but overall performance in this area had declined since the previous review (Round 13 – 97%, and Round 14 – 82%). Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, 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	167	91	776	32	538	707	339	271	399
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.										
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	82% 27/33	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		553	310	62	86	347	85	639	741	467
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1
		Individuals:									
#	Indicator		84	519	478	289	147	715	684	486	383
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	0/1	2/2	1/1
		Individuals:									
			758	226	766	712	667				
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	1/1	1/1	1/1	0/1				

Comments: c. Concerns included:

- Based on observation, assistive/adaptive equipment identified in the PNMP was not present for Individual #553 (i.e., hand splint) or Individual #86 (i.e., palm protectors).
- Based on observation of Individual #741, Individual #684, Individual #486 and Individual #667 in their wheelchairs, the outcome was that they were not positioned correctly. Overall, 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.

- Of note, Individual #667's sling back chair did not provide the needed support and could actually worsen posture. In interview, the OT stated this was because Individual #667 refused other chairs, but this was not addressed in the OT/PT comprehensive assessment the Monitoring Team reviewed.

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, dental refusals, and communication. At the time of the last review, two of the indicators sustained high performance scores sufficient to move to the category of less oversight. Presently, no additional indicators will move to the category requiring less oversight.

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

In ISPs, data need to be available (Indicator 3) in order for progress to be determined. Observations and interviews with individuals and staff, however, did indicate that some goals were being implemented consistently and that progress was occurring (even though documentation did not show this). This showed that QIDPs needed to do a better job of capturing data.

SAPs continued to contain some, but not all, of the required components. Without reliable data, progress on SAPs could not be determined. In cases where the Center's own data showed no progress, actions were not taken for any of those SAPs.

Performance inched upward regarding SAP integrity checks being done. However, all of the observations made by the Monitoring Team of implementation of SAPs included implementation errors by the staff.

More than half of the individuals observed by the Monitoring Team were engaged most times. Although the others were not engaged, staff were present and attempting to engage them. There were some very nice activities that the Center had in place and in which individuals were regularly engaged, such as the computer lab, the greenhouse, ceramics program, cooking, and woodworking. That being said, employment/work available to individuals on campus was quite limited.

Individuals did go into the community. The frequency goal was achieved for one individual. It was good to see about half of the individuals having some SAP training occur in the community. There were, however, no actions taken to address barriers for those individuals for whom community outing and community SAP training were not occurring as they should have been.

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

Based on the Monitoring Team's interactions with individuals as well as review of documentation, there was room for substantial growth with regard to the provision of alternative and augmentative communication (AAC) supports. With a census of 446 individuals, the list of AAC devices across the Center showed a total of 30 devices, including 10 shared devices and 20 personal devices. Since 1/6/16, only seven of these devices were added. Moreover, based on observations, in individuals' homes and

programs, there was a lack of implementation of those AAC devices that did exist. The Center should continue to focus on ensuring individuals have their AAC devices with them. Most importantly, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Even though 19 (of 36 possible) goal areas had personal goals that met criterion with indicator 1, and half of those also were written in measurable terminology (indicator 2), data need to be available (indicator 3) in order for progress to be determined. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	456	303	219	194	538	459			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
4-7. For personal goals that did not meet criterion as described above, there was no basis for assessing progress in these areas.

For the 10 personal goals that met criterion with indicators 1 and 2, there was no evidence that action plans to support those goals were consistently implemented because reliable and valid data were not available for any of the goals (i.e., indicator 3). Therefore, progress could not be determined.

See Outcome 7, Indicator 37, for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans.

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: It was good to see that staff for half of the individuals were knowledgeable about individuals' ISPs. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	456	303	219	194	538	459			

		Score									
39	Staff exhibited a level of competence to ensure implementation of the ISP.	50% 3/6	1/1	0/1	0/1	1/1	0/1	1/1			
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. Direct support professional staff interviewed and observed throughout the week were knowledgeable about individual's preferences and support needs and very respectful and supportive to each individual in their interactions.

The staff for three individuals, however, were not found to exhibit a level of competence to ensure implementation of the ISP. These were staff supporting Individual #303, Individual #219, and Individual #538. For the most part, this could be attributed to the lack of clear staff instructions for carrying out the supports included in the ISP. Staff were not fully implementing ISPs, so it was difficult to verify that they could exhibit competence in implementing support plans. ISPs rarely included detailed instructions to guide staff when implementing the ISP. As noted throughout this section of the report, ISPs often included service objectives that did not have specific implementation methodologies, and this contributed to the lack of implementation.

40. Action steps were not regularly and correctly implemented for all goals and/or action plans, as noted throughout this report.

Going forward, IDTs need ensure all staff have instructions for carrying out action plans and then monitor the implementation of all action plans and address barriers to 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: Without reliable data, progress on SAPs could not be determined for indicator 6. In cases where the Center's own data showed no progress, actions were not taken for any of those SAPs. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681
6	The individual is progressing on his/her SAPs.	8% 2/25	1/3	0/3	0/3	0/3	0/1	0/3	0/3	1/3	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A									
8	If the individual was not making progress, actions were taken.	0% 0/10	0/1	0/1	0/3		0/1		0/3		0/1
9	(No longer scored)										

Comments:
6. Based upon a review of data presented in the text of the QIDP Monthly Reports and graphically in the Client SAP Training Progress Note, it was determined that progress was being made in 14 of the 27 SAPs. However, this indicator is rated as zero for all, but two SAPs due to concerns with the reliability of data (see indicator 5). The two SAPs in which progress was evident and which had been assessed for data reliability were the clean-up work area for and the correct work SAP for Individual #194. It should be noted that two SAPs, Individual #219's identify abbreviations and appropriate peer interactions, were excluded from this analysis because only two months of data were available.

7. Based upon the evidence provided, it was determined that no goals/objectives had been met. It should be noted that data for all three of Individual #194's SAPs and two of Individual #681's SAPs indicated that criteria had been met. However, the step was not indicated, therefore it was not clear whether the skill had been acquired or a specific step had been mastered.

8. There was no evidence provided that action had been taken to address the lack of progress in the 10 identified SAPs.

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

Summary: SAPs continued to contain some, but not all, of the required components. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 456	227	592	303	219	154	10	194	681
13	The individual's SAPs are complete.	4% 1/27	0/3 16/29	0/3 11/29	0/3 22/29	1/3 25/29	0/3 19/27	0/3 22/29	0/3 10/29	0/3 13/30	0/3 18/30

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

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

One of the 27 SAPs was considered complete. This was the hand washing SAP for Individual #303.

While all of the SAPs included behavioral objectives, problems persisted in many cases (noted in indicator 3 above) because the objective indicated the individual would display the skill with the same prompt level indicated in the individual's current level of performance.

The majority of the SAPs included the following elements: a task analysis, when appropriate; an operational definition of the target behavior; a relevant discriminative stimulus; a plan for maintenance and generalization; and documentation methodology.

Problems included the following: teaching instructions often did not provide enough specificity to ensure consistent implementation of the SAP; schedules of implementation either did not specify the number of trials per teaching session or were considered too infrequent

to ensure skill acquisition; there was a lack of the use of individual specific positive reinforcement; and correction strategies did not provide adequate change in prompting levels (e.g., the verbal prompt often was identical to the discriminative stimulus).

Outcome 5- SAPs are implemented with integrity.

Summary: Performance inched upward in evidence of integrity checks being done. However, all of the observations made by the Monitoring Team of implementation of SAPs included errors by the staff in implementing the skill acquisition programming. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 456	227	592	303	219	154	10	194	681
14	SAPs are implemented as written.	0% 0/6	0/1	Attempted	0/1	0/1	Attempted	Attempted	0/1	0/1	0/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	15% 4/27	1/3	0/3	0/3	1/3	0/3	0/3	0/3	1/3	1/3

Comments:

14. A the Monitoring Team was able to observe the implementation of one SAP for each of six individuals. The exceptions were Individual #227, who did not attend work as scheduled, Individual #219, who informed staff that she did not want to be observed, and Individual #154, who declined to participate in the SAP. None of the SAPs were implemented as written. Individual specific problems are identified below.

- Although staff did not follow the SAP as written, the manner in which they implemented the clean work area SAP afforded Individual #456 a greater degree of independence. Individual #456 was provided a written list of steps that had to be completed and she did so independently. Staff are advised to probe the terminal objective, so that a new SAP can be introduced as appropriate.
- Individual #592 was expected to complete the first step in a laundry chain. Instead, he completed the entire task with minimal assistance from staff. The SAP included dispensing detergent manually, but an automatic dispenser had been installed. The SAP should have been revised to include this change. As noted above, it would be advisable to probe Individual #592's performance on the terminal objective to determine whether he has mastered this skill.
- The staff member working with Individual #303 did follow many of the steps of the hand washing SAP. He positioned Individual #303 in front of the sink, delivered the initial instruction, and provided physical assistance throughout the chain. The error was that he gave verbal instructions for each step in the chain, which was not part of the SAP instructions, and which is not advisable,
- The SAP indicated that Individual #10 will put her address on an envelope, but when this was observed she wrote her name in the middle of the envelope rather than in the return address section. Staff are advised to teach her to use a jig and preprinted labels to learn to address an envelope to a family member or other preferred person.
- The staff member did not provide the discriminative stimulus as indicated in Individual #194's correct work SAP. However, she did provide identified feedback for correct responding.

- When working with Individual #681 to write his name, the staff member provided instruction as indicated in the SAP, used appropriate levels of prompting, and provided praise as indicated. He did not use full physical prompting to help Individual #681 complete the remaining steps of the chain.

15. The Center had a policy of assessing each SAP for treatment integrity at a minimum of once every six months. The identified minimum level of correct implementation was 80%. Feedback and retraining was provided if this was not achieved. Of the 27 SAPs, there was evidence that four had been assessed for treatment integrity in the past six months. These were - clean work area, Individual #303 - choose activity, Individual #194 - correct work, and Individual #681 - write name.

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

Summary: Fewer SAPs had monthly reviews conducted than at the last review, though more SAPs had graphs of the individual's performance. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 456	227	592	303	219	154	10	194	681
16	There is evidence that SAPs are reviewed monthly.	19% 5/27	0/3	0/3	3/3	0/3	2/3	0/3	0/3	0/3	0/3
17	SAP outcomes are graphed.	96% 26/27	3/3	3/3	3/3	3/3	2/3	3/3	3/3	3/3	3/3

Comments:

16. There was evidence that five of the 27 SAPs were reviewed monthly in the QIDP report. These were Individual #592's three SAPs and Individual #219's identify abbreviations and appropriate peer interaction SAPs.

Problems in the remaining SAPs included repeated months with reports of no implementation and data that did not indicate whether the individual performed the SAP independently or with a specified level of prompting. The current step was not always identified.

17. Data had been graphed for 26 of the 27 SAPs. The exception was the identify abbreviation SAP for Individual #219. Although graphs were provided, different data were presented in the graph included in the document request and the graph provided onsite. For this reason, this SAP was scored zero. Staff are advised to list the specific step in the graph and note step changes when these occur.

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

Summary: More than half of the individuals were engaged most times when observed by the Monitoring Team. Although the others were not engaged, staff were present and attempting to engage them. The second paragraph in the comments below points to some very nice activities that the Center had in place and in which individuals were regularly engaged. Data were not being collected across the Center (indicator 21). These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681
18	The individual is meaningfully engaged in residential and treatment sites.	56% 5/9	1/1	1/1	1/1	0/1	1/1	0/1	0/1	1/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	The day and treatment sites of the individual have goal engagement level scores.										
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

18. Based upon observations conducted during the onsite visit, it was determined that five of the individuals were meaningfully engaged. These were Individual #456, Individual #227, Individual #592, Individual #219, and Individual #194. Although several of these individuals reportedly did not regularly attend work, they were observed engaged in the computer lab, woodworking class, and when present, in their work sites. While staff were observed encouraging activity participation by Individual #303, Individual #10, and Individual #681, these individuals were not engaged in meaningful activities.

The facility is commended for exploring individual special interests and adult education classes. Three individuals were observed in woodworking class and others were reported to be participating in cooking classes. Other activities identified included sports, cake decorating, bible study, and art studio. Similar to the last visit, it was positive to observe individuals working in the ceramics program and the greenhouse.

21. For all nine individuals, engagement frequency and/or goal levels were not met over a six-month period in both their home and day program sites.

Individual #10 was the sole individual for whom engagement was assessed in her home each month with a mean score of greater than 65%. For all others, engagement in their homes was assessed between two and five times during a six-month period. Mean engagement goal levels were achieved in the homes for Individual #456, Individual #227, Individual #592, and Individual #219.

With regard to day program sites, there was no documented assessment of engagement in the work sites for Individual #456, Individual #227, Individual #592, Individual #219, Individual #154, Individual #10, and Individual #194. Similarly, there was no report regarding engagement for Individual #681's day program. Engagement was assessed four times in a six-month period in Individual #303's day program site, with a mean score of greater than 65%

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: Individuals did go into the community. The frequency goal was achieved for one individual. It was good to see about half of the individuals having some SAP training occur in the community. There were, however, no actions taken to address barriers for those individuals for whom community outing and community SAP training were not occurring as they should have been. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	456	227	592	303	219	154	10	194	681
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	1/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	56% 5/9	0/1	1/1	1/1	1/1	0/1	1/1	0/1	0/1	1/1
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. Based on the documentation provided by the facility, there was evidence that Individual #154 was the only individual whose goal frequencies for community-based recreational activities had been met. Staff are advised to review all data to ensure that tracking of community-based recreational activities corresponds to community-based training opportunities.

23. There was evidence of SAP training in the community for five of the nine individuals. For Individual #227 and Individual #592, the identified SAP was money management. It was not clear that these trainings addressed Individual #227's managing her ledger or Individual #592's recording his weekly balance. Further, both these SAPs indicated that training would take place in their homes. For these reasons, these community training opportunities were rated zero.

Remaining were four SAPs that had been trained at least one time in the community. These were the play CD and hand washing SAPs for Individual #303, the make a purchase SAP for Individual #154, and the wash hands SAP for Individual #681.

24. There was no evidence that the IDT for each of the nine individuals had met to discuss barriers to community recreational activities or community-based training.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
Summary: The Center did most of the required collaborative/integrated activities with the public school (i.e., five of the six sub-indicators). This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall	468								

		Score										
25	The student receives educational services that are integrated with the ISP.	0%	0/1									
Comments: 25. None of the nine individuals in the review group were attending school, so a review was completed of the educational services provided to another individual, Individual #468. His ISP included school related information, and while his QIDP monthly reports also included information about school, there was no specific review of his report cards or educational progress. His QIDP attended Individual #468's annual meeting during which the IEP team discussed inclusion and extended day services.												

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/2	N/A	N/A	0/1	N/A	N/A	0/1	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/2			0/1			0/1			
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/2			0/1			0/1			
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/2			0/1			0/1			
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/2			0/1			0/1			
Comments: a. through d. For the two individuals that had refused dental services, IDTs had not developed specific goals/objectives related to their refusals.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Since the last review, some good improvement occurred with the measurability of communication goals/objectives the Monitoring Team reviewed Work is still needed to improve the clinical relevance of goals/objectives. It also will be important for SLPs to work with QIDPs to include data and analysis of data on communication goals/objectives in the QIDP integrated reviews. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. Individual #315 had a goal that was clinically relevant (i.e., press an adaptive switch to play music), but it was not implemented as written from 7/5/18 to 12/5/18, nor was there evidence of additional training or monitoring to ensure the frequency of program implementation was met. In addition, the goal was not measurable. Otherwise, none of the remaining eight individuals had communication goals, but should have based on their identified strengths and needs. c. through e. For the nine individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives.											

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.	
Summary: To move forward, QIDPs and SLPs should work together to make sure QIDP monthly reviews include data and analysis of data related to the implementation of communication strategies and SAPs. These indicators will	Individuals:

remain in active oversight.											
#	Indicator	Overall Score	194	303	538	149	315	459	201	276	781
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/2	0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	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: As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether the measurable strategies related to communication were implemented. Examples of concerns included:

- No evidence was found that the IDT met to discuss Individual #194's Service Objective (SO) to attend a signing class. As such, no clear goal or objective was identified, and, therefore, no clear purpose of the program was established.
- Individual #315's communication program was not implemented according to the set schedule from July 2018 to December 2018. She did not receive the required number of opportunities during any of those months.

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: Based on the Monitoring Team's interactions with individuals as well as review of documentation, there was room for substantial growth in this area. With a census of 446 individuals, the list of alternative and augmentative communication (AAC) devices across the Center showed a total of 30 devices, including 10 shared devices and 20 personal devices. Since 1/6/16, only seven of these devices were added. Moreover, based on observations, in individuals' homes and programs, there was a lack of implementation of those AAC devices that did exist. The Center should continue to focus on ensuring individuals have their AAC devices with them. Most importantly, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner. These indicators will remain in active monitoring.

[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	339	32	174	600	73				
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	40% 2/5	0/1	0/1	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.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	0% 0/3									
Comments: a. and b. It was concerning that often individuals' AAC devices were not present or readily accessible, and/or that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them. Overall, it was of concern that there were limited AAC devices on campus. Only four percent of individuals at the Center had a personal AAC device.											

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. After the last review, two indicators were in the category requiring less oversight. At this time, no additional indicators will move to the category requiring less oversight.

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

The Center had maintained earlier progress in identifying the measurable criteria upon which the Post-Move Monitor (PMM) could accurately judge implementation of each support, particularly for post-move needs. Center staff are encouraged to continue making improvements in the development of a comprehensive set of supports, with particular emphasis on identifying supports to address all important requirements with regard to pre-move training for provider staff and for behavioral, safety, healthcare, therapeutic, and supervision needs.

Post-move monitoring processes and methodologies continued to improve. Some of the areas in which continued efforts were needed related to the PMM consistently gathering reliable and valid data upon which to make accurate judgements about the presence of needed supports, and the PMM correctly scoring the presence or absence supports based on the evidence. The Center had developed a process to ensure that IDTs follow up in a timely manner when the PMM noted problems with the provision of supports. To improve this process, the Center should ensure the IDT's discussion is thorough, sufficiently analytical, and carefully documented.

While the IDT met as needed to discuss the potentially disrupted community transition (PDCT) event experienced by one of the two individuals in this review, improvements were needed to ensure this process included a thorough and critical analysis that will support the identification of process improvements that might help to avoid any similar issues for future CLDPs.

It was positive transition staff worked with several disciplines on the quality of transition assessments and recommendations. Some progress was observed, but additional improvement was needed in the completion of all needed assessments, as well as the inclusion of comprehensive and community-appropriate recommendations. Although Center staff provided training to community provider staff, the CLDPs did not define the training thoroughly, and Center staff still were not able to confirm that community provider staff were competent to meet individuals' needs at the time of transition.

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: Overall, the Center had maintained the progress described in the previous monitoring report, with regard to the development of defining clear and measurable supports, but improvement was still needed to ensure the set of supports was comprehensive and addressed all important needs. The IDTs also still needed to focus on measurable pre-move training supports, ensuring they defined specific competency criteria and ensuring the methodologies for measuring those competencies were thorough. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 717	424							
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1							
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1							

Comments: Since the last review, three individuals transitioned from the Center to the community. Two were included in this review (i.e., Individual #717 and Individual #424). Both individuals transitioned to a community group home. The Monitoring Team reviewed these two transitions and discussed them in detail with the Denton SSLC Admissions and Placement staff.

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how individuals' needs and preferences will be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. The IDTs still needed to focus on developing measurable pre-move training supports, ensuring that these defined the specific competency criteria and ensured the tools for measuring those competencies are thorough. Findings included, but were not limited to:

- Pre-move supports: The respective IDTs developed 29 pre-move supports for Individual #717 and 23 pre-move supports for Individual #424.
  - For Individual #717, 25 of the pre-move supports focused on ensuring the availability of equipment and needed materials/documents (e.g. adaptive and assistive equipment, 30-day supplies of nutritional supplements, and a State of Texas ID), as well as addressing environmental concerns, such as installing grab bars in the tub/shower, and handrails and ramps at the doors to the home. These met criterion for measurability.
  - For Individual #424, 17 pre-move supports also addressed ensuring the availability of equipment and needed materials/documents (e.g. positioning and mobility equipment, 45-day supplies of gastrostomy tube and suction tooth brush needs, and a State of Texas ID). These also met criterion for measurability.
  - For purposes of measurability, the Center still needed to ensure the training supports described competency criteria that were comprehensive, clearly stated, and defined an appropriate testing methodology. As written, in these two CLDPs, pre-move training supports did not yet consistently specify the competency criteria, but some improvement was noted. Findings included, but were not limited to:
    - The best examples of defining pre-move training needs and competencies were for occupational and physical

therapy- (OT/PT) related supports. Some of these also included a clear methodology for competency demonstration, but this was not yet consistent. For example, Individual #717's IDT developed a pre-move training support for her occupational and physical therapy needs, which included specific expectations about staff knowledge and required competency demonstration for some skills, including demonstration of texturizing food correctly and preparing drinks to the correct consistency. Similarly, Individual #424's support in this area specified the competency criteria for each OT/PT need, and included competency demonstration for lifting, transferring, and positioning. Otherwise, however, the supports specified competency would be assessed by having provider staff "verbalize comprehension," which would be an unreliable indicator and difficult to measure. The IDT could also continue to improve on these supports by specifying which provider staff needed to be trained.

- Other pre-move training supports typically only listed topics to be covered, but failed to identify the criteria by which competency could be accurately measured. For instance, Individual #424's pre-move training support for nutritional needs listed topics, including enteral nutrition support; type of formula, dietary history, significant weight loss or gain, and current diet order. The support provided no detail about his specific needs and indicated only that competency would be gauged through interview and survey. Unfortunately, the support did not describe the basis upon which that competency could be measured.

- Post-Move: The respective IDTs developed 51 post-move supports for Individual #717, and 43 post-move supports for Individual #424. Findings regarding measurability included, but were not limited to:
  - Some of Individual #717's post-move supports provided specific criteria for provider staff. For example, one of Individual #717's post-move supports called for provider staff to monitor for seizures and described three specific signs and symptoms staff should know, to include twitching of the mouth and eyes, being unresponsive to verbal or touch stimuli, and drooling excessively during recovery. The evidence appropriately required a review of documentation and interview of staff.
  - Some other supports for Individual #717 used overly-broad language that would not be measurable. For example, a post-move support called for participation in preferred activities on a "routine basis weekly to monthly." This would be subject to interpretation. Another support called for maintenance of her tracheostomy, which included suctioning and cleaning, on a daily basis and as needed in between by a nurse. The support did not provide any detail to describe on what basis "as-needed" intervention by a nurse should be assessed (i.e., what conditions would require this nursing intervention).
  - Both individuals had a post-move support to monitor for hearing changes, but neither provided any criteria as to what provider staff should be alert to that might indicate a hearing change.
  - Overall, Individual #424's other post-move supports were measurable. This was positive.

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

- Past history, and recent and current behavioral and psychiatric problems: Individual #424 did not have any significant behavioral history or needs, but Individual #717did have recent and historical concerns:

- Individual #717's past behavioral plans had addressed physical aggression towards others, inappropriate toileting behavior, and aggression toward property. She also had required one-to-one supervision in her bedroom at night to ensure she did not pull out her tracheostomy. The CLDP included a pre-move support for the Board-Certified Behavior Analyst (BCBA) to provide historic information regarding pulling out her tracheostomy tube; the "run and catch" game, wherein she would run from staff to get them to chase her; pulling out her hair; throwing objects in play; and patting people forcefully. This did not include all her historical behaviors or clearly indicate behavioral strategies that had been successful in addressing them. The support required no pre-move training or evidence the provider was knowledgeable of her historical or current behavioral needs. For example, the CLDP did not make clear whether the "run and catch" game should be seen as an undesirable or unsafe behavior or, as another support described, a preferred activity.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The respective IDTs developed supports in some areas related to safety, medical, healthcare, therapeutic and risk needs, such as for scheduling of health care appointments. To meet criteria, the IDTs still needed to develop clear and comprehensive supports in these areas. Findings included:
  - Neither CLDP described supports related to supervision needs, but other documentation indicated such needs existed. For example:
    - Individual #717's CLDP profile indicated she would require 24-hour staff and enhanced supervision in the home with line-of-sight supervision at all times. It also noted she would require supervision in the bathroom to ensure she would not pull out her trach and to assist with hygiene; further, she required one-to-one staff for safety when outdoors, on community outings and during the overnight hours. CLDP supports did not address these supervision needs.
    - Per Individual #424's 14-day ISPA meeting and the CLDP profile, he needed enhanced supervision, requiring staff to be in line of sight for the first 30 days; after that, staff would need to provide "periodic" checks. While it was not clear what a periodic check would entail, the CLDP did not even include a support with the more measurable criteria about the line-of-sight requirement.
  - Other examples of needed improvement for Individual #717 included, but were not limited to:
    - Individual #717 had a history of refusing health care appointments, tests, and treatments. For example, she had recent refusals to have a DEXA scan for osteoporosis and a mammogram. The nursing assessment further indicated she was resistive to physical examination. The IDT developed numerous supports for medical and health care needs, but none for provider knowledge of the likelihood of, or specific strategies to minimize, resistance to their completion.
    - The nutrition assessment indicated Individual #717 required daily nursing lung sound assessments. The 14-day ISPA also stated she should have lung sound assessments after medication passes. CLDP supports did not specifically address this need.
    - Per the habilitation therapy and nursing assessments, Individual #717 had "routine" respiratory therapy treatments related to her tracheostomy, but neither assessment specified what her specific "routine" needs were in this area. The CLDP did not include any supports related to respiratory therapy treatments.
  - Per Individual #424's Integrated Health Care Plan (IHCP) for skin integrity and infections, he needed to have his temperature monitored daily. The IDT had not specifically included this requirement in any CLDP supports.
- What was important to the individual: The Monitoring Team reviewed various documents to identify what was important to

the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. Both CLDPs did address some outcomes important to each individual, but only Individual #424's did so assertively.

  - The CLDP for Individual #717 indicated her important outcomes were getting out in the community more often, having more available activities in which to participate, exposure to more preferred food, and normalization. The IDT did not assertively address any of these, if at all. For example, one post-move support called for Individual #717 to have opportunities to participate in community activities of her preference on a routine basis of weekly to monthly. The support did not describe her preferences in this regard and a monthly expectation for community activities would not enable her to take meaningful advantage of living in the community. The CLDP also did not include supports for exposure to more preferred foods. Finally, the Monitoring Team was concerned that the IDT cited flipping through magazines, playing connect four, and repeatedly filling and dumping out boxes as primary preferred activities for which she should have opportunities for participation. These activities reflected substitutions at the Center for meaningful, and stimulating activities. The IDTs should not perpetuate them in the community, but rather work with the receiving community team on developing meaningful and creative options.
  - The CLDP for Individual #424 identified important outcomes that included being outdoors, one-to-one attention, community excursions, and personal time. The IDT addressed each of these with CLDP supports. Other supports also addressed important preferences identified in his ISP, such as those related to music.

- Need/desire for employment, and/or other meaningful day activities: One of two CLDPs met criterion.
  - For Individual #717, the IDT developed a post-move support for attending a day program, but offered little in the way of specific recommendations or supports for meaningful activities in integrated community activities.
  - For Individual #424, the IDT determined that he would participate in an in-home day program, but further required that the day program would include community excursions for at least three days per week, to be documented in a running log. It was positive the IDT went beyond a statement that he would attend day program to ensure that this included community participation on a frequent basis.
- Positive reinforcement, incentives, and/or other motivating components to an individual's success. One of two CLDPs met criterion, based on the individuals' needs in this area:
  - For Individual #717, the CLDP included a post-move support for opportunities to participate in preferred activities, but did not otherwise address incentives, positive reinforcement or other motivating components. For example, the IDT did not provide any strategies the provider could use to address Individual #717's known anxiety disorder and her resulting refusals to participate in health care appointments.
  - The IDT for Individual #424 developed several detailed supports about his preferences for activities and related to his environmental and sensory needs. The CLDP also included a support to ensure staff knew he preferred to be called by his nickname, which documentation indicated was important to him.
- Teaching, maintenance, participation, and acquisition of specific skills: The Monitoring Team could not fully evaluate whether the IDT planned for needed supports in this area, because the Center did not provide a functional skills assessment (FSA) for either of these individuals. Instead, it provided a QIDP summary that referenced the current skill acquisition plans. The FSA is an important tool that IDTs should review when assessing skill acquisition needs in the community, which may be different from those provided at the Center. It was positive, though, that the IDTs did include post-move supports for continuing Center-based skill acquisition plans. Examples included, but were not limited to:

- For Individual #717, the IDT developed a support to continue three specific skill training objectives for putting on lotion, greeting, and washing hands. A second support called for her to continue to work with daily living skills to increase her independence and things she could do, but it provided no specific expectations.
- Individual #424's CLDP included post-move supports to continue training objectives for washing hands, participating in lotion application, and tooth brushing, and for pressing a switch to activate an audiobook.

- All recommendations from assessments are included, or if not, there is a rationale provided: Denton SSLC had a process in place for documenting in the CLDP the team's discussion of assessments and recommendations, including the IDT's rationale for any changes or additional recommendations. The Monitoring Team was particularly impressed with the documented thoroughness with which transition staff probed for additional information and recommendations during the CLDP meeting, based on their reading of various assessments and other documents, such as the ISP. This process often elicited substantial discussion during the CLDP meeting that expanded on the recommendations, which were then included in the supports. This was a very positive practice on the part of transition staff, but it remains essential that the professional disciplines continue to improve the content of their assessments to ensure all necessary recommendations are identified. This is discussed further with regard to Indicator 12 below. For this review, the IDTs did not yet address all recommendations with supports or otherwise provide a justification, as described further above. Additional examples included:
  - For Individual #717, the Center's Registered Nurse Case Manager (RNCM) recommended the provider continue to monitor for metabolic syndrome, but the IDT determined this was not necessary, because she was at low risk. When making this decision, the IDT did not document considering that pharmacy staff made the same recommendation in the Quarterly Drug Regimen Review (QDRR). Give that two of the Center's health care professionals made the same recommendation, the IDT needed to document a full discussion about the level of need/risk, but did not.
  - Individual #424's day program assessment indicated one of his important needs was to increase his current communication abilities to let staff know when he needed to be changed, but the IDT did not address this.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.	
Summary: Post-move monitoring often discovered when individuals were not receiving the protections, supports, and services they were supposed to receive, but improvement was still needed to ensure that reliable and valid data were collected to support the PMM's ability to make accurate assessments and take follow-up measures as needed. The Center made progress toward ensuring individuals' IDTs participated as needed in reviewing post-move monitoring results, but still needed some improvements to that process as well. Overall, the PMM was very methodical and attentive to detail during the PMM visit completed while the Monitoring Team was on-site. The PMM needed to focus on taking care to interview all appropriate staff involved in providing supports and to avoid asking leading questions and over-prompting when probing staff knowledge. One indicator (i.e. Indicator 3) remained in the category requiring less oversight, but the other indicators will remain in active oversight.	Individuals:

#	Indicator	Overall Score	717	424							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1							
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1							
6	The PMM's scoring is correct based on the evidence.	0% 0/2	0/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, the IDT/Facility implemented corrective actions in a timely manner.	0% 0/2	0/1	0/1							
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	0% 0/1	NA	0/1							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	0% 0/1	NA	0/1							

Comments: 4. In many cases, the PMM Checklists provided reliable and valid data that reported/summarized the status regarding receipt of supports. The PMM provided narrative comments for all supports that frequently addressed the required evidence. The Center still needed to make improvements to ensure it obtained reliable and valid data, including, but not limited to, the following:

- It was sometimes not possible to ascertain whether reliable and valid data were present due to a lack of specificity and measurability of some supports as described with regard to Indicator 1.
- For both individuals, the PMM did not routinely provide documentation that he interviewed the direct support staff who had responsibilities for implementing the CLDP supports. Instead, the documentation often indicated that he interviewed program managers, supervisory, or nursing staff. The PMM must probe staff knowledge for all provider staff who have responsibilities for carrying out individuals' supports, such as direct support staff knowledge of signs and symptoms they need to report to the supervisory and/or nursing staff. It was positive, however, that during the PMM visit the Monitoring Team observed during the on-site review week, the PMM interviewed direct support staff. The Monitoring Team member encouraged him to ensure these interactions were documented in the future.
- The PMM's comments did not always fully address the intent of the support. For example:
    - A CLDP support for Individual #424 indicated he should have a visit with the community primary care practitioner (PCP) within 45 days, and specified 12 diagnoses and numerous other requirements to be covered. At the seven-

day PMM visit, the PMM documented only that the PCP visit had occurred and that no changes had been made. The comment did not reflect whether the PCP reviewed all the needed requirements.
    - Individual #717 had a similar support for which the PMM only documented the occurrence and not whether it met the support criteria.

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

- For both individuals, the PMM found a number of supports were not in place at the time of the seven-day PMM visit, because the provider was not completing the required documentation. For example, for Individual #717, the home provider had not maintained the required documentation to evidence implementation of the following: family contacts, tooth brushing, implementation of skill acquisition programming, and encouragement of independent living skills. For Individual #424, the provider had not kept documentation of signs and symptoms of GERD, or for engagement in preferred activities at the home or in the community.
- For Individual #717, the PMM Checklists also indicated the following supports had not been implemented as required:
    - The home provider did not have a bowel management plan at the time of the seven-day PMM visit.
    - At the time of the 45-day PMM visit, Individual #717 had not been seen, as CLDP supports required, by the pulmonologist, the registered dietitian, or the BCBA. Per the PMM Checklists, this was due to insurance issues. By the time of the 90-day PMM visit, the latter two supports had been completed, but she had still not seen the pulmonologist as needed due to refusal.
    - At the time of the 90-day PMM visit, on 1/8/19, Individual #717 had not had a CBC, CMP, or a Dilantin level drawn. The CLDP supports called for these to be completed by 11/30/18. Per the 45-day PMM Checklist, the provider had attempted to complete this support on 11/26/18, but this was unsuccessful. It further indicated the provider was going to be working with the PCP to find a lab with which Individual #717 might be more compliant. At the 90-day PMM visit, the provider noted Individual #717's resistiveness was at a level that the PCP had determined she would need to be sedated for this support to be completed, as well as the support to be seen by the pulmonologist.
    - Similarly, at the time of the 90-day PMM visit, Individual #717 had not engaged in activities in the community as required due to significant behavioral issues, including property destruction, when such activities were attempted. It was positive the provider had recently obtained behavioral services to assist with this situation.
- For Individual #424:
    - At the time of the seven-day PMM visit, no community excursions had taken place as part of his in-home day programming as required.
    - Also at the time of the seven-day PMM, the provider had not attempted to contact Individual #424's family as called for in the CLDP supports.

6. The PMM's scoring was often correct, based on the supports defined in the CLDP, but there continued to be instances in which the available evidence did not substantiate the PMM's finding, as described above with regard to Indicator 4. Other examples included, but were not limited to:

- For Individual #717, the PMM marked as in place a support for provider staff knowledge of signs and symptoms of seizures. The seven-day comment indicated the day program director knew two of the three signs and symptoms, and appropriately, the PMM recommended a re-in-service. This should have been marked as not in place, with follow-up to ensure the required in-service had been completed. The PMM Checklists did not provide any evidence of follow-up on this concern.
- As described above with regard to Indicator 5, Individual #717 had not been to see the pulmonologist or had her lab work completed due to significant behaviors. The PMM marked these as in place because they had been attempted, but not completed. This was an emerging issue that needed to be brought to the attention of the IDT, so these supports should have been marked as not in place and highlighted as unmet support needs.
- For Individual #424, a post-move support required that a registered dietitian be consulted regarding all G-tube feeding adjustments. The PMM marked this support as in place, but provided but no evidence this consultation occurred when the community PCP reduced the feeding schedule.

7. through 8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed up through to resolution. The PMM continued to be extremely diligent in following up to ensure corrective actions were implemented in a timely manner once a need was identified.

- As reported at the time of the previous monitoring visit, though, whether follow-up is completed as needed relies heavily on the accuracy of the PMM's assessment of whether supports were, or were not, in place; as described above with regard to Indicator 6, this continued to be of some concern for both individuals.
- Also at the time of the previous monitoring visit, the Monitoring Team found Denton SSLC did not have a clearly stated policy or a consistent process that would ensure the IDT will be able to weigh in on potential issues, such as emerging behaviors or changes to supports the provider might have implemented. The Center made progress in this area. The PMM had begun to routinely hold meetings with the IDTs to discuss any unmet supports identified during the PMM visits. Going forward, the PMM also should complete an ISPA or otherwise document the full discussion and recommendations of the IDT, as opposed to the current practice of just making a brief note in the PMM Checklist. This note did not typically describe the discussion or otherwise provide a clear rationale for the IDT's decisions. For example:
    - For Individual #424, the IDT made very strong recommendations that it was unsafe for provider staff to use a mechanical lift, with a sole exception for obtaining his weight, and must otherwise use a two-person transfer technique. The IDT and provider discussed this during the CLDP meeting, and provider staff received pre-move training regarding this safety need. Further, the IDT developed clear CLDP supports to this effect. At the time of the 45-day PMM visit, the PMM documented the provider had obtained an evaluation from a community physical therapist that determined the two-person transfer was unsafe and that provider staff were to only use the mechanical lift. The PMM appropriately reported this modification of the CLDP supports to the IDT, but the documentation of the unmet support meeting in the PMM Checklist indicated only that the IDT agreed to the change. It provided no details of the IDT's discussion or rationale for accepting a modification that was in direct conflict with their strongly-worded recommendations for ensuring Individual #424's safety. In interview, transition staff acknowledged that the IDT discussion and determination to accept the change did not provide a clear rationale that addressed their previous safety concerns.

9. The Monitoring Team observed the 90-day PMM visit for Individual #717. Findings included, but were not limited to:

- The PMM was very methodical and attentive to detail during the PMM visit completed while the Monitoring Team was on-site.
- In most instances, he was careful to address every CLDP support in a thorough manner and to interview staff, make observations, and review documentation.
- The PMM should take care to interview all appropriate and available staff. It was positive to see the PMM interviewed direct support staff as well as supervisory staff at the day program, since earlier PMM Checklists had not indicated this was his practice. It was positive the PMM interviewed the nurse-practitioner who owned and operated the residential setting, and served as the primary caregiver, extensively. He should also have interviewed the owner's daughter, who provides supports and was present in the home for a portion of the PMM visit. For example, day program staff reported that they called the home provider every day to report bowel movements, rather than provide the home with written documentation. In interview, the home provider indicated this was not the case; rather, day program staff would inform the owner's daughter about bowel movements when she picked Individual #717 up in the afternoon. The PMM did not confirm this with the owner's daughter. When asked by the Monitoring Team member, the owner's daughter stated the day program provider had not told her anything and further indicated that was not a common practice. This lack of a consistent process for documenting bowel movements had the potential for increasing Individual #717's risk in this area.
- The PMM needed to modify his interviewing style to avoid the use of leading questions as a part of his initial probes when speaking with provider staff. He frequently posed questions that included prompts for staff, both as initial probes and as follow-up questions, when needed. This methodology was effective and appropriate as a teaching tool, but prompted responses should not be used to justify a positive score about staff knowledge and competence. The Monitoring Team member discussed this with the PMM, who indicated he would not use prompted answers in this manner. In review of the PMM Checklist, the Monitoring Team member observed some instances in which the PMM accurately noted that staff had not been able to provide all the required information without prompting, such as for signs and symptoms for seizures. For other supports, such as for monitoring signs and symptoms of constipation and GERD, the Monitoring Team member also observed the PMM prompting day program staff, but the PMM Checklist documentation indicated staff were knowledgeable.

10. In most cases, the PMM Checklist was an accurate reflection of the PMM visit as observed; however, some exceptions did occur, such as the inaccurate portrayal of staff knowledge related to the signs and symptoms of constipation and GERD described above. In addition, the PMM Checklist did not fully convey the scope of the supports that had been negatively impacted by Individual #717's anxiety and refusals to participate. For example, she had not yet been to see the pulmonologist or had her lab work completed due to significant behaviors the provider described. The PMM marked these as in place, because they had been attempted, but not completed. Similarly, the provider indicated she would not be able to take Individual #717 to the neurologist due to behaviors until the PCP decided on pre-treatment sedation. The PMM marked this as not applicable because the support was not yet due, but did not capture the concern in the comments, instead indicating there were no issues. Individual #717 also had other pending medical and health care appointments that were not yet due at the time of the 90-day PMM visit, so it would have been important to bring the issue of these repeated refusals back to the IDT for possible assistance in addressing/remediating these concerns

Outcome 3 – Supports are in place to minimize or eliminate the incidence of preventable negative events following transition into the community.											
Summary: One individual had experienced a PDCT event. The IDT had met as needed to review the circumstances, but missed several opportunities to make a robust critical analysis of the event for the purposes of remediating any concerns and identifying process improvements to avoid any similar issues for future CLDPs. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	717	424							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	50% 1/2	1/1	0/1							

Comments: 11. Individual #717 had not experienced a PDCT event, but Individual #424 had one emergency department (ED) visit.

- Per the ISPA, dated 11/30/18, on 11/22/18, Individual #424 was transferred from his community home to the ED after experiencing diaphoresis (sweating), increased saliva, and low blood sugar (83). The evaluation at the ED resulted in an eventual diagnosis of "possible" constipation. The ED administered an enema and discharged him.
- The PDCT process should serve as an opportunity for the IDT to complete a critical analysis of the event, for the purposes of remediating any concerns and identifying process improvements to avoid any similar issues for future CLDPs. The Center missed several such opportunities in the completion of this PDCT ISPA. For example:
  - The provider bowel movement log indicated his last bowel movement had been recorded on 11/20/18 on the evening shift, so per his bowel management plan, the provider would have administered medication the same day he went to the ED. The IDT and provider should have discussed whether the bowel management plan might need to be adjusted as to how soon intervention of some sort needed to occur to avoid future ED visits.
  - The Center RNCM stated Individual #424 was known to sweat sometimes and their response had been to point a fan at him, but that they had never thought to take blood sugar since he was not diabetic. Per the community PCP, if these circumstances recurred, the provider should repeat taking his blood sugar and for further follow-up to be considered as needed. The PDCT documentation also indicated he had lab work due in January. The IDT agreed with this approach, but perhaps should have discussed whether some increased monitoring frequency for a period of time might be needed. Especially given that they acknowledged that for some time, this might have been an ongoing, but unrecognized, symptom.
  - The documentation indicated his temperature had been taken earlier in the day of the ED visit and was fine. This again highlighted the fact that Individual #424 had his temperature taken every shift while living at the Center, per his IHCP for skin integrity and infections, but the IDT had not specifically included this requirement in any CLDP supports. There was also no documentation that the Center had educated the provider about his propensity to perspire and what steps the Center had taken when that occurred. While the provider might have taken more efficacious steps, as described in the ISPA, the Center still should have communicated this possible symptom in his supports and/or

training so the provider would be aware to monitor for it.

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.												
Summary: Overall, this review demonstrated a continuing need for improvement in discipline assessments, particularly as they related to recommendations for a successful transition and for community living. It was positive transition staff were working with disciplines both before and during CLDP meetings to elicit needed information, clarifications, and recommendations from IDT members. Transition staff should continue to pursue these strategies, with the expectation that discipline assessment practices will improve over time. Some limited progress was observed with regard to training provided to community provider staff, particularly with regard to OT/PT supports. Center efforts were still hampered in this area by the overall lack of clear competency criteria and thorough competency demonstration methodologies. In turn, this negatively impacted the ability of Center staff to confirm that community provider staff were competent to meet individuals' needs at the time of transition. One indicator (i.e., Indicator 13) continued to be in the category requiring less oversight, but the other indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	717	424							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							

15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	100% 2/2	1/1	1/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	100% 2/2	1/1	1/1							
18	The APC and transition department staff collaborate with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition.	50% 1/2	0/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

Comments: 12. Assessments did not consistently meet criterion for this indicator, but the Center had implemented some improved processes. For example, transition staff reported using the 14-Day meeting to point out information and recommendations that should be included in the transition assessments. The Center also provided good documentation of persistent follow-up by transition staff for clarifications and additional information. The Director of Community and Family Relations further indicated the Center might do another round of discipline-specific training in this area. Transition staff should continue to pursue these strategies, with the expectation that discipline assessment practices will improve over time. The Monitoring Team considers the following sub-indicators when evaluating compliance:

- Assessments updated with 45 Days of transition: Assessments provided for review met criterion for timeliness, but neither individual had an FSA or update provided for review.
- Assessments provided a summary of relevant facts of the individual's stay at the Center: Many discipline assessments provided a summary of relevant facts in the available assessments, but this was not yet consistent. Examples included:
  - Neither individual had a communication assessment that fully discussed their skills and needs:
    - Individual #717's communication assessment did not reference her ability to use some signs.
    - Individual #424 had not had a comprehensive communication assessment since 2013. Given the significant upcoming changes in his environment, the IDT should have considered whether a comprehensive assessment would have better supported the transition. The update provided did not address conflicts with the day program assessment about his current visual functioning. The latter stated he would acknowledge symbol cards used to facilitate choice-making when presented to him by rolling his eyes, making noises and moving around in his chair; the former indicated staff should not use visual materials because he could not see.
  - For Individual #424, the CLDP discussion about his nursing needs documented important information the provider needed to know about potential G-tube complications, such as granuloma formation and buried bumper syndrome, as well signs and symptoms of seizures. None of that was covered in the nursing assessment.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community and that focus on the new community home and day/work settings: The Monitoring Team found a continuing need for improvement related to recommendations for a successful transition and for community

living, but some progress was noted. For example, Individual #424's habilitation and nutrition assessments provided a comprehensive set of recommendations related to his physical and nutritional management needs. It was also positive that transition staff often elicited substantial discussion during the CLDP meeting that expanded on the recommendations, which were then included in the supports. Examples of continuing concerns included:

- As described above, Individual #717's nursing assessment did not provide recommendations for monitoring specific potential g-tube complications.
- Individual #717's behavioral assessment did not provide recommendations for addressing refusals of health care appointments.
- Individual #424's day program assessment offered no recommendations for meaningful day activities.

14. Center staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required: This training did not yet meet criterion for these two CLDPs, as described with regard to Indicator 1 above and further below, but some improvements were noted. Findings included:

- Pre-move training supports provided a list of topics as the content to be covered under each broad area of training, but only a few indicated the specific knowledge provider staff would be required to have by the time of the transition. With the exception of OT/PT supports, most did not provide specific criteria by which competency could be measured.
- It was positive the IDTs had begun to consider whether didactic learning was appropriate for all needs, and whether other methodologies, such as demonstration or hands-on modeling might be better suited to some. This approach included having provider staff come to the Center for in vivo training for many OT/PT and nursing needs. As the IDTs continue to make improvements in identifying specific competency criteria, those should form the basis for determining how competency could best be measured.
- Likewise, it was positive habilitation and nursing staff had developed competency checklists that included and expanded on the criteria described in the pre-move training supports and used these to document provider staff competence. These would provide a good model for other disciplines to consider.

15. When necessary, Center staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The IDT should include in the CLDP a specific statement as whether any collaboration was needed, and if any was completed, summarize findings and outcomes. It was positive the respective IDTs had begun to discuss and document the need for any collaboration at the 14-Day ISPA meeting, and should ensure they update these findings and recommendations at the time of the CLDP meeting and document this discussion.

- For Individual #717, the IDT determined both nurse-to-nurse and doctor-to-doctor collaborations were needed.
  - The CLDP included a pre-move nurse-to-nurse support for information to be shared for the following topic areas: medication, weight, nursing comprehensive assessments, immunizations, the IRRF, and lab results and diagnostics, including an echocardiogram, mammogram, and DEXA scan. The support did not define specific competencies and indicated competency would be determined by having the provider "verbalize comprehension." It was not clear if this meant the provider would make a blanket statement indicating she understood everything she had been told or if she should be able to state the specific needs and strategies in each of the topic areas. Without a statement of the specific competencies, the latter would have been hard to accomplish. It was positive the collaboration did take place, but the Center needed to clearly establish how to ensure the individual's specific needs were covered, as well as document

provider competency related to those individualized needs.
    - The CLDP also included a pre-move collaboration between the PCPs, to cover the following needs: active diagnoses, current medications and treatments, labs, follow ups, and, neurology and pulmonary specialist requirements. The documentation indicated the collaboration was completed on 7/23/18, but it provided no information about what was discussed.
- Individual #424's IDT also determined both nurse-to-nurse and doctor-to-doctor collaborations were needed.
    - It was positive the CLDP provided a good summary of the nurse-to-nurse collaboration.
    - The IDT indicated the PCP collaboration should include information regarding diagnoses, current medications/treatments, labs, and follow-up and medical specialist needs. Again, the documentation provided indicated the collaboration occurred on 9/13/18, but did not provide any further detail about content.

16. SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs: The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. Both CLDPs met criterion. Again, it was positive the respective IDTs had begun to discuss and document the need for any settings assessment at the 14-Day ISPA meeting.

- For Individual #717, the IDT determined at the 14-day ISPA meeting that Center habilitation staff should complete a settings assessment for assistive equipment and possible modifications, including an assessment for bathing needs. The CLDP indicated this had been completed and included discussion of the findings and outcomes.
- For Individual #424, on 5/9/18, the transition team, including the transition OT, completed an assessment of the home and the CLDP documented its completion and outcomes.

17. Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual: The CLDP should include a specific statement of IDT considerations of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results. Examples include provider direct support staff spending time at the Center, Center direct support staff spending time with the individual in the community, and Center and provider direct support staff meeting to discuss the individual's needs. Both CLDPs included a pre-move support for direct support staff to participate in the transition process to assist the individual to adjust to the new environment and met criterion. This was positive.

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

- For Individual #717, collaboration was not sufficient to ensure a smooth transition, either before or after the transition date. Her transition was delayed from 7/23/18 until 10/12/18, due primarily to issues related to provider enrollment that were not discovered until the pre-move site review (PMSR). In addition, during the PMM visit held while the Monitoring Team was on-site, the provider reported that she had incurred many expenses to put required supports in place that were not reimbursed through the Home and Community-based Services (HCS) program. She also expressed frustration that she had learned belatedly that the SSLC could have potentially lent her some of the equipment she had purchased until HCS funding began to flow. Emails among the Center, the provider, the LIDDA and State Office staff confirmed a lack of effective coordination.

Transition staff indicated they had not had prior experience with a brand-new provider and intended to modify their processes going forward to support the provider through all of the necessary steps from the time of the provider selection meeting and throughout the transition.

- For Individual #424, the CLDP met criterion.

19. The PMSRs for both individuals were completed in a timely manner. It is essential the Center can directly affirm provider staff competency to ensure an individual's health and safety prior to relinquishing day-to-day responsibility. As described with regard to Indicator 1 and Indicator 14 above, neither of these two PMSRs fully accomplished confirmation of provider staff competency.

Outcome 5 – Individuals have timely transition planning and implementation.

Summary: This indicator will remain in active oversight. It was positive the Center had taken steps to adjust its transition planning processes to address avoidable delays that occurred with one of the two transitions.			Individuals:								
#	Indicator	Overall Score	717	424							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	50% 1/2	0/1	1/1							

Comments: 20. One of two CLDPs met criterion for this indicator.

- On 1/30/18, Individual #717 was referred, and on 10/12/18, transitioned. This exceeded 180 days and some avoidable delays occurred. On 6/29/18, the initial CLDP meeting was held, with a projected transition date of 7/23/18. The transition was delayed after the initial PMSR, however, when the LIDDA found the provider was not knowledgeable of HCS rules and regulations, and, further, was not listed as an approved provider in system. Per documentation, this was resolved by end of August, but it took approximately six weeks thereafter for transition to take place. Transition staff have now appropriately modified their processes to confirm enrollment has occurred at the time of the provider choice meeting. Further, transition staff are taking a more active role to ensure that new providers, in particular, have information and reminders as needed to complete all steps needed for a successful transition.
- On 3/5/18, Individual #424 was referred, and on 9/25/18, transitioned. This exceeded 180 days by just a few weeks. The Transition Log documented some justifiable delays due to concerns about provider performance following another transition to the same home from a different Center. It was positive the Centers had shared this information and coordinated regarding the concerns until they were resolved.

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

c. Medical
d. Nursing
e. Pharmacy
f. Dental

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

The individual-specific documents listed below:

- ISP document, including ISP Action Plan pages
- IRRF, including revisions since the ISP meeting
- IHCP
- PNMP, including dining plans, positioning plans, etc. with all supporting photographs used for staff implementation of the PNMP
- Most recent Annual Medical Assessment, including problem list(s)
- Active Problem List
- ISPAs for the last six months
- QIDP monthly reviews/reports, and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request
- QDRRs: last two, including the Medication Profile
- Any ISPAs related to lack of progress on ISP Action Plans, including IHCP action plans
- PNMT assessment, if any
- Nutrition Assessment(s) and consults within the last 12 months

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

- For individuals who received TIVA or medical and/or dental pre-treatment sedation, copy of informed consent, and documentation of committee or group discussion related to use of medication/anesthesia
- ISPAs, plans, and/or strategies to address individuals with poor oral hygiene and continued need for sedation/TIVA
- For any individual with a dental emergency in the last six months, documentation showing the reason for the emergency visit, and the time and date of the onset of symptoms
- Documentation of the Pharmacy's review of the five most recent new medication the orders for the individual
- WORx Patient Interventions for the last six months, including documentation of communication with providers
- When there is a recommendation in patient intervention or a QDRR requiring a change to an order, the order showing the change was made
- Adverse Drug Reaction Forms and follow-up documentation
- PCP post-hospital IPNs, if any
- Post-hospital ISPAs, if any
- Medication Patient Profile form from Pharmacy
- Current 90/180-day orders, and any subsequent medication orders
- Any additional physician orders for last six months
- Consultation reports for the last six months
- For consultation reports for which PCPs indicate agreement, orders or other documentation to show follow-through
- Any ISPAs related to consultation reports in the last six months
- Lab reports for the last one-year period
- Most recent colonoscopy report, if applicable
- Most recent mammogram report, if applicable
- For eligible women, the Pap smear report
- DEXA scan reports, if applicable
- EGD, GES, and/or pH study reports, if applicable
- Most recent ophthalmology/optometry report
- The most recent EKG
- Most recent audiology report
- Clinical justification for Do Not Resuscitate Order, if applicable
- For individuals requiring suction tooth brushing, last two months of data showing implementation
- PNMT referral form, if applicable
- PNMT minutes related to individual identified for the last 12 months, if applicable
- PNMT Nurse Post-hospitalization assessment, if applicable
- Dysphagia assessment and consults (past 12 months)
- IPNs related to PNMT for the last 12 months
- ISPAs related to PNMT assessment and/or interventions, if applicable
- Communication screening, if applicable
- Most recent Communication assessment, and all updates since that assessment
- Speech consultations, if applicable
- Any other speech/communication assessment if not mentioned above, if any within the last 12 months

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

The individual-specific documents listed below:

- ISP document
- IRRF, including any revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment
- Active Problem List
- All ISPAs for past six months
- QIDP monthly reviews/reports (and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request)
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- These annual ISP assessments: nursing, habilitation, dental, rights
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment

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

- A list of all injuries for the individual in last six months.
- Any trend data regarding incidents and injuries for this individual over the past year.
- If the individual was the subject of an injury audit in the past year, audit documentation.

For specific individuals who have moved to the community:

- ISP document (including ISP action plan pages)
- IRRF
- IHCP
- PSI
- ISPAs
- CLDP
- Discharge assessments
- Day of move checklist
- Post move monitoring reports
- PDCT reports
- Any other documentation about the individual's transition and/or post move incidents.

APPENDIX B - List of Acronyms Used in This Report

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

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

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