United States v. State of Texas

Monitoring Team Report

Denton State Supported Living Center

Dates of Remote Review: June 21st to 24th, 2021

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Background

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

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

In addition, the parties set forth 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.

For this review, this report summarizes the findings of the two Independent Monitors, each of whom have 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 Center'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 review, the Monitoring Teams requested various types of information about the individuals who lived at the Center and those who had transitioned to the community. From this information, the Monitoring 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 Center's compliance with all provisions of the Settlement Agreement.

b. **Onsite review** – Due to the COVID-19 pandemic and resultant safety precautions and restrictions, the Monitoring Teams did not visit the campus in person. Instead, the Monitoring Teams collaborated with the Parties to create a remote virtual review protocol that allowed for the monitoring of all of the outcomes and indicators.
    1. 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 Center-wide documents. During the week of the remote review, the Monitoring Team requested and reviewed additional documents.
    2. Attending meetings – The Monitoring Team attended various regularly occurring meetings at the Center by calling in to a teleconference, or utilizing a video meeting platform (Microsoft Teams). Examples included daily morning medical meeting, daily incident management review team, physical nutritional management team, ISPs annual and preparation meetings, and QAQI Council.
    3. Interviews – The Monitoring Team conducted interviews of staff, managers, clinicians, individuals, and others by calling in to a teleconference, or utilizing a video meeting platform (Microsoft Teams).
    4. Observations – The Monitoring Team conducted observations of individuals and staff engaged in various activities with the usage of a video platform (Microsoft Teams). The Center assigned a staff member to host each observation. That staff member used a portable mobile device (e.g., iPhone) to show the individual and staff. Activities included administration of medication, implementation of skill acquisition plans, and engagement in activities at home.
c. **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 move to the category of requiring less oversight. At the next review, indicators that move to this category will not be rated, but may return to active oversight at future reviews if the Monitor has concerns about the Center's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the Center's plans for continued quality assurance and improvement. In this report, any indicators that were moved to the category of less oversight during previous reviews are shown as shaded and no scores are provided. The Monitor may, however, include comments regarding these indicators.

Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the 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 Center'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. 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.
g. **Quality improvement/quality assurance:** The Monitors' report regarding the monitoring of the Center's quality improvement and quality assurance program is provided in a separate document.

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 Monitors and Monitoring Team members recognize that the COVID-19 global pandemic has required Center staff to make some significant changes to their practices, and that the steps necessary to protect individuals and staff

require substantial effort. The time since the pandemic began has undoubtedly been a challenging one at the Centers, as it has been across the country.

In a letter, dated 8/23/21, after the draft report was submitted, the Monitor notified the parties that the Center achieved substantial compliance with most of the requirements of Section Q of the Settlement Agreement. The exceptions are: 1) implementation of a policy/clinical guideline that is consistent with current generally accepted standards of care on perioperative assessment and management of individuals needing TIVA/general anesthesia for dental work, which the Monitoring Team will continue to assess and apply the findings to paragraphs H.7; and 2) personal goals/objectives for individuals who are at risk for dental problems, as well as the development and implementation of plans for individuals who require suction tooth brushing, which the Monitoring Team will assess as part of Section F. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Denton SSLC exited from the other requirements of Section Q of the Settlement Agreement.

State Office shared a chart in which Center staff outlined activities that were put on hold, and provided information about how staff believe such changes potentially impacted the delivery of supports and services that the Settlement Agreement requires. In conducting the review and making findings, the Monitors have taken into consideration the impact COVID-19 might have had on the scores for the various indicators. In some instances, the Monitors have indicated that they were unable to rate an indicator(s) due to this impact.

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at Denton SSLC for their assistance with the review. The Monitoring Team appreciates the assistance of the Center Director, Settlement Agreement Coordinator, and the many other staff who assisted in completing the remote review activities.

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.

As described in further detail below, at the time of the last review, the Center exited from Section C and had exited from Section D of the Settlement Agreement. This Domain currently includes five outcomes and 21 underlying indicators. At the time of the last review, one of the indicators was in the less oversight category. 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.

Restraint

As indicated in the last report, the Center showed sustained substantial compliance with many of the requirements of Section C of the Settlement Agreement. The exceptions are Section C.5 related to licensed health care staff's (nurses' and/or physicians') roles in the monitoring of all types of restraints, and physicians' roles in defining monitoring schedules, as needed; and Section C.6 related to assessments for restraint-related injuries, as well as monitoring of individuals subjected to medical restraint. The Monitoring Teams will continue to monitor these remaining areas for which Center staff have not obtained substantial compliance using the outcomes and indicators related to these subjects. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Denton SSLC exited from the other requirements of Section C of the Settlement Agreement.

For two of the five physical restraints reviewed, nurses performed physical assessments, and documented whether there were any restraint-related injuries or other negative health effects. For the remaining two physical restraints, timeliness of the initiation of nursing assessments was the main problem, and sometimes, this was due to staff not notifying the nurse timely.

For the one protective mechanical restraint for self-injurious behavior (PMR-SIB) reviewed, the IDT had not developed an integrated health care plan (IHCP) addressing it, including definition of the nursing interventions. However, nursing staff consistently implemented assessments required by the nursing guidelines, which was good to see. Some work was needed with regard to the quality of the skin assessments, though.

Abuse, Neglect, and Incident Management

After a previous review, the Center achieved and maintained substantial compliance with the requirements of section D of the Settlement Agreement, and, as a result, exited from section D of the Settlement Agreement.

Other

The Center was addressing some aspects of attending to pretreatment sedation as required. However, all of the requirements for activity, review, and documentation were not occurring.

Restraint

The Center showed sustained substantial compliance with many of the requirements of Section C of the Settlement Agreement. The exceptions are Section C.5 related to licensed health care staff's (nurses' and/or physicians') roles in the monitoring of all types of restraints, and physicians' roles in defining monitoring schedules, as needed; and Section C.6 related to assessments for restraint-related injuries, as well as monitoring of individuals subjected to medical restraint. The Monitoring Teams will continue to monitor these remaining areas for which Center staff have not obtained substantial compliance using the outcomes and indicators related to these subjects.

With the understanding that these topics are covered elsewhere in the Settlement Agreement, Denton SSLC exited from the other requirements of Section C of the Settlement Agreement.

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

Summary: For three of the five physical restraints reviewed, nurses performed physical assessments, and documented whether there were any restraint-related injuries or other negative health effects. For the remaining two physical restraints, timeliness of the initiation of nursing assessments was the main problem, and sometimes, this was due to staff not notifying the nurse timely.

For the one PMR-SIB restraint reviewed, the IDT had not developed an IHCP addressing it, including definition of the nursing interventions. However, nursing staff consistently implemented assessments required by the nursing guidelines, which was good to see. Some work was needed with regard to the quality of the skin assessments, though.

If the Center sustains its progress with regard to nursing staff documenting whether there are any restraint-related injuries or other negative health effects following restraints, then, after the next review, Indicator c might move to the category requiring less oversight.

Individuals:

#	Indicator	Overall Score	150	159	303	41	219				

a.	If the individual is restrained using physical or chemical restraint, nursing assessments (physical assessments) are performed in alignment with applicable nursing guidelines and in accordance with the individual's needs.	60% 3/5	0/1	0/1	N/A	1/1	2/2				
b.	If the individual is restrained using PMR-SIB:										
	i. A PCP Order, updated within the last 30 days, requires the use of PMR due to imminent danger related to the individual's SIB.	100% 1/1	N/A	N/A	1/1	N/A	N/A				
	ii. An IHCP addressing the PMR-SIB identifies specific nursing interventions in alignment with the applicable nursing guideline, and the individual's needs.	0% 0/1			0/1						
	iii. Once per shift, a nursing staff completes a check of the device, and documents the information in IRIS, including: a. Condition of device; and b. Proper use of the device.	100% 1/1			1/1						
	iv. Once per shift, a nursing staff documents the individual's medical status in alignment with applicable nursing guidelines and the individual's needs, and documents the information in IRIS, including: a. A full set of vital signs, including SPO2; b. Assessment of pain; c. Assessment of behavior/mental status; d. Assessment for injury; e. Assessment of circulation; and f. Assessment of skin condition.	100% 1/1			1/1						
c.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	100% 6/6	1/1	1/1	1/1	1/1	2/2				
d.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	100% 2/2	1/1	N/A	N/A	N/A	1/1				

Comments: The restraints reviewed included those for: Individual #150 on 4/30/21, at 8:25 p.m. (horizontal side-lying); Individual #159 on 4/4/21, at 9:38 p.m. (unapproved technique); Individual #303 from 4/24/21 to 4/30/21 (PMR-SIB); Individual #41 on 5/4/21 at 10:20 a.m. (helmet as crisis intervention restraint); Individual #219 on 3/31/21 at 5:59 p.m. (SUR multi-person arm hold), and on 3/28/21 at 7:44 p.m. (horizontal side-lying).

a. through c. For Individual #219 on 3/31/21 at 5:59 p.m. (SUR multi-person arm hold), and on 3/28/21 at 7:44 p.m. (horizontal side-lying), as well as for Individual #41 on 5/4/21 at 10:20 a.m. (helmet as crisis intervention restraint), the nurses performed physical assessments, and documented whether there were any restraint-related injuries or other negative health effects.

It also was positive that for all the physical restraints reviewed, nursing staff documented whether there are any restraint-related injuries or other negative health effects. They also took action based on assessment results to meet individual's needs.

The following provide examples of problems noted:

- On 4/30/21, Individual #150 had two restraints in short succession, including one at 8:20 p.m., and one at 8:25 p.m. The Monitoring Team reviewed the latter. Nursing staff completed the assessments thoroughly, and in accordance with nursing guidelines. The only issue was the timeliness of the assessments, which seemed to be due to staff not notifying the nurse timely of the restraint. The restraint ended at 8:28 p.m., but staff did not notify the nurse until 10:30 p.m. At 10:40 p.m., the nurse arrived and initiated assessments. The nurse reassessed the individual due to a high heart rate. The nurse also assessed and provided treatment to the individual's abrasion and scratch.
- On 4/4/21, Individual #159 had a restraint that lasted six minutes, and was categorized as: "Other: Technique is not approved SUR at DSSLC." The nursing note indicated it was a bi-lateral hand hold that ended at 9:45 p.m. Staff did not notify the nurse until 4/5/21 at 12:15 a.m. So, again, nursing staff completed the assessments thoroughly, and in accordance with nursing guidelines. The only issue was the timeliness of the assessments, which was due to the notification process. However, there were some discrepancies, because IView entries showed vital signs at 10:06 p.m., on 4/4/21.
- For Individual #303, the Monitoring Team reviewed PMR-SIB documentation from 4/24/21 to 4/30/21. It was positive that nurses documented checks of the helmet every shift. Overall, the nurses completed the required nursing assessments. However, the skin assessments indicated: "normal for ethnicity," which did not provide information about any redness, or injuries related to the use of the chin strap, helmet, etc. It was positive though, that nurses documented circulation, and that there was no redness. Based on submitted documentation, staff did not develop the required IHCP to address the use of PMR-SIB, including definition of the nursing interventions.

Abuse, Neglect, and Incident Management

After a previous review, the Center achieved and maintained substantial compliance with the requirements of section D of the Settlement Agreement and, as a result, was exited from section D of the Settlement Agreement.

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5

a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	N/A									
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									
Comments: a. and b. Based on the documentation provided, during the six months prior to the review, none of the individuals in the physical health review group received total intravenous anesthesia (TIVA)/general anesthesia or oral pre-treatment sedation.											

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	50% 2/4	N/A	N/A	N/A	0/1	N/A	N/A	1/2	1/1	N/A

Comments: a. For Individual #19, who was admitted to the hospital for a colonoscopy on 4/8/21, nursing staff followed the nursing guidelines for monitoring his vital signs upon his return.

For Individual #108:

- On 3/5/21, she received intravenous (IV) sedation at the hospital for a breast biopsy. Prior to her transport to the hospital and upon her return, nursing staff followed the vital sign assessment guidelines.
- On 4/9/21, she received sedation for placement of a Mediport. No evidence was found to show that nursing staff took and recorded her vital signs before her transport to the hospital.

On 1/18/21, Individual #35 received pre-treatment sedation for a mammogram. In reviewing her AMA and ISP, no evidence was found that the PCP determined the medication and dosage range with interdisciplinary input. The AMA stated that pre-treatment sedation had not been necessary, and the ISP did not include any discussion of the need for sedation. It was positive that informed consent was present, and that nursing staff followed the nursing guidelines for pre- and post-procedure monitoring of the individual's vital signs.

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: The Center was addressing some aspects of attending to PTS as required, however, all of the requirements for activity, review, and documentation were not occurring. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	115	112	297	150	479	407	483	344

1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	0% 0/1				0/1					
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	0% 0/1				0/1					
4	Action plans were implemented.	0% 0/1				0/1					
5	If implemented, progress was monitored.	0% 0/1				0/1					
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/1				0/1					

Comments:
1-6. This outcome applied to one individual in the review group (Individual #297). The Center provided some documents and information, but the full response to tier 2 document request 38 was incomplete.

He was identified as having had PTS. The Center provided a report that addressed (a) the dental procedure for which PTS would be administered, (b) the interfering behaviors that were observed in the past, (c) a consideration of risk versus benefit, and (d) Unit Level Strategies to Reduce PTS, including familiar staff accompanying him to the appointment and the provision of preferred items including a beverage and music.

It was good to see these documents and that the team was giving some consideration to addressing PTS, however, missing were pages from the ISP, the QIDP monthly report in which PTS usage was reviewed, and evidence of informed consent. Further, there was no evidence in the ISP of an action plan developed as either a service objective or a SAP.

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	82	235	365	583					
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 4/4	1/1	1/1	1/1	1/1					
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1					

Comments: a. Since the document submission for the last review, 13 individuals died. The Monitoring Team reviewed four deaths.

- On 10/1/20, Individual #327 died at the age of 55 with causes of death listed as cardiogenic shock, acute myocardial infarction, and atherosclerotic coronary artery disease; hyperlipidemia.
- On 10/5/20, Individual #556 died at the age of 74 with causes of death listed as COVID-19 pneumonia causing respiratory failure, and acute renal failure.
- On 10/6/20, Individual #357 died at the age of 68 with causes of death listed as pneumonia, and COVID infection.
- On 11/13/20, Individual #82 died at the age of 62 with causes of death listed as acute respiratory failure with hypoxia, ileus, and intellectual disability.
- On 11/29/20, Individual #628 died at the age of 64 with cause of death listed as breast with both intraductal cell and cellular carcinoma.
- On 1/15/21, Individual #235 died at the age of 71 with causes of death listed as asystole, coronary artery disease, and atherosclerosis.
- On 2/1/21, Individual #365 died at the age of 47 with cause of death listed as chronic respiratory failure.
- On 2/17/21, Individual #583 died at the age of 65 with causes of death listed as respiratory failure secondary to longstanding tracheostomy requirements, and dementia.
- On 2/17/21, Individual #92 died at the age of 73 with cause of death listed as cardiac arrest.
- On 2/18/21, Individual #144 died at the age of 70 with cause of death listed as large cell carcinoma (i.e., salivary gland cancer).
- On 3/18/21, Individual #292 died at the age of 72 with causes of death listed as cardiac arrest due to myocardial infarction, coronary artery disease, and atherosclerotic cardiovascular disease.

- On 5/2/21, Individual #108 died at the age of 38 with causes of death listed as severe sepsis with septic shock, pneumatosis intestinalis and ischemic colon, and chemotherapy-induced pancytopenia; breast cancer.
- On 5/7/21, Individual #674 died at the age of 64 with causes of death listed as urinary tract infection (UTI), COVID-19 pneumonia, and cerebral policy.

b. through d. The Center completed death reviews for each of the four individuals. These reviews identified concerns, and resulted in some important recommendations. However, evidence was not submitted to show the Center staff conducted thorough reviews of the care and treatment provided to individuals, or an analysis of the mortality reviews to determine additional steps that should be incorporated into the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews. Some examples of concerns included:

- For Individual #235:
    - In the months prior to his death, he was hospitalized six times. The clinical death review committee should have used this as an opportunity to discuss whether frequent hospitalizations should prompt the IDT to discuss whether hospice should be a consideration for the individual. Of course, the individual's prognosis and qualifying diagnosis for out of hospital do not resuscitate (OOH DNR) status would need to be part of the discussion.
    - As part of the nursing review, the auditor noted that nurses had not written acute care plans and Integrated Health Care Plan (IHCP) interventions correctly, and they had not implemented them. However, the nursing review did not include recommendations to address these concerns.
    - In the pharmacy review, the reviewing pharmacist identified that in the Quarterly Drug Regimen Review (QDRR), the Clinical Pharmacist missed identifying the need for a DEXA scan, the individual's current waist measurement, and addressing hyperkalemia. However, no recommendation was pulled forward.
    - The medical reviewer did not conduct a review of the full two weeks prior to the individual's death, and did not respond to the prompt as to whether they had any recommendations.
- For Individual #365:
    - On 4/20/20, she was admitted to hospice services. On 2/1/21, she died. Her death would have been an opportunity to review the criteria for hospice admission, as well as the procedures for review of hospice service admission/qualification at intervals.
    - As part of the nursing review, the auditor again noted that nurses had not written acute care plans interventions correctly, and they had not implemented them. The auditor noted that nursing staff: "continues to provide coaching to all RNs to improve implementation and documentation of ACP process." Given the repeat nature of these findings, consideration should have been given to the need for additional or different action, but the nursing review did not include recommendations to address these concerns.
- For Individual #583:
    - The nurse reviewer documented similar findings related to acute care plans as mentioned above. The reviewer noted: "Ongoing coaching regarding the ACP process to all nurses to improve the development, implementation and documentation is being provided by nursing." The coaching did not appear to be effective, and the reviewer should have considered alternative recommendations.
    - This individual's death would have been an opportunity to review the blistering diseases, differential diagnoses of blistering disorders, and diagnostic approaches.

- It also would have been an opportunity to identify and begin to implement questionnaires or screening tools for documenting individuals' serial decline in function due to dementia to assist with the prognosis, the plan of care, and end-of-life decisions. The Monitoring Team has included more information about such resources with regard to medical Outcome #8.

e. For some of the recommendations, evidence showed incomplete implementation. For example:

- For Individual #82, for the recommendation that read: "BCBA to include psychiatric symptoms/dementia screening dates in BCBA progress notes," no documentation was submitted to show that Center staff completed the required audits. A note addressing the audit said: "Auditor has been out. Will have more info at end of January." However, nothing further was submitted.
- For Individual #235, based on review of the documentation submitted, the following recommendations had not been completed:
  - For nursing staff to review and provide action related to use of backboard (i.e., staff initiated cardiopulmonary resuscitation while the individual was in bed without a backboard); and
  - For Habilitation Therapy to consider if guidelines should be amended for review following emesis.
- For Individual #365, the one clinical death review recommendation read: "The RNCM assigned to individual will have her caseload audited monthly x 3 months on 2 random individuals to ensure documentation within the plans." In response to the Monitoring Team's request for evidence of implementation, Center staff provided a statement that: "The service or assessment was due but has not been completed or could not be located."
- For Individual #583, Center staff submitted documentation for one of three recommendations (as discussed below, this was raw data that did not allow confirmation of completion of the recommendation). Those for which Center staff did not submit documentation included:
  - For all disciplines to provide updated refresher training/handout related to dementia; and
  - For Residential Services to search for items from over five years ago to see if still stored at property, and develop location/system to address future situations should someone come to live at the Center with extensive items that they can no longer use.

Continued improvement was noted with regard to the mortality committee writing recommendations in a way that ensured that Center practice improved. For example, a recommendation read: "Nursing will be retrained regarding the location to input data, importance of documenting why a medication was held, and importance of documenting blood pressure prior to giving a medication with blood pressure parameters…" This resulted in an in-service training. The Administrative Death Review Committee also appropriately required "Charge nurses to monitor nursing documentation/MAR once weekly for 4 continuous weeks once training is completed…" This provided a mechanism to help determine whether or not the training was effective.

However, other recommendations did not follow this format. For example, another recommendation was for all disciplines to "provide updated refresher training/handout related to dementia." The evidence of completion was "Training and documentation of those trained." Although the Administrative Review Committee identified an expected outcome to "Improve staff knowledge which may impact services for those with Down Syndrome related to [sic] Alzheimers [sic]," they provided no mechanism to measure an improved outcome (e.g., a pre- and post-test as part of the training).

Center staff often provided raw data as evidence of implementation. For example, staff training rosters were included, but Center staff did not include information about how many staff required training, and, at times, signature blanks were noted on the rosters. As a result, this documentation could not be used to determine whether or not staff fully implemented the recommendation. Staff should summarize data, including, for example, the number of staff trained (n), and the number of staff who required training (N).

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.

After the last review, this Domain contained 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, 45 of these indicators had sustained high performance scores and moved to the category requiring less oversight.

- Since the last review, the Monitor found that that the Center achieved and maintained substantial compliance with the requirements of section J of the Settlement Agreement and, as a result, was exited from section J of the Settlement Agreement. The reduces this Domain by five outcomes, and 20 indicators.

As a result, this Domain now contains 26 outcomes, and 120 underlying indicators. At the time of the last review, 32 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, psychology, physical and nutritional management (PNM), Occupational/Physical therapy (OT/PT), and skill acquisition.

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.

<u>Assessments</u>
For the ISPs, the team arranged for and obtained the needed, relevant assessments prior to the IDT meeting for two-thirds of the individuals, more so than ever before.

In behavioral health, all but one individual had a current, and complete annual behavioral health update. About two-thirds of the functional assessments were current and complete.

All but one FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP meeting. Two-thirds included recommendations for skill acquisition.

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

Primary care providers (PCPs) should continue to improve the quality of the medical assessments, particularly with regard to the inclusion, as applicable, of updated family history, and thorough plans of care for each active medical problem, when appropriate.

For four of the nine individuals, PCPs completed timely quarterly interval medical reviews (IMRs). For three of the remaining individuals, no IMRs were submitted, and for two individuals, PCPs did not complete one of the three necessary quarterly reviews.

It was good to see that seven of nine individuals received annual dental exams that included all of the required components. The two dental exams that did not meet criteria each were only missing one of the required components.

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

Over the last two review periods and during this review, individuals generally were referred to the PNMT timely, and the PNMT completed timely reviews. The related indicators will move to the category requiring less oversight. The PNMT should focus on completing comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT reviews and comprehensive assessments.

Due to the Center's sustained performance with the provision of the correct type of Occupational/Physical Therapy (OT/PT) assessment, the related indicator will move to the category requiring less oversight. Center staff should continue to focus on ensuring that annual and change-of-status assessments are completed in a timely manner. The quality of OT/PT assessments also continues to be an area on which Center staff should focus.

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

<u>Individual Support Plans (ISPs)</u>
In the ISPs, none of the individuals had goals that met criteria for indicator 1 in all six ISP areas, however, two individuals' goals met criteria for all five personal goal areas. This was good to see. Moreover, across the six individuals, personal goals met

criteria in from two to five areas for a total of 22 goals that met criteria, about the same total as at the last review. More work is needed regarding health goals (i.e., the IHCP).

All of one individual's personal goals were written in measurable terminology and, 70% of the goals, and 82% of the goals that met criterion with indicator 1, were written in measurable terminology.

Few of the goals had reliable data, though more so than at the last review. Five goals had reliable data and progress could be assessed. Two of these were showing some progress. Actions were not taken to address goals and action plans not implemented or not showing progress.

ISP action plan implementation was impacted by COVID-19, however, many action plans that could have been implemented were not implemented. On the positive, there was good discussion observed at ISP-related meetings during the review week.

QIDPs were knowledgeable of the goals, strengths, and support needs of the individuals on their caseloads. This was good to see. On the other hand, action plans were not revised when individuals were not making progress.

- QIDPs were doing a better job of reviewing all goals and including data in the QIDP monthly review when available.
- QIDPs did not generally include a summary of progress towards goals based on the data they had.

In behavioral health, data collection and reliability assurances continued to improve. Inter-observer agreement (IOA) met criteria for eight of the eight individuals, and data collection timeliness (DCT) met criteria for five of the eight. For the three that did not meet criteria, DCT was not assessed often enough. This was the highest score ever for Denton SSLC on indicator 5.

All PBSPs were current and implemented timely. About one-third of the PBSPs contained all of the required components.

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

With continuing efforts and attention to detail, by the time of the next review, Habilitation Therapy staff could make additional progress on the quality of Physical and Nutritional Management Plans (PNMPs).

For skill acquisition, it was good to again see all individuals having many SAPs. Many of them, however, were not written in measurable terminology. This needs to improve in order for indicator 2 to remain in the category requiring less oversight after the next review. About two-thirds to three-fourths of the SAPs were based on assessment results and also were practical, meaningful, and functional. The Center had suspended checking reliability of SAP data collection due to COVID-19.

ISPs

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

Summary: None of the individuals had goals that met criteria for indicator 1 in all six ISP areas, however, two individual's goals met criteria for all five personal goal areas. This was good to see. Moreover, across the six individuals, personal goals met criteria in from two to five areas for a total of 22 goals that met criteria, about the same total as at the last review. More work is needed regarding health goals (i.e., the IHCP).

The Monitor has provided additional calculations to assist the Center in identifying progress as well as areas in need of improvement. For indicator 1, the data boxes below separate performance for the five personal goal areas from the health-IHCP goals. Both types of goals need to meet criteria, however, the State has reported that it is working towards improving both types of goals with two concurrent support and training programs.

Indicator 2 shows performance regarding the writing of goals in measurable terminology. Although none of the individuals had a full set of goals that were written in measurable terminology, all of one individual's personal goals were written in measurable terminology and, 70% of the goals, and 82% of the goals that met criterion with indicator 1, were written in measurable terminology. Indicator 3 shows that few of the goals had reliable data, though more so than at the last review. These three indicators will remain in active monitoring.

Individuals:

#	Indicator		Overall Score	115	112	479	344	269	35			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	Personal goals	33% 2/6 73% 22/30	4/5	2/5	4/5	2/5	5/5	5/5			
		Health goals	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
2	The personal goals are measurable.		0% 0/6 72% 21/29	3/6 3/4	3/5 2/2	4/6 4/4	2/6 0/2	5/6 5/5	4/6 4/5			

		82% 18/22									
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	0/5	1/5	2/5	1/5	0/5	1/5			

Comments: The Monitoring Team reviewed the ISP process for six individuals at the Denton State Supported Living Center: Individual #344, Individual #112, Individual #115, Individual #479, Individual #35, and Individual #269. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed staff, including DSPs and QIDPs, and directly observed all of the individuals in their natural settings on the Denton SSLC campus.

1. None of the individuals had a comprehensive score that met criterion for the indicator, however, as shown in the individual scoring boxes, criterion was met for all five of the personal goal areas for two of the six individuals. This was good to see. During the last monitoring visit, the Monitoring Team found 23 goals that met criterion for being individualized, reflective of the individuals' preferences and strengths, and based on input from individuals on what was important to them. For this review, 22 goals met this criterion. The personal goals that met criterion were:

- the leisure goal for Individual #112, Individual #115, Individual #479, Individual #35, and Individual #269.
- the relationship goal for Individual #344, Individual #479, Individual #35, and Individual #269.
- the work/day/school goal for Individual #115, Individual #479, Individual #35, and Individual #269.
- the independence goal for Individual #344, Individual #115, Individual #35, and Individual #269.
- the living options goals for Individual #112, Individual #115, Individual #479, Individual #35, and Individual #269.

For those individuals, the goals were attainable, aspirational and based on their preferences and support needs. For example:

- Individual #344's greater independence goal was to make his own snacks on the weekends.
- Individual #112's recreation/leisure goal was to participate in a Special Olympic bowling tournament.
- Individual #115's work/day goal was to work part time at Chick-Fil-A.
- Individual #479's recreation/leisure goal was to volunteer at least quarterly at the Victory Therapy Center.
- Individual #35's relationship goal was to build friendships with fellow fashion show contestants by decorating outfits together monthly.
- Individual #269's work/day goal was to work part-time in supported employment delivering newsletters and mail.

Some goals did not meet criterion for the indicator because they did not reflect the individual's specific preferences, strengths, and needs. Findings included:

- Individual #344's recreation goal was to operate his tablet to complete educational software programs on his iPad daily. Discussion in his ISP indicated that the IDT recommended opportunities to explore additional leisure activities during the upcoming year because "he played on his tablet all day, every day." His DSP recommended that he become involved in recreational activities on campus hosted at the gym, such as Texercise, dances, and movie night. His LAR reported that he can become obsessed with using his tablet and not in engage in other activities. His work goal was to work at the recycle center full time. The IDT has not identified his work interest through an adequate assessment process. His vocational assessment

recommended further assessment to determine his interests and training needed. His living option goal to live at Denton SSLC was not aspirational.

- Individual #112's relationship goal was combined with her recreation/leisure goal, however, she did not have related action plans to support relationship building. She did not have a greater independence goal. Her work goal to work full time in supported employment was not individualized based on her preferences and skills.
- Individual #479's greater independence goal was combined with his recreation/leisure goal to volunteer at Victory Therapy Center. The IDT had not identified specific skills or training related to his goal that would increase his independence.
- Individual #115 did not have a relationship goal.

2. Of the 22 personal goals that met criterion for indicator 1, 18 also met criterion for measurability. Three other that did not meet criteria for indicator 1 were measurable (Individual #344's work/day and living option goals, Individual #112 work/day goal). Those that were measurable:

- Recreation/Leisure: Individual #112, Individual #115, Individual #479, Individual #35, and Individual #269
- Relationship: Individual #479, Individual #35, and Individual #269
- Job/School/Day: all six
- Greater Independence: Individual #269
- Living Option: all six.

Goals that did not meet criterion for measurability did not provide enough information about what the individual was expected to do or how many times they were expected to complete trials, tasks, or activities to meet the mastery criterion. Those included:

- Recreation/leisure: Individual #344
- Relationship: Individual #344, Individual #112, and Individual #115
- Greater Independence: Individual #344, Individual #115, Individual #479, Individual #35, and Individual #112

3. Of the 18 goals that met criteria with indicators 1 and 2, five had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals.

Of the other goals, many of the action plans were on hold due to COVID-19 restrictions. Even so, there were improvements in the collection of consistent reliable data and QIDPs were doing a better job of including data in their monthly reviews. They were not typically summarizing progress made towards goals based on that data.

The QIDP Coordinator reported that the QIDP department had focused on the collection of data during the monthly review process and would be focusing on summarizing progress in the upcoming months.

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Five goals had reliable data and progress could be assessed. Two of these were showing some progress. Actions were not taken to address goals and action plans not implemented or not showing progress. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	112	479	344	269	35			
4	The individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6 20% 2/5	0/5	1/5 1/1	1/5 1/2	0/5 0/1	0/5	0/5 0/1			
5	If personal goals were met, the IDT updated or made new personal goals.	N/A									
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/5	0/4	0/4	0/5	0/5	0/5			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/5	0/5	0/5	0/5	0/5	0/5			

Comments: A personal goal that meets criterion for indicators 1 through 3 is a pre-requisite for evaluating whether progress has been made. In other words, goals that do not meet criterion for indicators 1 through 3 receive a zero score for indicators 4 through 7.

4-7. Across the six individuals, there were 19 personal goals that met criterion for indicators 1 and 2. Five of the goals had corresponding data that were reliable or valid.

- There were data related to Individual #344's relationship goal. He was not making progress towards his goal. The IDT had not addressed barriers to progress.
- Data related to Individual #112's recreation/leisure goal indicated that she had made slight progress.
- Individual #479 was making slight progress on his SAP related to his recreation/leisure goal. He was not making progress towards his relationship goal. The IDT had not addressed barriers to his progress.
- Individual #35 was not making progress towards her work goal. The IDT had not revised training to address barriers to progress.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.	
Summary: Eight of these indicators scored higher than at the last review. Progress was noted in many areas, and especially regarding indicator 18. Numerous examples are provided in the comments below. These indicators will remain in active monitoring.	Individuals:

#	Indicator		Overall Score	115	112	479	344	269	35			
8	ISP action plans support the individual's personal goals.		0% 0/6 55% 12/22	1/4	1/2	1/4	1/2	4/5	4/5			
9	ISP action plans integrated individual preferences and opportunities for choice.	Individual preferences	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
		Opportunities for choice	67% 4/6	0/1	1/1	0/1	1/1	1/1	1/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.		50% 3/6	1/1	1/1	0/1	0/1	1/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.		83% 5/6	1/1	0/1	1/1	1/1	1/1	1/1			
12	ISP action plans integrated strategies to minimize risks.		17% 1/6	0/1	0/1	1/1	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.		33% 2/6	0/1	0/1	1/1	0/1	1/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.		33% 2/6	0/1	1/1	1/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.		50% 3/6	1/1	1/1	1/1	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.		33% 2/6	1/1	0/1	1/1	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 37% 11/30	1/5	1/5	1/5	1/5	3/5	4/5			
Comments:												

8. For the 22 goals that met criterion for being personal and individualized, 12 had corresponding action plans that were supportive of goal-achievement. There was progress noted over the review period in developing action plans that supported goal achievement and this was observed during an ISP preparation meeting and an annual ISP meeting during the review week. The QIDP Coordinator reported that this had been a recent focus by the QIDP department. Discussion observed during the review week was much more focused on addressing any barriers and support needs specific to the individual and their preferences. Goals that had action plans that were likely to lead to achievement of goals included:

- Individual #344's greater independence goal.
- Individual #112's leisure goal.
- Individual #115's greater independence goal.
- Individual #479's leisure goal.
- Individual #35's leisure, relationship, work/day, and greater independence goals.
- Individual #269's leisure, relationship, work/day, and greater independence goals.

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

- Four individuals had a living option goal to live in the community. All four had similar action plans to present living option information to the individual annually, attend provider fairs, and go on outings to increase community awareness. The action plans were not individualized and did not offer enough detail on how information would be presented, what supports were needed, or what information would be gathered to determine preferences.
- Individual #115 had a goal to work part-time at Chick-Fil-A. Action steps did not include steps for obtaining a job in the community. Her recreation/leisure goal was to attend a music concert. The three related action plans were related to reading.
- Individual #479 had a goal to get a janitorial job in the community. Supporting action plans did include training on skills needed for a janitorial job, however, there were no action plans related to seeking a job in the community.

9. Six of the ISPs had action plans that integrated preferences. Four offered opportunities to make choices:

- Individual #115's ISP action plans did not integrate opportunities to make choices. She had skill acquisition plans for cooking and reading that could have supported opportunities to make choices, however, training strategies did not include opportunities for her to choose what to cook or read.
- Similarly, Individual #479's action plans did not integrate opportunities to make choices.

10. Three of the six individuals had ISPs that met criterion for the indicator. In general, Capacity Assessments identified deficit areas and an individual's inability to make informed decisions. ISP action plans did not identify training or supports to mitigate those deficits for Individual #344, Individual #479, and Individual #35.

11. Five of the six ISPs had action plans that supported the individuals' overall independence. For each of those individuals, action steps taught functional skills, such as personal hygiene and domestic skills, For example:

- Individual #344 had action plans to brush his teeth and make his own snack.
- Individual #115 had action plans for reading and identifying her medication.
- Individual #479 had action plans to sanitize his hands, complete janitorial jobs, and count money.
- Individual #35 had action plans for learning to mop, writing her name, and washing her clothes.

- Individual #269 had action plans for brushing her teeth and taking pictures with her tablet.

Individual #112 did not have a greater independence goal and it was not evident that action plans supported her overall independence.

12. One of the ISP's met criterion for the indicator (Individual #479). While some risks were addressed through the individuals' PBSPs, IRRFs and IHCPs, supports were not integrated into their ISP action plans to mitigate risks presented or to offer guidance to staff who were implementing action plans. For example:

- Individual #344's IHCP recommended encouraging physical activity to address his risk for constipation and weight gain. His ISP did not include plans for physical activity or learning to choose healthy foods. He had an action plan to prepare pizza for a snack and a skill acquisition plan (SAP) to learn to cut his food. Implementation of his SAP for cutting his food was observed. He was given two hotdogs for a snack to cut.
- Individual #112's IHCP included recommendations regarding counseling for diet choices and health risks and a goal to lose weight. Recommendations were not integrated into action plans.
- Individual #115 had an action plan to improve her hygiene from fair to good in the coming year. Training to address her hygiene was not integrated in her plan.
- Individual #35 had many healthcare concerns that placed her at risk, including her weight, active seizures, and uncontrolled hyperglycemia. Her action plans did not include supports to address risk areas.
- Individual #269 had frequent falls. The IDT had not aggressively addressed her risks for falls by monitoring and revising supports. Strategies to address her risk were not integrated in her ISP. This was a repeat finding from the 2017 Monitoring Team review.

13. Two of the six ISPs met criterion for the indicator. Findings included:

- Individual #269's ISP integrated some of her behavioral and communication strategies in action plans related to her personal goals.
- Individual #479's behavioral support strategies were integrated into some of his action plans related to her personal goals.

For the other four individuals, support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were not well-integrated, and they were not incorporated into action plans. For example:

- Individual #344's ISP included recommendations to integrate his tablet use with communication goals. This had not yet been completed. Communication and behavioral strategies were not well-integrated in Individual #344's ISP.
- Medical supports were not well-integrated in Individual #35 or Individual #112's ISPs.

14. Two of the ISPs included action plans to support meaningful integration into the community. All had action plans to support visits into the community, however, the IDTs stopped short of considering activities that would support meaningful integration. Findings included:

- Individual #112 had action plans for bowling and participating in art classes in the community.
- Individual #479 had action plans related to volunteering in the community.

For the four other individuals, their action plans did not integrate encouragement of community integration. In general, action plans included steps for individuals to participate in community outings. Action plans did not include support to help individuals to become active community members. Individual #344 had one action plan related to virtual school that was not implemented and was then discontinued without being replaced with action plans that might lead towards community integration.

15. Three ISPs included action plans to support opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Individual #112, Individual #115, and Individual #479's ISPs documented consideration of day programming in a more integrated setting.

IDTs were doing a better job considering new employment opportunities based on individual's preferences. According to the QIDP Coordinator, QIDPs were working closely with vocational staff to identify more meaningful employment opportunities and training that could be provided at the center that might support community employment. Day programming had been on hold due to COVID-19 restrictions over the past year, so it was not possible to determine if planning would lead to new opportunities for day programming.

16. Four 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. Observations did not support that those individuals were functionally engaged for most of their day. Many action plans were on hold due to Covid-19 restrictions. IDTs had not met to modify training that could be implemented at the home.

- Individual #344's action plans were not revised to include functional training when it was agreed that he would not attend the school's transition program. He was scheduled to attend the sheltered workshop in the afternoons where he had one skill acquisition plan to count hangers. He had a goal to complete educational software on his tablet. The IDT did not identify what type of program or what skills he needed to learn. The software had not been purchased. Based on observations, it appeared that he spent much of his day scrolling through videos on his tablet.
- Individual #112 had 15 of 17 action plans on hold due to COVID-19 restrictions. The IDT had not met to formally develop a plan for active treatment over the past year. According to IDT members, she refused most activities offered and was rarely engaged in activities.
- Individual #35 had limited opportunities for functional training. Her day programming had been on hold due to COVID-19 restrictions. The sheltered workshop had recently opened, and she was scheduled to go to work two mornings per week. Staff reported that she rarely went to work due to staffing shortages. The IDT had not met to revise her action plans or address barriers to implementation.
- Individual #269 had SAPs to brush her teeth, learn to use a lock box, take pictures, and learn the ASL sign for choking. Sixteen of 21 action plans were on hold due to COVID restrictions. Her day programming had been on hold for the past year. She had an action plan to purchase a tablet by 12/16/21 to take pictures. Her tablet was purchase in June 2021, so her SAP for taking pictures was on hold until recently. The IDT had not met to revise her action plans, offer other training activities at home, or address barriers to implementation.

For the other two individuals, action plans supported functional engagement with sufficient frequency to meet personal goals and needs.

- Individual #115 had opportunities for functional engagement throughout her day. She had a money management SAP and cooking SAP to be implemented on the weekends, a reading SAP to be implemented nightly, and a medication identification SAP implemented five days per week. She worked daily at the sheltered workshop.
- Individual #479 had training that supported his goal to obtain a janitorial job. Additionally, he had training to sanitize his hands, greet his girlfriend appropriately, and learn to count his money.

17. ISPs did not adequately address barriers to achieving goals and learning new skills. Individuals were making minimal progress on action plans and IDTs did not address barriers to progress. 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 or discussing barriers.

18. Action plans described detail about data collection and review for 11 of the goals. For those goals, action plans had been developed that included specific implementation strategies and criteria for documenting and assessing progress. This was an area of significant improvement for the center. Action plans that supported these goals met criteria:

- Individual #344's greater independence goal.
- Individual #112's recreation/leisure goal.
- Individual #115's greater independence goal.
- Individual #479's recreation/leisure goal.
- Individual #35's recreation/leisure, relationship, work/day, and greater independence goals.
- Individual #269's recreation/leisure, work/day, and greater independence goals.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.

Summary: Some indicators showed good progress, but others still needed additional attention (e.g., 26, 28). On the other hand, due to sustained high performance, indicator 21 will be moved to the category of requiring less oversight. The others will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	112	479	344	269	35			
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).	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
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.										
21	The ISP included the opinions and recommendation of the IDT's staff members.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			

22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
23	The determination was based on a thorough examination of living options.	67% 4/6	0/1	1/1	1/1	1/1	1/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	N/A									
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	N/A									
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A									

Comments:

21. Six ISPs included the opinions and recommendations of the IDT's staff members.

23. Four of the individuals had a thorough examination of living options based upon preferences, needs, and strengths. Individual #115 and Individual #35's IDT did not document an individualized discussion of available settings that might meet the individual's needs.

25 and 27. These indicators were not scored.

26. The indicator was not met for any of the six individuals. None of their ISPs contained individualized, measurable action plans to address their obstacles to community referral.

28. None of the individuals had individualized and measurable action plans to educate the individual and/or LAR on living options that might be available to support their needs.

29. None of the individuals had been referred for community placement.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
Summary: ISP action plan implementation was impacted by COVID-19, however, many action plans that could have been implemented were not implemented (indicator 32). On the positive, there was good discussion observed at ISP-related meetings during the review week (indicator 34). These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	112	479	344	269	35			
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.	67% 4/6	1/1	1/1	1/1	1/1	0/1	0/1			

Comments:

32. Action steps that were on hold due to COVID-19 restrictions were not considered in the rating of this indicator. For this indicator, none of the individuals had ISPs that were fully implemented within 30 days of their ISP meeting. Findings included:

- Individual #344's SAP for money management, cutting his food, preparing a pizza, identifying his staff, and playing a DVD were all implemented less than 50% of the expected trials October 2020 through April 2021.
- Individual #112 had two action plans that were implemented. Her bowling SAP was implemented less than 50% of the scheduled trials and her medication SAP was implemented less than 85% of the scheduled trials.
- Two of Individual #115's action plans related to reading stories on her tablet were not implemented for four months because her tablet was broken. Her reading and cooking SAPs were not implemented for two months, then not fully implemented for the next three months.
- Individual #479's three SAPs were implemented less than 58% of the scheduled trials from February 2021 through May 2021.
- Individual #35's SAPs to wash clothes, mop, and trace her name were implemented less than 20% of expected trials. Her SAPs to brush her teeth and wash her hands were implemented less than 65% of expected trials.
- Individual #269's action plan to purchase a tablet by 12/16/20 was not completed until June 2021. Action plans to support Individual #269's goal to take pictures on her tablet could not be implemented until her tablet was purchased. Her SAP to learn to use a padlock was not implemented until April 2021. Her SAP for learning the ASL sign for choking was implemented less than 17% of expected trials. Her SAP to brush her teeth was implemented less than 33% of the trials.

34. Four of the six individuals had appropriately constituted IDTs, based on their strengths, needs and preferences, who participated in the planning process. For the other two individuals, crucial members of the IDT did not attend the meeting. Findings included:

- For Individual #35, direct support staff or other residential staff did not attend the meeting.
- For Individual #269, her occupational and/or physical therapist did not attend her meeting. She was at high risk for falls and had 22 falls in the year prior to her ISP meeting. One fall resulted in a spine fracture.

It was good to see that at the ISP Preparation meeting for Individual #479 and the annual ISP meeting for Individual #335, IDT members from each discipline actively participate in the meeting and made recommendations for supports. Individual #335 was supported by IDT members to participate in her meeting.

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

Summary: Indicator 36 scored higher than ever before. It will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	112	479	344	269	35			
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	67% 4/6	1/1	0/1	1/1	1/1	1/1	0/1			

Comments:

36. The indicator was met for four of the six individuals. Findings included:

- Individual #112's functional skills assessment and behavioral health assessments were not submitted at least 10 days prior to her annual ISP meeting for review by IDT members.
- Individual #35's annual medical assessment and functional skills assessment were not submitted at least 10 days prior to her annual ISP meeting for review by IDT members.

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

Summary: These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	112	479	344	269	35			
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. None of the ISPs met criterion for the indicator. In general, IDTs did not meet to review ISP action plans or to develop strategies to revise action plans that were on-hold due to COVID-19. IDTs also did not meet to review data or to discuss an individual's lack of progress towards goal-achievement.

38. QIDPs were knowledgeable of the goals, strengths, and support needs of the individuals on their caseloads. This was good to see. On the other hand, as noted for Indicator 37, action plans were not revised when individuals were not making progress.

- QIDPs were doing a better job of reviewing all goals and including data in the QIDP monthly review when available.
- QIDPs did not generally include a summary of progress towards goals based on data submitted.

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

Summary: For all individuals, most of their action steps were on-hold due to COVID-19 community and gathering restrictions. For action steps that were not impacted by COVID-19, few had been implemented consistently and with enough frequency to determine progress towards goal-achievement. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	115	112	479	344	269	35			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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:
40. Across all six individuals, there was a total of 102 action steps evaluated, six of which had been consistently implemented. Of the 96 remaining action steps that were not implemented, 68 could not be implemented due to COVID-19 community and gathering restrictions. Thus, of the 34 that could have been implemented, six were implemented (18%).

Individual	# of Action Steps in ISP	Action Steps Implemented	Action Steps Not Implemented Due to COVID-19	Action Steps Not Fully Implemented
Individual #344	17	1	9	7
Individual #112	17	0	15	2
Individual #115	12	0	5	7
Individual #479	15	2	10	3
Individual #35	20	2	13	5
Individual #269	21	1	16	4

For all individuals, most of their action steps were on-hold due to COVID-19 community and gathering restrictions. For action steps that were not impacted by COVID-19, few had been implemented consistently and with enough frequency to determine progress towards goal-achievement. Examples included:

- For Individual #344, one SAP was implemented over 50% of the required trials. His toothbrushing SAP was implemented between 75% and 95% of the time for the months reviewed. All other SAPs were implemented less than 50% of the required number of trials.
- Individual #112 had two action plans that were not on hold. Neither were implemented at the frequency required.
- Two of Individual #115's action plans related to reading stories on her tablet were not implemented for four months because her tablet was broken. Her reading and cooking SAPs were not implemented within 30 days of ISP development, then not fully implemented for the past three months.
- Individual #479's three SAPs were implemented less than 58% of the scheduled trials from February 2021 through May 2021. He had one SAP to sanitize his hands that was implemented at the required frequency. Documentation indicated that his action plan for the BCBA and QIDP to review appropriate interactions with him continued to be implemented. Progress was not documented.
- Individual #35's SAPs to wash clothes, mop, and trace her name were implemented less than 20% of expected trials. Her SAPs to brush her teeth and wash her hands were implemented less than 65% of expected trials. The two action plans that were implemented were actions for staff to take to support Individual #35 (staff to remind Individual #35 to complete household chores and the QIDP to follow-up with her LAR about renewing guardianship).
- Individual #269's action plan to purchase a tablet by 12/16/20 was not completed until June 2021. Action plans to support Individual #269's goal to take pictures on her tablet could not be implemented until her tablet was purchased. Her SAP to learn to use a padlock was not implemented until April 2021. The one action plan that was fully implemented was for staff to encourage and assist her to work on her scrapbook.

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

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

#	Indicator	Overall Score	Individuals: 112	344	269	35	503	715	108	19	5
a.	The individual's risk rating is accurate.	58% 7/12	1/2	2/2	0/2	N/R	2/2	2/2	0/2	N/R	N/R
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.	42% 5/12	1/2	1/2	2/2		0/2	0/2	1/2		

Comments: For six individuals, the Monitoring Team reviewed a total of 12 IRRFs addressing specific risk areas (i.e., Individual #112 – weight, and skin integrity; Individual #344 – weight, and constipation/bowel obstruction; Individual #269 – cardiac disease, and falls; Individual #503 – infections, and weight; Individual #715 – aspiration, and infections; and Individual #108 – polypharmacy/medication side effects, and weight).

a. The IDTs that effectively used supporting clinical data, and used the risk guidelines when determining a risk level were those for Individual #112 – weight; Individual #344 – weight, and constipation/bowel obstruction; Individual #503 – infections, and weight; and Individual #715 – aspiration, and infections.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. It also was positive that the following IDT reviewed and/or modified individual's risk ratings based on changes of status: Individual #269 - falls.

However, it was concerning that often when changes of status occurred that necessitated at least review of the risk ratings, IDTs 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 #112 – skin integrity, Individual #344 – constipation/bowel obstruction, Individual #269 – cardiac disease, and Individual #108 – weight.

Psychiatry

The Monitor found that that the Center achieved and maintained substantial compliance with the requirements of section J of the Settlement Agreement and, as a result, was exited from section J of the Settlement Agreement.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.												
Summary: Data collection and reliability assurances continued to improve at Denton SSLC. IOA met criteria for eight of the eight individuals, and DCT met criteria for five of the eight. For the three that did not meet criteria, DCT was not assessed often enough. This was the highest score ever for Denton SSLC on this indicator. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	335	115	112	297	150	479	407	483	344
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	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									

	impede his or her growth and development, the individual has a PBSP.										
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.										
5	Reliable and valid data are available that report/summarize the individual's status and progress.	63% 5/8		0/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1

Comments:
5. Based upon the information provided in table format regarding data collection timeliness and inter-observer agreement, it was determined that data were reliable for five of the eight individuals.

Facility staff provided a summary of data collection timeliness, inter-observer agreement, and treatment integrity measures collected over a seven month period for each of the eight individuals who had a PBSP. Based upon this information, it was determined that data were reliable for five of the eight individuals: Individual #297, Individual #150, Individual #479, Individual #407, and Individual #344.

No measures were provided regarding data collection timeliness for six months for Individual #115 and Individual #112, and for four months for Individual #483. This measure was 100% in the last month for Individual #115 and Individual #112, and averaged 50% across the last three months for Individual #483.

In this same seven month period, inter-observer agreement was assessed four times for Individual #115 yielding an average of 50%, five times for Individual #112 with scores of 100%, and six times for Individual #483 with scores of 100%.

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

Summary: With sustained high performance and with an increase in performance, indicators 10 and 11, respectively, might be moved to the category of requiring less oversight after the next review. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 335	115	112	297	150	479	407	483	344
10	The individual has a current, and complete annual behavioral health update.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The functional assessment is current (within the past 12 months).	75% 6/8		1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1
12	The functional assessment is complete.	63% 5/8		1/1	1/1	0/1	1/1	0/1	1/1	1/1	0/1

Comments:
10. Eight of the nine individuals had a current and complete behavioral health assessment. The exception was Individual #115. While her report did include the necessary components, it was dated February 2019 and included goals to be met by February of 2021.

11. The functional assessment was considered current for six of the eight individuals. The exceptions were Individual #297 and Individual #150, for whom observations were last completed more than 12 months prior.

12. The functional assessment was considered complete for five of the eight individuals. The exceptions were Individual #297, Individual #479, and Individual #344. Although observations had been completed, no target behaviors were observed or described. There was no explanation as to why additional observations weren't necessary.

While formal observations of Individual #407 also revealed no occurrence of target behaviors, the BCBA explained that information from others and her own interactions with Individual #407 over time had allowed her to form a hypothesis regarding behavioral function. This was scored positively.

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

Summary: Due to sustained high performance, indicators 13 and 14 will be moved to the category of requiring less oversight. Indicator 15 scored lower than at the last review, though, as detailed in the comments below, PBSPs contained most of the required components. That is, some components were missing or needed improvement. Indicator 15 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 335	115	112	297	150	479	407	483	344
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	88% 7/8		0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	The PBSP was current (within the past 12 months).	100% 8/8		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	38% 3/8		0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1

Comments:
13. Documentation provided by facility staff indicated that the PBSP for seven of the eight individuals had been implemented within 14 days of all required consents. The exception was Individual #112 whose plan had been implemented just days past the 14 day requirement.

14. All eight individuals had a current PBSP.

15. Three of eight PBSPs were considered complete. These were the plans for Individual #297, Individual #479, and Individual #407.

For the other remaining plans, the majority of components were present in more than 80% of the plans.

Components that were missing from some of the other five plans included adequate operational definitions of targeted problem behaviors, the use of reinforcement in a manner that was likely to affect positive change, and the presence of clear and precise consequences.

Individual specific feedback is provided below.

- It was positive to find suicidal threats and gestures accurately defined in Individual #407's PBSP. On the other hand, these terms were still reversed in the PBSP for Individual #115 and the PBSP summary for Individual #407. Individual #344's plan included both aggression and property destruction. The definitions for both included harm to objects, resulting in overlap and possible confusion for staff.
- All of the plans included acceptable operational definitions of functional replacement behaviors. There were also adequate guidelines for reinforcing and/or teaching these replacement behaviors.
- Four plans did not include an adequate description of the use of reinforcement to affect positive behavior change. While Individual #115's plan noted that tickets would be given when she exhibited her replacement behavior, it was not clear how or when these tickets were to be exchanged. The schedule for teaching her replacement behavior was limited to once per shift. The plans for Individual #112 and Individual #483 included guidelines for encouraging replacement behavior that may unintentionally reinforce identified target behaviors. Individual #344's plan noted he would be reinforced once per shift for the absence of target behaviors.
- Antecedent strategies were generally appropriate. It was positive to find guidelines for using first/then statements with Individual #407 to help her complete activities followed by access to preferred items/activities.
- The antecedent strategies included in Individual #150's plan related to stealing and inappropriate sexual behavior, but there were no general guidelines for prevention of all targeted problem behaviors.
- As has been noted multiple times, the use of the term "junk" behavior should be eliminated from all plans. This was still found in the plans for Individual #297 and Individual #344. While not intended, this term implies a level of disrespect for the individual. Further, it does not provide an operational definition of the behavior that staff should ignore or not respond to.
- Staff are also cautioned to use language that conveys professionalism and is not subject to misinterpretation. Individual #479's plan references his "right hook" and noted that he appreciated a "take charge" individual. This latter term may imply to staff that they should be tough and perhaps intimidating when interacting with him.
- Individual #479's plan included guidelines for searching his room if he was suspected of taking someone else's property. Included should be a plan for fading this restriction.
- As noted above, there was possible unintentional reinforcement of target behaviors for Individual #112 and Individual #483. For instance, Individual #112 was to be encouraged to use her coping skills when she exhibited verbally disruptive behavior. This included telling her to look at you and talking with her. This contradicted the consequent guidelines that indicated staff should neither make eye contact or talk with her. Similarly, Individual #483's plan indicated that staff should encourage her replacement behavior when she curses at or hits others. Here, too, this was in direct conflict with the consequent guidelines included in her plan.

- Individual #112's plan identified four targeted problem behaviors, but there were no guidelines for staff following the occurrence of two of these behaviors: signs of agitation and intentional descent.
- It was positive to find guidelines for toilet training in Individual #344's plan. His QIDP, however, reported that it had not been addressed since his move to his current home.
- None of the PBSPs included treatment objectives. While these were found in the Behavior Health Assessments, they should be included in the PBSP as well.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.												
Summary: One individual was receiving counseling services, from a community based BCBA. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	335	115	112	297	150	479	407	483	344
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.	N/A									
Comments: 24-25. Individual #407 was the only individual in the review group who was enrolled in counseling. It was positive to learn that she was receiving services from a community-based practitioner who was also a BCBA.												

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: PCPs should complete interval medical reviews quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable"). Indicator c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
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 individualized needs, but no less than every six months	44% 4/9	1/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1

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

For Individual #269, Individual #35, and Individual #108, no IMRs were submitted. For Individual #503, the PCP did not complete the IMR due in November 2020. For Individual #19, the PCP did not complete the IMR due in December 2020.

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

Summary: Center staff should continue to improve the quality of the medical assessments, particularly with regard to the inclusion, as applicable, of updated family history, and thorough plans of care for each active medical problem, when appropriate. Indicators a and c will remain in active oversight.

#	Indicator	Overall Score	Individuals: 112	344	269	35	503	715	108	19	5
a.	Individual receives quality AMA.	44% 4/9	1/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1	1/1
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.	44% 8/18	2/2	2/2	0/2	0/2	0/2	2/2	0/2	0/2	2/2

Comments: a. It was positive that four individuals' AMAs (i.e., Individual #112, Individual #715, Individual #19, and Individual #5) included all of the necessary components, and addressed the selected chronic diagnoses or at-risk conditions with thorough plans of care. Problems varied across the remaining medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed 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. Most, but not all included pre-natal histories. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history, and thorough 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 #112 – diabetes/metabolic syndrome, and infections; Individual #344 – skin integrity, and weight; Individual #269 – falls, and other: menopause; Individual #35 – diabetes, and seizures; Individual #503 – aspiration, and seizures; Individual #715 – aspiration, and skin integrity; Individual #108 –polypharmacy/medication side effects, and other: cancer; Individual #19 – diabetes, and osteoporosis; and Individual #5 – osteoporosis, and seizures).

As noted above, for three individuals, PCPs completed/submitted no IMRs. The IMRs that followed the State Office template, and provided necessary updates related to the risks reviewed included those for: Individual #112 – diabetes/metabolic syndrome, and

infections; Individual #344 – skin integrity, and weight; Individual #715 – aspiration, and skin integrity; and Individual #5 – osteoporosis, and seizures.

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
Summary: As indicated in the last several reports, 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	112	344	269	35	503	715	108	19	5
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

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 #112 – diabetes/metabolic syndrome, and infections; Individual #344 – skin integrity, and weight; Individual #269 – falls, and other: menopause; Individual #35 – diabetes, and seizures; Individual #503 – aspiration, and seizures; Individual #715 – aspiration, and skin integrity; Individual #108 –polypharmacy/medication side effects, and other: cancer; Individual #19 – diabetes, and osteoporosis; and Individual #5 – osteoporosis, and seizures).

The following IHCP 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 #108 – other: cancer.

b. As noted above, per the instruction of State Office, and as memorialized in the State Office Medical Care policy #009.3, with an effective date of 2/29/20, PCPs now are expected to complete IMRs quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable"). As a result, IHCPs no longer need to define the parameters for interval reviews, so the Monitoring Team did not rate this indicator.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.	
Summary: It was good to see that seven of nine individuals received annual dental exams that included all of the required components. The two dental exams that did not meet criteria each were only missing one of the required components.	Individuals:

#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
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.	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.	Due to the Center's sustained performance with these indicators, they moved to the category requiring less oversight.									
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.										
b.	Individual receives a comprehensive dental examination.	100% 7/7 Cannot fully rate due to COVID -19	1/1	1/1	N/R – C19	N/R – C19	1/1	1/1	1/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	Due to the Center's sustained performance with this indicator, it moved to the category requiring less oversight.									

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

- An oral hygiene rating completed prior to treatment;
- Periodontal condition/type;
- The recall frequency;
- Caries risk;
- An oral cancer screening;
- Information regarding last x-ray(s) and type of x-ray, including the date;
- Sedation use;
- Number of teeth present/missing;
- Treatment provided (treatment completed);
- Periodontal risk;
- An odontogram; and,
- A treatment plan that addresses the individual's needs.

Based on the documentation submitted for Individual #269 and Individual #35, Dental Department staff last completed periodontal charting in 2019. Based on the State's comments on the draft report, these individuals required TIVA for the completion of this service, and the delays occurred due to COVID-19.

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
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.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.										
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.										
Comments: None.											

Outcome 4 – Individuals have quality nursing assessments to inform care planning.											
Summary: Work is needed to improve the content and thoroughness of annual and quarterly physical assessments, and to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to individuals' at-risk conditions. When individuals experience exacerbations of their chronic conditions, nurses need to complete assessments in accordance with current standards of practice. All of these indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
a.	Individual receives a quality annual nursing record review.	0% 0/6	0/1	0/1	0/1	N/R	0/1	0/1	0/1	N/R	N/R

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.	0% 0/6	0/1	0/1	0/1		0/1	0/1	0/1		
c.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/12	0/2	0/2	0/2		0/2	0/2	0/2		
d.	Individual receives a quality quarterly nursing record review.	0% 0/6	0/1	0/1	0/1		0/1	0/1	0/1		
e.	Individual receives quality quarterly nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	0% 0/6	0/1	0/1	0/1		0/1	0/1	0/1		
f.	On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk.	0% 0/12	0/2	0/2	0/2		0/2	0/2	0/2		
g.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	10% 1/10	0/2	0/1	1/2		0/2	0/2	0/1		

Comments: a. The annual nursing record reviews the Monitoring Team reviewed were often missing key components, or information was incomplete. It was positive that all of them included, as applicable:

- Tertiary care.

Most, but not all included, as applicable:

- Active problem and diagnoses list updated at the time of annual nursing assessment (ANA);
- List of medications with dosages at the time of the ANA;
- Consultation summary; and

- Allergies or severe side effects to medication.

The components on which Center staff should focus include:

- Family history;
- Procedure history;
- Social/smoking/drug/alcohol history;
- Immunizations; and
- Lab and diagnostic testing requiring review and/or intervention.

b. Concerns with the physical assessments included a lack of follow-up for abnormal findings, incomplete systems assessments, no reference to the pain scale used, a missing tracheostomy assessment for one individual, and a lack of weight and/or abdominal circumference.

c. and f. For six individuals, the Monitoring Team reviewed a total of 12 IHCPs addressing specific risk areas (i.e., Individual #112 – weight, and skin integrity; Individual #344 – weight, and constipation/bowel obstruction; Individual #269 – cardiac disease, and falls; Individual #503 – infections, and weight; Individual #715 – aspiration, and infections; and Individual #108 – polypharmacy/medication side effects, and weight).

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. Overall, nurses did not include status updates, including relevant clinical data in the annual assessments, or in the quarterly assessments (i.e., the only exceptions were for Individual #715 – aspiration, and infections). Nurses also did not analyze such information, including comparisons with the previous quarter or year, and/or make 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 conditions to the extent possible.

d. The quarterly nursing record reviews the Monitoring Team reviewed were often missing key components, or information was incomplete. Most, but not all of the quarterly nursing record reviews the Monitoring Team reviewed included, as applicable:

- Active problem and diagnoses list updated at the time of the quarterly assessment;
- List of medications with dosages at the time of the quarterly nursing assessment;
- Consultation summary;
- Tertiary care; and
- Allergies or severe side effects to medication.

The components on which Center staff should focus include:

- Family history;
- Procedure history;
- Social/smoking/drug/alcohol history;
- Immunizations; and
- Lab and diagnostic testing requiring review and/or intervention.

e. Problems with the quarterly physical assessments included a lack of follow-up for abnormal findings, incomplete systems assessments, incomplete abdominal assessments, and/or no reference to the pain scale used.

g. The following is an example of when assessing exacerbations in an individual's chronic conditions (i.e., changes of status), nurses adhered to nursing guidelines in alignment with the individual's signs and symptoms.

- On 5/9/21, Individual #269 fell. At 1:10 p.m., a nurse assessed her in alignment with the nursing guidelines for falls.

The following provide a few examples of concerns related to nursing assessments in accordance with nursing guidelines or current standards of practice in relation to exacerbations in individuals' chronic conditions (i.e., changes of status):

- Between 2/12/21 and 3/12/21, Individual #112 lost nine pounds. Nursing staff did not conduct an assessment or a review to address the weight loss. Although the individual was overweight, and initially had a goal to lose five pounds per quarter, she lost more than that in one month. At the ISP meeting, on 12/14/20, team members expressed concern that she was losing weight too fast.
- On 11/22/20, at 12:44 p.m., staff identified a new boil on Individual #112's left lower abdomen. Nursing staff did not assess it according to the nursing guidelines for skin impairments. The assessment was missing the size, including the length, and width. The nurse did note the individual's discomfort. On the next day, a provider saw the individual in the clinic, and ordered by mouth (PO) antibiotics to begin on 11/24/20. Subsequent nursing assessments did not include the size of the skin impairment, or other assessment information except for "firm red boil" or "scabbed with redness and slight swelling but no drainage."
- Between September and October 2020, Individual #344 had an unplanned weight gain of six pounds. Nursing staff did not complete an assessment. Over the previous year, he did well with his planned weight loss program, but then, between September 2020 and February 2021, he gained back about a third of the weight he lost.

  In its comments on the draft report, the State provided the following as clarification: "#344 [sic] between September and October he lost 5 pounds and then from September of 2021 and February of 2021 he gained five pounds. Over a six-month period, he had an overall weight gain of 3 pounds, not six pounds. See document TX-DE-2106-II.24.a. On page 16 the weight is noted on 8/5/20 as 192.4; on 9/3/20 as 190.9 and on 10/2/20 as 185. On page 39 the weight is noted on 12/12/20 as 188.6; 1/7/21 as 191.3, and on 2/4/21 as 195.2."

  This individual had been at high risk for weight management the previous year, and between 10/11/19 and 8/5/20, he had a planned weight loss of 31.37 pounds. Due to his successful weight loss, his IDT decreased his risk for weight to medium. While he stayed within his EDWR, there was no assessment or review of his steady weight gain between 11/30/20 (i.e., 184.99 per page 19 of TX-DE-2106-II.14), and 2/4/21 (i.e., 195.2 per page 39 of TX-DE-2106-II.24.a), which was a steady increase of 10 pounds over four months. According to his Quarterly Assessment, dated 12/2/20 (i.e., Document TX-DE-2106-II.24.a), his weight was 188.6, and on 2/4/21, his weight was 195.2; a weight gain of 6.6 pounds. Again, while the individual was within his EDWR, he had successfully lost over 31 pounds the previous year, and was steadily gaining the weight back. He was close to the high range of his EDWR of 196 pounds. Nursing staff should have conducted an assessment to determine the potential factors contributing to the weight gain.

- On 11/20/20, Individual #269 had a blood pressure reading of 146/94. Based on the documents submitted, nursing staff did not conduct or attempt a follow-up reassessment.
- On 3/11/21 at 11:15 p.m., Individual #503 had a fever, and was tachypneic and tachycardic. Upon discovery of these symptoms, a nurse assessed him and monitored him according to the applicable nursing guidelines. The nurse contacted the Respiratory Therapist (RT) for treatment and applied oxygen (O2). The nurse called the provider, and the individual was transferred to the ED. Based on review of IView entries and IPNs, nursing staff had not completed vital sign assessments for 36 hours prior to the incident. This individual had a history of infections, requiring multiple hospital admissions, and his IDT rated him at high risk for aspiration/respiratory compromise.
- Individual #503's IHCP required that staff weigh him weekly due to significant weight loss and the need for a gastrostomy tube (G-tube) placement. His goal was gain one to five pounds per month. Based on documents submitted, in November and December 2020, staff did not weigh him weekly. Nursing staff did not appear to monitor him or his weight records to evaluate him for changes in weight either up or down.
- On 11/25/20, Individual #715 experienced emesis. Based on review of IView entries and IPNs, on that date, nursing staff did not document vital sign assessments, except at 4:00 p.m. It was unclear when the emesis occurred (i.e., in the note at 7:17 p.m., the nurse stated that it happened earlier and another note was labeled at 4:00 p.m.). The note indicated that the individual had emesis, and at the time, was sitting up in a chair. The nurse documented that the individual's lungs were clear times four, but this individual had a baseline of rhonchi. The nurse did not note whether the lung sound assessments were anterior and/or posterior. The assessment was not in alignment with the nursing guidelines for vomiting. The nurse did not identify whether the individual's enteral feeding was running at time of the emesis, and, if so, whether or not staff turned it off. At 7:17 p.m., the individual was unresponsive.
- Individual #715 had a suprapubic catheter, and staff needed to record his output. Leading up to 1/2/21, staff were inconsistent in documenting his output in IView, and it did not appear nursing staff identified the concerns. For example, on 12/28/20, staff documented only 600 cubic centimeters (cc) of output; on 12/29/20, 1300 cc; on 12/30/20, 900 cc; on 12/31/20, 2000 cc; on 1/1/21, 2150 cc; and on 1/2/21, staff documented no output in IView, and in an IPN, a nurse stated the individual had 50 cc output at 11:00 a.m. At 11:00 a.m., the individual had emesis with respiratory issues and was transported to the hospital, where was diagnosed with pneumonia and a UTI. The nursing assessment following the individual's emesis was consistent with nursing standards, but there was no documentation to show that nursing staff followed the tracking of his urinary output, and conducted necessary assessments given the findings.
- On 3/31/21, in relation to her diagnosis of aggressive breast cancer, Individual #108 began receiving Norco, which has a possible side effect of constipation. This individual already was at high risk for constipation, even though it was not listed as a risk area. Nursing staff did not address this possible side effect, even after there was an increase in usage of the Norco beginning on 3/31/21. On 4/12/21, staff noted her bowel movement was small, and Type 2 on the Bristol stool chart. Nursing staff did not conduct an assessment in alignment with the applicable nursing guidelines. Staff's tracking of her bowel movements was inconsistent, which made it difficult for nursing staff to monitor for side effects of medications. Her course was complicated due to problems with constipation, and related surgery. On 4/25/21, she passed away.

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 many review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
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% 0/12	0/2	0/2	0/2	N/R	0/2	0/2	0/2	N/R	N/R
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/12	0/2	0/2	0/2		0/2	0/2	0/2		
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	17% 2/12	1/2	0/2	0/2		1/2	0/2	0/2		
d.	The IHCP action steps support the goal/objective.	0% 0/12	0/2	0/2	0/2		0/2	0/2	0/2		
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	33% 4/12	0/2	0/2	2/2		1/2	0/2	1/2		
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	42% 5/12	1/2	0/2	2/2		0/2	1/2	1/2		

Comments: a. through f. Individual #344 did not have an IHCP for weight, but should have. The remaining 11 IHCPs all included nursing interventions, but were missing key nursing supports. For example, RN Case Managers and IDTs generally had not individualized interventions in relevant nursing guidelines and included in the action steps of IHCPs specific assessment criteria for regular nursing assessments at the frequency necessary to address conditions that placed individuals at risk [e.g., if an individual was at risk for skin breakdown/issues, then an action step(s) in the IHCP that defines the frequency for nursing staff to assess the color, temperature, moisture, and odor of the skin, as well as the drainage, location, borders, depth, and size of any skin integrity issues]. In addition, often, the IDTs had not included in the action steps nursing assessments/interventions to address the underlying cause(s) or etiology(ies) of the at-risk or chronic condition (e.g., if an individual had poor oral hygiene, a nursing intervention to evaluate the quality of the individual's tooth brushing, and/or assess the individual's oral cavity after tooth brushing to check for visible food; if an individual's positioning contributed to her aspiration risk, a schedule for nursing staff to check staff's adherence to the positioning instructions/schedule; if an individual's weight loss was due to insufficient intake, mealtime monitoring to assess the effectiveness of adaptive equipment, staff adherence to the Dining Plan, environmental factors, and/or the individual's food preferences, etc.). Significant work is needed to include nursing interventions that meet individuals' needs into IHCPs.

a. None of the IHCPs that included individualized interventions for ongoing nursing assessments that were in alignment with applicable nursing guidelines/standards of care.

b. IHCPs generally did not include preventative interventions. In other words, they did not include interventions for staff and individuals to proactively address the chronic/at-risk condition. Examples might include drinking a specific amount of fluid per day to prevent constipation, washing hands before and/or after completing certain tasks to prevent infection, etc.

c. The IHCPs with measurable objectives for tracking progress were for: Individual #112 – weight, and Individual #503 - weight.

e. The IHCPs that included specific clinical indicators for measurement were for: Individual #269 – cardiac disease, and falls; Individual #503 – weight; and Individual #108 – weight.

f. The IHCPs that identified the frequency of monitoring/review of progress were for: Individual #112 – skin integrity; Individual #269 – cardiac disease, and falls; Individual #715 – infections; and Individual #108 – polypharmacy/medication side effects.

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, individuals generally were referred to the PNMT timely [Round 15 – 75% (6/8), Round 16 – 86%, and Round 17 - 100%], and the PNMT completed timely reviews (Round 15 – 86%, Round 15 – 80%, and Round 16 - 100%), Indicators a and b will move to the category requiring less oversight. The PNMT should focus on completing comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT reviews and comprehensive assessments.

#	Indicator	Overall Score	Individuals: 112	344	269	35	503	715	108	19	5
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	100% 6/6	N/A	N/A	2/2	N/A	2/2	2/2	N/A	N/A	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	100% 5/5			2/2		2/2	1/1			
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	40% 2/5			0/1		1/2	1/2			

d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	40% 2/5			1/2		1/2	1/2			
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	17% 1/6			0/2		1/2	0/2			
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% 0/1			0/1		N/A	N/A			
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/5			0/1		0/2	0/2			

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

- For Individual #269:
  - On 11/11/20, after a fall, she was diagnosed with a fracture of the spine (i.e., L.1, L.2, and L.3). At this point, she also had fallen more than three times in 30 days. On 11/12/20, the PNMT made a self-referral. On 11/12/20, the PNMT conducted a review. It appeared that the PT was the only one who wrote/completed the review.

    In the review, the PNMT stated the presenting problem clearly along with the relevant history. Data regarding falls over the past 90 days were included, as well as the context surrounding the event. The PNMT believed that the cause of the fracture involved an event on 11/10/20, when she attempted to take food that did not belong to her. The PNMT also stated that sometimes she wore her shoes on the wrong feet. In September 2020, the individual's falls increased. Based on a review of trends over the past three years, the frequency of her falls were higher during September through December, reportedly due to her excitement about her birthday and the holidays.

    The PNMT's recommendation was that the home PT and OT should assess the individual for mobility, transfer, and bathing by close of business on the same day (i.e., 11/12/20). However, the PNMT provided no guidance on what the home team should potentially focus. For example, the review noted impulsivity, and "food stealing" as being the "root cause," but their recommendations did not clearly address these issues.

- On 5/5/21, Individual #269, was referred again to the PNMT due to more than three falls in 30 days. On 3/19/21, 4/1/21 (x2), 4/9/21, 4/28/21, 5/3/21, and 5/9/21, she fell. On 5/10/21, the PNMT completed a review. The PNMT review included a brief overview, and then stated to continue program "as is." Due to the ongoing nature of the individual's falls and recent history of a spinal fracture, an assessment was warranted to dive deeper into how to mitigate the risks associated with the individual's decreased awareness, impulsivity, and behavior of "food stealing." It appeared that the RN was the only one who wrote/completed the review.

- For Individual #503:
  - On 10/7/20, the individual's IDT referred him to the PNMT due to recurrent pneumonia. On 10/13/20, the PNMT completed a review. Since September 2020, the individual had experienced a significant change of status, including weight loss, severe dysphagia, and the placement of a G-tube (i.e., on 9/25/20). Considering the individual's decline, the PNMT's rationale was unclear for not completing a comprehensive assessment to assist the IDT in charting a new plan of care.

    In the review, the PNMT did a nice job including the individual's history and diagnoses. However, they did not identify recommendations to address potential root causes for the recurrent pneumonia. For example, they identified concerns about poor oral care and mucus plugs, but offered no plan(s) to address these concerns.
  - On 3/22/21, the individual was referred to the PNMT due again to recurrent hospitalizations and pneumonia. On 4/20/21, the PNMT completed an assessment. It was positive that numerous disciplines participated in the assessment, including the Registered Dietician (RD), OT, PT, Speech Language Pathologist (SLP), RN, and QIDP. The quality of the assessment is discussed below.
- For Individual #715:
  - From 11/25/20 to 12/10/20, he was hospitalized. He was referred to the PNMT due to emesis with a diagnosis of pneumonia. On 12/9/20, the PNMT conducted a review. In the previous six months, the PNMT had conducted two other reviews of this individual for the same presenting problems (i.e., on 7/28/20, for emesis and pneumonia; and on 10/20/20, for emesis and pneumonia). The PNMT's justification for not completing a comprehensive assessment was that the IDT was handling the issues. However, given the repeat problems, the PNMT should have completed an assessment to determine if additional supports or services might have been necessary to reduce the individual's risk to the extent possible. On 12/9/20, it appeared that the PT was the only one who wrote/completed the review.

    In the review, the PNMT provided information regarding the presenting problem of aspiration pneumonia, and ongoing emesis associated with abdominal adhesions and potential overfeeding. They discussed the risks related to dental, GI and respiratory/aspiration, but did not discuss other risk categories that might be impacted, such as skin integrity (i.e., the impact of continued aspiration and tube feeding issues on the individual's ability to maintain his skin integrity). In discussing current services, the PNMT included discussion of head-of-bed elevation (HOBE), but offered no evidence that this was reassessed in the face of ongoing issues with emesis. The PNMT completed no observation of suction toothbrushing, despite the individual's history of refusals and the impact of oral bacteria and saliva on his aspiration pneumonia risk. The review primarily outlined the resulting surgical intervention, and stated he had no problems since his return from the hospital on 12/9/20, which was one day prior to the review. The recommendation

focused on surgical follow-up, and the PNMT offered no recommendations to improve other areas that would help mitigate risk.
    - Again from 1/2/21 to 1/11/21, the individual was hospitalized, and then referred to the PNMT due to emesis and pneumonia. On 2/26/21, the PNMT completed an assessment. It was slightly delayed due to the need for the individual to quarantine upon return from the hospital, and then the blizzard conditions in the state. It appeared that the SLP was the only one who wrote/completed the assessment. The quality of the assessment is discussed below.

h. As noted above, one individual should have had a comprehensive PNMT assessment, but did not (i.e., Individual #269). In addition, two individuals should have had comprehensive PNMT assessments earlier than they did (i.e., Individual #503, and Individual #715). The following summarizes some of the findings noted with the two assessments that the PNMT completed:

- It was positive that both assessments, addressed the following thoroughly.
    - Presenting problem;
    - Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs;
    - The individual's behaviors related to the provision of PNM supports and services;
    - Discussion of medications that might be pertinent to the problem, and discussion of relevance to PNM supports and services; and
    - Identification of some of the potential causes of the individual's physical and nutritional management problems.
- For Individual #503, the following describe some of the concerns with the assessment:
    - The HOBE evaluation justified the 25 degrees of HOBE for enteral nutrition. However, what was missing was the residual triggers and thresholds.
    - The PNMT concluded that the current supports were effective, based on the absence of aspiration pneumonia. However, trace aspiration of oral bacteria could have been the cause of his bacterial pneumonia.
    - Recommendations included improved oral care and monitoring. Although the PNMT noted the importance of positioning during oral care, they recommended that the monitoring of the individual's positioning occur for 30 days, and monitoring of his oral care occur once a month for a year. This level of monitoring was not sufficient to the factors identified as contributing to increased risk.
- For Individual #715, the following describe some of the concerns with the assessment:
    - The PNMT discussed the risks related to dental, GI and respiratory/aspiration, but did not discuss other risk categories that might be impacted, such as skin integrity (i.e., the impact of continued aspiration and tube feeding issues on the individual's ability to maintain his skin integrity).
    - Overall, the PNMT assessment lacked substantive detail and data to support statements/conclusions. Some examples included:
        - In reviewing the individual's oxygen (O2) saturation levels, the PNMT assessment stated that O2 levels were reviewed by month and hour, but offered no information about the position in which the person was, even though this was noted as "imperative" in the PNMT assessment.
        - Similarly, for emesis, the PNMT stated that three episodes of emesis occurred in the last year (i.e., all resulting in hospitalizations), but they did not describe what position the individual was in when these occurred or additional information regarding the tube feedings at the time.

- As with the review in December 2020, HOBE was referenced, but the PNMT provided no evidence of re-assessment to make sure it met the individual's needs.
- The PNMT mentioned a positioning schedule, but provided no details about the schedule.
- Despite potential impact of oral care/suction toothbrushing on the individual's risk of aspiration due to bacteria, there was no evidence that the PNMT observed this activity.
- In an annual assessment, dated 1/21/21, the RD stated that connecting the G-tube to the drainage bag might help reduce emesis. However, there did not appear to be follow-up. The PNMT noted four days of possible overfeeding that occurred on 1/24/21, 1/25/21, 1/26/21, and 1/27/21.

- The PNMT suspected the root causes of the individual's recurrent pneumonias were multifactorial, including: 1) his tracheostomy, 2) dysphagia, 3) that he was enterally fed, 4) the individual touching his tracheostomy site with un-sanitized hands, and 5) possible aspiration under sedation during replacement of his enteral feeding tube. Given the incompleteness of the assessment information, it was not clear that the PNMT identified the full set of potential causes and/or a comprehensive set of recommendations to address the individual's such causes.

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(s) or etiology(ies) of the PNM issues in the action steps.

With continuing efforts and attention to detail, by the time of the next review, Habilitation Therapy staff could make additional progress on the quality of PNMPs. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 112	344	269	35	503	715	108	19	5
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).	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/1	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.	56% 5/9	0/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	12% 2/17	0/2	0/2	0/2	0/2	2/2	0/2	0/1	0/2	0/2

f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	0% 0/13	0/1	0/1	0/2	0/2	0/2	0/2	N/A	0/1	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	6% 1/17	0/2	0/2	0/2	1/2	0/2	0/2	0/1	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: Individual #112 - weight, and skin integrity; Individual #344 - aspiration, and skin integrity; Individual #269 – fractures, and falls; Individual #35 - aspiration, and choking; Individual #503 - aspiration, and respiratory compromise; and Individual #715 – GI problems, and aspiration; Individual #108 – skin integrity, and falls; Individual #19 - choking, and falls; and Individual #5 - aspiration, and choking.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP.

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

c. All individuals reviewed had PNMPs and/or Dining Plans. Five of the PNMPs reviewed fully met the individuals' needs. The problems with the remaining four included:

- Risk levels related to supports and individual triggers, if applicable: Individual #112 and Individual #344's PNMPs were missing three to four PNM-related risks. Individual #715's PNMP indicated he had no individualized triggers, but some of his triggers would be emesis for aspiration, or excessive touching his tracheostomy.
- Photographs: Individual #715's PNMP provided no clear picture focusing on the height of the drainage bag.
- Transfers: Individual #503's assessment stated that joint compression/axial loading assisted him after transfers to relax and that this should be included in the PNMP. However, the PNMP did not include this information.
- Oral Hygiene, including positioning and brushing instructions: Individual #503's PNMP lacked information on sensory input prior to oral care as stated in OT/PT assessment completed in August 2020. Individual #715's PNMT assessment mentioned his refusal at times with suction toothbrush, but the PNMP offered no guidance for staff should this happen.

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 progress on improving individuals' PNMPs.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for: Individual #503 - aspiration, and respiratory compromise.

g. Often, the IHCPs reviewed did not include the frequency of PNMP monitoring. The one that did was for: Individual #35 - choking.

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	112	344	269	35	503	715	108	19	5
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	100% 2/2	N/A	N/A	N/A	N/A	1/1	1/1	N/A	N/A	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/1					0/1	N/A			
Comments: a. and b. Two individuals in the review group received enteral nutrition: • On 4/23/21, Individual #503's IDT discussed a recommendation to begin use of the Frazier Water Protocol. However, no evidence was found to show that this occurred. • In September 2009, Individual #715 had a G-tube placed due to failure to thrive/dehydration. After a hospitalization on 7/25/16, he returned to nothing-by mouth (NPO) status with continuous feeding. After a hospitalization for pneumonia on 1/24/17, pleasure feedings were discontinued.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: Due to the Center's sustained performance with the provision of the correct type of assessment (Round 15 – 100%, Round 15 – 100%, and Round 16 - 89%), Indicator b will move to the category requiring less oversight. Center staff should continue to focus on ensuring that annual and change-of- status assessments are completed in a timely manner. The quality of OT/PT assessments also continues to be an area on which Center staff should focus. The remaining indicators will continue in active monitoring.			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
a.	Individual receives timely screening and/or assessment:										

	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	75% 6/8	1/1	0/1	1/1	1/1	1/1	0/1	N/A	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	22% 2/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	N/A									

Comments: a. and b. For the individuals reviewed, Occupational and Physical Therapists (OTs/PTs) completed most OT/PT assessments in accordance with individuals' needs, and they completed many, but not all, assessments in a timely manner. The following describes the exceptions noted:

- For Individual #344, Center staff last provided a comprehensive assessment on 9/20/19, and, due to finding that his OT/PT status was within functional limits, determined a screening would not be due until 2024. However, based on concerns with regard to the individual's elevated choking risk requiring related adaptive strategies, a screening every five years would not be sufficient to meet his needs.
- In July 2020, October 2020, December 2020, and January 2021, Individual #715 experienced emesis, and then developed aspiration pneumonia. No evidence was found to show that Habilitation Therapy staff completed a HOBE evaluation.

d. As described above, the Center did not provide a current assessment for Individual #344. It was positive that of the eight current comprehensive assessments reviewed, those for Individual #35 and Individual #19 met all criteria for a quality assessment. It was also positive that all the remaining six 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;
- The individual's preferences and strengths were used in the development of OT/PT supports and services; and,
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments.

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

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services; and,
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living.

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

- 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);
- 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.

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: ISPs reviewed contained needed descriptions of how the individuals functioned from an OT/PT perspective, which was positive. If the Center sustains this progress, then after the next review, Indicator a might move to the category requiring less oversight. However, at the time of annual ISP meetings, IDTs often did not document discussions of needed changes to the PNMP/Positioning Schedule. As indicated in previous reports, this was an issue that needed attention. To move forward, QIDPs and OTs/PTs should work together to make sure IDTs discuss and consistently include information related to individuals' OT/PT supports in ISPs and ISPAs. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 112	344	269	35	503	715	108	19	5
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	56% 5/9	0/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	0% 0/9	0/1	0/1	N/A	N/A	0/1	N/A	0/2	0/2	0/2
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. The ISPs reviewed included concise, but thorough, descriptions of individuals' OT/PT functional statuses, which was positive.

b. Simply including a stock statement such as "Team reviewed and approved the PNMP/Dining Plan" did not provide evidence of what the IDT reviewed, revised, and/or approved. Therapists should work with QIDPs to make improvements.

c. and d. IDTs did not address individuals' OT/PT needs by including in their ISP/ISPA action plans the recommended interventions and/or goals/objectives for direct therapy that OT/PTs recommended or implemented. Therapists should work with QIDPs to make improvements.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: Significant work is needed to improve the quality of communication assessments in order to ensure that SLPs provide IDTs with clear understandings of individuals' functional communication status; AAC options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
a.	Individual receives timely communication screening and/or assessment:	Due to the Center's sustained performance with these indicators, they moved to the category requiring less oversight.									
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.										
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.										
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.										
b.	Individual receives assessment in accordance with their individualized needs related to communication.										
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;	N/A									

	▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	N/A									

Comments: d. It was positive that all of the 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 communication.

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

- The individual's preferences and strengths are used in the development of communication supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- The effectiveness of current supports, including monitoring findings; and
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated.

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

- 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;
- 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.

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: Improvement continued to be needed with regard to the IDTs' review and approval of individuals' Communication Dictionaries. To move forward, QIDPs and SLPs should also work together to make sure IDTs discuss and include	Individuals:

information related to individuals' communication supports in their ISPs, and develop appropriate strategies, interventions, and programs. Indicators b through d will continue in active oversight.											
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
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.	Due to the Center's sustained performance with this indicator, it moved to the category requiring less oversight.									
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	38% 3/8	N/A	1/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	N/A									
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									
Comments: b. For many of the applicable individuals reviewed, the ISPs only indicated a one-word response of "yes" with regard to the approval of the Communication Dictionary, and did not document any discussion or note if there were, or were not, changes to the document. Moving forward, ISPs will need to provide evidence with regard to what the IDT reviewed, revised, and/or approved, and/or whether the current Communication Dictionary was effective at bridging the communication gap. c. and d. As described with regard to Outcome 1 above, individuals reviewed did not have communication goals, but most had unaddressed and unmet needs with regard to communication. In addition, as documented with regard to Outcome 2, communication assessments often did not provide needed recommendations to provide guidance to the IDTs toward development of needed and appropriate strategies, such as therapy interventions and skill acquisition programs.										

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: Again, it was good to see all individuals having many SAPs. Many of them, however, were not written in measurable terminology. This needs to improve in order for indicator 2 to remain in the category of requiring less oversight after	Individuals:

the next review. About two-thirds to three-fourths of the SAPs were based on assessment results and also were practical, meaningful, and functional. The Center had suspended checking reliability of SAP data collection due to COVID. These three indicators will remain in active monitoring.											
#	Indicator	Overall Score	335	115	112	297	150	479	407	483	344
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.	78% 21/27	0/3	2/3	3/3	3/3	2/3	2/3	3/3	3/3	3/3
4	SAPs are practical, functional, and meaningful.	63% 17/27	1/3	3/3	2/3	2/3	2/3	1/3	1/3	3/3	2/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	Not scored due to COV19									

Comments:
All nine individuals had skill acquisition plans (SAPs). It was positive to find that seven of the nine individuals had between five and six SAPs each. Three SAPs were reviewed for each individual.

2. Nine of the 27 SAPs were measurable. These were the following: all of Individual #335's and Individual #115's SAPs, Individual #407's job application SAP, and Individual #483's floss teeth and set table SAPs. While the remaining SAPs included most of the necessary components of a good objective, they did not indicate whether the individual was to perform the skill independently or with some level of prompting.

3. Twenty-one of the 27 SAPs were based on assessment results. The exceptions included SAPs in which no baseline assessment or current level of performance was provided (all of Individual #335's SAPs and the cook eggs SAP for Individual #115); Individual #150's call 911 SAP because his FSA indicated he knew to call this number in an emergency; and Individual #479's sanitize his hands SAP because his FSA indicated he was skilled in washing his hands indicating he had the motor skills to perform this chain.

It was positive to learn that staff were hoping to resume baseline assessment before introducing new SAPs.

4. Seventeen of the 27 SAPs were considered practical, functional, and/or meaningful. The majority of exceptions were SAPs that did not support the identified goal. Following a stroke, Individual #335 was learning to use her right hand to complete work. This did not increase her earnings and would appear to be better addressed in therapy. Similarly, her medication SAP did not address her goal of learning to make pudding. Individual #112 was learning to send an e-mail, a skill that would not enhance her goal of participating in the Special Olympics bowling competition. Individual #297 was learning to point to a named coin, but this did not support his goal of participating in the SSLC Music Festival or verifying his change when dining out. Individual #479 was learning to sanitize his hands, but

this did not address his goal of volunteering in the community. Similarly, he was learning to make change, a skill that would not assist him in obtaining a janitorial job in the community. Individual #407 was learning to balance a ledger, but this did not address her goal of learning to cook. Similarly, she was learning to complete math problems so that she could combine different doses of medication to meet her prescribed dose. This was not likely a skill she would need to live in a group home. Last in this category was Individual #344's learning to make a purchase from a vending machine. This did not address his goal of learning to use a tablet to complete educational software programs. Finally, it was noted that Individual #150 knew to call 911 in an emergency. This was not a new skill.

5. Due to the COVID-19 pandemic the facility had suspended all monitoring of SAP implementation including assessment of data reliability. For this reason, this indicator was not scored.

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: Due to sustained high performance, indicator 11 will be moved to the category of requiring less oversight. Performance on indicator 12 remained the same for four consecutive reviews. It will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 335	115	112	297	150	479	407	483	344
10	The individual has a current FSA, PSI, and vocational assessment.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	67% 6/9	1/1	1/1	1/1	0/1	1/1	0/1	0/1	1/1	1/1

Comments:

11. Based upon the QIDP tracking data, the required assessments had been available to their IDTs 10 days prior to the scheduled ISP meeting. The exception was Individual #112 whose FSA was late.

12. Recommendations for skill acquisition plans were provided in both the FSA and vocational assessment for six individuals. These were Individual #335, Individual #115, Individual #112, Individual #150, Individual #483, and Individual #344. No SAP recommendations were found in the FSA for Individual #297 and Individual #479, or the vocational assessment for Individual #407.

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.

After the last review, this Domain contained 37 outcomes and 158 underlying indicators. Thirty-nine of these indicators were in the category requiring less oversight.

- Since the last review, the Monitor found that that the Center achieved and maintained substantial compliance with the requirements of section J of the Settlement Agreement and, as a result, was exited from section J of the Settlement Agreement. The reduces this Domain by nine outcomes, and 26 indicators.

As a result, this Domain now contains 27 outcomes, and 94 underlying indicators. At the time of the last review, 22 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, one additional indicators will move to the category requiring less oversight in the area of psychology.

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

Goals/Objectives and Review of Progress

Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress with regard to individuals' physical and/or dental health. In other words, IDTs did not identify activities in which individuals needed to engage or skills that they needed to learn to improve their health (e.g., exercise to lose weight, improve cardiac health; learn to wash their hands or apply cream to dry skin to reduce the risk for skin infections; etc.), and then, develop goals/objectives/SAPs to measure individuals' progress with such activities or skill acquisition. 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.

Regarding PBSP data collection, reliability and treatment integrity, good and improved performance was found. The Center should re-consider the sole use of episode data recording for some individuals.

Acute Illnesses/Occurrences

Similar to the last review, two of the six acute care plans reviewed met individuals' needs and met the criteria for quality. Nursing staff also consistently implemented four of the six plans reviewed. More work was needed to ensure that nurses followed relevant guidelines when conducting assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis.

When PCPs assess acute issues at the Center, they need to document the source of the information. For acute events that occur after hours/on a holiday, PCPs need to write IPNs to summarize the events leading up to the events and the disposition. PCP

follow-up for acute issues addressed at the Center, as well as when individuals return from the ED or hospital was sometimes still an issue.

Implementation of Plans

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 a 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 10 of the 18 chronic or at-risk conditions reviewed, individuals' 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.

Only one of the 18 IHCPs selected for review included a full set of action steps to address individuals' medical needs. The PCP did not implement all of the action steps in this IHCP. Although PCPs implemented the few action steps included in the remaining IHCPs, many of these action steps related to the completion of IMRs, and they called for reviews every six months, which did not meet individuals' needs, and no longer was consistent with State Office policy.

Three of the nine individuals reviewed received all of the preventative care they needed. Some problems were noted with the provision of immunizations. It was positive that all nine individuals in the review group had up-to-date hearing screenings. The six individuals who needed osteoporosis screening, and the six individuals who needed colorectal cancer screening received it. Three of four women who required cervical cancer screening received it timely. In a couple of instances, individuals had not yet received vision screenings that were postponed due to COVID-19 precautions, and their IDTs had not met to discuss the risk/benefit of continued postponement versus completion of the appointments.

Medical practitioners should make sure to review and address, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

Overall, the Center continued to perform well with the provision of necessary dental treatment in the Dental Clinic. Focus should be placed on providing suction tooth brushing as defined in individuals' IHCPs, and conducting monitoring to assess the quality and safety of the suction tooth brushing provided.

With regard to medication administration, areas that require focused efforts are nurses' adherence to infection control procedures, and the inclusion in IHCPs of respiratory assessments for individuals with high risk for respiratory compromise that are consistent with the individuals' level of need, and the implementation of such nursing supports.

Many, but not all, individuals observed had assistive/adaptive equipment that appeared to be the proper fit.

Based on observations, there were still numerous instances (40% of 40 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. Often, the errors that occurred (e.g., staff not intervening when individuals took large bites, ate at an unsafe rate, and/or did not take sips of liquid in between bites) placed individuals at significant risk of harm. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. An interdisciplinary group of Center staff (including skill acquisition staff) should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, individuals' need for skill development, etc.), and address them.

In behavioral health, now that criteria were being met for most individuals showing that PBSP data were reliable, progress could be determined and more than half of the individuals were scored positively for this, the highest score ever for Denton SSLC. The Center now needs to ensure that goals/objectives are updated when met, and that actions are taken and implemented when no progress is seen.

Staff training on PBSPs, and plans for float staff, were occurring and were available, however, not enough staff were shown to be trained on the PBSPs, and each PBSP summary was missing some components.

Restraints

As noted in Domain #1 of this report, the Monitor found that that the Center achieved substantial compliance with many of the requirements of Section C of the Settlement Agreement, including the Center's response to frequent usage of crisis intervention restraint (i.e., more than three times in any rolling 30-day period).

Psychiatry

The Monitor found that that the Center achieved and maintained substantial compliance with the requirements of section J of the Settlement Agreement and, as a result, was exited from section J of the Settlement Agreement.

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: Now that criteria were being met for most individuals showing that PBSP data were reliable, progress could be determined and more than half of the individuals were scored positively on indicator 6, the highest score ever for Denton SSLC. The Center now needs to ensure that goals/objectives are updated when met, and that actions are taken and implemented when no progress is seen. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 335	115	112	297	150	479	407	483	344
6	The individual is making expected progress	63% 5/8		0/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/3				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% 0/3		0/1	0/1					0/1	0/1
9	Activity and/or revisions to treatment were implemented.	N/A									

Comments:

6. The progress notes reviewed included data into May 2021. A review of the graphs and tables showed that five of the eight individuals were making progress. These were Individual #297, Individual #150, Individual #479, Individual #407, and Individual #344. For the other individuals, progress was not evident on some of the targeted problem behaviors exhibited by Individual #115 and Individual #112, and/or the replacement behavior was worsening (Individual #115, Individual #483). Additionally, their data were not reliable (see indicator 5).

7. Based on the data presented in the PBSP progress notes, at least one objective had been met by four individuals. Individual #297 met his property destruction objective; Individual #150 met his stealing, attempted unauthorized departure, and inappropriate sexual behavior objectives; and Individual #479 met his inappropriate touching objective. These objectives had not been revised. Individual #407 recently met her aggression objective, but she was excluded from this analysis because there had not been sufficient time to revise the objective.

8-9. Based upon the information provided in the PBSP progress notes, actions had not been taken to address these individuals' lack of progress.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
Summary: Staff training on PBSPs, and plans for float staff, were occurring and were available, however, not enough staff were shown to be trained on the PBSPs, and each PBSP summary was missing some components. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	115	112	297	150	479	407	483	344
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/8		0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
17	There was a PBSP summary for float staff.	0% 0/8		0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments: 16. A comparison was made between staff rosters and training rosters provided by the facility. These data indicated that between 0% and 64% of assigned staff had received training. Additional training rosters were reviewed following the BHS director's report that further training had occurred after the initial document request. While this resulted in an increase in the percentage of assigned staff who had received training for some individuals, scores still did not exceed 80%. 17. A PBSP summary was provided for all eight individuals. While these brief summaries were dated to indicate their correspondence to the current PBSP, none addressed the consequences staff should employ when target problem behaviors occurred. Further, the summary for Individual #112 did not address two of her four problem behaviors, and the summary for Individual #407 confused the terms suicidal threat versus gesture.										

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
Summary: Indicator 19 will remain in the category of requiring less oversight, however, the Monitor has provided some commentary regarding aspects of the monthly progress notes that should be addressed by the BHS department. For the other indicators, some improvement in the graphs and peer review follow-up remained needed. With sustained high performance, indicator 21 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	335	115	112	297	150	479	407	483	344

19	The individual's progress note comments on the progress of the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
20	The graphs are useful for making data based treatment decisions.	13% 1/8		0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 2/2				1/1					
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	50% 1/2					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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

19. All eight individuals who had PBSPs had monthly progress notes, but only those for Individual #297, Individual #407, and Individual #344 were consistently signed and dated. This allowed the Monitoring Team to determine that these were completed in a timely manner. There were no dates indicating time of completion in the progress notes for Individual #115, Individual #150, Individual #479, and Individual #483. For Individual #112, it was about half. Without this date, the Monitoring team cannot determine whether these were completed in a timely manner.

Although most reports included a targeted rate of behavior across an identified number of months, this did not indicate the expected date of completion. The monthly progress notes should include the complete objective for all target and replacement behaviors. This will allow staff to easily determine whether objectives have been met and are in need of revision.

20. The graphs for Individual #407 were found to be useful for making data based treatment decisions. For the other seven individuals, problems were found in one of three areas.

- While most graphs were easy to read, in all but the last progress reports for Individual #150 and Individual #479, there was at least one graph with four data paths. Further, when daily data were presented, between five and six measures were displayed on one graph. These practices made the graphs difficult to read.
- In other cases, graphs were labeled frequency when at least one target behavior was documented as episodes. This was true for Individual #115, Individual #112, and Individual #483.
- Phase change lines depicting significant events were not consistently included in graphs. Examples of significant events include implementation of new or revised PBSPs, changes in medication, initiation of COVID-19 restrictions and lifting of the same, transition to a new home or within a home, etc.
- The placement of phase change lines was not always accurate. It will be important to include phase change lines in both monthly and daily graphs because the latter provides a more precise analysis of the individual's response to the identified change.
- Progress notes for Individual #150 included data on verbally disruptive behavior that was not addressed in his PBSP.

21. An observation was conducted of the psychiatric clinic for Individual #297 and Individual #50. For both individuals, the BCBA presented current data.

22. Documentation provided prior to the remote review indicated that two individuals had been presented to the Internal Peer Review Committee. Individual #150 was reviewed three times between November 2020 and March 2021, but there was no evidence of revisions to his PBSP because it was implemented in August 2020. Further, there was no evidence of a token system in his plan.

Individual #407 was reviewed in December 2020. In her latest PBSP, implemented in May 2021, there were guidelines for staff to encourage her to sing favorite songs or read her bible when she exhibited precursor behavior. These were similar to recommendations made at the time of her review. She was also involved in twice weekly counseling sessions.

Outcome 8 – Data are collected correctly and reliably.

Summary: Good and improved performance was found for this outcome. The Center should re-consider the sole use of episode data recording for some individuals. Indicator 27 showed sustained high performance and will be moved to the category of requiring less oversight. With sustained high performance, the same might occur for indicators 28 and 29 after the next review. Indicator 30 scored higher than ever before. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 335	115	112	297	150	479	407	483	344
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	0/1	1/1	1/1	0/1	1/1	0/1	1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	88% 7/8		1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 8/8		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 8/8		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	63% 5/8		0/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1

Comments:
26. The data collection systems adequately measured target behaviors for four of the eight individuals (Individual #297, Individual #150, Individual #407, Individual #344).

For Individual #115, Individual #112, Individual #479, and Individual #483, at least one of their target behaviors was defined as an episode separated by the passage of time (i.e., between 30 and 5 minutes) without any occurrence of the targeted response. As episodes can vary dramatically in length, it is likely that this measurement system resulted in an underreporting of the problem. The BHS staff

should consider measuring the duration of episodes or converting to a partial interval recording system using relatively short intervals of time.

27. Data collection systems described in the PBSPs adequately measured replacement behaviors for all eight individuals. However, this indicator is rated zero for Individual #112 because her taking responsibility replacement behavior was not included in the sample data sheet. As a result, it was unclear how staff were to document this behavior.

28-29. As noted following the last monitoring review, the BHS director had introduced a monitoring form that all staff were expected to use when assessing data collection timeliness, inter-observer agreement, and treatment integrity. The form included four sections: treatment integrity interview, treatment integrity observation, inter-observer agreement, and data timeliness.

When reporting on treatment integrity, staff should report on the observation section only. It will also be important to ensure that treatment integrity is based upon an actual observation rather than a role play situation. Both inter-observer agreement and data timeliness allow staff to report separately on target behaviors and replacement behaviors. Assessment of these measures was to occur at a minimum of once each month, with acceptable levels established at 80%.

30. When presented in table format, data collection timeliness scores were consistently reported at 100% for six or seven of the last seven consecutive months for Individual #297, Individual #150, Individual #479, Individual #407, and Individual #344. These same data were not included in their monthly PBSP progress reports.

Inter-observer agreement scores presented in table format were consistently reported at better than 90% in six or seven of the last seven consecutive months for Individual #297, Individual #150, Individual #479, Individual #407, Individual #483, and Individual #344. This corresponded to reports of IOA in the PBSP progress notes for each individual, but Individual #112 and Individual #297, for whom no scores were reported until the last month.

Adequate measures of treatment integrity were reported in table format for six or seven of the last seven months for Individual #112, Individual #297, Individual #150, Individual #479, Individual #407, Individual #483, and Individual #344.

To summarize, Individual #115 and Individual #112 did not meet criteria for DCT and IOA, and Individual #483 did not meet criteria for zero for DCT. And Individual #115 did not meet criteria for TI.

In the future, it will be important to ensure correspondence between data reported in the monthly progress note and summary data.

Lastly, many of the reported IOA and treatment integrity scores were based upon observations in which neither the target nor replacement behaviors occurred. The BHS director addressed this concern by advising her staff to schedule observations during times when data suggest that target behaviors may be more likely to occur.

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 develop goals/objectives that reflected clinically relevant actions that the individuals could take to reduce their at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/17	0/2	0/2	0/1	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.	12% 2/17	1/2	0/2	0/1	1/2	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).	12% 2/17	1/2	0/2	0/1	1/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/17	0/2	0/2	0/1	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% 0/17	0/2	0/2	0/1	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 #112 – diabetes/metabolic syndrome, and infections; Individual #344 – skin integrity, and weight; Individual #269 – falls, and other: menopause; Individual #35 – diabetes, and seizures; Individual #503 – aspiration, and seizures; Individual #715 – aspiration, and skin integrity; Individual #108 –polypharmacy/medication side effects, and other: cancer; Individual #19 – diabetes, and osteoporosis; and Individual #5 – osteoporosis, and seizures).

IDTs developed clinically relevant, achievable, and measurable goals for none of these risk areas. In other words, IDTs did not identify activities in which individuals needed to engage or skills that they needed to learn to improve their health (e.g., exercise to lose weight, or improve cardiac health; engage in specific activities to stop smoking; make specific diet modifications to reduce gastroesophageal reflux disease (GERD); drink a specific amount of fluid per day to prevent constipation; etc.), and then, develop goals/objectives/SAPs to measure individuals' progress with such activities or skill acquisition.

The following chronic or at-risk condition required an action plan, but did not require a personal goal/objective in which the individual or direct support professionals needed to engage to improve the individual's health: Individual #269 – other: menopause.

Although the following goals/objectives were measurable, because they did not specify what the individuals could do to improve their health, the related data could not be used to measure the individuals' progress or lack thereof: Individual #112 – diabetes/metabolic syndrome, and Individual #35 - diabetes.

c. through e. It was positive that for Individual #112's diabetes goal, the QIDP included data about weight loss in the integrated monthly reviews. Individual #35's QIDP included information about the A1c lab values. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. As a result, it was difficult to determine whether or not individuals were making progress with regard to taking steps to improve their chronic or at-risk conditions, 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: Three of the nine individuals reviewed received all of the preventative care they needed. Some problems were noted with the provision of immunizations. It was positive that all nine individuals in the review group had up-to-date hearing screenings. The six individuals who needed osteoporosis screening, and the six individuals who needed colorectal cancer screening received it. Three of four women who required cervical cancer screening received it timely. In a couple of instances, individuals had not yet received vision screenings that were postponed due to COVID-19 precautions and their IDTs had not met to discuss the risk/benefit of continued postponement versus completion of the appointments.

Medical practitioners should make sure to review and address, 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	112	344	269	35	503	715	108	19	5
a.	Individual receives timely preventative care:										
	i. Immunizations	56% 5/9	0/1	1/1	0/1	1/1	1/1	1/1	0/1	0/1	1/1
	ii. Colorectal cancer screening	100% 6/6	N/A	N/A	1/1	1/1	1/1	1/1	N/A	1/1	1/1
	iii. Breast cancer screening	100% 3/3	1/1	N/A	1/1	1/1	N/A	N/A	N/A	N/A	N/A
	iv. Vision screen	78% 7/9	1/1	1/1	0/1	1/1	0/1	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%	N/A	N/A	1/1	1/1	N/A	1/1	1/1	1/1	1/1

		6/6									
	vii. Cervical cancer screening	75% 3/4	1/1	N/A	1/1	0/1	N/A	N/A	1/1	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	56% 5/9	1/1	0/1	1/1	0/1	0/1	1/1	0/1	1/1	1/1

Comments: a. The following provide examples of findings:

- It was positive that all nine individuals in the review group had up-to-date hearing screenings.
- The six individuals who needed osteoporosis screening, and the six individuals who needed colorectal cancer screening received it.
- Three of four women who required cervical cancer screening received it timely.
- Individual #112's immunization record indicated that on 8/30/16, she received the first dose of the varicella vaccine. In response to a document request for confirmation of the second dose, Center staff submitted a copy of an order for a varicella titer, dated 6/22/21 (i.e., during the Monitoring Team's remote review). This suggested that information about a second dose was not available.
- For Individual #269:
  - She was 55 years old, but the PCP had not ordered the Shingrix vaccine.
  - On 12/4/19, she had her last vision exam with a recommendation to return in one year. No ISPA was submitted to show that the IDT discussed the risk/benefit considerations of delaying or moving forward with a vision appointment.
- On 5/5/15, Individual #35 had her last pap smear and pelvic exam. On 2/25/19, she was uncooperative with a follow-up exam. Since then, there had been no follow-up, and based on interview, no system to track the need for follow-up.
- On 7/10/19, Individual #503 had his last vision exam with a recommendation to return in one year. Follow-up was scheduled for 7/15/20, but did not occur due to COVID-19 precautions. Based on documents submitted, he had not had a vision screening in 2020 or thus far in 2021. No ISPA was submitted to show that the IDT discussed the risk/benefit considerations of delaying or moving forward with a vision appointment.
- Individual #108's Hepatitis B vaccine status was unclear. Her official immunization record included no information. Her AMA indicated that on 2/14/11, lab work showed she was Hepatitis B antibody negative. However, no further information was included about vaccine booster administration, or a repeat series. It appeared that the original series in 2008 was incomplete.
- Individual #19 was 72 years old, but the PCP had not ordered the Shingrix vaccine.

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, and discuss what changes can be made to medications based on this information, document any additional monitoring to be done based on prescribed medication/polypharmacy side effects, or state if the individual is clinically stable and changes are not indicated. For three of the individuals reviewed, PCPs had not conducted the necessary analysis, and/or stated the plan.

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	112	344	269	35	503	715	108	19	5
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	N/A									
Comments: a. None											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: When PCPs assess acute issues at the Center, they need to document the source of the information. For acute events that occur after hours/on a holiday, PCPs need to write IPNs to summarize the events leading up to the events and the disposition. PCP follow-up for acute issues addressed at the Center, as well as when individuals return from the ED or hospital was sometimes still an issue. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
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.	55% 6/11	2/2	0/1	0/1	0/1	2/2	0/1	1/2	1/1	N/A
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.	78% 7/9	1/1	1/1	0/1	N/A	1/2	1/1	2/2	1/1	
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	63% 5/8	N/A	N/A	1/1	2/2	0/2	1/2	1/1	N/A	N/A

	IPN with a summary of events leading up to the acute event and the disposition.										
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	100% 1/1			N/A	N/A	N/A	1/1	N/A		
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	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.	75% 6/8			1/1	1/2	1/2	2/2	1/1		
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	100% 5/5			N/A	1/1	2/2	2/2	N/A		
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.	57% 4/7			1/1	0/2	2/2	1/2	N/A		

Comments: a. For eight of the nine individuals reviewed, the Monitoring Team reviewed 11 acute illnesses addressed at the Center, including: Individual #112 (abscess on thigh on 3/4/21, and abdominal abscess on 11/13/20), Individual #344 (cuts to right foot on 1/16/21), Individual #269 (bite to right wrist and left otitis media on 12/3/20), Individual #35 (wet cough on 3/3/21), Individual #503 (rash to abdomen on 3/17/21, and wound to the lateral right foot on 5/7/21), Individual #715 (right heel eschar on 12/15/20), Individual #108 (lesion on left cheek on 4/13/21, and breast mass on 2/9/21), and Individual #19 (swelling of right forearm on 2/26/21).

PCPs assessed the following acute issues according to accepted clinical practice: Individual #112 (abscess on thigh on 3/4/21, and abdominal abscess on 11/13/20), Individual #503 (rash to abdomen on 3/17/21, and wound to the lateral right foot on 5/7/21), Individual #108 (breast mass on 2/9/21), and Individual #19 (swelling of right forearm on 2/26/21). For the remaining acute illnesses/occurrences, PCPs had not identified the source of the information.

b. For the following acute illnesses/occurrences, the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized: Individual #112 (abdominal abscess on 11/13/20), Individual #344 (cuts to right foot on 1/16/21), Individual #503 (rash to abdomen on 3/17/21), Individual #715 (right heel eschar on 12/15/20), Individual #108 (lesion on left cheek on 4/13/21, and breast mass on 2/9/21), and Individual #19 (swelling of right forearm on 2/26/21).

The following provide examples of concerns noted:

- According to an IPN, dated 12/3/20, at 3:11 p.m., during the annual exam, the PCP found Individual #269 had left otitis media with perforation, as well as a superficial abrasion on her right wrist. The PCP prescribed Augmentin. Based on documentation submitted, the PCP conducted no follow-up related to the perforation of the individual's left tympanic membrane.
- In an IPN, dated 5/7/21, at 3:01p.m., the PCP documented that Individual #503 had a lateral right foot injury of unknown cause. The PCP described the wound as covered with eschar, with erythema around it. The plan was to continue dressing the wound, and start doxycycline. Based on documents submitted, the PCP did not conduct any follow-up.

c. For five of the nine individuals reviewed, the Monitoring Team reviewed eight acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #269 (ED visit for fracture of her spine on 11/11/20), Individual #35 (hospitalization for seizures on 2/4/21, and ED visit for status epilepticus on 3/19/21), Individual #503 (hospitalization for pneumonia and UTI on 3/11/21, and hospitalization for acute hypoxic respiratory failure on 4/21/21), Individual #715 (hospitalization for aspiration pneumonia, sepsis, and possible small bowel obstruction on 1/2/21, and hospitalization for GJ-tube drainage and pneumonia on 3/17/21), and Individual #108 (hospitalization for chest pain and tachycardia on 4/25/21).

c. and d., f. through 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, as needed: Individual #269 (ED for fracture of her spine on 11/11/20), and Individual #108 (hospitalization for chest pain and tachycardia on 4/25/21).
- In an IPN, dated 2/5/21, at 10:43 a.m., the PCP noted that on 2/4/21, at 8:24 p.m., Individual #35 had a prolonged seizure. Nursing staff administered Diastat, with no response. Emergency medical services (EMS) transported her to the ED while she was still having a seizure. Based on the documentation submitted, nursing and/or medical staff did not communicate with hospital staff. On 2/10/21, the individual returned to the Center. According to a PCP IPN, dated 2/11/21, at 11:01 a.m., the individual had a presumed UTI. She received Ceftin for two days, required intubation and sedation on a Diprivan drip, as well as Precedex for seizure control. Neurology provided a consult, and the individual was started on Rocephin for the suspected UTI. The PCP documented no further follow-up.
- On 3/19/21, Individual #35 experienced status epilepticus. Nursing staff administered Diastat, and called EMS. The individual was transported to the ED. Upon her return, the PCP documented only one post-hospital note, which was not sufficient for this event.
- For Individual #503's hospitalization for pneumonia and a UTI on 3/11/21, and his hospitalization for acute hypoxic respiratory failure on 4/21/21, which occurred after hours/on a holiday, the PCP did not write IPNs to summarize the events leading up to the acute events and the dispositions. In addition, for the second hospitalization, clear documentation was not submitted to show that nursing or medical staff communicated relevant information to hospital staff.
- For Individual #715's hospitalization for aspiration pneumonia, sepsis, and possible small bowel obstruction on 1/2/21, which occurred after hours, the PCP did not write an IPN to summarize the events leading up to the acute events and the disposition.
- On 3/17/21, Individual #715 was hospitalized for GJ-tube drainage and pneumonia. On 3/24/21, he returned to the Center. According to a provider IPN, dated 3/25/21, at 9:28 a.m., the individual returned with a diagnosis of pneumonia. No antibiotics were prescribed upon discharge. His GJ-tube site had drainage, but this had improved. His oxygen saturation was 97% on 4 liters per minute (LPM) of oxygen. He was admitted to the Infirmary. The PCP did not document further follow-up.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: Indicator e will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
b.	PCP completes review within five business days, or sooner if clinically indicated.										
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.										
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.										
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	50% 1/2	N/A	1/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A

Comments: For seven of the nine individuals reviewed, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed included those for Individual #112 for gynecology on 12/21/20, and hematology on 5/19/21; Individual #344 for podiatry on 4/14/21; Individual #269 for podiatry on 2/3/21, and gastroenterology (GI) on 5/5/21; Individual #35 for neurology on 12/9/20, and nephrology on 1/13/21; Individual #715 for surgery on 12/17/20, and allergy on 4/29/21; Individual #108 for hematology/oncology on 4/22/21, and surgery on 4/1/21; Individual #19 for hematology on 1/7/21, and podiatry on 3/5/21; and Individual #5 for neurology on 11/20/20, and neurology on 2/26/21.

e. In response to Individual #344's podiatry appointment on 4/14/21, the PCP made a referral to the IDT. On 4/22/21, the IDT met to discuss ways to encourage the individual to wear shoes.

On 12/9/20, Individual #35 had a neurology consultation. It was not until 6/23/21, which was during the week of the Monitoring Team's onsite review, that the PCP conducted a review of the consultation report. Six months after the consultation, the PCP determined IDT referral was not needed.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
Summary: Medical Department staff continue to need to make improvements with regard to the assessment and planning for individuals' chronic and at-risk conditions. For 10 of the 18 chronic or at-risk conditions reviewed, PCPs conducted medical assessments, tests, and evaluations consistent with current standards of care, and/or identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	56% 10/18	2/2	2/2	0/2	0/2	0/2	2/2	0/2	2/2	2/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #112 – diabetes/metabolic syndrome, and infections; Individual #344 – skin integrity, and weight; Individual #269 – falls, and other: menopause; Individual #35 – diabetes, and seizures; Individual #503 – aspiration, and seizures; Individual #715 – aspiration, and skin integrity; Individual #108 –polypharmacy/medication side effects, and other: cancer; Individual #19 – diabetes, and osteoporosis; and Individual #5 – osteoporosis, and seizures).

a. For the following individuals' chronic or at-risk conditions, PCPs conducted medical assessments, tests, and evaluations consistent with current standards of care, and the PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #112 – diabetes/metabolic syndrome, and skin infections; Individual #344 – skin integrity, and weight; Individual #715 – aspiration, and skin integrity; Individual #19 – diabetes, and osteoporosis; and Individual #5 – osteoporosis, and seizures).

The following provide examples of concerns noted:

- For several years, Individual #269 had frequent falls. Contributing factors crossed many clinical areas. On 11/11/20, when trying to obtain food from the kitchen, she fell, and subsequently was diagnosed with three transverse process lumbar spine fractures. Over time, the IDT had taken different steps to try to identify the cause(s) of her falls, and put steps in place to reduce them. Unfortunately, falls were an ongoing challenge for this individual. The following provide some of the outstanding concerns that the IDT with leadership from the PCP had not addressed in order to reduce her fall risk to the extent possible.
    - She was prescribed Tenex and Aripiprazole, which have known side effects of dizziness and hypotension. However, nursing staff often were not able to obtain vital signs due to the individual's lack of cooperation. This resulted in a lack of information about whether or not hypotension contributed to her falls, or whether she had episodes of tachycardia or bradycardia. Based on submitted documentation, it did not appear that Behavioral Health Services staff were involved in developing and implementing a plan to assist her to cooperate with vital sign assessments.
    - She has a profound sensorineural hearing loss, but could read lips when one was in her field of vision. She also tended to be excitable and impulsive, resulting in a rapid pace of walking. On 10/30/20, at an ISPA meeting, the IDT documented that staff were to continue to follow the PBSP in redirecting behavior that might lead to falls. Given her profound hearing loss, it was not clear that staff had been provided direction to consistently prompt her to slow down

and pay attention to her environment. For example, it was not clear if staff knew the exact words or signs to use to prompt her. In addition, if she was walking rapidly with her head down, providing these instructions effectively would be difficult.

- A PNMT review, dated 11/12/20, indicated that behaviors contributed to the fall that resulted in the fractures, because she was not paying attention (i.e., the "root cause"), and she walked with her head down. There was no discussion about whether or not staff had attempted to assess her posture while walking with her head down, or to systematically teach her to pay attention while walking and/or walk with her head up.
- On 12/7/20, she developed an otitis media with perforation, which might have at least temporarily caused imbalance with a tendency to fall. The PCP did not complete timely follow-up to determine if the tympanic membrane healed or was contributing to her imbalance.
- The PNMP indicated she was to wear shoes that did not have shoelaces, and the QIDP was to go through the closet to make sure her shoes were consistent with her PNMP. However, at the time of the Monitoring Team's remote visit with the individual, staff indicated she wore shoes with shoelaces.
- A 1/27/21 pharmacy IPN documented that in the past, providers decreased Depakote and Tenex doses to determine if lowering the doses would reduce her falls. The falls did decrease, but her behaviors and SIB increased, necessitating an increase in the Depakote dosage.
- With continued falls, at an ISPA meeting on 4/3/21, the IDT documented review of the PNMP with no changes. The QIDP requested purchases of no-slip mats for inside and outside the tub to minimize any further falls during bathing.
- A PNMT review, dated 5/10/21, indicated that the root cause of her falls was not paying attention. It also stated "PNMT services are not indicated at this time as supports, services, and action plans placed by the IDT are adequately addressing her needs." On 5/11/21, at an ISPA meeting with the PNMT, the IDT reviewed and agreed with this finding. As illustrated above, it was not clear that the IDT had taken all of the necessary steps to reduce her risk to the extent possible.

On 11/12/20, the PCP attended the ISPA meeting at which the IDT discussed the individual's fracture, and the necessary supports and follow-up. However, the PCP did not attend the ISPA meetings on 10/29/20, 12/2/20, 4/5/21, and 5/11/21, at which the IDT discussed falls. PCP input would have been beneficial in assisting the IDT to discuss the multi-factorial etiology(ies) of her frequent falls.

- In the preventive care section of the AMA, dated 12/15/20, the PCP stated that Individual #269's last menses occurred on 9/17/10, with the comment that staff reported her menses occurred every three months, but they were not documenting it consistently. She was 55 years old. The AMA also stated she had gynecological evaluations under conscious sedation, with the most recent pelvic exams with pap smear testing on 6/3/14, and 7/31/17. The 2017 consult did not mention any medication she was taking, such as her birth control pill (i.e., levonorgestrel ethinyl estradiol extended cycle). The PCP's request of the consultant was for a pap and pelvic exam under conscious sedation, but the PCP made no request for the consultant to review the individual's use of birth control pills. In 2014, reference was made to a hormone evaluation for menopause. There was no further updated lab provided. In November 2020, a gynecological evaluation with a pap and pelvic was scheduled, but the individual would not cooperate. However, the PCP did not write a request to ask the consultant to assist in reviewing the

prescription of birth control pills, and/or to recommend alternative treatment. Additionally, the Clinical Pharmacist did not question the administration of this medication in a 55-year-old woman.

The ongoing prescription of birth control pills needs further review, especially considering the individual's age, and comorbidities (chronic kidney disease Stage 1, prehypertension, hypercholesterolemia, and diabetes mellitus). For example, telephone communication with the gynecologist or an endocrinologist might be an option to expedite the review and choice of options. The submitted documentation was silent on the risk-benefit considerations as well as any next steps/options.

- According to the AMA, dated 11/4/20, Individual #35 had insulin dependent uncontrolled diabetes mellitus, along with hyperlipidemia and obesity. She was prescribed a 1200-calorie diabetic, low cholesterol, low fat diet. Staff were to offer Glucerna if she ate less than 50% of a meal. Supplementation included Prostat. Dating back to 9/12/11, she had proteinuria, and nephrology followed her periodically. Since that time, she was treated with Losartan and/or Lisinopril for renal protection. On 5/18/16, the nephrologist recommended starting Aldactone at 12.5 milligrams (mg) daily, but this was not available from the pharmacy, so it was not initiated at the time. The plan of care for diabetes mellitus in the AMA stated that her Lisinopril would be continued, but the AMA medication list did not list Lisinopril but rather listed Losartan, which made it unclear which medication was prescribed at the time of the AMA. The plan of care for proteinuria indicated she was prescribed Losaratan, consistent with the list of medications in the AMA. She is was prescribed aspirin (ASA) and atorvastatin. The PCP should review the AMA and resolve the inconsistencies and inaccuracies.

  She was diagnosed with obesity, with a body mass index (BMI) of 30.9 and weight 185.6 pounds. In the year prior to the AMA he had a slight weight gain. Her hemoglobin (Hgb) A1C had ranged from 7.6 to 8.1. The PCP checked these labs quarterly. According to the AMA, her urine microalbumin was elevated at 691 on 9/11/20. Creatinine and protein were rechecked every six months. However, on 1/13/21, at a tele-visit, the nephrologist documented a lack of lab results for the urine protein creatinine ratio. She had a slightly elevated cortisol level of uncertain etiology and significance, which continued to be evaluated.

  In a note, dated 11/5/20, the nutritionist pointed out the lack of in-service training and a lack of understanding on the part of the home staff, which complicated compliance with the individual's diet. During a follow up related to emesis, the nutritionist learned that staff gave the individual pizza at times. Also, when residential staff "thought" her blood sugar was low, they gave her extra food without notifying the nurse to complete a nursing evaluation and testing of the individual's blood sugar. The home staff needed further training concerning her diabetes, including how to identify concerns, as well as steps to take and to not take.

  Endocrinology followed her with ongoing recommendations for aspart insulin and glargine insulin dosage and timing. Ophthalmology also followed her, and recent findings indicated no background diabetic retinopathy. Podiatry followed her as well. There was no information regarding the necessary yearly evaluation for any presence or progression of diabetic peripheral neuropathy. Nursing staff completed monthly diabetic foot assessments and documented nail care and skin breakdown, but not sensation. The American Diabetic Association recommends: "All patients should be assessed for distal

symmetric poly neuropathy starting at diagnosis of type 2 diabetes and 5 years after the diagnosis of type 1 diabetes and at least annually thereafter." The latter would apply to this individual.

- Individual #35 had a long history of seizures. There had been periods of time when the seizures were well controlled. In her AMA, dated 11/4/20, the PCP documented her last seizure as occurring on 9/15/09, which was inconsistent with further statements in the AMA, such as a notation that she had status epilepticus on 7/9/19. At that time, the neurologist believed her seizure was due to hypoglycemia and her Lantus insulin was decreased. The AMA also stated she had six seizures in the past ISP year. She was prescribed levetiracetam and Dilantin. The PCP prescribed Diastat, at a dosage of 10 mg rectal, for prolonged seizures. Considering her obesity, the dosage was less than the recommended dosage based on weight, which might be the reason she often did not respond to one dosage, but required a second dosage. There was no information as to the reason for the relatively low dosage administered based on weight. There may be other clinical, nursing, and/or administrative reasons, but these could not be found in submitted documentation. Medical staff should conduct further review related to this concern, and document rationale for the dosage prescribed,

  She continued to have prolonged or cluster seizures (i.e., on 11/3/20, 2/4/21, 3/20/21, and 5/19/21). At the time of the prolonged seizure on 11/3/20, the ED obtained a urine sample, and determined she had a UTI. Antibiotics were subsequently given. Until 2/4/21, she had only been prescribed one anti-epileptic drug (AED). During her hospitalization in February 2021, hospital neurology services added Keppra. Although during the 3/20/21 hospital admission, she was treated for a UTI, the cultures were negative for any growth, suggesting asymptomatic bacteriuria. At the time of the ED or hospital discharges, the PCP did not contact the Center's consulting neurologist for any further recommendations to decrease the risk of a recurrence of a prolonged seizure, or review the ED visit or hospital admission findings with the neurologist. Instead, the PCP advised that she should see neurology routinely, which was already scheduled (12/9/20, and 5/21/21). Her seizures remained poorly controlled, with continued prolonged seizures. There were several areas needing further review.

- Individual #503 had a history of dysphagia and GERD. On 12/4/16, the gastroenterologist recommended anti-reflux measures, and a daily proton pump inhibitor (PPI). From 9/12/20 to 9/17/20, the individual was hospitalized for pneumonia and a UTI. On 9/23/20, he underwent a G-tube placement to sustain his nutrition and hydration. From 10/5/20 to 10/15/20, he was hospitalized again for atypical pneumonia with bilateral interstitial infiltrates. He was COVID-19 and flu negative. On 3/11/21, he developed tachypnea, tachycardia, and hypoxia, and was sent to the ED. He was hospitalized for pneumonia, a UTI, and leukocytosis. A chest x-ray showed mild basilar infiltrates. In retrospect, medical staff believed he had mucous plugs causing the respiratory distress. At an ISP meeting on 3/22/21, the IDT reviewed his fluid requirements and found they were adequate and not a cause of the mucous thickening. On 4/19/21, he was transferred to the hospital for tachypnea and hypoxia, as well as a productive cough. He was diagnosed with a right lower lobe pneumonia. On 4/21/21, he returned from the hospital, at which time he was found to be hypoxic, requiring a nonrebreather mask at 15 LPM. He was transported back to the ED by 911. At that time, he underwent intubation and removal of many mucous plugs during bronchoscopy. The hospital staff also noted intermittent apnea from Cheyne Stokes breathing. Before discharge, an evaluation was completed to rule out the cause of his apnea spells, which included a work-up for heart failure, intracranial mass, and a lab panel. No factor was found, and hospital staff believed he had central sleep apnea. It was noted he may need bi-level positive airway pressure (BiPAP) or continuous positive airway pressure (CPAP). At an ISPA meeting on 4/23/21, the IDT reviewed further interventions. Oral care was

needed twice day, especially to remove the film on his tongue. Staff were to be in-serviced concerning this change. The IDT approved a tongue scraper to assist in removing the plaque. The IDT implemented a more specific bed positioning schedule to improve his postural drainage, including timeframes for the position changes. The IDT considered a Frazier Water Protocol.

The IDT identified contributing factors to his repeated pneumonias, such as inadequate oral hygiene and the need for rigorous positioning to aid in postural drainage. It was not clear whether he had intermittent gastroparesis as a contributing cause for his recurrent pneumonia. The severity of his GERD was not evaluated as a possible contributor to his recurrent pneumonias. Additionally, he appeared to have mucous plugs as a cause for hypoxia. He was prescribed a mucolytic agent on a PRN basis for coughing. However, at the time of the Monitoring Team's visit, there was no routine mucolytic dosage to assist in maintaining secretion thinning, and it was not clear that the PCP had considered this option.

- Individual #503 had Alzheimer's disease and Trisomy 21. In 2020, he began to lose weight due to his increased need to sleep, which caused him to miss meals. He was also unable to finish meals, because he would fall asleep. He lost 17 pounds in a year. Ensure plus was added as a supplement, and a trial of cyproheptadine was tried, but these interventions were not effective. On 9/23/20, a G-tube was placed due to a lack of oral intake. On 2/21/21, his weight was recorded as 95.2 pounds, with an estimated desired weigh range (EDWR) of 100 to 123. At an ISPA meeting, on 3/5/21, the IDT documented that as of 8/6/20, the psychiatrist discontinued his psychotropic medication. He no longer had behaviors needing treatment. On 4/1/21, staff observed that his respiratory rate would spontaneously decrease and stop, and then resume to a normal rate when he was stimulated. During one observation, he became hypoxic until his respiratory rate increased. This was also observed at the hospital, and his Cheyne stokes breathing was evaluated with the conclusion that he had central apnea.

  Prior to placement of his G-tube, the IDT did not request input from the Ethics Committee. The severity of his dementia was suggested by his lack of hunger, lack of behaviors, reduced awareness of his environment, increased somnolence, and new onset of apnea. Since the G-tube placement on 9/23/20, he was referred to the hospital several times (i.e., 10/5/20, 3/11/21, 4/19/21, and 4/21/21). National guidelines generally do not recommend enteral feeding in those with advanced Alzheimer's disease due to a lack of benefit and potential complications. However, documentation of the severity of his Alzheimer's disease was not evident in his medical reviews. Submitted documentation did not include an indication of the pace of his deterioration over time, including, for example, serial data as to what activities of daily living (ADLs) he had lost and/or retained. Such information would provide the IDT and PCP guidance in adjusting plans of care as the dementia worsened. During the Monitoring Team's remove visit, staff in the home stated he deteriorated over the past two years. He had several signs suggesting moderate to severe/advanced dementia. Given his current status and the need to make decisions about his code status (i.e., currently full code) and/or the need for hospice care, improved data collection, Ethics Committee review, and State Office guidance were warranted. In the past in reports for a few of the SSLCs, the Monitoring Team has shared a link to the National Task Group on Intellectual Disabilities and Dementia Practices, which might provide helpful guidance: https://www.the-ntg.org.

- In Individual #108's AMA, dated 5/6/21 (posthumous), the PCP documented she had an invasive intraductal carcinoma of the left breast (this was incorrect, because the cancer was in the right breast). Her cancer diagnosis and pre-treatment evaluation were rapid. On 2/9/21, she first complained of a breast mass, which already was nonmobile and fixed to the chest wall. On

2/18/21, she completed a mammogram. By 2/22/21, the size of the mass increased visibly in size. On 2/26/21, she underwent a further diagnostic mammogram and ultrasound; followed on 3/5/21, by a biopsy; on 3/26/21, a computed tomography scan (CT) of the chest, abdomen, and pelvis; on 3/26/21, a CT of the head; and on 3/31/21, an oncology visit. On 4/9/21, a Mediport was placed. Further evaluation included an echocardiogram on 4/20/21, and a positron emission tomography (PET) scan on 4/15/21. As the PET scan indicated a locally advanced disease with lymph node involvement, but no distant metastases, on 4/22/21, she was started on therapy. During this time, several staff were identified to assist in counseling her for depression as the illness began to impact her emotional status.

On 3/16/21, psychiatry staff met with the IDT and guardians concerning immunosuppression as a side effect to the chemotherapy, which might impact continued use of Clozaril and Depakote. The psychiatrist advised starting granulocyte colony stimulating factor at the start of chemotherapy as opposed to waiting until leukopenia occurred in order to prevent discontinuation of Clozaril. The PCP agreed to communicate with the oncologist about this concern. However, this did not occur. At the time of the Monitoring Team's visit, the PCP did not recall this meeting or any action step to be taken. On the evening after her chemotherapy, the individual received the granulocyte colony stimulating factor. Despite this, at the time of hospitalization on 4/25/21, the individual had a low white blood cell count (WBC).

The AMA had misinformation as to which breast was involved in the cancer. Once identified as a cancer, Center staff rapidly obtained consultation for her with the appropriate specialists, and obtained the recommended diagnostic work-up.

- On 4/25/21, Individual #108 developed weakness and chest pain and was admitted to the hospital with pneumatosis intestinalis, ischemic colon, and septic shock. In a progress note, dated 4/27/21, the psychiatrist indicated that on 4/25/21, the PCP and on-call provider were contacted when the psychiatrist learned of the individual's transfer to the ED. According to the note, the PCP and on-call provider "were informed of the discussion in psych QTR [quarterly] meeting on 4/19/21 with RNCM and IDT regarding use of Norco with Clozaril and the risk of constipation/bowel obstruction. According to PCP, it is unclear if [the individual] had any Norco after 4/20/21." From the IView files, her last dose might have been on 4/19/21. However, it appeared that several days prior (i.e., starting on 3/1/21), the use of PRN Norco may have contributed to or potentiated the finding. She was independent with toileting. In an IPN on 11/13/20, a nurse indicated that the bowel movement recording in the Care Tracker was an ongoing challenge, with gradual improvement. In an IPN on 4/16/21, a nurse indicated that her bowel movement documentation was slowly improving. Given the findings at the time of hospitalization, her megacolon and ischemic bowel might have reflected a lack of adequate documentation; this issue needed further review. Reliance on the history of bowel movements by the individual with her psychiatric diagnoses needed to be reviewed. She might have had incomplete bowel evacuation, as noted by the PCP, but the history of incomplete documentation complicated the treatment of comorbid conditions during the rapid advance of her cancer.

  The IDT needed guidance concerning the risk of lower GI tract concerns and staff should have received in-service training on timely and accurate documentation. However, the drug-drug interaction was not identified until she was hospitalized, and it does not appear that the potential for the interaction that the psychiatrist raised in the meeting on 4/19/21, received further follow-up. For example, with leadership from the PCP, the IDT could have met to develop a close monitoring procedure for the

individual's bowel movements, as well as monitoring for pain management and pain management options. This was a missed opportunity to prevent a drug-drug interaction, which may have complicated her clinical course.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.

Summary: Only one of the 18 IHCPs selected for review included a full set of action steps to address individuals' medical needs. The PCP did not implement all of the action steps in this IHCP. Although PCPs implemented the few action steps included in the remaining IHCPs, many of these action steps related to the completion of IMRs, and they called for reviews every six months, which did not meet individuals' needs, and no longer was consistent with State Office policy. 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	112	344	269	35	503	715	108	19	5
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	71% 12/17	2/2	2/2	0/1	0/2	2/2	2/2	0/2	2/2	2/2

Comments: a. As noted above, only one of the IHCPs selected for review included a full set of action steps to address individuals' medical needs (i.e., for Individual #108 – other: cancer). However, the action steps assigned to the PCPs were implemented for the following IHCPs:

- Individual #112 – diabetes/metabolic syndrome, and infections; Individual #344 – skin integrity, and weight; Individual #503 – aspiration, and seizures; and Individual #19 – osteoporosis. In these IHCPs, the only interventions assigned to medical staff were to conduct quarterly to semi-annual interval chart reviews, or interval reviews every six months. These interventions were no longer consistent with State Office policy, which required quarterly reviews, except in very limited circumstances, and they did not meet the individuals' needs.
- Individual #715 – aspiration, and skin integrity. These IHCPs required the PCP to implement interval medical reviews every three months, which was in alignment with the individual's needs. However, the IHCPs were missing other necessary medical interventions.
- Individual #19 – diabetes. This IHCP included four interventions that were jointly assigned to medical and nursing staff. They required referrals to specialists, and lab monitoring. The plan also included an intervention for the PCP to complete interval medical reviews every six months, which again was not consistent with State Office policy or in alignment with the individual's needs.
- Individual #5 – osteoporosis, and seizures. These IHCPs included interventions for referrals to specialists, medication monitoring, and lab monitoring. The osteoporosis IHCP also included an intervention for the PCP to complete interval medical reviews every six months, which again was not consistent with State Office policy or in alignment with the individual's needs.

Due to ongoing problems with the quality of the medical plans included in IHCPs, this indicator did not provide an accurate picture of whether or not PCPs implemented necessary interventions.

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 goals/objectives. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	0/1	0/1	0/1	0/1	N/A	0/1	0/1	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/6	0/1	0/1	0/1	0/1		0/1	0/1		
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/6	0/1	0/1	0/1	0/1		0/1	0/1		
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/6	0/1	0/1	0/1	0/1		0/1	0/1		
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/1	0/1	0/1	0/1		0/1	0/1		

Comments: Individual #503, Individual #19, and Individual #5 were edentulous and did not require formal dental goals. The Monitoring Team reviewed six individuals who had elevated dental risks due to periodontal disease (i.e., one individual had Type I periodontal disease, two had Type II, and three had Type III), poor to fair oral hygiene ratings, and/or they required GA or TIVA for dental care. None of these individuals had clinically relevant, achievable, and measurable goals/objectives related to their dental risks.

In order for IDTs to demonstrate that a goal/objective is clinically relevant, the IDT needs to document baseline data in the IRRF, ISP or ISPA, and the goal/objective would need to reflect the reason why the individual is at risk with regard to their dental health. For example, if the individual is not brushing his/her teeth at the recommended frequency or for the recommended duration, is it due to a skill deficit? If so, then the IDT needs to develop a skill acquisition plan (SAP) to address the individual's specific skill deficit. Or rather, is it an issue related to the individual's ability to tolerate staff brushing his/her teeth? If so, then the IDT needs to develop a goal/objective to increase the individual's tolerance for tooth brushing. Does the individual need to brush a certain part of their mouth better (e.g., back teeth)? If so, the IDT needs to develop a goal to address this specific need, and specify whether staff will do the brushing, or the individual will improve their skill or completion of this task. Does the individual brush his/her teeth well, but they never floss? If so, then baseline data should show this, and the IDT should develop an objective related to flossing, and again look at whether or not it is a skill deficit, or that the individual does not follow a routine that incorporates flossing. For the individuals for whom IDTs developed goals/objectives, IDTs had not identified the underlying cause of the dental problem.

With regard to measurability of goals/objectives, it is important to define the: 1) subject, or who, will accomplish what (e.g., the individual will brush her teeth, staff will brush the individual's teeth, the individual will cooperate with tooth brushing, etc.); 2) a specific, observable action (e.g., independently brush all four quadrants of mouth, with verbal prompts floss upper teeth, keep mouth open while staff brush, etc.); 3) define the expected frequency (e.g., once a day for at least 25 days of each month, twice per day, etc.), which should reflect clinically accepted guidelines taking into consideration the individual's baseline; 4) the duration, as needed (e.g., tooth brushing for two minutes), also taking into consideration the individual's baseline; 5) criteria for completion (e.g., for two consecutive months, for 20 consecutive sessions, etc.); and 6) an expected timeframe for completion (e.g., within six months, within one year, etc.). While the goals/objectives reviewed had some aspects of measurability, which was positive, none included all of them. For example, goals/objectives did not typically define the criteria for completion or the timeframe for completion. The goals/objectives in the IHCPs generally defined the expected frequency and duration. However, based on the documentation submitted, it did not appear the IDTs took into account individualized frequency or duration baseline data. For example, all of the IHCPs reviewed indicated the individuals should brush their teeth for two minutes, but none provided baseline documentation. Individual #269 and Individual #35 also had identical tooth brushing skill acquisition programs (SAPs) to thoroughly brush all of their teeth 17 out of 20 trials for three consecutive months, but the IDTs did not present baseline data. In other words, as written in the IHCP, the goals/objectives did not provide the IDTs with a way to meaningfully measure individuals' progress.

c. through e. Monthly integrated progress reports generally included data with regard to tooth brushing frequency and duration, which was positive, but they did not provide meaningful analysis of the data. 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 Individual #269 and Individual #35, who had identical tooth brushing SAPs, the QIDP integrated monthly progress reports frequently reported percentages of achievement based on only a small number of trials, which was not sufficient to measure progress. In addition, the QIDPs took only very limited action in response and did not report follow-up to ensure those actions resulted in the needed remediation.

For all nine individuals, the Monitoring Team conducted full reviews of the processes related to the provision of dental supports and services. Three individuals were edentulous (i.e., had not achieved positive dental outcomes) and/or had risks related to oral hygiene, so full reviews were conducted for them.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	N/R									
c. As indicated in the dental audit tool, the Monitoring Team will only score this indicator 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: N/A			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	Due to the Center's sustained performance with these indicators, they moved to the category requiring less oversight.									
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.										
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.										
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.										
e.	If the individual has need for restorative work, it is completed in a timely manner.										
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A									
Comments: f. Based on the documentation provided, during the six months prior to the review, none of the individuals in the physical health review group required an extraction.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
b.	If the dental emergency requires dental treatment, the treatment is provided.										
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.										
Comments: a. through c. None.											

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	112	344	269	35	503	715	108	19	5
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	100% 2/2	N/A	N/A	N/A	N/A	1/1	1/1	N/A	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 periodically to ensure quality of the technique.	0% 0/2					0/1	0/1			
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/2					0/1	0/1			

Comments: a. and b. For the two applicable individuals, the IDTs provided a measurable strategy for suction tooth brushing (i.e., at least two times daily for two minutes by direct support staff) in their IHCPs.

b. Based on documentation submitted for both individuals (i.e., Suction Toothbrushing Detailed Entry Charts, dated 2/1/21 to 5/25/21), lapses occurred in the provision of suction tooth brushing. For Individual #503, the documentation indicated that staff did not complete the majority of required sessions, because he was sleeping. It was unclear why Center staff scheduled most opportunities for suction tooth brushing during third shift, often between midnight and 5:00 a.m. For Individual #715, Center staff typically completed two sessions per day, but the majority of sessions lasted between 30 seconds and one minute, rather than the two-minute duration specified. Reasons were not provided for the days/times that staff did not provide him with the required tooth brushing duration.

c. For both applicable individuals, Center staff did not develop an ISP/IHCP action plan for monitoring or provide evidence they completed any monitoring. Since the inception of the Dental Audit Tool, in January 2015, the interpretive guidelines for this indicator have read: "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." Moving forward, IDTs should ensure that individuals with suction tooth brushing have IHCPs that define the frequency of monitoring, and it is implemented according to the schedule.

d. QIDP reports did not include specific data with regard to the provision of 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). In addition to monitoring and reporting the data, when issues arise with regard to the implementation,

monitoring and/or outcomes of suction tooth brushing, the QIDP should re-convene the IDT to discuss and make needed corrections with regard to implementation and/or make revisions to the strategies.

Outcome 9 – Individuals who need them have dentures.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	Due to the Center's sustained performance with this indicator, it has moved to the category of requiring less oversight.									
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: b. Based on the documentation provided, during the six months prior to the review, none of the individuals in the physical health review group required dentures.											

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: Similar to the last review, two of the six acute care plans reviewed met individuals' needs and met the criteria for quality. Nursing staff also consistently implemented four of the six plans reviewed. More work was needed to ensure that nurses followed relevant guidelines when conducting assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	50% 3/6	0/1	1/1	1/1	N/R	0/1	0/1	1/1	N/R	N/R
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.	50% 3/6	0/1	0/1	1/1		0/1	1/1	1/1		

c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	50% 2/4	0/1	1/1	0/1		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.	50% 2/4	N/A	N/A	1/1		0/1	0/1	1/1		
e.	The individual has an acute care plan that meets his/her needs.	33% 2/6	0/1	1/1	0/1		0/1	0/1	1/1		
f.	The individual's acute care plan is implemented.	67% 4/6	1/1	1/1	1/1		0/1	0/1	1/1		

Comments: The Monitoring Team reviewed six acute illnesses and/or acute occurrences for six individuals, including Individual #112 – boil to right inner thigh on 3/2/21; Individual #344 – COVID-19 positive on 11/20/21; Individual #269 – fracture of the transverse process of L1, L2, and L3 on 11/10/20; Individual #503 – urinary tract infection (UTI) on 3/12/21; Individual #715 – hospitalization for aspiration pneumonia on 11/25/20; and Individual #108 – breast lump/cancer identified on 2/8/21.

a. The acute illnesses/occurrences for which initial nursing assessments (physical assessments) were performed in accordance with applicable nursing guidelines were for Individual #344 – COVID-19 positive on 11/20/21; Individual #269 – fracture of the transverse process of L1, L2, and L3 on 11/10/20; and Individual #108 – breast lump/cancer identified on 2/8/21.

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 for: Individual #269 – fracture of the transverse process of L1, L2, and L3 on 11/10/20; Individual #715 – hospitalization for aspiration pneumonia on 11/25/20; and Individual #108 – breast lump/cancer identified on 2/8/21.

a. through e. The following provide some examples of findings related to this outcome:

- Individual #112 had a history of wound issues and boils with infections. On 3/2/21, at 7:49 p.m., staff identified a reddened area. A nurse documented that it was tender and reddened, but they did not take and/or document measurements. On 3/3/21, at 10:06 a.m., nursing staff first took measurements, at which point the nurse placed the individual on the clinic list. No information was submitted to show what information nursing staff shared with the PCP. On 3/3/21, the individual refused to go to clinic. On 3/4/21, the provider visited her at her home. Reportedly, the size of the area had increased by this time. After this, although nursing staff documented vital signs and information about redness and drainage, they did not take and/or document any further measurements.

  Although a nurse identified the boil on 3/2/21, nursing staff did not initiate an acute care plan until 3/4/21. The acute care plan did not include an intervention to measure the wound. Measurements are part of the skin care nursing guidelines, and would have been important to allow nurses to measure progress, and determine whether the goal for the wound to heal in five days was met. It was positive that nurses implemented the other interventions that were included in the acute care plan.

- On 11/6/20, nursing staff initiated an at-risk for COVID-19 acute care plan for Individual #344, due to possible exposure. It was not until 11/7/20, that a nurse documented the reason why the plan was implemented. On 11/7/20, at 9:00 a.m., nursing staff documented a lung sound assessment. On 11/10/20, at 3:45 p.m., the individual received a positive test result for COVID-19. No documentation was submitted to show that nursing staff notified the provider of the positive test results, and/or the individual's assessment results. The individual moved to the home designated for individuals with positive test results. Nursing staff initiated the implementation of the standard COVID-19 acute care plan. It was positive that nurses implemented the interventions included in the plan. The individual was asymptomatic during the course of the illness, and on 11/30/20, he returned to his home.
- On 11/10/20, at 10:50 a.m., Individual #269 fell. Although the individual was not fully cooperative with the vital sign assessment, the nurse conducted an assessment in alignment with the nursing guidelines for falls and skin integrity issues. The nurse noted a skin tear, including the measurements. At 6:32 p.m., in an IPN, a nurse made reference to assessment information in IView for vital signs, pain, cognition, GI, and skin. However, there was no assessment information after 11:00 a.m. On 11/11/20, the individual refused an assessment, but was in pain. At 1:15 p.m., a nurse administered Tylenol, but at 2:15 p.m., the individual reported no relief from the Tylenol. The nurse noted a bruise, including the size.

  Nursing staff notified the provider both initially, and when the individual's condition began to worsen, at which time the PCP ordered transfer of the individual to the ED. Prior to her transfer to the ED, and upon her return to the Center, nursing staff conducted assessments in alignment with the applicable guidelines.

  Upon her return, nursing staff initiated an acute care plan for pain, and implemented it. The acute care plan included interventions to assess vital signs, cognition, skin, and pain every shift, and notify the PCP if her pain level was greater than three. However, the nursing guidelines for a fracture note to document vital signs, pain, skin, range of motion (ROM), edema, as well as changes in ambulation and weight-bearing status at least every shift. The acute care plan should have addressed the fractures, as well as pain. After her injury, the individual continued to refuse vital signs, but nursing staff did not document information with regard to the individual's ROM or pain levels every shift either in IView or IPNs.
- On 3/2/21, Individual #503 had diminished lung sounds, which seemed to resolve until 3/6/21. Nurses checked his lung sounds daily, and they continued to be diminished. On 3/10/21, nurses did not assess his lung sounds. On 3/11/21, at 11:15 p.m., the individual had a fever, and shortness of breath. His oxygen (O2) saturation was 88% on room air. He was tachypneic, and tachycardic, with crackles to his lungs. Nursing staff place him on O2 at two to three liters (l). Based on the documentation submitted, beginning on 3/2/21, nursing staff did not conduct full assessments to address his signs and symptoms of illness. In the documents submitted, no nursing IPNs were found between 3/6/21, and 3/12/21. On 3/12/21, he was sent to the ED and admitted until 3/15/21, for a UTI, and pneumonia.

  On 3/12/21, the nurse notified the provider, but did not provide the notification/document in Situation, Background, Assessment, and Recommendation (SBAR) format, as called for in the related nursing guidelines. Nursing staff did not full assessments prior to or upon the individual's return from the ED/hospital in accordance with the nursing guidelines for Emergency/Hospital Transfers.

Although nursing staff initiated an acute care plan following the individual's hospitalization, it did not address all of his relevant health issues. It addressed his risk for skin integrity issues. However, other relevant issues included gas exchange, as well as UTI, and infections.

- According to an IPN, on 11/25/20, sometime "earlier" than 7:17 p.m., Individual #715 experienced emesis. No IView entry or IPN was found to indicate when the emesis occurred. In an IPN at 4:00 p.m., a nurse stated emesis occurred. The assessment the nurse completed at that time was not consistent with the vomiting nursing guideline, because it was missing a full assessment of the individual's lungs. In addition, nursing staff noted that the individual had rhonchi (i.e., at 1:56 a.m., 6:38 a.m., and 1:28 p.m.). Then, based on the assessment completed at 4:00 p.m., the nurse noted lungs clear times four via stethoscope. The next assessment was at 7:17 p.m., at which point the individual was non-responsive, tachypneic, and tachycardic, with O2 saturation at 73%. It was not clear that the assessment at 4:00 p.m. was accurate. The nurse immediately activated the emergency response system, and the individual was transported to the hospital with diagnosis of aspiration pneumonia and small bowel obstruction (SBO).

  Upon the individual's return to the Center, on 12/9/20, nursing staff did not complete a full skin assessment as indicated in the related nursing guidelines. During the initial skin assessment, the nurse did review for areas of bruising related to the individual's hospitalization, including intravenous (IV) and venipunctures. On 12/14/20, nursing staff identified that the individual had a 3 centimeter (cm) by 3 cm brown scabbed area on his right heel. It was unclear if the individual sustained this injury in the hospital.

  On 12/9/20, nursing staff initiated an acute care plan for a risk for bowel obstruction following surgical intervention for a SBO. The individual also was hospitalized for pneumonia, but nurses did not implement an acute care plan for impaired gas exchange. The acute care plan included two interventions to assess the individual's bowel movements, bowel sounds, abdominal distention, and constipation, but they included conflicting times for when to assess the individual (i.e., daily versus every shift). Other interventions were not measurable, making it difficult to determine whether or not nurses implemented them thoroughly.
- On 2/8/21, when Individual #108 reported finding a lump on her breast, the nurse immediately completed the necessary assessment, and placed the individual on the clinic list. As treatment plans were developed, nurses completed daily breast exams.

  Nurses developed a series of acute care plans. The first one, which was the one the Monitoring Team scored, was dated 2/22/21. It addressed pain and possible metastasis. It was consistent with generally accepted standards of care. Nurses implemented it thoroughly.

  On 4/23/21, after her first chemotherapy treatment, the individual became lethargic, weak, tachycardic, and hypoxic with complaints of chest pain. A nurse assessed her in response to these symptoms in alignment with relevant nursing guidelines. The individual was transported to the hospital. Unfortunately, the individual did not return from this hospitalization.

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 develop goals/objectives that reflected clinically relevant actions that the individuals could take to reduce their at-risk conditions. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 112	344	269	35	503	715	108	19	5
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/12	0/2	0/2	0/2	N/R	0/2	0/2	0/2	N/R	N/R
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	25% 3/12	1/2	0/2	0/2		1/2	0/2	1/2		
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/12	0/2	0/2	0/2		0/2	0/2	0/2		
d.	Individual has made progress on his/her goal/objective.	0% 0/12	0/2	0/2	0/2		0/2	0/2	0/2		
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/12	0/2	0/2	0/2		0/2	0/2	0/2		

Comments: For six individuals, the Monitoring Team reviewed a total of 12 risk areas, and the IHCPs, as available, to address them (i.e., Individual #112 – weight, and skin integrity; Individual #344 – weight, and constipation/bowel obstruction; Individual #269 – cardiac disease, and falls; Individual #503 – infections, and weight; Individual #715 – aspiration, and infections; and Individual #108 – polypharmacy/medication side effects, and weight).

IDTs developed clinically relevant, achievable, and measurable goals for none of these risk areas. In other words, IDTs did not identify activities in which individuals needed to engage or skills that they needed to learn to improve their health (e.g., exercise to lose weight and/or improve cardiac health, learn to wash their hands or apply cream to dry skin to reduce the risk for skin infections, elevate their legs at specific intervals throughout the day to reduce edema, make specific diet modifications to reduce GERD, drink a specific amount of fluid per day to prevent constipation, etc.), and then, develop goals/objectives/SAPs to measure individuals' progress with such activities or skill acquisition.

Although the following goals/objectives were measurable, because they did not reflect a clinically relevant actions the individuals could take to reduce their risks, the related data could not be used to measure the individuals' progress or lack thereof: Individual #112 – weight, Individual #503 - weight, and Individual #108 – weight.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. As a result, it was difficult to determine whether or not individuals were making progress with regard to taking steps to improve their chronic or at-risk conditions, 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 six 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. At times, nurse implemented the couple of interventions included in the IHCPs reviewed. However, without IHCPs that comprehensively addressed individuals' needs, these positive scores were not a true indicator of whether nurses provided individuals with the supports they needed.

In addition, often IDTs did not collect and analyze information, and develop and implement plans to address the underlying etiology(ies) of individuals' risks. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 112	344	269	35	503	715	108	19	5
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% 0/11	0/2	0/1	0/2	N/R	0/2	0/2	0/2	N/R	N/R
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/9	0/2	0/1	0/1		0/2	0/2	0/1		
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).	18% 2/11	2/2	0/1	0/2		0/2	0/2	0/2		

Comments: As noted above, the Monitoring Team reviewed a total of 12 specific risk areas for six individuals, and as available, the IHCPs to address them. Individual #344 did not have an IHCP for weight, but should have. Based on an interview with the RNCM, this appeared to have been an oversight/error.

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

- For Individual #112's weight IHCP, nursing staff followed the one nursing intervention to monitor her weight monthly. That said, this intervention was not fully measurable, because it directed nurses to report "significant" changes to the PCP, but did not define what significant meant for this individual.
- For Individual #112's skin integrity IHCP, nursing staff completed Braden scores quarterly, completed quarterly reviews, and provided direct support professionals with instructions, including in relation to the use of antibacterial soap.

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

In other instances, nurses/staff did not consistently document specific data required by the nursing interventions included in individuals' IHCPs (e.g., weights, bowel movements, residuals, etc.). At times, this placed individuals at significant risk. For example:

- On 4/25/21, Individual #108 developed weakness and chest pain, and was admitted to the hospital with pneumatosis intestinalis, ischemic colon, and septic shock. In a progress note, dated 4/27/21, the psychiatrist referred to a "discussion in psych QTR [quarterly] meeting on 4/19/21 with RNCM and IDT regarding use of Norco with Clozaril and the risk of constipation/bowel obstruction." This individual was at high risk for constipation, due to high anticholinergic burden, and medications with possible side effects of constipation. Her IHCP for medication side effects/interactions included an intervention that read: "N- RNCM will provide instruction in CT/PT profile on common S/E's of Clozaril." Despite constipation being a primary complication of Clozaril and hydrocodone, nursing staff did not implement/instruct DSPs to implement bowel tracking.

  Another intervention was to complete MOSES screening "as indicated," which was not measurable. However, nurses only conducted MOSES screenings on 1/21/21, 1/26/21, and 4/19/21. A change is scoring of 8 points (from 4 to 12) was noted between 1/26/21, and 4/19/21. However, nursing staff did not complete and/or document any follow-up.

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

- Individual #112 had a goal to lose weight (i.e., one to five pounds per quarter). The goal did not specify what the individual could/should do to achieve the goal, and the interventions in the IHCP did not provide guidance on this either. She did lose weight. However, the dietician's review indicated that she might be losing weight too fast. For example, in February 2020, she weighed 212 pounds, and on 11/18/20, she weighed 190.6 pounds. On 3/12/21, she weighed 185.6 pounds. In addition, the individual refused meals, although it was not entirely clear how often this occurred. She also had medication changes, which might have contributed to her weight loss. Based on submitted documents, the IDT did not address these concerns, and/or modify her IHCP to include interventions to assist her to safely lose weight. By May 2021, she regained some weight, and weighed 189.8 pounds.
- During the review period, Individual #112 experienced two wound infections (i.e., 11/22/20, and 3/2/21). Given her diagnosis of diabetes mellitus, such infections heighted her risk. Her IHCP for skin integrity did not include specific and measurable interventions to assist her in preventing such infections. More specifically, the IHCP required nursing staff to conduct quarterly reviews/assessments, obtain Braden scores quarterly and as needed, and "Provide Risk Group 4 instructions to DSPs." It also included an intervention for residential and nursing staff to "Make sure [individual] has antibacterial body soap available quarterly." This was not helpful, because it did not identify how and how often she should use the soap. In addition, no method

was detailed for determining whether she had access to the soap when she needed it, and whether or not she used it. Despite ongoing skin infections, her IDT did not meet to review the IHCP or its implementation, and make changes, as needed.

- Individual #344 did not have an IHCP for weight, but should have. During the previous year, he was at high risk for weight due to obesity. He lost 33 pounds, which was positive. However, the IDT needed a mechanism to monitor his weight, and to provide supports to assist him in maintaining his weight loss. Various documentation included discrepancies with regard to his diet. For example, at the time of the IRRF, on 9/14/20, he had an order for a 2500-calorie diet. At the time of the Monitoring Team's review, his current PNMP listed a 2200-calorie diet. The nursing quarterly indicated he was on an 1800- to 2200-calorie diet. Between October 2020 and March 2021, he began gaining weight again. Based on the ISPAs submitted, the IDT did not meet for a change of status (CoS) ISPA meeting to address his weight gain of over 10 pounds (i.e., which placed him in the overweight category again), and develop an IHCP.
- For several years, Individual #269 had frequent falls. Contributing factors crossed many clinical areas. On 11/11/20, when trying to obtain food from the kitchen, she fell, and subsequently was diagnosed with three transverse process lumbar spine fractures. Over time, the IDT had taken different steps to try to identify the cause(s) of her falls, and put steps in place to reduce them. Unfortunately, falls were an ongoing challenge for this individual. The following provide some of the outstanding concerns that the IDT had not addressed in order to reduce her fall risk to the extent possible.
    - She was prescribed Tenex and Aripiprazole, which have known side effects of dizziness and hypotension. However, nursing staff often were not able to obtain vital signs due to the individual's lack of cooperation. This resulted in a lack of information about whether or not hypotension events contributed to her falls, or whether she had episodes of tachycardia or bradycardia. Based on submitted documentation, it did not appear that Behavioral Health Services staff were involved in developing and implementing a plan to assist her to cooperate with vital sign assessments.
    - She has a profound sensorineural hearing loss, but could read lips when one was in her field of vision. She also tended to be excitable and impulsive, resulting in a rapid pace of walking. On 10/30/20, at an ISPA meeting, the IDT documented that staff were to continue to follow the PBSP in redirecting behavior that might lead to falls. Given her profound hearing loss, it was not clear that the IDT had provided staff with direction to consistently prompt her to slow down and pay attention to her environment. For example, it was not clear if staff knew the exact words or signs to use to prompt her. In addition, if she were walking rapidly with her head down, providing these instructions effectively would be difficult.
    - A PNMT review, dated 11/12/20, indicated that behaviors contributed to the fall that resulted in the fractures, because she was not paying attention (i.e., the "root cause"), and she walked with her head down. There was no discussion about whether or not staff had attempted to assess her posture while walking with her head down, or to systematically teach her to pay attention while walking and/or walk with her head up.
    - On 12/7/20, she developed an otitis media with perforation, which might have at least temporarily caused imbalance with a tendency to fall. The PCP did not complete timely follow-up to determine if the tympanic membrane healed or was contributing to her imbalance.
    - The PNMP indicated she was to wear shoes that did not have shoelaces, and the QIDP was to go through the closet to make sure her shoes were consistent with her PNMP. However, at the time of the Monitoring Team's remote visit with the individual, staff indicated she wore shoes with shoelaces.

- A 1/27/21 pharmacy IPN documented that in the past, providers decreased Depakote and Tenex doses to determine if lowering the doses would reduce her falls. The falls did decrease, but her behaviors and SIB increased, necessitating an increase in the Depakote dosage.
- With continued falls, at an ISPA meeting on 4/3/21, the IDT documented review of the PNMP with no changes. The QIDP requested purchases of no-slip mats for inside and outside the tub to minimize any further falls during bathing.
- A PNMT review, dated 5/10/21, indicated that the root cause of her falls was not paying attention. It also stated "PNMT services are not indicated at this time as supports, services, and action plans placed by the IDT are adequately addressing her needs." On 5/11/21, at an ISPA meeting with the PNMT, the IDT reviewed and agreed with this finding. As illustrated above, it was not clear that the IDT had taken all of the necessary steps to reduce her risk to the extent possible.

- Within a two-month period, Individual #503 had three infections, including on 3/12/21, a UTI and pneumonia; and on 4/19/21, pneumonia. For each, the IDT held ISPA CoS meetings, but both ISPAs were held later than five days from his hospital discharge. In addition, the IDT did not make changes to his IHCP, which as noted elsewhere in this report, was insufficient to meet his needs. For this individual with history of multiple hospitalizations for pneumonia and UTIs (i.e., five admissions since June 2020), some of the problems with the IHCP were that it did not provide interventions to avoid infections to the extent possible, or for proper nursing assessments, including the frequency of monitoring; it was missing interventions, such as ensuring appropriate calorie intake, ensuring that he was receiving enough fluids (other than to evaluate hydration, but it did not state how or what level of hydration was expected), or reporting any foul-smelling urine; and it did not include interventions for nurses to monitor his respiratory status or urine for signs and symptoms of infection.
- On 9/25/20, after being diagnosed with failure to thrive, Individual #503 had a G-tube placed. His IHCP included an intervention for nursing staff that read: "RNCM to obtain weekly weight and notify PCP\QIDP and RD of any significant changes." Based on documentation submitted, nurses did not document weekly weights in IView or IPNs. Based on the weight log submitted with the nursing quarterly reviews, weekly weights were noted in November 2020, but no weights were documented for December 2020, only one weight was noted in January 2021, and two weights were noted in February 2021. According to a weight log submitted (i.e., Document #31), staff only documented weights twice in March 2021, once in April 2021, and twice in May 2021.

  Based on the review of the IPSAs submitted, the IDT only met once to discuss the individual's weight (i.e., 4/23/21), and this was for a PNMT follow-up regarding eating concerns and weight loss. Although it appeared that the individual was gaining weight, it did not appear that the IDT met to review either weight gain or loss, despite this individual having a new G-tube that was placed due to extreme failure to thrive.
- Individual #715 had multiple hospitalizations for infections, including aspiration pneumonia and UTIs. These included: aspiration pneumonia on 11/25/20; a UTI, aspiration pneumonia, and sepsis on 1/2/21, with discharge on 1/11/21; and bacterial pneumonia on 3/17/21. Although the IDT met after each hospitalization, they did not review, and revise, as needed the IHCPs for aspiration and/or infections, which as referenced elsewhere in this report, did not meet the individual's needs. The following provide a few examples of problems noted: 1) the individual's IHCP did not include an intervention for nursing staff to regularly monitor his lung sounds; 2) although emesis was identified as a cause of his aspiration pneumonia, the IHCPs did not include related preventive interventions; 3) the aspiration IHCP included an intervention to check residuals, but this was inconsistent with nursing standards, because the individual had a drainage bag.

- As noted above, between 1/26/21, and 4/19/21, Individual #108 had a change is MOSES scoring of 8 points (from 4 to 12). However, nursing staff and/or the IDT did not complete and/or document any follow-up.

  In addition, the IDT did not address inconsistencies in documentation related to bowel tracking. On 3/9/21, the individual was started on Norco, which had a potential to increase concerns for this individual with chronic constipation. The IDT did not address possible side effects, even after an increase in usage beginning on 3/31/21. On 4/25/21, she developed weakness and chest pain, and was admitted to the hospital with pneumatosis intestinalis, ischemic colon, and septic shock. On 5/2/21, she passed away.

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

Summary: Areas that require focused efforts are nurses' adherence to infection control procedures during medication administration, and the inclusion in IHCPs of respiratory assessments for individuals with high risk for respiratory compromise that are consistent with the individuals' level of need, and the implementation of such nursing supports. At this time, all of these indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 112	344	269	35	503	715	108	19	5
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R							N/A		
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).										
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.										
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	0% 0/3	N/A	N/A	N/A	0/1	0/1	0/1	N/A	N/A	N/A

	documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.										
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	0% 0/4	N/A	N/A	N/A	0/1	0/2	0/1	N/A	N/A	N/A
	a. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	50% 1/2	N/A	N/A	N/A	0/1	1/1	N/A	N/A	N/A	N/A
	b. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	50% 1/2	N/A	N/A	N/A	0/1	1/1	N/A	N/A	N/A	N/A
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).										
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.										
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	38% 3/8	0/1	0/1	1/1	0/1	0/1	0/1		1/1	1/1
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	60% 3/5	0/1	1/1	N/A	1/1	0/1	1/1		N/A	N/A
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	60% 3/5	0/1	1/1	N/A	1/1	0/1	1/1		N/A	N/A
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									

i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R										
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R										
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R										
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R										
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R										

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of seven individuals, including Individual #112, Individual #344, Individual #269, Individual #35, Individual #503, Individual #715, Individual #19, and Individual #5.

d. The following provides a summary of problems noted in relation to respiratory assessments for individuals at high risk for aspiration/respiratory issues:

- Individual #503 was at high risk for respiratory compromise/aspiration, and received his medication through an enteral tube. His IHCP included an intervention to "Ensure tube placement, auscultation, aspiration prior to use." Based on a review of a sample of IView and IPN documentation, nurses did not document checking tube placement. During the medication administration observation, the nurse only checked with aspiration, and got very little pull back. The nurse should have checked with auscultation too. The Center's nurse auditor identified this problem, and provided the medication nurse with further instruction.
- On the following dates, Individual #715 was diagnosed with pneumonia: 11/25/20 (aspiration pneumonia), 1/2/21 (aspiration pneumonia), and 3/17/21 (bacterial pneumonia). He had a tracheostomy, and a G/J-tube. His IHCP did not include an intervention for regular lung sound/respiratory assessments.
- According to her IRRF, Individual #35 was at high risk for aspiration/respiratory compromise due to a diagnosis of aspiration pneumonia in March 2020. Her IDT included no interventions in her IHCP for nursing staff to regularly conduct respiratory assessments. During the medication administration observation, the individual coughed, but the nurse did not check her lung sounds, and the Center's nurse auditor did not prompt the nurse to do so.

g. For the individuals observed, the following concerns were noted with regard to medications nurses' adherence to infection control practices:

- The medication nurse for Individual #112 did well with washing her hands. However, she did not clean the entire surface of the top of the medication cart. The Center's auditor did not identify and/or address this concern.
- The medication nurse for Individual #344 did not fully wash off the soap residue from their wrists. In addition, the nurse handed the individual the gel without sanitizing it, and then placed it on the PNMP pages. The nurse cleaned one page of the

PNMP, but not the others, and then flipped through them during the medication pass, which potentially caused cross-contamination. The nurse also touched their mask several times during the medication pass. It was positive that the Center's nurse auditor identified these issues and addressed them.

- The medication nurse for Individual #35 adhered to most infection control practices. However, by touching the PNMP pages, which she had not cleaned, and then touching the computer and other items, she engaged in practices that potentially resulted in cross-contamination. It was positive that the Center's nurse auditor identified these issues and addressed them.
- For Individual #503, the medication nurse engaged in a number of practices that potentially resulted in cross-contamination. For example, the nurse touched the lips of cups and medication cups. In addition, the nurse placed a barrier for the G-tube syringe, but placed the syringe wrapper on the barrier, and then placed the syringe on the wrapper. The Center's auditor identified some issues, but not all of these issues. For example, the Center's auditor did not identify the concerns related to the potential cross-contamination of the syringe.
- The medication nurse for Individual #715 adhered to many of the infection control procedures. However, the nurse did not gel between changing gloves. It was positive that the Center's nurse auditor identified this issue and addressed it.

Physical and Nutritional Management

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

Summary: IDTs and/or the PNMT did not develop goals/objectives that reflected clinically relevant actions that the individuals could take to reduce their PNM risks. As a result, it was difficult to determine whether or not individuals were making progress with regard to taking steps to improve their chronic or at-risk conditions, or when progress was not occurring, that the IDTs took necessary action. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/12	0/2	0/2	N/A	0/2	N/A	N/A	0/2	0/2	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	17% 2/12	1/2	0/2		1/2			0/2	0/2	0/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/12	0/2	0/2		0/2			0/2	0/2	0/2
	iv. Individual has made progress on his/her goal/objective; and	0%	0/2	0/2		0/2			0/2	0/2	0/2

		0/12									
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/12	0/2	0/2		0/2			0/2	0/2	0/2
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	N/A	N/A	0/2	N/A	0/2	0/2	N/A	N/A	N/A
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/6			0/2		0/2	0/2			
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/6			0/2		0/2	0/2			
	v. Individual has made progress on his/her goal/objective; and	0% 0/6			0/2		0/2	0/2			
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/6			0/2		0/2	0/2			

Comments: The Monitoring Team reviewed 12 goals/objectives related to PNM issues that six individuals' IDTs were responsible for developing. These included goals/objectives related to: Individual #112 - weight, and skin integrity; Individual #344 - aspiration, and skin integrity; Individual #35 - aspiration, and choking; Individual #108 – skin integrity, and falls; Individual #19 - choking, and falls; and Individual #5 - aspiration, and choking.

a.i. and a.ii. IDTs developed clinically relevant, achievable, and measurable goals for none of these risk areas. In other words, IDTs did not identify activities in which individuals needed to engage or skills that they needed to learn to improve their health (e.g., exercise to lose weight, make specific diet modifications to reduce GERD or emesis, adhere to specific dining techniques to slow their eating pace, learn to navigate around obstacles in their path or slow their walking pace to reduce falls, etc.), and then, develop goals/objectives/SAPs to measure individuals' progress with such activities or skill acquisition.

Although the following goals/objectives were measurable, because they did not specify what the individuals could do to improve the identified health issues or risk factors, and/or relate to the underlying cause of the risk, the related data could not be used to measure the individuals' progress or lack thereof: Individual #112 – weight, and Individual #35 - choking.

b.i. The Monitoring Team reviewed six areas of need for three 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 those for: Individual #269 – fractures, and falls; Individual #503 - aspiration, and respiratory compromise; and Individual #715 – GI problems, and aspiration.

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.

a.iii. through a.v, and b.iv. through b.vi. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. As a result, it was difficult to determine whether or not individuals were making progress with regard to taking steps to improve their chronic or at-risk conditions, 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 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.

Individuals:

#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
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% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/1	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.	14% 1/7	N/A	N/A	0/2	N/A	1/2	0/2	N/A	0/1	N/A
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	N/A									

Comments: a. As noted above, none of the IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Monthly integrated reviews generally only included statements about the number of occurrences of bad outcomes (e.g., falls, fractures, diagnoses of pneumonia, etc.). They generally provided no specific information or data about the status of the implementation of the action steps. One of the problems that contributed to the inability to determine whether or not staff implemented supports was the lack of measurability of many of the action steps.

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

- On 11/11/20, after a fall, Individual #269 was diagnosed with a fracture of the spine (i.e., L.1, L.2, and L.3). On 11/12/20, the PT conducted a mobility assessment. No evidence was found to show that the IDT discussed and integrated a plan of care to address the root cause(s) of the fracture, which the PNMT identified as impulsivity, and "food stealing."
- Individual #269's falls continued (e.g., on 3/19/21, 4/1/21 (x2), 4/9/21, 4/28/21, 5/3/21, and 5/9/21). The IDT put no plan in place to address her ongoing falls, including mitigation of behaviors associated with the increased risk. Although the IDT noted an increase in falls from September to December (i.e., related to her birthday and the holidays), they offered no plan to address the root cause of her impulsivity.
- It was positive that after Individual #503 had a G-tube placed, the home therapists completed a HOBE evaluation to determine the level of head elevation during meals. On 9/28/20, a Habilitation Therapy note indicated the results, and the staff modified his PNMP accordingly.
- In the PNMT assessment for Individual #503, dated 4/23/21, the team discussed the potential for the implementation of the Frazier Free Water Protocol. However, based on review of ISPAs, his IDT had not met to discuss the options for him to progress towards oral intake.
- In July 2020, October 2020, December 2020, and January 2021, Individual #715 experienced emesis, and then developed aspiration pneumonia. No evidence was found to show that Habilitation Therapy staff completed a HOBE evaluation.
- In response to Individual #715's emesis episodes followed by aspiration pneumonia, on 2/26/21, the PNMT completed an assessment. They offered a number of recommendations. No evidence was found to show that the IDT met to discuss the recommendations, and/or develop plans to implement any agreed-upon recommendations. For example, no results were found of the monitoring that the PNMT recommended.
- On 12/14/20, Individual #19 fell. The PT/OT provided a consultation on the same day. The consult stated that the individual's functioning remained the same, but lacked any additional discussion regarding the cause of the fall and/or how future falls could be prevented to the extent possible.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: Based on observations, efforts are needed to continue to improve Dining Plan implementation, as well as positioning. Often, the errors that occurred (e.g., staff not intervening when individuals took large bites, ate at an unsafe rate, or did not take sips of liquid in between bites) placed individuals at significant risk of harm. Center staff, including Habilitation Therapies, as well as Residential and Day Program/Vocational staff, and Skill Acquisition/Behavioral Health staff should determine the issues preventing staff from implementing PNMPs correctly or effectively (e.g., competence, accountability, need for skill training for individuals, etc.), and address them. These indicators will continue in active oversight.			
#	Indicator	Overall Score	

a.	Individuals' PNMPs are implemented as written.	60% 24/40
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	Not rated

Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs/Dining Plans. Based on these observations, individuals were positioned correctly during six out of 10 observations (60%). Staff followed individuals' dining plans during 18 out of 30 mealtime observations (60%).

The following provides more specifics about the findings:

- With regard to Dining Plan implementation, the great majority of the errors related to staff not using correct techniques. 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 they did not drink liquids in between bites. In one instance, staff used their thumb to hold the individual's head up in order to give the individual a bite; this was not an approved technique in the individual's PNMP. It was good to see that during all of the observations, texture/consistency was correct, and adaptive equipment was correct. With one exception, 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. In two of the six observations, staff had not used adaptive/assistive equipment correctly.

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	112	344	269	35	503	715	108	19	5
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A					N/A	N/A			

Comments: a. None of the individuals reviewed had measurable plans to assist in moving along the continuum to oral intake.

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.	
Summary: It was positive that three individuals reviewed had clinically relevant goals/objectives to address their needs for formal OT/PT services. Of concern,	Individuals:

though, none were fully measurable or integrated into the individuals' ISPs/IHCPs. In addition, QIDP interim reviews did not include data related to existing goals/objectives. As a result, IDTs did not have information in an integrated format related to individuals' progress or lack thereof. OTs/PTs should work with QIDPs to make improvements. These indicators will remain in active oversight.											
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	67% 6/9	0/1	N/A	0/1	N/A	0/1	N/A	2/2	2/2	2/2
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/9	0/1		0/1		0/1		0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/7	0/1		0/1		0/1		0/2	N/A	0/2
d.	Individual has made progress on his/her OT/PT goal.	0% 0/7	0/1		0/1		0/1		0/2	N/A	0/2
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/7	0/1		0/1		0/1		0/2	N/A	0/2

Comments: a. and b. Individual #344, Individual #35, both of whom had functional motor skills, and Individual #715 did not have needs identified that would require OT/PT goals/objectives, but all three did require some related supports (e.g., a PNMP). For the remaining six individuals reviewed, three had goals/objectives that were clinically relevant.

The following describes the goals/objectives that were clinically relevant. However, none of these goals were fully measurable because they did not provide a timeframe for achievement.

- Individual #108's goals/objectives (i.e., maintain a neutral pelvis for one minute, and maintain standing activity for 5 minutes).
- Individual #19's goals/objectives (i.e., increase bilateral lower extremity strength, and improve sit to/from stand).
- Individual #5's goals/objectives (i.e., roll right and left with minimal assistance, and sit on edge of bed with moderate assistance).

It was positive that some individuals had goals/objectives that were clinically relevant. However, IDTs did not integrate any of the goals/objectives reviewed in the individuals' ISPs/ISPAs. This was an important missing piece to ensure that an individual's IDT approved the OT/PT goals/objectives, and was aware of the progress with regard to their implementation, and could build upon and integrate those goals/objectives into a cohesive overall plan. Integration of goals/objectives into the ISP/ISPA remains a key requirement overall.

c. through e. For the existing goals/objectives, QIDP monthly integrated progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary

action. The Monitoring Team conducted full reviews for all nine individuals. This included Individual #344, Individual #35, and Individual #715, all of whom did not have needs identified that would require OT/PT goals/objectives, but did require OT/PT supports and services.

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

Summary: For the individuals reviewed, necessary measurable goals/objectives and actions steps were not included in their ISPs/ISPAs, and QIDP monthly integrated reviews did not provide evidence that OT/PT supports were implemented. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 112	344	269	35	503	715	108	19	5
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	N/A									
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A

Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to OT/PT needs were implemented. As described above with regard to Outcome 1, none of the goals/objectives reviewed were measurable. In addition, individuals' ISPs did not include those strategies and action plans, and related data were not or reflected in the QIDP monthly integrated progress reports. OTs and PTs should work with IDTs to ensure that goals/objectives, including formal therapy plans, meet criteria for measurability and are integrated in individuals' ISPs through a specific action plan.

b. It was positive that for Individual #503, on 4/14/21, the IDT met to discuss the termination of the use of a sensory blanket.

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

Summary: Many, but not all, individuals observed had assistive/adaptive equipment that appeared to be the proper fit. 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	732	420	617	664	313	86	353	456	47
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with this indicator, it has moved to the category of requiring less oversight.									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	83% 24/29	1/1	1/1	1/1	1/2	1/2	1/1	2/2	1/1	1/1
		Individuals:									
#	Indicator		546	580	373	19	483	666	75	185	268
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	1/1	1/1	0/1	1/1
		Individuals:									
#	Indicator		694	283	449	57	503	586	746	295	
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	1/1	1/1	

c. Based on observations of 29 pieces of assistive/adaptive equipment, many appeared to be the proper fit for the individuals. The exceptions were for Individual #664, Individual #313, Individual #483, and Individual #185, for whom the outcome was that they were not positioned correctly in their wheelchairs. 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. Therefore, it was good that Center staff reported that the Center ordered and was awaiting new wheelchairs for Individual #483, and Individual #185.

The Monitoring Team also observed that Individual #546 kept removing his plate guard from his plate, so a better alternative might be a high-sided dish.

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 11 outcomes and 31 underlying indicators in the areas 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.

Most SAPs contained many of the required components.

There were positive aspects to the implementation of every SAP that was observed. There were, also, some aspects that were not implemented as written in the SAP. SAP integrity checks had not yet started up again due to COVID-19.

Three-fourths of SAPs had regular QIDP monthly review. Six had all of the required content. Graphs were in place for all SAPs. About one-third were complete in content and presentation.

Two-thirds of individuals were typically engaged when observed by the Monitoring Team.

Some aspects of the Center's requirements for students in public school were being met, and some were not.

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

Continued improvement was seen with regard to ensuring individuals had their AAC devices with them. Moving forward, 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 (indicators 4-7) and Outcome 8 (indicators 39-40) now appear within domain #2 above.

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 implementation and without reliable data, progress cannot be determined. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	115	112	297	150	479	407	483	344
6	The individual is progressing on his/her SAPs.	0% 0/22	0/2	0/1	0/3	0/3	0/3	0/3	0/2	0/3	0/2
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% 0/15	0/2		0/1	0/2	0/3	0/2		0/3	0/2
9	(No longer scored)										

Comments:

6. To determine progress, the Client SAP Training Progress Notes were reviewed. If the SAP had been implemented for less than three months, it was excluded from this analysis. As a result, it was determined that progress was being made on two of 22 SAPs. These were the laundry SAP for Individual #297 and the sweeping SAP for Individual #479. However, due to the lack of data reliability, these SAPs were also rated zero.

Many SAPs had been placed on hold due to the COVID-19 pandemic, but it appeared that no effort had been made to adapt or revise these SAPs so that the individual could be learning the skill. The data indicated that, on average, 50% or fewer scheduled trials had been implemented over a three-month period for 11 SAPs that had not been suspended due to the COVID-19 pandemic. As monitoring of SAPs resumes in full, it will be necessary to ensure that SAPs are implemented with integrity and as scheduled.

7. None of the 27 SAPs had been mastered.

8. There was no evidence that actions were taken to address the SAPs on which the individual was not making progress.

Outcome 4- All individuals have SAPs that contain the required components.											
Summary: Most SAPs contained many of the required components. Continued work to address the types of improvements are detailed in the comments below. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	115	112	297	150	479	407	483	344
13	The individual's SAPs are complete.	0% 0/27	0/3 20/28	0/3 23/29	0/3 20/30	0/3 21/29	0/3 18/29	0/3 20/29	0/3 12/29	0/3	0/3

										23/ 30	24/ 30

Comments:

13. Although none of the SAPs were considered complete, 70% or more included the following:
    - a task analysis, when appropriate;
    - operational definitions of the behavior;
    - an appropriate discriminative stimulus;
    - a schedule for teaching the skill;
    - guidelines for reinforcing correct responding;
    - plans for maintenance and generalization of the learned skill; and
    - succinct directions for documenting the individual's performance.

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.

Comments are provided below.

- The objectives identified in the majority of the SAPs did not indicate whether the individual would perform the skill independently or with some level of prompting. Other necessary components were present.
- While most operational definitions were adequate, there were a few in which the individual's behavior was not described in sufficient detail. For example, Individual #335 was to complete a work product using her right hand/arm, but the work product was not described. Depending on the job she was expected to complete, the behaviors expected of her could be very different. Individual #115 was learning to read, but the SAP did not indicate how many words she was expected to read. Individual #407 was learning to complete a job application, but the SAP didn't specify what information she was expected to provide. Individual #483 was learning to set the table, but the placement of materials was not indicated in the operational definition. This lack of clear operational definitions can also lead to problems with documentation.
- The instructions section was the weakest of all components across this set of SAPs. The goal is to make these specific and clear enough so that there is very little variation in the teaching session from one staff member to another. Other comments follow below:
    - When teaching a skill that requires the use of multiple materials, the order in which the materials are presented should be indicated. This applied to Individual #335's make pudding SAP, Individual #115's cooking eggs, and Individual #483's setting a table SAP.
    - In some cases, the instructions did not match the skill being taught (e.g., Individual #335's SAMS SAP and Individual #115's reading SAP).
    - Occasionally, the instructions did not indicate how the individual could determine the amount of work required. For example, how Individual #115 would know the number of items she must replace when completing her inventory SAP, how Individual #479 would know how much change to provide, and how Individual #344 would know what constituted a sufficient amount of sauce, cheese, or pepperoni when making his pizza.

- In several SAPs, examples included in the instructions were not related to the skill being taught. This included Individual #297's use of a pallet jack (e.g., Put the book in the box), and Individual #344's make pizza and make a purchase SAPs (e.g., Do you want milk or juice).

- Many SAPs indicated that multiple trials should be conducted during each training session. This is a commendable strategy for increasing the number of learning opportunities, however, it is not appropriate for all skills. Some SAPs for which this was an appropriate strategy included Individual #297's identification of coins and Individual #344's use of a knife to cut meat. For others, such as Individual #344's learning to make a personal pizza or making a vending machine purchase, this strategy was not appropriate.
- Guidelines following incorrect responding were not included in Individual #335's SAPs. In some cases, staff were advised to point to the materials, however, it might be more effective if staff were to provide a model of the expected behavior. Examples included Individual #112's bowling and e-mail SAPs, Individual #297's laundry SAP, Individual #479's sanitize hands SAP, Individual #407's balance a ledger SAP, and Individual #483's flossing teeth SAP.
- In all three of Individual #407's SAPs, the discriminative stimulus was listed rather than her expected behavior in the reporting or documentation section.
- It was positive to find guidelines for determining the maintenance of a skill via data-based assessment.

Outcome 5- SAPs are implemented with integrity.

Summary: There were positive aspects to the implementation of every SAP that was observed. There were, also, some aspects that were not implemented as written in the SAP. SAP integrity checks had not yet started up again due to COVID. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 335	115	112	297	150	479	407	483	344
14	SAPs are implemented as written.	11% 1/9	0/1	0/1	1/1	0/1	0/1	0/1	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.	Not scored due to COV19									

Comments:

14. The Monitoring Team observed the implementation of one SAP for each of the nine individuals. Individual specific feedback is provided below.

- The staff member working with Individual #335 did a very nice job allowing her to be as independent as possible, while offering support when needed as she made pudding. Although the milk was not poured into a measuring cup prior to having Individual #335 come to the table, the staff member did a nice job teaching the skill. She also encouraged Individual #335 to complete all steps in the chain even though the SAP indicated that some were deferred. BHS staff should review the materials used to ensure that these are most appropriate for the task and for Individual #335's physical abilities.

- The staff member did a nice job supporting Individual #115 as she read. She provided assistance when Individual #115 struggled with a word, and she used pantomime throughout to help Individual #115 answer questions related to the reading. The one component of the SAP that was not observed was providing Individual #115 with time using her tablet when she was finished reading. While staff are commended for developing a SAP that addresses an interest of Individual #115's, and an activity she clearly appeared to enjoy, they should consult with a reading specialist who could provide appropriate guidance regarding reading materials and instruction.
- With encouragement from staff, Individual #112 was able to set up the bowling pins with little difficulty. She then repeatedly rolled the ball to knock down the pins. The staff members who were present, provided enthusiastic praise and support throughout. This SAP was implemented as written.
- Individual #297's coin identification SAP was taught following the instructional guidelines. The staff member placed multiple coins on the table top and then asked Individual #297 to show her the quarter. He pointed to the quarter and then removed each of the three quarters. The staff member then took this opportunity to have him count to three. While not indicated in the SAP, this was a good example of incidental teaching. Praise was provided, but Individual #297 was not offered music as indicated in the SAP.
- The staff member working with Individual #150 asked him to name appropriate times to call 911. Individual #150 named fire, emergency, and accident. He did not identify crime which was indicated as a mastered step. Although praise was provided, music was not, as written in the SAP.
- Individual #479 did a nice job sweeping the floor. The staff member provided additional verbal instructions that were not indicated in the SAP. Individual #479 did appear to have acquired this skill as he used the dust pan and emptied the gathered material into the trash. He then put the broom and dust pan away when staff unlocked the closet door. He was not provided with a magazine, a peanut butter cup, or music when he completed the task. Staff may want to probe the terminal objective to determine whether this SAP has been mastered.
- The staff member working with Individual #407 completed the job application SAP as indicated. She was very supportive and provided time for Individual #407 to complete parts of the form independently, waiting to provide support when Individual #407 paused or indicated she didn't know the information (e.g., zip code, phone number). Praise was provided, but the provision of a coloring book or scrapbook was not observed. BHS staff should probe the terminal objective because it appeared that Individual #407 had mastered this skill.
- Individual #483 was observed signing in to work. Although the SAP indicated that the sign-in sheet will be kept in one location, the staff member brought the sheet to her. Individual #483 wrote her first name, but was not prompted to write her last name. Casual conversation did not follow her response as indicated in the SAP.
- Individual #344 was working on learning to use a knife to cut meat. He was given a hot dog and immediately tried to consume a large portion, raising the risk of choking. Individual #344 repeatedly pushed the staff member away when she tried to provide assistance. Although he never used the fork, he did eventually hold the hot dog with one hand as he applied the knife to slice several pieces. Although he did not cut the hot dog into small pieces as noted in the SAP, he appeared to already have this skill.

15. The facility 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 were provided if this was not achieved. Due to the COVID-19 pandemic, assessment of SAP integrity had been suspended for the six month period prior to the review. For this reason, this

indicator is rated as not applicable. It was positive to learn that the goal was to resume this activity as COVID-19 restrictions were lifted.

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

Summary: Three-fourths of SAPs had regular QIDP monthly review. Six had all of the required content. Graphs were in place for all SAPs. About one-third were complete in content and presentation. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 335	115	112	297	150	479	407	483	344
16	There is evidence that SAPs are reviewed monthly.	26% 6/23	0/3	0/2	0/1	0/3	2/3	2/3	0/2	0/3	2/3
17	SAP outcomes are graphed.	41% 11/27	1/3	0/3	0/3	3/3	3/3	0/3	1/3	0/3	3/3

Comments:

16. There was evidence of a monthly review in the QIDP monthly report for 20 of the 27 SAPs. Six of these included information that identified the current step and data regarding the percentage of trials completed independently or with prompting: Individual #150's sort clothes and call 911 SAP, Individual #479's sanitize hands and make change SAPs, and Individual #344's make a pizza and make a purchase SAPs. It should be noted that four SAPs were excluded from this analysis because they were on hold due to COVID-19.

17. Graphs were provided for all 27 SAPs. Eleven of these included a reference and/or description of the current step: Individual #335's make pudding SAP, Individual #297's three SAPs, Individual #150's three SAPs, Individual #407's job application SAP, and Individual #344's three SAPs.

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

Summary: Two-thirds of individuals were typically engaged when observed by the Monitoring Team. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 335	115	112	297	150	479	407	483	344
18	The individual is meaningfully engaged in residential and treatment sites.	67% 6/9	1/1	1/1	0/1	1/1	1/1	0/1	1/1	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.	Not scored due to COV19										

Comments:
18. Observations were conducted throughout the week of the remote review. Based on multiple observations, six of the nine individuals, more often than not, were engaged in some meaningful activity. This was Individual #335, Individual #115, Individual #297, Individual #150, Individual #407, and Individual #483. Individual #112 was often sitting idly, Individual #479 was often engaged in repetitive activity in his room, and Individual #344 was observed scrolling through the same material on his iPad.

21. The facility had a plan for regularly assessing engagement across all homes, day programs, and work sites. Engagement goal levels were established at 65%. However, due to the COVID-19 pandemic, this activity had been interrupted. Between November 2020 and May 2021, engagement was assessed between one and five months in the homes for seven of the individuals. Scores averaged 65% or better for Individual #335, Individual #112, Individual #407, and Individual #483. However, this indicators is rated as not applicable, due to visitation restrictions and the temporary closure of all day program and work sites.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.												
Summary: Community outings/activities were suspended due to COVID-19 precautions since March 2020.			Individuals:									
#	Indicator	Overall Score	335	115	112	297	150	479	407	483	344
22	For the individual, goal frequencies of community recreational activities are established and achieved.	N/A									
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	N/A									
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	N/A									

Comments:

Outcome 9 – Students receive educational services and these services are integrated into the ISP.												
Summary: Some aspects of the Center's requirements for students in public school were being met, and some were not. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	335	115	112	297	150	479	407	483	344

25	The student receives educational services that are integrated with the ISP.	0% 0/1										

Comments:
25. An IEP meeting was held for Individual #344 in January 2021. At that time, the team agreed to have him graduate from school because he was experiencing difficulty attending his remote learning provided on campus.

Instead, the IEP, ISP, and latest QIDP monthly progress report were reviewed for Individual #447. Individual #447's IEP meeting was held in January 2021. Her QIDP participated in her IEP meeting during which both inclusion and extended year services were reviewed. There was school related information included in her ISP. A review of her most recent QIDP monthly report did not provide evidence of the IDT meeting after her IEP meeting. There was also no evidence that the IDT reviewed her school progress or report cards.

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 goals/objectives related to dental refusals. These indicators will remain in active oversight			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/2	0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/2	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. Based on the documentation Center staff submitted, two individuals had refused dental services, but their IDTs did not develop specific goals/objectives related to their refusals. The following describes concerns noted:

- Based on the documentation the Center submitted in response to the Tier I document request, Individual #112 refused dental services on 4/20/21. However, based on dental integrated progress notes (DIPNs), the individual also refused dental services, (i.e., a prophylaxis and a restoration to the #7 tooth) on 4/1/21, 4/14/21, and 5/12/21. On 5/12/21, Dental Department staff documented a referral to the "dental refusal team" for the purpose of accomplishing the restoration. The QIDP integrated progress notes for these periods (i.e., 3/23/21 to 4/22/21 and 4/23/21 to 5/22/21) did not document the refusals. On

5/25/21, the IDT held an ISPA meeting and, due to her refusals, agreed to refer the individual to the Dental Department for a desensitization plan. However, Center staff did not submit any additional documentation to show the initiation of any activity to develop a plan. It was positive the IDT met and considered the need for desensitization, but based on the documentation submitted, the response was not timely and Center staff did not implement it.

- Based on the documentation submitted, on 7/21/20, Individual #269 refused dental services. Center staff did not submit any documentation to show she had a clinically relevant and/or measurable goal to address the refusal. On 11/23/20, Dental staff completed an IPN stating that the individual needed a dental desensitization assessment. On 11/24/20, the QIDP monthly integrated progress report stated a referral for dental desensitization had been submitted. However, based on the documentation submitted, Center staff did not complete any further related action.

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: None of the applicable individuals reviewed had needed goals/objectives to expand or explore communication options and skills. To move forward, it will be important for IDTs and SLPs to work together to ensure recommendations for clinically relevant and measurable goals/objectives are considered, and that, as needed, goals/objectives are developed, and implemented. It will also be important for SLPs to work with QIDPs to include data and analysis of data on those communication goals/objectives in the QIDP integrated reviews. These indicators will remain under active oversight

#	Indicator	Overall Score	Individuals: 112	344	269	35	503	715	108	19	5
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/7	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% 0/7	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% 0/7	0/1	0/1	0/1	0/1	0/1	0/1	0/1		
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1	0/1		

Comments: a. through e. Individual #19 and Individual #5 did not require formal communication objectives, but did have communications supports (i.e., Communication Dictionaries and communication instructions). The seven remaining individuals had

communication needs that called for formal supports, but none had goals/objectives to expand or explore communication options and skills. Moving forward, IDTs and SLPs will need to work together to ensure recommendations for clinically relevant and measurable goals/objectives are considered, and that, as needed, goals/objectives are developed, and implemented. It will also be important for SLPs to work with QIDPs to include data and analysis of data on those communication goals/objectives in the QIDP integrated reviews.

As noted above, Individual #19 and Individual #5 did not require formal communication objectives, but did have communications supports, so the Monitoring Team conducted full reviews for them. For the remaining seven individuals, the Monitoring Team also completed full reviews due to a lack of clinically relevant, achievable, and measurable goals.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: The applicable individuals did not have needed strategies and action plans included in the ISPs/ISPAs related to communication. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	112	344	269	35	503	715	108	19	5
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	N/A									
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									
Comments: a. As described with regard to Outcome 1 above, individuals reviewed did not have communication goals, but most had unaddressed and unmet needs with regard to communication.											

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: Continued improvement was seen with regard to ensuring individuals had their AAC devices with them. Moving forward, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	669	373	800	620	194	61	27	666	702
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	78% 7/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1

b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	50% 4/8	0/1	1/1	1/1	1/1	N/A	0/1	0/1	1/1	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.	N/R									
Comments: a. and b. For many individuals reviewed, but not all, their AAC/EC devices were present in each setting and readily available to the individuals. The exceptions were for Individual #194 (i.e., communication book missing), and Individual #666 (i.e., sign/gesture poster on wall and not accessible in various locations). However, even when the devices/supports were present, individuals did not consistently use their devices in a functional manner and Center staff did not correctly prompt them to do so. For example, for Individual #27, Center staff did not appear familiar with his picture schedule and, when asked by the Monitoring Team to demonstrate, did not present the schedule in a functional (i.e., forward sequencing) manner. In another example, for Individual #702, Center staff could not demonstrate the functional use of her communication cards as a means to supplement her speech.										

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. Two indicators remained in 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 continued to make some progress in identifying the measurable criteria upon which the Post-Move Monitor (PMM) can accurately judge implementation of each support. While progress was noted, IDTs still needed to focus on developing pre-move training supports that were measurable and defined the specific competency criteria provider staff would need to meet. For this review, some of the pre-move supports provided detailed criteria, but others did not. Even when the pre-move supports included detailed criteria, it was not always clear the IDTs had carefully considered the content.

Center staff are encouraged to continue making improvements in the development of a comprehensive set of supports. Of note, even when assessments and CLDP discussion/recommendations identified important support needs, the post-move supports did not always include them. Transition staff should thoroughly review these two Community Living Discharge Plans (CLDPs), along with the supporting documents (e.g., the 14-day ISPA, the ISP, the IRRF, the discharge assessments, and the CLDP narrative) and complete their own critical review of how supports were developed and/or overlooked.

Neither individual experienced a preventable negative event since their transitions in early June 2021. Post-move monitoring processes and methodologies continued to require some improvement. Some of the areas in which continued efforts were needed included 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. In addition, while there were some good examples of follow-up to resolve areas of concern and unmet supports, the PMM did not always correctly identify issues that required follow-up or take timely follow-up action.

It was positive transition staff continued to work with disciplines on the quality of transition assessments and recommendations. Some progress was observed, but additional improvement was needed in 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 continued to make progress with regard to the development of 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 the methodologies for measuring provider staff competencies were thorough. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 143	322							
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, two individuals (i.e., Individual #143 and Individual #322) transitioned from the Center to the community. 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. Of note, the Center had recently undergone a complete turn-over of transition staff positions, but it was fortunate both the new Admissions and Placement Coordinator (APC) and PMM had previous experience in this area. In addition to her previous work at the Center, the new APC also had worked with the Local Intellectual and Developmental Disabilities Authority (LIDDA). This should serve the Center well.

In summary for Outcome 1, the Monitoring Team has consistently advised Centers that the development of clear and comprehensive supports and confirmation of provider staff competency to provide those supports are the foundations for a successful transition. In light of this, the Monitoring Team again encouraged Center staff to focus their efforts on a set of primary tasks, those being:

- Work with individuals' IDTs to identify and prioritize what provider staff need to know and/or know how to do;
- Clearly define which provider staff need to know, or know how to do, for each of the prioritized supports;
- Create clearly defined, cohesive and measurable supports that will facilitate provider staff understanding of the requirement. It was positive transition staff were using discipline assessments and training materials as resources to develop pre-move training supports and competency quizzes, but the Center's clinical staff continued to need to make improvements in both assessment recommendations and proposed training before they could be relied upon entirely. When crafting those supports, it will also be important to avoid Center-specific language that will not be applicable in the community settings, which could lead to confusion. Instead, transition staff should work with IDT members to identify how those needs could be otherwise met in the community;
- Clearly define the competency criteria for each of the prioritized supports;
- Make sure competency tests address the specified criteria for each of the prioritized supports. Continued improvement was still needed overall; and,

- Prior to the individual's transition date, ensure that Center staff have confirmed competency for all levels of provider staff who will have responsibility for implementing supports, rather than only for supervisory or management staff. The current training model often relied on the provider supervisor, manager, and/or nurse to train direct support staff, which was not sufficient to allow Center staff to confirm provider staff competency.

1. IDTs should 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. Overall, for this review, the Center needed to continue focusing on developing comprehensive and measurable supports, with the primary emphasis on ensuring that, prior to transition, provider staff can demonstrate they have the needed competencies to meet individuals' needs. The following provides examples of pre-move and post-move supports that met criteria and that did not meet criteria.

Pre-Move Supports: The respective IDTs developed eight pre-move supports for Individual #143, and nine pre-move supports for Individual #322. 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:

- For both CLDPs, some pre-move supports focused on ensuring the availability of equipment and materials, such as a binder containing pertinent health care and programmatic documents from Denton SSLC [the CLDP, Integrated Risk Rating Form (IRRF), Physical/Nutritional Management Plan (PNMP), etc.]. These supports typically met criterion for measurability.
- The CLDPs also included pre-move training supports in the areas of medical/nursing, behavioral health, and/or habilitation therapy. As written in these two CLDPs, pre-move training supports often specified the required competency criteria, but some improvement was still needed. Findings included, but were not limited to:
    - Some, but not all, of the pre-move training supports provided clearly stated and detailed competency criteria (i.e., what provider staff needed to know or know how to do). For Individual #143, these included the supports for two areas of need (i.e., OT/PT, and behavioral health), but not in the area of nursing needs. For Individual #322, both the behavioral health, and nursing pre-move training supports provided competency criteria. That said, when developing competency criteria, the IDT should be judicious. For example, the behavioral health pre-move training support for Individual #322 appeared to be comprised of the entire positive behavior support plan (PBSP), including some references to Center-specific language (e.g., use of Ukeru pads). While the behavioral health pre-move training support for Individual #143 was somewhat briefer, it also included some of the same Center-specific language.
    - As the Monitoring Team recommended at the time of the previous review, it was good to see that Center staff also specified which provider staff needed to be trained. However, the supports still did not specify the training methodology (i.e., another aspect of measurability), but should have. Going forward, the IDTs should also consider whether didactic learning is appropriate for all needs, and whether other methodologies, such as demonstration or hands-on modeling might be better suited as the measurement methodology for some. For these transitions, Center staff reported they provided virtual training. On a positive note, the training was completed on a platform with video capabilities, which would allow for demonstration and even some forms of return demonstration. The Monitoring Team was unable to view the video training, and neither the pre-move supports or available training documentation

specified the training methodologies, so it was unclear whether Center staff employed any methodology other than didactic learning.

- As reported at the time of the last review, pre-move training supports often continued to specify that competency would be assessed by having provider staff "verbalize comprehension," which would be an unreliable indicator not amenable to measurability, with only an occasional reference to a written quiz. However, based on the documentation submitted, Center staff typically did administer written quizzes. The quizzes provided for review still did not test competency in a comprehensive manner. As discussed with transition staff, testing needed to be constructed to measure the specific criteria that would demonstrate provider staff were competent to provide supports as required. The written tests reviewed for these CLDPs did not include questions for most of the topics and/or competencies listed for each support, so there was no corresponding measurable evidence of related staff knowledge. The following describes examples of concerns noted:
    - For Individual #143, despite extensive criteria in the behavioral health and habilitation therapy pre-move training supports, the corresponding competency quizzes were very brief and addressed only a few of the criteria. For example, his habilitation therapy quiz consisted of three questions, including how he takes his medications (i.e., crushed or in liquid form); what his medications get mixed with (i.e., pudding); and what type of adaptive equipment he uses (i.e., high sided, deep divided dish). The pre-move support also included seven other specific criteria for staff instructions related to dining, but the habilitation competency testing did not address them. Only one of the seven instructions (i.e., to remain upright for one hour after meals) was addressed elsewhere (i.e., in the nursing competency quiz). The habilitation therapy quiz also did not address stated criteria related to communication strategies or positioning.
    - Individual #322's behavioral health and nursing supports also included extensive criteria, but the corresponding competency quizzes were likewise very brief and addressed only a few of the criteria. For example, the behavioral health quiz only required provider staff to answer four questions, including to name her target behaviors and behaviors for decrease, to name her replacement behaviors, behaviors for increase and behaviors for maintenance, and to give two examples each of prevention and behavior management strategies. The quiz did not address the crisis intervention plan at all, even though both pre-move and post-move supports indicated this was a requirement for staff to know and to implement.
- As also reported at the time of the previous review, the Center continued to rely on provider management staff to deliver training to the home and day program staff. It remained concerning that Center staff sometimes obtained little evidence of day program staff competency prior to individuals' transitions. For example, for this review, as evidence of provider staff competency for Individual #322, Center staff only provided competency quizzes for one provider staff and only documented interviewing that single staff prior to transition. Thus, it was not surprising that, at the time of the seven-day PMM visit, the PMM discovered that other direct support staff had not received the required training.

Post-Move: Supports: The respective IDTs developed 22 post-move supports for Individual #143, and 33 post-move supports for Individual #322. Many of the post-move supports were measurable, but this was not yet consistent. Examples of concerns included, but were not limited to:

- Both individuals' CLDPs included three identical supports indicating that in the event the individual experienced a change in change in physical capabilities, hearing or speech, the provider would arrange for the individuals to be seen by an appropriate

clinician or the primary care provider (PCP). In general, while the intent of these supports was good (i.e., to require provider staff to be alert to, and respond appropriately to changes of status), IDTs should individualize such supports with the specific parameters or examples for each person, rather than using broad and inexact terms.

- For Individual #143, the CLDP included a post-move support that called for the provider staff to implement the PBSP, but referenced no criteria or probes the PMM could use to judge if it was implemented as required.
- For Individual #322, a post move support called for her to participate in day programming or volunteer activities when not scheduled for work. She was not working, but the support did not provide any expectations about frequency or duration for day programming or volunteer activities.

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

- Past history, and recent and current behavioral and psychiatric problems:
    - Neither of the CLDPs included supports that addressed provider staff knowledge of the individuals' behavioral histories.
    - For Individual #143, the Center did not provide a full behavioral health assessment (BHA) for review, so the Monitoring Team could not fully evaluate if, or how well, the supports addressed any pertinent behavioral history.
    - Individual #322 had a recent (2018) history of an unsuccessful community placement due to ongoing physical altercations with her peers in the home. Based on her BHA, she also had a history of refusing to work, refusing to do chores, refusing to cooperate with requests, and attempting to attack her mother while in a car. There were also reports of attempts of unauthorized departures. The post-move supports did not provide for staff knowledge of this history. It is important for provider staff to have knowledge of prior history so that they can be alert to signs that the behaviors might be re-emerging in a less structured setting, and be prepared to quickly address them. Where feasible, Center staff should also share with provider staff those interventions that were previously successful.
    - As described above, the behavioral health post-move supports for Individual #143 only required that provider staff implement the PBSP, but provided no other criteria.
    - Individual #322's post-move supports provided more detail, including monitoring and tracking psychiatric symptoms, and expectations for how to address replacement behaviors, and how to implement her crisis intervention plan. However, the supports provided only broad and non-specific description of other behavioral interventions (i.e., staff instructions, verbal prompts, physical blocking extinction) and did not indicate how and when each of the interventions should be implemented.
- 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 all applicable areas, as indicated in the examples provided below:
    - Neither of the respective IDTs developed a post-move support describing the level and types of supervision the individuals required.

- For Individual #143, the IDT did not develop a post-move support for direct support staff to have knowledge of, and report to nursing, any side effects of his medications (e.g., signs and symptoms of lithium toxicity).
- For Individual #143, with the exception of administering the AIMS and MOSES periodically to assess potential side effects of medications, and for weight monitoring, the IDT did not develop any post-move supports for nursing oversight or monitoring. He had other relevant needs for nursing monitoring. For example, the individual had a diagnosis of constipation, and his nursing assessment indicated provider staff should notify nursing if he did not have a bowel movement in three days, but his CLDP did not include a support to track his bowel movements. In addition, his medical assessment indicated he should be monitored for signs and symptoms of constipation (e.g., abdominal distention, nausea, abnormal bowel sounds, etc.), and that staff should encourage ambulation and fluids. His CLDP supports did not address these needs.
- Individual #143's CLDP did not include post-move supports for implementation of his dining plan instructions or his communication strategies.
- For Individual #322, who had a diagnosis of hypothyroidism that was managed with medication, the CLDP did not include a post move support for provider staff to have knowledge of the possible signs and symptoms (e.g., signs of lethargy, confusion, sluggishness, arrhythmia, hypothermia, cold or warm intolerance, abnormal gastrointestinal symptoms, etc.) for which to monitor and report to nursing.
- Just prior to Individual #322's transition, the Pre-move Site Review (PMSR) documented that the Center PCP consulted with the community practitioner to provide updated information about required follow-up with a neurologist due to left renal calculi with moderate severity hydronephrosis, as well as follow-up testing in four to six weeks for Hepatitis C due to a bite of a positive individual. The IDT should have modified the CLDP post-move supports to ensure tracking the implementation of these important needs, but did not.

- 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. Neither of two CLDPs met criterion.
  - For Individual #143, the IDT identified three important outcomes: 1) to eat good meals in the community, 2) to work on naming his medications, and 3) to watch certain videos (i.e., of a specific Elvis Impersonator) on the internet. Overall, it appeared that the IDT could have more carefully considered his preferences and strengths and his personal goals to identify important outcomes. However, based on this set of outcomes, the CLDP addressed naming his medications. Otherwise, the supports included going out to eat as one of several activities in which he could participate at least four times a month. However, as the Monitoring Team has previously pointed out, this support could be considered met even if he did not go out to eat. In the same vein, another support called for providing him with opportunities to participate in social activities and activities of his preference daily. The support also listed some of his preferences, which included watching Elvis videos on the computer, and stating that the specific Elvis impersonator. Again, this support did not specifically require that the outcome the IDT identified be addressed.
  - For Individual #322, the IDT identified that she would like to live closer to her family, to have independence and make her own decisions throughout the day, live in her own apartment one day, and work somewhere that felt constructive and rewarding. While the transition apparently allowed her to live closer to her family, supports for the remaining outcomes were limited and not concrete. For example, although she was living closer to her family, the only post-move support for family contact was to coordinate visitations with her family as the family requested. Supports did not

include concrete opportunities for learning home management skills to further her desire to live in her own apartment one day or offer opportunities for making her own decisions. With regard to the latter, the only support that included the option for choices called for the provider to afford her with opportunities to participate in community events of her preference "at least four times a month." It was, however, positive that the IDT developed a clear employment support calling for the provider to continue current enrollment with the Texas Workforce Commission within 45 days after transition, and to ensure that the individual attended all meetings with the employment specialist. In addition, another support identified her preferred type of work (at a veterinarian clinic or with animals).

- Need/desire for employment, and/or other meaningful day activities: One of two CLDPs met criterion.
    - For Individual #143, the CLDP included a post-move support calling for him to participate in day programming or volunteer activities within seven days of transition. This did not clearly address his needs and preferences as outlined in assessments and discussed at the CLDP planning meeting. For example, the CLDP narrative noted that he did well at the Center's vocational workshop, was a hard worker, and, as a result, was earning money. The CLDP participants also discussed the potential for finding employment, including the recommendation from the Center's vocational staff that he attend a workshop, possibly helping to set up a garden or grow plants. The vocational staff also indicated it might be possible for the individual to have community employment with the support of a job coach. The IDT determined that the individual should have daily activity to provide structure, but would not require a workshop. The IDT did not provide any other rationale for not adopting the recommendations related to work or to support his identified strengths in the area of employment.
    - For Individual #322, employment was a very important outcome. As described above, her IDT developed relevant supports.
- 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 #322, it was positive the CLDP included behavioral supports that described behaviors for increase, and how to reinforce and motivate her. The CLDP for Individual #143 did not include relevant post-move supports.
- Teaching, maintenance, participation, and acquisition of specific skills: For both individuals, it was good to see that the IDTs included post-move supports for continuing some Center-based goals and skill acquisition plans. That said, for both individuals, the assessments related to their functional skills provided very little information about any other skill acquisition needs. For Individual #143, the Center did not provide a stand-alone Functional Skills Assessment (FSA). Instead, the QIDP summary provided only a brief narrative about his existing functional skills, primarily focusing only on those for which he was already independent. The QIDP summary was also undated, so it was not clear how current it might be. For Individual #322, the FSA was not completed until 5/24/21, which was after the IDT met to develop the CLDP on 5/14/21. In other words, it was not clear the respective IDTs had adequate information for determining the supports the individuals needed in this area. It also appeared that, for Individual #143, the IDT did not consider whether the Center supports were relevant in the community. For example, the post-move supports indicated he should continue to work on a training objective to correct work errors related to a work-jig, but, based on the CLDP supports, he would not be working once he transitioned.
- 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. However, for this review, the IDTs did not yet address all recommendations with supports or otherwise provide a justification, as described throughout the discussion about this outcome. Even when

	assessments and CLDP discussion/recommendations identified important support needs, the post-move supports did not always include them. The Monitoring Team recommended that the new transition staff sit down with these two CLDPs, along with the supporting documents (e.g., the 14-day ISPA, the ISP, the IRRF, the discharge assessments, and the CLDP narrative) and complete a critical review of how supports were developed and/or overlooked.

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. One indicator (i.e., Indicator 3) remained in the category of requiring less oversight, but the other indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	143	322							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight									
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1							
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1							
6	The PMM's scoring is correct based on the evidence.	0% 0/2	0/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, the IDT/Facility implemented corrective actions in a timely manner.	0% 0/2	0/1	0/1							
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A	N/A	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A	N/A	N/A							
Comments: 4. Due to the recency of both individuals' transitions, many of the supports were not yet due. For those supports that were due, the PMM provided narrative comments for all supports. However, for both individuals, the provider often did not make available											

the required documentation as evidence of implementation, so the PMM could not verify that the information the provider staff offered during interviews was reliable and valid. It was positive, though, that in most, but not all, of these instances, the PMM correctly marked those supports as not in place. The following describes examples of concerns noted.

- Overall, it continued to be the case, as described with regard to Indicator 1, that supports did not always have a level of clarity and measurability to guide the PMM about the criteria that would confirm the presence of various supports. For example, for both individuals, several supports called for the provider to obtain consultations if the individuals experienced changes in status, but did not provide any parameters by which to judge if changes occurred. This was particularly significant in the first seven days, since the provider staff were not familiar enough with the individuals to make those judgements accurately. However, based on the report of provider staff for both individuals, the PMM marked the supports as not applicable. This could not be considered sufficient reliable or valid data to make that determination.
- In another example of the lack of needed specificity and measurability preventing the collection of reliable and valid data, for Individual #143, the PMM did not provide a comprehensive comment describing the provider staffs' knowledge of the individual's PBSP or obtain evidence of its implementation. The PMM documented interviewing the day program director about the individual's behaviors targeted for decrease, as well as interviewing two other staff about their knowledge of his PBSP, targeted behaviors and replacement plan. The comment provided no specific detail about what staff were able to recall. In addition, based on the criteria described in the pre-move training support, the PMM should also have probed for specific knowledge of prevention and intervention strategies, but did not document doing so. Documenting probing for "knowledge of the PBSP" and stating that staff were able to "provide the information" did not suffice as evidence of reliable and valid data.
- For Individual #322, the provider did not allow the PMM to observe the individual due to their understanding of COVID-19 restrictions, and, overall, this also prevented the collection of valid and reliable data for her. It was positive, though, that the PMM called a timely meeting involving the provider, Center staff, and the individual's advocate to strategize about how the PMM could complete the needed monitoring.
- The PMM's comments did not always clearly or fully address what appeared to be the intent of the support. For example, Individual #322's CLDP included a post-move support calling for the provider to ensure environmental engineering of the home to minimize potential damage to property and to maintain a daily routine schedule. The PMM's comments stated that were several different exits the individual could use to leave, but it was unclear how this was responsive to the support. The PMM did not otherwise document probing provider staff knowledge about environmentally engineering or maintaining a daily schedule.
- The PMM did not always attempt to obtain required documentation to confirm that information obtained in interviews was correct. For example, for Individual #322, a support for the continued implementation of her training goals was due on 6/8/21, the day of the seven-day PMM visit. The PMM's comment indicated that provider staff stated they were collecting data and would begin implementation after that was complete. The PMM marked the support as not applicable. It was unclear what the provider staff were collecting data about or how that was relevant to this support. In any event, the PMM should have then asked to see the data collected, and the required log, as evidence that provider staff had begun implementation as required.

5. As described above, the Monitoring Team sometimes could not evaluate or confirm whether individuals received supports due to the lack clarity and measurability in the supports as written and/or because valid and reliable data were not available. In addition, based on information the PMM collected, at the time of their seven-day PMM visits, both individuals had frequently not received supports as

listed and/or described in the CLDP. Based on the PMM's evaluation, examples of supports not in place as required included the following:

- For Individual #143, provider staff did not make documentation available to show they completed the following: family phone contact; filing to become representative payee; implementation of community activities, participation in leisure activities, training programs or tooth brushing; consults with the nurse practitioner and psychiatrist; and, staff-in-service trainings.
- For Individual #322, provider staff did not make documentation available to show they completed the following: family phone contact; attendance at day program; and, implementation of a routine schedule, community activities, social activities, opportunities to increase independence, tooth brushing, and her crisis intervention plan. In addition, the provider did not provide evidence of needed staff training, sample menus, a medication administration record, a log for psychiatric indicators, behavioral data sheets, and did not provide the needed documentation of a behavioral incident that occurred.

6. The PMM's scoring often appeared to be correct, based on the supports defined in the CLDP. For most supports, the PMM accurately captured that they were not yet due and therefore not applicable, or were not met because the provider did not have the required documentation to review. However, there were exceptions for which the PMM did not provide accurate scoring. These are described above with regard to Indicator 4.

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. Due to the recency of these two transitions, it was sometimes too early to fully assess timely follow-up to every problem. However, 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. The following provides examples of pertinent findings:

- It was positive to note some examples of good follow-up to resolution with regard to PMSR concerns, as well as some of the issues the PMM identified at the time of the seven-day PMM visit. For example, for Individual #322, the PMM took swift action to convene the IDT, provider, and LIDDA staff to address the lack of provider staff competency training discovered at the time of the seven-day PMM visit.
- In some instances, the PMM identified a potential concern, but did not take needed action to confirm a clear, comprehensive, or timely plan for resolution:
    - For Individual #143, the PMM did not include the need to obtain documentation of provider staff training with regard to the PBSP in the Area of Concern/Unmet Support section of the PMM Checklist. This appeared to have been an oversight.
    - For Individual #322, at the time of the seven-day PMM visit, the PMM documented the individual had a behavioral incident in which she hit two provider day program staff and, further, that she had a visible black eye. However, various comments throughout the PMM Checklist provided conflicting information about the circumstances. The initial comment (i.e., for post-move support #12) did not state how the black eye occurred and noted the provider did not make available any documentation. The comment for a later support indicated that Individual #322 hit one provider staff, and that a peer at the day program hit Individual #322, but did not clearly state that the black eye resulted from the peer's aggression. In the Additional Questions section of the PMM Checklist, the PMM noted for one question (i.e., Additional Question 4a) that she received an email stating that it was the peer aggression that caused the injury. However, for another question (i.e., Additional Question #3), the comment stated the individual

had a black eye from provider staff hitting her after she hit another provider staff. The PMM again indicated that she had not been able to obtain additional documentation on how and why the incident happened. This was concerning. The PMM should have documented a clear description from provider staff about how the injury occurred and whether there was any reason to suspect abuse (e.g., retaliation by staff). This might have also resulted in the need to make a report of suspected abuse to the Department of Family and Protective Services (DFPS), as well as to ensure the implementation of any immediate protections that might be needed. The PMM noted in the Area of Concern/Unmet Support section of the PMM Checklist the need to obtain documentation regarding the individual's behavior, with a due date of 6/11/21. Given the individual's injury, the PMM should have documented immediate action to ensure needed protections.

The Monitoring Team requested documentation to show that Center staff completed any needed follow-up to this incident, including, but not limited to, evidence that they initiated a report of suspected abuse to DFPS or ensured the needed reporting occurred. Based on the additional evidence submitted (i.e., the 45-day PMM Checklist), it appeared Center staff did not complete needed follow-up or reporting. The version of the 45-day PMM Checklist submitted omitted the page that included Additional Question #3, so the Monitoring Team could not see any follow-up documentation related to the statement that a provider staff caused the injury. However, the available documentation showed that the provider had not ever submitted any evidence (i.e., an incident report or investigation) that showed how the injury occurred and who was responsible. The Monitoring Team then met with Center transition staff and State Office staff to discuss the need to ensure follow-up and reporting of the possible suspected abuse. The PMM noted that she made an error in the documentation for Additional Question #3 and that she did not have a reason to believe staff caused the injury. However, she also acknowledged that she should not have relied solely on staff report to confirm that no abuse occurred and should have made a DFPS report when the provider did not submit the additional evidence she requested. Further, she stated she would proceed immediately to call the incident in and notify the Monitoring Team when she accomplished that. Shortly after, the Center provided confirmation that the PMM reported the allegation to DFPS.

The Monitoring Team also discussed with Center staff that the supervisory review of the seven-day PMM Checklist should have detected the suspicion of abuse and led to immediate action on the part of Center staff. They reported that after receiving the Monitoring Team's request for additional information, they met about these circumstances and clarified the responsibilities of all transition staff to be alert to possible allegations of abuse and to take timely actions.

9 through 10. Post-move monitoring did not occur during the week of the onsite review. Therefore, these two indicators were not scored.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of preventable negative events following transition into the community.												
Summary: Neither individual experienced a preventable negative incident following transition. At this time, this indicator will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	143	322								
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	100% 2/2	1/1	1/1								
Comments: 11. Neither individual had experienced a Potentially Disrupted Community Transition (PDCT) event.												

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.												
Summary: Overall, 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. Center efforts also were still hampered by the lack of 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	143	322								
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting	0% 0/0	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	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight										

	for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.										
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/2	0/1	0/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/1	0/1							
18	The APC and transition department staff collaborate with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition.	100% 2/2	1/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

Comments: 12. Assessments did not consistently meet criterion for this indicator. At the time of the previous review, the Monitoring Team found 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. Transition staff should continue to pursue these strategies, and provide additional training with disciplines with regard to the expectations for their assessments. It was very good to hear that the APC had recently targeted training on community living options to the QIDP staff, after recognizing that they sometimes did not have sufficient awareness of the resources available in the community and that this impacted their ability to make meaningful recommendations. The Monitoring Team considers the following sub-indicators when evaluating compliance:

- Assessments updated with 45 Days of transition: Many assessments provided for review met criterion for timeliness, although there were exceptions. The following describes examples of concerns noted:
  - For Individual #143, the medical assessment provided for review was dated 1/11/21. While it appeared the assessment referenced some more recent data, it was not signed or dated. The social history/assessment and QIDP assessment, which included a summary of functional skills, were also undated. His psychiatry assessment, which was dated 4/8/21, was not within 45 days of his transition on 6/1/21. The Center submitted a current PBSP, but did not submit a full BHA.
  - For Individual #322, the social assessment was unsigned and undated.

- 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. Areas of concern included the issues described above with regard to various assessments. Also, as described above with regard to Indicator 2, for various reasons (i.e., timeliness, availability, and/or thoroughness) the assessments describing the individual's functional skill acquisition needs were not adequate to assist the IDTs in developing a comprehensive list of protections, supports, and services in a community setting.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community/specifically address 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. For example, overall, the CLDP assessments reviewed for these transitions did not clearly describe provider training needs. It was very good to hear that the APC recently targeted training on community living options to the QIDP staff, after recognizing that they sometimes did not have sufficient awareness of the resources available in the community. Similar training might be helpful to the various disciplines to assist in the development of recommendations for successful transitions and for adjusting support needs in a manner consistent with community living.

14. Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required: This training did not yet meet criterion for these two CLDPs, as described with regard to Indicator 1 above. Findings included:

- Although improvement was noted, IDTs did not yet consistently identify the expected provider staff knowledge or competencies that needed to be demonstrated. As a result, it was not possible to confirm that staff training addressed all important support needs.
- The Center still needed to consider the method of training needed based on the nature of the support, and document that in the pre-move training supports.
- When the Center relies on written exams to demonstrate competency, it should ensure those are constructed to cover essential knowledge comprehensively. The testing materials the Monitoring Team reviewed fell short of this mark. Competency testing did not clearly document provider staff had knowledge of essential supports based on each individual's needs.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The IDT should include in the CLDP a specific statement as to whether any collaboration was needed, and if any were completed, summarize findings and outcomes. Neither CLDP included a clear statement describing the IDTs' consideration of any potential collaborations that might be needed. To move forward, the Center should provide a specific statement of the various needs for collaboration the IDT considered and the rationales for determining why or why not. The Monitoring Team noted that the Center did not use the available CLDP template that included a prompt for this requirement and suggested they ask State Office to provide it. However, it was positive that both CLDPs included pre-move supports for some consultations to occur (i.e., between nursing staff, PCPs, and BCBAs for Individual #143; and between nursing staff, and PCPs for Individual #322). For Individual #322, it was also positive that her PMSR summarized the findings and outcomes of the completed collaborations. In contrast, for Individual #143, the PMSR only confirmed the PCP completed the collaboration, but did not provide any summary. Based on review of an integrated progress note (IPN) by the PCP, dated 5/13/21, the PCP informed the community practitioner that the individual had a new daily medication added for tachycardia and that his pulse was 87. The IPN also stated the PCP shared that the Center completed a chest x-ray and an EKG, but

did not state the results. The IPN further stated that the individual was scheduled for an echocardiogram and thyroid scan the day following the collaboration. It was not clear why the PCP did not complete an additional consultation to inform the community practitioner of the results of these tests and any additional needed follow-up.

16. SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs: The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. For these CLDPs, the IDTs did not include a statement with regard to settings assessments. The Monitoring Team noted that the Center did not use the available CLDP template that included a prompt for this requirement and suggested they ask State Office to provide it.

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. These two CLDPs did not provide a specific statement that defined the need for or level of direct support staff participation. Again, the Monitoring Team suggested that transition staff obtain the existing CLDP template that includes a prompt for this requirement.

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

19. The PMSRs for both individuals were completed in a timely manner. However, it is essential Center staff 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, due to overall deficiencies in the processes for pre-move training and provider staff competency demonstration, and the reliance on those processes for the PMSR, neither of these two PMSRs fully accomplished confirmation of provider staff competency. The following provided additional examples of concerns noted:

- For Individual #143, a pre-move support called for the PMM to observe that the provider had a pill crusher available, to interview staff about how to use it, and to review training documentation about medication administration. The PMM did not provide any comments, but marked the support as in place.
- For Individual #322, based on the pre-move training documentation provided, the PMM only documented interviewing provider staff about her nursing needs and not for her behavioral support needs.

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	143	322								

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 3/4/20, Individual #143 was referred, and on 6/1/21, he transitioned to the community. This exceeded 180 days and the transition logs indicated some avoidable delays occurred when IDT members were unresponsive for several weeks with regard scheduling the 14-day ISPA meeting. The documentation indicated that, on 3/13/20, transition staff began contacting the QIDP to schedule the meeting, but did not receive a response until 4/6/20. Transition staff communications acknowledged that the requirements of COVID-19 pandemic might result in the need to defer the referral meeting, and twice offered that option to the IDT, but the QIDP did not respond on a timely basis to acknowledge the communications.
- On 11/13/20, Individual #322 was referred, and on 6/1/21, she transitioned. This slightly exceeded 180 days, but the transition log did not indicate any avoidable delays.

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.
    - HHSC PI 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 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 within past two years, 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 HHSC PI 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
HHSC PI	Health and Human Services Commission Provider Investigations
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
PNA	Psychiatric nurse assistant
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
SUR	Safe Use of Restraint
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone
UTI	Urinary Tract Infection
VZV	Varicella-zoster virus