United States v. State of Texas

Monitoring Team Report

Lubbock State Supported Living Center

Dates of Onsite Review: February 6th through 10th, 2017

Date of Report: May 1, 2017

Submitted By:	Maria Laurence, MPA Alan Harchik, Ph.D., BCBA-D Independent Monitors
Monitoring Team:	James M. Bailey, MCD-CCC-SLP Victoria Lund, Ph.D., MSN, ARNP, BC Edwin J. Mikkelsen, MD Susan Thibadeau, Ph.D., BCBA-D Teri Towe, B.S. Scott Umbreit, M.S. Wayne Zwick, MD

Table of Contents

Background

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

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

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

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

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

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

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

Methodology

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

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

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

Organization of Report

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

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

Executive Summary

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

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

Status of Compliance with the Settlement Agreement

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

This Domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, mortality review, and quality assurance. Nineteen of these indicators had sustained high performance scores and will be moved to the category of requiring less oversight. This included five outcomes: Outcomes 3, and 15 related to restraint, and Outcomes 4, 5, and 9 related to abuse, neglect, and incident management.

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

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

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

<u>Restraint</u>
Crisis intervention restraint usage at Lubbock SSLC had increased over this period as well as compared with the past two review periods. There were, however, some problems with the restraint data system that may have resulted in some inflated scores. If so, this should be worked out and resolved. Overall, when crisis intervention restraints occurred at Lubbock SSLC, they were managed in a safe manner for this review and for the last two reviews, too. Documentation and review had improved to the point that with sustained high performance, relevant indicators might move to the category of requiring less oversight. Based on the results of this review, nine indicators regarding crisis intervention restraint will move to the category of requiring less oversight.

Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: monitoring individuals for potential side effects of chemical restraints and providing follow-up for abnormalities; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and ensuring documentation is accurate and consistent in the various places that restraint documentation is maintained.

Abuse, Neglect, and Incident Management

Nine indicators moved to the category of requiring less oversight. These had to do with protecting individuals after an allegation was made, completing the various aspects of an investigation, conducting audits of serious injuries, and the creation and management of recommendations. Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury for all but one individual. Even so, attention needs to be paid to this (indicator 1) to ensure ongoing high performance. Similarly, just under half of the investigations included late reporting by facility staff, though some of these might have been corrected with more thorough review of the investigation (e.g., documentation entries). Finally, investigations need to include all relevant evidence, as described in the comments for indicators 9 and 10 below.

Other

It was good to see that pretreatment chemical restraint was addressed for most individuals when needed and that the IDTs determined if action plans were, or were not, needed. Though in the one case where actions were called for, they were not developed.

It was good to see that the Center completed clinically significant DUEs. Given the Center's performance during this review and the last two reviews, this indicator will move to the category requiring less oversight. The indicator related to follow-up on DUE recommendations will continue under active monitoring.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.												
Summary: Crisis intervention restraint usage at Lubbock SSLC had increased over this period as well as compared with the past two review periods, too. Six of the 10 individuals had decreasing or very low occurrences of crisis intervention restraint. Both indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	27	233	82	322	131	320	174	236	197	242
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	58% 7/12	This is a facility indicator.									
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	60% 6/10	1/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1	0/1
Comments: 1. Twelve sets of monthly data provided by the facility for the past nine months (April 2016 through December 2016) were reviewed. A data problem was identified during the onsite review. This was that the IRIS system required that each re-application of crisis intervention during a single physical restraint to be counted separately, thereby, inflating the numbers. This was problematic in terms of making valid longitudinal comparisons, for the facility and state to accurately monitor crisis intervention restraint usage, and for												

correct following of policy. The Monitoring Team requested and allowed for re-submission of these data, adjusted to be in line with the way crisis intervention frequency was being recorded over the past years.

The census-adjusted rate of crisis intervention restraint at Lubbock SSLC showed an ascending trend across the nine-month period, as well as when compared with the previous two nine-month periods, too. When compared with other SSLCs, Lubbock SSLC was about in the top/middle, being the fifth highest in the state. The frequency of crisis intervention physical restraint showed a similar pattern, not surprising given the majority of crisis intervention restraints were crisis intervention physical restraints. The average duration of a crisis intervention physical restraint was also ascending, though the average duration was the fourth lowest in the state at around three and a half minutes. The use of crisis intervention chemical restraint was low, and the use of crisis intervention mechanical restraint was zero.

The number of injuries that occurred during, or due to, restraint application was very low; there was only one instance and it was a non-serious injury. The number of individuals who had crisis intervention restraint each month ranged from six to 14, was not descending, and was about twice as many as at the time of the last review. The number of individuals with protective mechanical restraint for self-injurious behavior (PMR-SIB) remained low at one individual.

There were no occurrences of non-chemical restraints for medical or dental procedures. The facility's graph of chemical restraint for medical procedures showed zero, but the tier 1 document request showed 10, albeit in a decreasing trend. Similarly, the facility's graph of chemical restraint for dental procedures showed zero, but there the tier 1 document request showed 27 applications of TIVA.

Thus, facility data showed low/zero usage and/or decreases in seven of these 12 facility-wide measures (i.e., frequency of crisis intervention chemical and mechanical restraints, number of injuries during restraint, number of individuals with PMR-SIB, usage of non-chemical restraints for medical or dental procedures, and use of chemical restraint for medical procedures).

2. Five of the individuals reviewed by the Monitoring Team were subject to restraint. In addition, one individual who had PMR-SIB was also included, for a total of six. Of these, four received crisis intervention physical restraints (Individual #27, Individual #82, Individual #131, Individual #320), one received crisis intervention chemical restraint (Individual #322), and one received PMR-SIB (Individual #242). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for two of the six (Individual #27, Individual #82). It was good to see that the facility was now keeping data on the usage of PMR-SIB for Individual #242.

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.	
Summary: Overall, Lubbock SSLC managed crisis intervention restraint in a safe manner for this review and for the last two reviews, too. Therefore, five of the indicators in this outcome will be moved to the category of requiring less oversight (3, 4, 5, 6, 8). With sustained high performance, indicators 7 and 11 are likely to be moved to the category of requiring less oversight after the next review. Indicator 9	Individuals:

will require attention and documentation. These three indicators as well as indicator 10 will remain in active monitoring.											
#	Indicator	Overall Score	27	82	322	131	320	242			
3	There was no evidence of prone restraint used.	100% 8/8	2/2	1/1	1/1	2/2	1/1	1/1			
4	The restraint was a method approved in facility policy.	100% 8/8	2/2	1/1	1/1	2/2	1/1	1/1			
5	The individual posed an immediate and serious risk of harm to him/herself or others.	86% 6/7	2/2	1/1	1/1	1/2	1/1	N/A			
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 5/5	2/2	1/1	N/A	1/1	1/1	N/A			
7	There was no injury to the individual as a result of implementation of the restraint.	100% 8/8	2/2	1/1	1/1	2/2	1/1	1/1			
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 8/8	2/2	1/1	1/1	2/2	1/1	1/1			
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/4	Not rated	Not rated	0/1	0/1	0/1	0/1			
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	86% 6/7	2/2	1/1	0/1	2/2	1/1	N/A			
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	88% 7/8	2/2	0/1	1/1	2/2	1/1	1/1			

Comments:
The Monitoring Team chose to review eight restraint incidents that occurred for six different individuals (Individual #27, Individual #82, Individual #322, Individual #131, Individual #320, Individual #242). Of these, five were crisis intervention physical restraints, one was a crisis intervention chemical restraint, and one was for the use of PMR-SIB. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

5. For Individual #131 12/5/16, documentation said that he became physically aggressive, that is, not sufficiently indicating that there was an immediate and serious risk of harm.

9. Because criterion for indicator #2 was met for two of the individuals, this indicator was not scored for them. For the other four, criteria for this indicator were not met because of problems with assessments not including all target behaviors or direct observations (Individual #322, Individual #131, Individual #320) or lack of engagement throughout the day or in the daily planned schedule of activities (Individual #242).

10. For Individual #322 11/2/16, the required consultation prior to chemical restraint was dated after the restraint application.

11. Criteria were met for all individuals, except for Individual #82. In this case, a template option was not selected.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
Summary: Staff correctly answered questions about the usage of crisis intervention restraint. This indicator was scored at 100% for this review and the two previous reviews (with one exception in July 2015) and, therefore, this indicator will move to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	27	82	322	131	320	242			
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 5/5	Not rated	1/1	1/1	1/1	1/1	1/1			
Comments: 12. Because criteria for indicators 2-11 were met for Individual #27, this indicator was not scored for him.											

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.											
Summary: Performance improved to 100% for both indicators when compared with the two previous reviews. With sustained high performance, both indicators may move to the category of requiring less oversight after the next review. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	27	82	322	131	320	242			
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 7/7	2/2	1/1	1/1	2/2	1/1	N/A			
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1			
Comments:											

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

Summary: Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: monitoring individuals for potential side effects of chemical restraints and providing follow-up for abnormalities; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and ensuring documentation is accurate and consistent in the various places that restraint documentation is maintained. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 27	82	322	131	320	242			
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	38% 3/8	1/2	0/1	0/1	2/2	0/1	0/1			
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	63% 5/8	2/2	1/1	0/1	2/2	0/1	0/1			
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	38% 3/8	1/2	0/1	0/1	2/2	0/1	0/1			

Comments: The crisis intervention restraints reviewed included those for: Individual #27 on 10/13/16 at 5:12 p.m., and 11/23/16 at 5:14 p.m.; Individual #82 on 8/26/16 at 7:38 a.m.; Individual #322 on 11/2/16 at 3:24 p.m. (chemical); Individual #131 on 9/16/16 at 8:41 p.m., and 12/5/16 at 8:18 p.m.; Individual #320 on 12/6/16 at 5:20 p.m.; and Individual #242 for seven days of PMR for SIB from 12/3/16 to 12/9/16.

a. For four of the seven crisis intervention restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint. The exceptions were for Individual #82 on 8/26/16 at 7:38 a.m., Individual #322 on 11/2/16 at 3:24 p.m. (chemical), and Individual #320 on 12/6/16 at 5:20 p.m.

For four of the eight restraints, nursing staff monitored and documented vital signs. The exceptions were for:

- For Individual #320 on 12/6/16 at 5:20 p.m., the Center provided a note indicating the restraint time was actually at 4:20 p.m., which was not in alignment with any of the times of restraint in the document request. The flow sheet indicated that the nurse arrived at 4:29 p.m. However, the initial vital signs were documented at 4:20 p.m. The flow sheet indicated that vital signs were identical at 4:20 p.m., 4:23 p.m., 4:46 p.m., 4:47 p.m., and 4:50 p.m. The Monitoring Team was unable to interpret the data and documents provided.
- For Individual #242, no nursing IPN was provided for the use of the binder. The Monitoring Team could not interpret the documentation that the Center did provide.
- For Individual #322 on 11/2/16 at 3:24 p.m. (chemical), the Monitoring Team could not interpret the documentation provided. For example, it appeared that some information might have been cut off. The IPNs from the PCP included good information. However, although vitals signs were taken, the additional assessments that might have been completed (e.g., neurological

checks, gait assessment, orthostatic hypotension, sedation/level of consciousness) could not be adequately assessed, since many of the "comments" were not fully visible on the forms. Also, the documentation indicated that the individual's blood pressure went from 136/98 at 9:20 p.m. to 110/65 at 10:30 p.m. However, no additional vitals signs were taken after such a significant drop. In addition, the order was entered into IRIS on 1/4/17 (for the 11/2/16 restraint) without explanation.

- For Individual #82 on 8/26/16 at 7:38 a.m., it was unclear from the IPN when the nurse actually took the individual's vital signs. The Restraint Checklist noted vitals were taken at 7:33 a.m. and 7:38 a.m. However, the IPN indicated the individual refused assessment until 11:00 a.m. Moreover, the flow sheet indicated that the nurse arrived at 8:00 a.m.

Nursing staff documented and monitored mental status of the individuals for three of the eight restraints. On a positive note, for Individual #131 on 12/5/16 at 8:18 p.m., the nurse wrote a good IPN with a specific description of the individual's behavior and mental status. Examples of problems included:

- For Individual #322 on 11/2/16 at 3:24 p.m. (chemical), nursing IPNs did not include specific information regarding mental status after both chemical restraints were given [i.e., Ativan 2 mg intramuscular (IM) at 1 p.m. and Haldol 5mg IM at 3:24 p.m.].
- For Individual #82 on 8/26/16 at 7:38 a.m., nursing staff documented mental status as "no change from baseline," which did not provide necessary details.
- No mental status was found for the restraint of Individual #27 on 10/13/16 at 5:12 p.m.

b. As noted above, no documentation was provided or documentation could not be interpreted for three of the restraint episodes (i.e., for Individual #320, Individual #242, and Individual #322).

c. For the restraint of Individual #27 on 10/13/16 at 5:12 p.m., the Post Injury Report noted the individual scratched the right and left side of his face during SIB, but did not document the use of restraints.

As noted above, for Individual #322 on 11/2/16 at 3:24 p.m. (chemical), the documentation indicated that the individual's blood pressure went from 136/98 at 9:20 p.m. to 110/65 at 10:30 p.m. However, no additional vitals signs were taken after such a significant drop.

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

Summary: Performance showed steady improvement when looking at this review and the last two reviews. With sustained high performance, this indicator may move to the category of requiring less oversight after the next review. It will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	27	82	322	131	320	242			
15	Restraint was documented in compliance with Appendix A.	100% 8/8	2/2	1/1	1/1	2/2	1/1	1/1			

Comments:

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.												
Summary: Good improvement was noted as reflected in the 100% scores for both indicators. With sustained high performance, these indicators might move to the category of requiring less oversight after the next review. They will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	27	82	322	131	320	242				
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 5/5	Not rated	1/1	1/1	2/2	1/1	N/A				
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 5/5	Not rated	1/1	1/1	2/2	1/1	N/A				
Comments: 16-17. Because indicators 2-11 were scored positively for Individual #27, these two indicators were not scored for those restraints. Because the restraints for Individual #242 were PMR-SIB (i.e., not crisis intervention restraint), these indicators were not scored for her. The IMC restraint summary information was very good; it was well organized and worthy of consideration of replication at other facilities.												

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)												
Summary: Psychiatry involvement in crisis intervention chemical restraint met criteria for all three indicators for all individuals for this review and the last two reviews, too. Therefore, all three indicators will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	131	322								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 2/2	1/1	1/1								
48	Multiple medications were not used during chemical restraint.	100% 2/2	1/1	1/1								
49	Psychiatry follow-up occurred following chemical restraint.	100% 2/2	1/1	1/1								
Comments 47. Two individuals, Individual #131 and Individual #322 had received chemical restraint in the prior review period. For each of these individuals, the documentation had been reviewed independently by both the clinical pharmacist and the psychiatrist within 10 days												

post restraint.

48. Each episode of chemical restraint involved only one medication.

49. For each individual, the psychiatrist followed-up after the restraint and documented this with an integrated progress note.

Abuse, Neglect, and Incident Management

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

Summary: Criteria were met for all but two investigations, both of which were for an individual who had multiple medical and behavioral complexities. Aspects of the various sub-indicators were not met for both investigations, however, the Monitoring Team noted progress from the time of the first to the second investigation. Follow-up to ensure implementation and modification of supports is the area to focus upon. This indicator will remain in active monitoring. Also, please see the comments below regarding the chronic caller list.

Individuals:

#	Indicator	Overall Score	233	82	322	320	174	144	240		
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	78% 7/9	1/1	1/1	1/1	1/1	1/3	1/1	1/1		

Comments:

The Monitoring Team reviewed nine investigations that occurred for seven individuals. Of these nine investigations, six were DFPS investigations of abuse-neglect allegations (one confirmed, two unconfirmed, one inconclusive, one unfounded, one administrative referral). The other three were for facility investigations of discovered laceration injuries and an unauthorized departure. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #233, UIR 16-244, DFPS 44442564, administrative referral of alleged verbal abuse, 6/21/16
- Individual #82, UIR 16-238, DFPS 44424928, unconfirmed allegation of physical abuse, 6/13/16
- Individual #322, UIR 16-272, DFPS 44592011, unconfirmed allegation physical abuse, neglect, 8/1/16
- Individual #320, UIR 16-233, DFPS 44398263, inconclusive allegation of physical abuse, 6/8/16
- Individual #174, UIR 17-019, DFPS 44882924, unconfirmed allegation of neglect, 10/2/16
- Individual #174, UIR 17-025, DFPS 44882924, confirmed allegation of physical abuse, 10/11/16
- Individual #174, UIR 16-280, witnessed laceration, head, 8/14/16
- Individual #144, UIR 17-022, unauthorized departure, no date
- Individual #240, UIR 16-234, DFPS 44412884, unfounded allegation of physical abuse, 6/13/16

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

For all investigations, criminal background checks and duty to report forms were completed. In fact, for all but two of the investigations, all four of the above sub-indicators were met. For many of the investigations, there was no trend identified by the facility or by the Monitoring Team (i.e., no prior occurrences). Two investigations of serious injuries resulting from falls for Individual #174 (UIR 16-280, UIR 17-019) did not meet criteria for this indicator because the Monitoring Team was unable to confirm that the facility had a system for gathering accurate data to identify trends. Request for trend information regarding falls and serious injuries, both prior to the review and while onsite, yielded inconsistent data. The list of falls provided by the incident management department did not include three falls that had resulted in serious injury, as well as multiple other falls identified in other documents. Without an accurate data collection system in place, the facility was not able to effectively recognize and address trends and risk factors that might result in potential injuries for this individual. A thorough review of trends (sub-indicator b) had not occurred at the time of the first investigation in August 2016 (UIR 16-280) and although supports were put into place in November 2016 (UIR 17-019, sub-indicator c), all of the supports were not implemented, especially the supports recommended from the PNMT (sub-indicator d).

One individual was identified as a chronic caller for streamlined investigations (Individual #154). Based upon the Monitoring Team's review of his case, information provided by the facility and DFPS Investigator Supervisor, and the various Tier 1 documents and other facility-wide reports, the Monitoring Team does not question the decision for him to be placed on the chronic caller list. However, that being said, the facility needs to ensure that the specific policy/procedure requirements are documented, such as quarterly review of continued placement on this list.

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

Summary: Four investigations did not meet reporting criteria due to some documentation problems regarding law enforcement notification or time of reporting. Two investigations pointed to need for some additional training regarding to whom report needs to be made (e.g., facility director, too) as well as requirements for serious injury reporting. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	233	82	322	320	174	144	240		
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	56% 5/9	0/1	1/1	1/1	0/1	1/3	1/1	1/1		

Comments:

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

Those not meeting criterion are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them. A good incident management system needs to analyze whether or not reporting occurred within facility/state policy (and Settlement Agreement) requirements and document this analysis (and conclusions) in the body of the UIR.

- Individual #233 UIR 16-244: The UIR cover sheet showed that the incident occurred at 8:42 am, not between 8:42 and 8:47. The cover sheet needs to accurately display data. The DFPS report showed that it was reported to them at 9:09 am. It was reported to facility director at 9:45 am (just past the hour requirement). Likely, whoever reported it to DFPS did not also report it to facility director/designee. In its response to the draft report, the state noted that the reporter was not an employee of the SSLC and, therefore, had no obligation to report to the director within one hour. However, the UIR did not contain any hypothesis about the reporter, such as noting that it was perhaps a DADS regulatory staff or other person not an employee of the SSLC.
- Individual #320 UIR 16-233: This was an allegation of physical abuse. The DFPS report did not contain the customary entry for law enforcement notification, which is always to be the case with allegations of physical abuse. OIG (i.e., law enforcement) did investigate and did not substantiate, but without notation on the DFPS report, the Monitoring Team cannot validate the date and time of notification. This error in report preparation by DFPS was not detected in facility review.
- Individual #174 UIR 17-019: The injury incident occurred at 10:48 am, but was not reported to the facility director or designee (the IMC was the designee in this case) until 4:15 pm. Based on the presenting circumstances of the injury it should have been reported shortly after discovery.
- Individual #174 UIR 17-025: This incident was promptly reported to DFPS and the facility director as a result of video monitor detection. This was an excellent practice and good to see. Unfortunately, the DFPS report had no entry for law enforcement notification, which is always expected when there is an allegation of physical abuse, resulting in this investigation not meeting the criteria for this indicator. In its response to the draft of this report, the state noted that it would follow-up with field staff regarding this.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting.

Summary: Given the need for improvement in reporting, indicator 3 will remain in active monitoring. Ensuring posters are in all homes will increase the score for indicator 4. Both will remain in active monitoring. Performance on indicator 5 has been at 100% for this and the last two reviews. Therefore, this indicator will be moved to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	233	82	322	320	174	144	240		
3	Staff who regularly work with the individual are knowledgeable	100%	Not	Not	Not	Not	1/1	Not	Not		

	about ANE and incident reporting	1/1	rated	rated	rated	rated		rated	rated		
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	71% 5/7	1/1	0/1	0/1	1/1	1/1	1/1	1/1		
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1		

Comments:

3. Because indicator #1 was met for all but one of the individuals, this indicator was not scored for them. The indicator was scored for the other one individual. Staff were able to answer all of the Monitoring Team's questions. One staff member, however, said that unusual incidents should be reported to the habilitation therapies director.

4. The reporting poster was not present in one home where two of the individuals lived. All of the other criteria for this indicator were met.

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

Summary: This indicator will be moved to the category of requiring less oversight. It has been at 100% for this and for the previous two reviews.

#	Indicator	Overall Score	Individuals: 233	82	322	320	174	144	240		
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 9/9	1/1	1/1	1/1	1/1	3/3	1/1	1/1		

Comments:

6. For Individual #174 UIR 17-025, the UIR noted that the alleged perpetrator was re-assigned, however, the DFPS report listed three alleged perpetrators. While onsite, full documentation was provided showing re-assignment of all alleged perpetrators. In the future, reassignment must be correctly and fully noted in the UIR because it is the official investigation report.

For Individual #240 UIR 16-234, increased supervision rather than re-assignment of alleged perpetrators was done, which was reasonable given the nature of the allegations.

Outcome 5– Staff cooperate with investigations.

Summary: Staff cooperation was scored as meeting all criteria for all investigations for this review and for the last two reviews with one exception in July 2015. This indicator will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 233	82	322	320	174	144	240		

7	Facility staff cooperated with the investigation.	100% 9/9	1/1	1/1	1/1	1/1	3/3	1/1	1/1		
Comments:											

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
Summary: Lubbock SSLC investigations included all of the specific elements for this review and for the last two reviews, too, for 100% of the investigations reviewed. Therefore, indicator 8 will be moved to the category of requiring less oversight. Even so, some additional/deeper collection of evidence and subsequent analysis were required in some of the investigations. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	233	82	322	320	174	144	240		
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 9/9	1/1	1/1	1/1	1/1	3/3	1/1	1/1		
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	56% 5/9	1/1	1/1	0/1	0/1	1/3	1/1	1/1		
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	56% 5/9	1/1	1/1	0/1	0/1	1/3	1/1	1/1		

Comments:
8. Facility-only investigations were very thorough and well-written.

9-10. During the onsite week's preliminary review of some of the Monitoring Team's findings, these investigations and these indicators were discussed and some additional information was provided and discussed. Even so, four investigations did not meet criteria with these two indicators because some aspect of collection and analysis of evidence was not done. Examples were interviewing anyone who had a key to the mechanical room over the weekend (Individual #322 UIR 16-272), video review to perhaps determine possible peer-peer interaction (Individual #320 UIR 16-233), exploring whether PNMP was implemented (Individual #174 UIR 16-280), and pursuing whether anyone intentionally or unintentionally pushed the individual (Individual #174 UIR 17-019). For the latter, the state, in a response to the draft report, noted that there was no indication that the individual was pushed. However, there was no questioning of witnesses in the regard to this.

Outcome 7– Investigations are conducted and reviewed as required.	
Summary: Investigations were routinely commenced within 24 hours of the report for this review and the past two reviews, thus, this indicator (11) will be moved to	Individuals:

the category of requiring less oversight. All investigations were completed within 10 days, or with appropriate extensions, with one exception as well as with exceptions in the previous two reviews, too. Further, supervisory review did not identify some of the problems with some of the investigations. Indicators 12 and 13 will remain in active monitoring.											
#	Indicator	Overall Score	233	82	322	320	174	144	240		
11	Commenced within 24 hours of being reported.	100% 9/9	1/1	1/1	1/1	1/1	3/3	1/1	1/1		
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	89% 8/9	1/1	1/1	1/1	0/1	3/3	1/1	1/1		
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	44% 4/9	1/1	1/1	0/1	0/1	0/3	1/1	1/1		

Comments:

12. For Individual #320 UIR 16-233, the incident was reported on 6/8/16 and the investigation was completed on 6/28/16. The extension requests were reasonable, but the first attempt to contact staff was not until day 8 (6/16/16, per DFPS report) and the first actual staff interview was not until day 14 (6/22/16). In a response to the draft report, the state wrote that the investigation met all extension requirements and that an alleged perpetrator was not identified in the allegation, however, this was an allegation of physical abuse and no attempts to talk with any staff occurred until day 8.

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

The facility's assistant independent ombudsman also reviewed all investigation reports. This provided an additional level of protection for individuals.

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.	
Summary: Audits for significant injuries needing to be reported for investigation were done to criteria for all individuals for this review and for the last two reviews, too. Therefore, indicator 14 will be moved to the category of requiring less	Individuals:

oversight. Non-serious injury investigations showed improvement since the last two reviews. For two individuals, some discovered injuries should have been subject to this review. Indicator 15 will remain in active monitoring.											
#	Indicator	Overall Score	233	82	322	320	174	144	240		
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	1/1		
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	71% 5/7	0/1	1/1	1/1	1/1	0/1	1/1	1/1		
Comments: 15. Discovered injuries for Individual #233 (e.g., 8/19/16 swelling to right eyebrow, 10/7/16 laceration to right eyebrow) and for Individual #174 (e.g., 7/17/16 injury to middle back) should have been subjected to the non-serious injury investigation process.											

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
Summary: Lubbock SSLC met all criteria for all three indicators for this review and for the past two reviews, too. All three will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	233	82	322	320	174	144	240		
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 9/9	1/1	1/1	1/1	1/1	3/3	1/1	1/1		
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 7/7	1/1	N/A	1/1	1/1	2/2	1/1	1/1		
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 9/9	1/1	1/1	1/1	1/1	3/3	1/1	1/1		
Comments: 17. Lubbock SSLC did a good job of developing relevant recommendations during review of investigation reports and had very good documentation and tracking of implementation and completion. Over this review period, there were five investigations that included a confirmation of physical abuse category 2. In only one of these cases was an employee's employment maintained (UIR 16-259). In addition to disciplinary action, root cause discussions were conducted, additional staff training was provided, and the individual's PBSP was updated. All of this was good to see. The decision to maintain employment was reviewed by facility director, ADOP, IMC, QA director, director of residential services, unit director, and											

facility investigator.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.												
Summary: This outcome consists of facility indicators. Progress and improvement had occurred since the last review. With sustained high performance, these indicators might move to the category of requiring less oversight after the next review.			Individuals:									
#	Indicator	Overall Score										
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes										
20	Over the past two quarters, the facility's trend analyses contained the required content.	Yes										
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	Yes										
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	Yes										
23	Action plans were appropriately developed, implemented, and tracked to completion.	Yes										

Comments:

19-21. The facility continued to have a very good system for tracking and trending a variety of aspects of abuse, neglect, allegations, incidents, injuries, investigations, and so forth. This was primarily a result of the activities of the Executive Safety Committee and documented in the monthly Executive Safety Committee report. For example, the group took action (through various CAPs and root cause analyses) to try to identify and address factors that contributed to the high number of serious injuries and peer-to-peer aggressions.

22-23. The facility (and the Executive Safety Committee) implemented a corrective action plan process. This was evident from the Monitoring Team's review of QAQI Council meeting minutes. The facility had responded to the Monitoring Team's comments in the last report.

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	N/A	0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. As discussed in the last report, the Center's policies with regard to criteria for the use of TIVA, as well as medical clearance for TIVA need to be expanded and improved. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures. Given the risks involved with TIVA, it is essential that such policies be developed and implemented.

For these two instances of the use of TIVA, informed consent for the TIVA was present, nothing-by-mouth status was confirmed for one but not the other (i.e., Individual #235), and an operative note defined procedures and assessment completed. However, post-operative vital sign flow sheets were submitted, but they showed discrepancies between the nurses' monitoring and the requirements of the policy (i.e., the nurses did not document vital signs at the frequency the policy requires).

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

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to assess this indicator.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: Informed consent was not provided for the pre-treatment medical sedation of Individual #174 on 11/28/16.

Outcome 1 - Individuals' need for pretreatment chemical restraint (PTCR) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTCR.	
Summary: It was good to see that PTCR was addressed for most individuals when needed and that the IDTs determined if action plans were, or were not, needed.	Individuals:

Though in the one case where actions were called for, they were not developed. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	233	320	174	197					
1	IDT identifies the need for PTCR and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	75% 3/4	1/1	1/1	0/1	1/1					
2	If PTCR was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTCR, or (b) determined that any actions to reduce the use of PTCR would be counter-therapeutic for the individual.	100% 4/4	1/1	1/1	1/1	1/1					
3	If treatments or strategies were developed to minimize or eliminate the need for PTCR, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTCR, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	0% 0/1	N/A	0/1	N/A	N/A					
4	Action plans were implemented.	0% 0/1	N/A	0/1	N/A	N/A					
5	If implemented, progress was monitored.	0% 0/1	N/A	0/1	N/A	N/A					
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/1	N/A	0/1	N/A	N/A					
Comments: 1-5. There was evidence that four individuals (Individual #233, Individual #320, Individual #174, Individual #197) had had PTCR during the six-month period prior to the onsite visit. With the exception of Individual #320, these were procedures that were not routine exams or procedures. Individual #233 and Individual #197 had colonoscopies, and Individual #174 required an ultrasound of his knee. Individual #197 also required extraction of teeth. Although action plans were recommended by the dental department for Individual #320, documentation did not provide evidence that these action plans had been implemented.											

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	90	127	102						

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% 3/3	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% 0/3	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% 0/3	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% 0/3	0/1	0/1	0/1						
e.	Recommendations are followed through to closure.	0% 0/3	0/1	0/1	0/1						

Comments: a. Since the last review, four individuals died. The Monitoring Team reviewed three of the four deaths. At the time of the Monitoring Team's review, the Center's review and follow-up activities for Individual #76 were not complete. Causes of death were listed as:

- On 7/21/16, Individual #90 at the age of 56 of ischemic heart disease, ST-Elevation Myocardial Infarction, and cardiogenic shock;
- On 8/24/16, Individual #127 at the age of 65 of cholangiocarcinoma;
- On 9/27/16, Individual #102 at the age of 45 of aspiration complicating seizure disorder; and
- On 1/10/17, Individual #76 at the age of 55 of pneumonia, ileus, congestive heart failure, and encephalopathy. Two different dates were provided for the Clinical Review, so timeliness could not be determined.

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

e. The recommendations generally were not written in a way that ensured that Center practice had improved. For example, a recommendation that read: "the Nursing Department will in-service RNCMs and Nursing Staff regarding hospice care, including the importance of pain assessment and management for individuals on hospice" resulted in an in-service training. This in no way ensured that concerning practices changed. The recommendation should have been written in a manner that required monitoring to determine whether or not nursing staff were assessing individuals on hospice for pain, and providing pain management, as needed.

The Center did not submit documentation to show that the recommendation for Individual #102 was implemented. The

recommendation read: "reinforce monitoring for intake and diet consistency when individuals are off campus and apply PNMT supports regarding intake and food restrictions/preparation."

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	ADRs are reported immediately.	N/A									
b.	Clinical follow-up action is completed, as necessary, with the individual.	N/A									
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A									
d.	Reportable ADRs are sent to MedWatch.	N/A									
Comments: a. through d. Center staff had not identified and/or reported adverse drug reactions for any of the individuals reviewed.											

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
Summary: Given that during the last two review periods and during this review, the Center completed clinically significant DUEs (Round 9 – 100%, Round 10 – 100%, and Round 11 – 100%), Indicator a will move to the category of requiring less oversight. Indicator b will remain in active monitoring.		Individuals:
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 3/3
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	N/A
Comments: a. and b. In the six months prior to the review, Lubbock SSLC completed three DUEs, including: • A DUE on Olanzapine that was presented to the Pharmacy and Therapeutics (P&T) Committee on 7/28/16, for which no follow-up was needed; • A DUE on Metaforin that was presented to the P&T Committee on 10/31/16, for which no follow-up was needed; and • A DUE completed in January 2017 on Benztropine that had not yet been presented to the P&T Committee, but recommended no follow-up action.		

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Thirteen of these, in psychiatry, psychology/behavioral health, medical, and skill acquisition and engagement, had sustained high performance scores and will be moved the category of requiring less oversight. This included the entirety of Outcome 6 for psychiatry.

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

Assessments

The IDTs considered what assessments the individuals needed, however, they did not always arrange for and obtain these needed, relevant assessments prior to the IDT meeting.

Psychiatry CPEs and annual updates were done completely and, as a result, five of the related indicators will move to the category of requiring less oversight. Behavioral and functional assessments and PBSPs were current, but these assessments and plans were missing some important components.

For the most part, skill-related assessments were current and were made available to the IDTs, but most did not include specific recommendations for skills that the individual might be taught to improve his or her quality of life and/or independence.

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

On a positive note, for this review and the previous two reviews, Medical Department staff completed the medical assessments in a timely manner. As a result, the related indicator will be placed in the category requiring less oversight.

Although additional work was needed, the Center made progress with regard to the quality of medical assessments. Three of the nine individuals had quality annual medical assessments that included the necessary components and addressed individuals'

needs. Moving forward, the Medical Department should focus on ensuring medical assessments include plans of care for each active medical problem, when appropriate.

For seven of the nine individuals reviewed, successful/completed annual dental exams did not occur in a timely manner. In some cases, individuals had not had exams and/or treatment since 2014. On a positive note, though, the new Dental Director was taking steps aimed at improving the rate of timely annual dental exams and the completion of needed restorative work. The quality of annual dental exams as well as summaries also requires continued attention.

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.

Some improvement was seen with regard to the timeliness of referrals to the PNMT. The Center should focus on sustaining its progress in this area, as well as improving referral of all individuals that meet criteria for PNMT review and timely completion of the PNMT initial review, completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT comprehensive assessments.

The Center should continue its efforts to ensure individuals receive timely OT/PT annual assessments and/or consults when individuals experience changes in status. The quality of OT/PT assessments needs improvement. It was positive that IDTs of individuals reviewed updated PNMPs/Positioning Schedules at least annually, or as the individual's needs dictated.

Individualized Support Plans

The development of individualized, meaningful personal goals was not yet at criteria, but much progress was evident. All six ISPs, for instance, included at least two goals that met criteria. Overall, about half of the six ISP goal areas had goals that met criteria. Now, Lubbock SSLC needs to make sure these goals are written in measurable terms, are implemented, and are regularly reviewed.

Another focus area for the facility (and its QIDP department) is to ensure the actions plans meet the various 11 indicators in outcome 3, which is regarding the full set of action plans. A lot of detail is provided below regarding these 11 indicators.

ISPs were revised annually, but not implemented in a timely manner, and some aspects were not implemented at all. IDTs did not meet often enough to review progress or revise supports and services when needed. Reliable and valid data were often not

available and little progress was made towards achieving personal goals.

The psychiatry department demonstrated very good progress in developing goals related to the individual's psychiatric status. For six individuals, the annual PTP identified specific observable psychiatric indicators that were linked to the psychiatric diagnosis. To fully meet criteria, the goals also need to have a criterion for success and appear in the IHCP. In addition, there needs to be one or more goals for the positive behaviors that indicate improvement in the individual's psychiatric status.

PBSPs included measurable goals, but many were not related to assessments, and all had problems with the reliability of the data that were being collected throughout the facility for PBSPs.

All individuals had skill acquisition programs and most were written in measurable terms. But, even so, most were not meaningful for the individual and none had good reliable data regarding the individual's performance.

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.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: The development of individualized, meaningful personal goals in six different areas, based on the individual's preferences, strengths, and needs was not yet at criteria, but much progress was evident as described below. All six ISPs, for instance, included at least two goals that met criteria, and two ISPs had four goals that met criteria. Overall, about half of the six ISP goal areas (19) had goals that met criteria. This was very good progress since the last review. About half of these goals, however, were not written in measurable terms, and only three were implemented sufficiently, correctly, and with adequately collected data to determine progress. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	197	174	27	320	182	188			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	3/6	3/6	4/6	2/6	3/6	4/6			
2	The personal goals are measurable.	0% 0/6	0/6	2/6	3/6	0/6	2/6	4/6			

3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	1/6	1/6	0/6	1/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #197, Individual #174, Individual #27 Individual #320, Individual #182, and Individual #188. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Lubbock SSLC campus.

1. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and also need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology. None of the six individuals had individualized goals in all six areas, therefore, none had a comprehensive set of goals that met criterion.

That being said, there was much improvement in the individualization of personal goals. For these six individuals, the IDT had defined some personal goals that met criterion for being individualized based on the individual's preferences and strengths. Overall, 19 of 36 personal goals met criterion for this indicator. These included:

- Individual #197's goals for leisure/recreation, employment, and living options.
- Individual #174's goals for leisure/recreation, relationships, and independence
- Individual #27's goal for leisure/recreation, employment, independence and living options
- Individual #320's goal for leisure/recreation and relationships.
- Individual #182's goals for leisure/recreation, relationships and independence.
- Individual #188's goals for leisure/recreation, relationships, employment, and living options.

Although IDTs had established the above goals that were more individualized (and based on known preferences), few had been fully implemented, and many were discontinued. Thus, individuals did not have person-centered ISPs that were really leading them towards achieving their personal goals. The facility needs to focus on barriers that are preventing individuals from achieving their goals and develop plans to address those barriers.

Examples of goals that did not meet criterion because they were not aspirational, individualized, and/or based on preferences included:

- Individual #174's living option goal to live at Lubbock SSLC was not aspirational or clear based on his preferences.
- Individual #320's relationship goal to establish a relationship with someone in the community was not individualized or based on his preferences.
- Individual #182's employment goal to increase his work attendance by 15% was not individualized or based on an adequate preference assessment.
- Individual #188's greater independence goal to lose two pounds per month did not have a clear link for supporting her to become more independent.

- It was not clear how Individual #197's greater independence goal to identify her medications was determined to be a priority for her. Her relationship goal was related to using her phone. Her FSA indicated that she could independently use her phone. It was not clear what new skills she would gain from this goal.

2. When personal goals for the ISPs did not meet the criterion described above in indicator 1, there can be no basis for assessing compliance with measurability or the individual's progress towards its achievement. The presence of a personal goal that meets criterion is a prerequisite to this process. Eleven of the 19 personal goals that met criterion for indicator 1 also met criterion for measurability. This was also good progress. Those that were measurable were:

- Individual #174's relationship and independence goals.
- Individual #27's leisure/recreation, independence, and living option goals.
- Individual #182's living and independence goals.
- Individual #188's leisure/recreation, relationship, independence, and living option goals.

Examples of goals that were not measurable included:

- Individual #197's goal to choose an event off campus to attend did not clearly indicate what she would have to do to accomplish this goal.
- Individual #320's living option goal to gain more knowledge of living options was not individualized or specific enough that progress could be measured.

3. For the 11 goals that were determined to be measurable, only three had reliable and valid data available to determine if the individual met, or was making progress towards achieving, his/her overall personal goals. As noted throughout this report, it was not possible to determine if ISP supports and services were being consistently implemented or determine the status of goals due to the lack of data and documentation provided by the facility. It appeared that few goals were consistently implemented and were often discontinued without the IDT establishing replacement goals. The three that did have reliable data to determine status of the goal were Individual #174 and Individual #182's independence goals and Individual #27's living option goal.

The QIDP Coordinator reported that QIDPs and other team members would soon be participating in additional training offered by the state office on ISP development. The training will be focused on SAP development and implementation. Hopefully, this will assist the IDTs in developing more functional goals that will support individuals to learn new skills based on their preferences.

The Monitoring Team observed Individual #197's annual ISP meeting during the onsite week. Overall, the IDT did a nice job of developing a vision statement and goals for Individual #197 based on her input at the meeting. Team members still struggled with developing functional action plans to support her vision and goals. For example, Individual #197 expressed the desire to learn to cook. There was a lengthy discussion regarding math skills that she would need to learn prior to cooking a meal. Suggested action plans were not functional for learning cooking skills and were not likely to lead towards accomplishment of her goal.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: When considering the full set of ISP action plans, the various criteria included in the set of indicators in this outcome were not met. That being said, four of the 11 indicators showed some improvement since the last review. A focus area for the facility (and its QIDP department) is to ensure the actions plans meet these various 11 items. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	197	174	27	320	182	188			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	1/6	2/6	0/6	1/6	2/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	33% 2/6	1/1	0/1	1/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	33% 2/6	0/1	0/1	1/1	0/1	0/1	1/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	67% 4/6	1/1	1/1	1/1	1/1	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.	50% 3/6	1/1	0/1	1/1	0/1	0/1	1/1			
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	1/6	1/6	2/6	0/6	4/6	1/6			
8. Many personal goals did not meet criterion in the ISPs, as described above in indicator 1, therefore, action plans could not be											

evaluated in this context. A personal goal that meets criterion is a prerequisite for such an evaluation. Action plans are evaluated further below in terms of how they may address other requirements of the ISP process.

For the 19 personal goals that met criterion under indicator 1, six had action plans that were likely to lead to the accomplishment of the goal. These were:

- Individual #174's action plans to support his independence goal.
- Individual #27's action plans to support his leisure/recreation and living option goals.
- Individual #182's action plans to support his independence goals.
- Individual #188's leisure/recreation and living option goals.

9. Preferences and opportunities for choice were not routinely integrated in the individuals' ISP action plans. Action plans did not provide individual's opportunities to make choices and have some control over their day. There were, however, two positive exceptions:

- Individual #197's ISP indicated that she participated in activities of her choice frequently during the day. Interviews with Individual #197 confirmed that she was able to choose her activities and schedule throughout the day.
- Individual #27's ISP also supported his preferences and provided opportunities to make choices.

10. ISP action plans did not comprehensively addressed identified strengths, needs, and barriers related to informed decision-making. No action plans were identified that clearly supported decision-making skills.

11. Individuals did not have action plans to support greater independence. Greater independence goals were rarely based on an adequate assessment process

- Individual #174's action plans were primarily focused on compliance and offered little opportunity to learn new skills.
- Individual #27 had action plans for cooking to increase his greater independence. While this was positive, the IDT should have considered additional skills that would support him to have greater independence in the community since he had been referred to move into the community.
- Individual #182's ISP included a SAP for bathing which was a skill identified for training in his FSA. He did not have other action plans that would support his greater independence or opportunities for greater control over his day.
- Individual #188's FSA identified areas of need to gain greater independence included tying his shoes, shaving, and math skills. These were not addressed in her ISP.
- Individual #320 had SAPs for signing, writing his name, and caring for his hearing aid. His FSA indicated that these were skills that he could already perform independently.
- Individual #197 had action plans for using the telephone and money management. Her FSA indicated that she was independent in using the phone and had good money management skills.

12. IDTs did not fully integrate strategies to minimize risks in ISP action plans. Further discussion regarding the quality of strategies to reduce risks can be found throughout this report. In most cases, IDTs did not have updated assessments and data available for review prior to the ISP meeting to adequately determine risk ratings. Examples where strategies were not integrated in the ISP included:

- Individual #182's ISP was not revised when he had a change in health status. Much of his supports and programming had been

discontinued without revision to support his current risks. On a positive note, when this was identified by the Monitoring Team while onsite, the IDT met to implement new programming.

- Individual #188's ISP did not address all identified health risk, including a diagnosis of MS and the need for a cervical cancer screening. It was not clear that her risk for falls had been adequately addressed. She had recommendations for the use of a leg brace and walker, which she reportedly refused to use. Alternate strategies to reduce her risk for falls, were not documented in her ISP.
- Individual #320 had a PBSP in place to address behavioral risk, however, his ISP noted that he had been the victim of peer-to-peer aggression in 53 incidents over the past year. The IDT did not develop a plan to protect him from aggression from his peers.
- Individual #27's supports to address his weight and aggression were not integrated into action plans to support his move into the community.
- Many supports had been put into place to address Individual #174's risk for falls, however, his IDT had not developed a well-integrated comprehensive plan to address the many factors that might be contributing to his falls, including behavior, psychotropic medications, and medical issues.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated in ISPs. In particular, psychiatry and medical supports were rarely integrated into support plans developed by other disciplines. In addition to the examples provided in indicators 11 and 12 above:

- It was not evident that Individual #197 had adequate psychiatry input into her ISP. Her psychiatrist did not attend her ISP meeting and her assessment was not submitted in time for IDT review prior to the annual ISP meeting.
- As noted above for Individual #174, it did not appear that the team had taken an integrated approach to developing supports to prevent falls.
- For Individual #320, his LAR had requested that he not leave the home at all due to medical concerns. His team met while the Monitoring Team was onsite to develop a new active treatment plan on the home. The discussion did not include integrated program revisions that would support his medical, therapy, and behavioral needs.
- Individual #188's diet and mobility supports were not well integrated into other ISP goals and action plans.

14. Meaningful and substantial community integration was largely absent from the ISPs. There were few specific plans for community participation that would have promoted any meaningful integration for individuals. The exceptions were Individual #27 and Individual #188's action plans. Individual #27 had action plans to work and live in the community and Individual #188 had action plans to go to a rock concert in the community, pursue supported employment, and live in the community.

15. Four of six ISPs considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. This was good to see. Individual #182 was attending day programming on his home with no individualized schedule for active treatment or work opportunities. Individual #188 had expressed an interest in supported employment, however, action plans were not developed to pursue employment in the community.

16. Three of six ISPs had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. ISPs and observations did not support that Individual #174,

Individual #320, or Individual #182 had opportunities to spend a majority of their day engaged in functional or meaningful activities. When individuals did not attend day programming consistently, IDTs were not addressing barriers to attendance or considering other options for day programming based on the individual's preferences.

The facility offered a range of activities and programming for meaningful engagement, including cooking, computer, and arts and craft classes. More attention needs to be paid to individuals participating in these offerings as well as an additional focus on opportunities for skill building in the community.

17. Barriers to various outcomes were not consistently identified and addressed in ISPs. None of the ISPs had been consistently implemented. IDTs did not meet to address barriers to implementation. Often goals were continued from previous ISPs without addressing barriers to earlier implementation.

18. Some action plans described detail about data collection review, however, overall, ISPs did not consistently include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action plans were broadly stated and, as noted above, in many cases, skill acquisition plans were never developed to ensure consistent training would occur. Living options action plans generally had no measurable outcomes related to awareness.

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

Summary: Criterion was met for some indicators for some individuals, and the scores for five indicators improved from the time of the last review, but overall, more work was needed to ensure that all of the activities occurred related to supporting most integrated setting practices within the ISP. Primary areas of focus are reconciliation of team member recommendations for referral, and the conduct of a thorough living options discussion. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	197	174	27	320	182	188			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	67% 4/6	1/1	0/1	1/1	1/1	0/1	1/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	50% 3/6	1/1	0/1	1/1	0/1	1/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	67% 4/6	0/1	1/1	1/1	0/1	1/1	1/1			

23	The determination was based on a thorough examination of living options.	50% 3/6	0/1	0/1	1/1	0/1	1/1	1/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	80% 4/5	0/1	1/1	N/A	1/1	1/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	50% 3/6	0/1	0/1	1/1	0/1	1/1	1/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	50% 2/4	N/A	0/1	1/1	0/1	1/1	N/A			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	50% 1/2	0/1	N/A	1/1	N/A	N/A	N/A			

Comments:

19. Four of six ISPs included a description of the individual's preference and how that was determined. The exceptions were;
    - Individual #174's ISP noted that he did not understand his living options. His known preferences in relation to his living options were not included in his ISP.
    - Individual #182's ISP noted that his preferences were unknown.

20. Individual #197's annual ISP meeting was observed. She stated her preference was to live in the community. She had lived in the community and toured living options, so was familiar with her options.

21. Three of the ISPs met criterion for this indicator. Those that did not were:
    - All but two members of the IDT independently indicated Individual #320 could be served in the community and recommended transition. As a team, they concluded he could not be served in the community and did not recommend referral. It was not clear how the team reconciled various opinions offered by each discipline.
    - Recommendations from Individual #174's OT/PT, communication, psychiatry, vocational, and dental assessments were not summarized in the ISP.
    - Recommendations from Individual #188's behavioral, psychiatry, and dental assessments were not summarized in her ISP.

22. Four of six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR. The two that did not were:
    - Individual #197's consensus statement to not refer her for community placement did not include a clear justification. All team

members agreed that she could be referred and Individual #197 wanted to move into the community.

- Individual #320's living option consensus statement indicated that he while gaining exposure to the community. Previous statements in the ISP noted that behavior was a barrier to moving into the community.

23. Three of the individuals (Individual #27, Individual #182, Individual #188) had a thorough examination of living options based upon their preferences, needs, and strengths. For other individuals that were either unable to express their preferences or were unaware of their living options, it was not clear that IDTs considered other options that might support their individualized needs.

24. Four of five ISPs identified a thorough and comprehensive list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed.

- Individual #197's ISP identified individual choice as a barrier to referral, however, she stated that her preference was to live in the community.

25. At Individual #197's annual ISP meeting observed, her behavior was identified as a barrier to referral by her psychiatrist and LIDDA, however, the IDT did not identify specific behaviors that could not be supported in the community or clearly define when the team would reconsider referring her to the community. Individual #197 told the IDT that she was ready to move into the community. Her LAR and a majority of her team members agreed that she could be supported in the community. It was evident that Individual #197 was upset with the IDT's final decision not to refer her to the community.

26. Three of the six individuals had individualized, measurable action plans to address obstacles to referral or transition, if referred. Individual #197, Individual #174, and Individual #320 did not have measureable action plans to address barriers to referral.

27. Specific plans to address obstacles to referral were not developed at Individual #197's ISP meeting observed by the Monitoring Team. Team members used descriptors such as "better behavior" and "full compliance" in describing what Individual #197 would need to do to be referred. The IDT needs to develop specific criteria that Individual #197 must meet in order to move into the community.

28. Two of four ISPs (Individual #27, Individual #182) included specific action plans to educate individuals on living options. Individual #197 and Individual #188 had lived in the community and were familiar with living options.

29. Individual #27 had been referred to the community. His ISP included specific action plans to move forward with the referral.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.												
Summary: ISPs were revised annually, but not implemented in a timely manner, and some aspects were not implemented at all. Not all IDT members participated in the important annual meeting. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	197	174	27	320	182	188				
30	The ISP was revised at least annually.	100%	1/1	1/1	1/1	1/1	1/1	N/A				

		5/5									
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	83% 5/6	1/1	1/1	1/1	1/1	0/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
30-31. ISPs were developed on a timely basis.

32. Documentation was not submitted that would support that all action plans were implemented on a timely basis. The facility reported that the implementation of IRIS resulted in a gap in reporting data, however, consistent data were not available for individuals from July 2016 through November 2016. Examples in which timeliness criteria were not documented included:

- For Individual #197, the Monitoring Team was not able to confirm implementation of the ISP within 30 days due to the lack of data. It appears that her living option and vocational goals were never fully implemented and not revised.
- Individual #27's recreation and independence outcomes were not implemented for five months, then revised another five months after development.
- Per Individual #320's July 2016 QIDP monthly review, his recreation and work goals were not implemented within 30 days of development. Three out of four of his action plans to support his independence goal were never implemented and two out of four of his action plans to support his living option goal were never implemented.
- Per Individual #182's QIDP monthly reviews, his recreation and living option goals have not been consistently implemented.
- Per Individual #188's QIDP monthly reviews, action plans were not all implemented within 30 days.

33. Five of six individuals participated in their ISP meetings. Individual #182 did not attend his annual ISP meeting. His ISP noted that his home was quarantined due to illness.

34. None of the individuals had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. Only two individuals had consistent, timely QIDP monthly reviews to indicate that services and supports were routinely monitored and reviewed. Overall, there was a lack of participation in the planning process by relevant disciplines:

- For Individual #197, no participation by psychiatry or dental staff.
- For Individual #174, no participation by his SLP. The IDT determined that attendance at the annual ISP meeting was not necessary, although Monitoring Team observation indicated that communication supports should have been an integral part of

his daily supports.

- For Individual #320, no participation by his SLP or PCP.
- For Individual #182, no participation by his SLP and no integration of his communication needs.

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

Summary: Criteria were met for both indicators for two individuals. Overall, however, more attention needed to be paid to these important assessment-related indicators. Both will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 197	174	27	320	182	188			
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.	80% 4/5	1/1	1/1	1/1	1/1	0/1	N/A			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	33% 2/6	0/1	0/1	1/1	1/1	0/1	0/1			

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting, for four of five individuals (Individual #188 was a new admission).

- For Individual #182, the IDT did not identify the need for a positioning and alignment assessment or augmentative communication assessment.

36. IDTs did not always arrange for and obtained needed, relevant assessments prior to the IDT meeting. Without relevant assessments available to IDTs prior to the annual ISP meeting, it was unlikely that all needed supports and services were included in the ISP. Assessments that were either not submitted or submitted late included:

- For Individual #182, his last comprehensive dental assessment was in 2014. His habilitation therapy assessment did not address positioning and alignment and his communication assessment did not include adequate recommendations to guide the IDT in developing supports.
- For Individual #197, her psychiatric assessment was not submitted 10 days prior to her annual ISP meeting,
- Individual #174 did not have a comprehensive communication assessment.
- For Individual #188, her annual dental exam was not completed. Her vocational assessment and functional skills assessment was completed after her annual ISP meeting. Her QDRR was not up to date and she did not have an order for a cervical cancer screen.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
Summary: Progress was not adequately being reviewed by QIDPs and IDTs. Consequently, actions were not developed or taken. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	197	174	27	320	182	188			
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.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			

Comments:

37. IDTs did not meet often enough to review progress or revise supports and services as needed. Reliable and valid data were often not available to guide decision-making, in any event. As noted throughout this report, little progress was made towards achieving personal goals.

For all individuals, the IDTs did not meet to discuss lack of progress and address barriers or revise supports. When additional assessments were completed during the ISP year, there was rarely documentation that the team met to discuss recommendations from the assessment or assess the efficacy of revised supports. For example,

- Individual #197's team did not meet and document changes in supports and service to address falls or effectiveness of supports implemented to address falls. According to the QIDP monthly reviews, data were not recorded for implementation of her vocational goal from July 2016 through September 2016. The IDT did not take action to address the lack of implementation. Records indicated that Individual #197 was experiencing pain due to dental issues from March 2016 through October 2016. The IDT did not document supports for pain management until November 2016.
- Individual #174's IDT did not consistently gather data and document review of supports to address his high number of falls.
- Individual #27's IDT did not document meetings when he transitioned to the community to ensure supports were in place prior to his move. Monthly reviews indicated that SAPs were not available between July 2016 and November 2016. His cooking goal was not implemented between July 2016 and November 2016. The IDT did not address this lack of implementation.
- Individual #182's team did not discuss his weight gain over the past year. Only one of three falls was reported and reviewed by habilitation therapy. Implementation of a majority of Individual #182's goals was put on hold due to a change in medical status. The IDT did not meet to revise his goals.
- Individual #188's record indicated that the team met and made plans for her to transition to San Angelo SSLC on 1/11/17. She did not transition on that date and the team did not document discussion regarding barriers to the move.

QIDPs recently began using the IRIS system to populate monthly reviews of services. There was still quite a bit of inconsistency in how this information was being used. The QIDPs will need to be sure that they are gathering data for the month, summarizing progress, and revising the ISP as needed.

Outcome 1 – Individuals at-risk conditions are properly identified.											
Summary: In order to assign accurate risk ratings, IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings within no more than five days. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	The individual's risk rating is accurate.	12% 2/17	0/2	0/2	1/2	0/2	0/1	1/2	0/2	0/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	18% 3/17	0/2	0/2	0/2	0/2	0/1	1/2	0/2	1/2	1/2
Comments: For nine individuals, the Monitoring Team reviewed a total of 17 IRRFs addressing specific risk areas [i.e., Individual #174 – falls, and dental; Individual #197 – fractures, and weight; Individual #6 – dental, and gastrointestinal (GI) problems; Individual #182 – falls, and weight; Individual #8 – dental, and skin integrity (at the time the annual ISP meeting, skin integrity was not an issue for Individual #8); Individual #235 – dental, and skin integrity; Individual #102 – falls, and constipation/bowel obstruction; Individual #186 – other: hypothyroidism, and urinary tract infections (UTIs); and Individual #188 – falls, and constipation/bowel obstruction]. a. The IDTs that effectively used supporting clinical data, used the risk guidelines when determining a risk level, and as appropriate, provided clinical justification for exceptions to the guidelines were those for Individual #6 – dental, and Individual #235 – skin integrity. b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs completed IRRFs for individuals within 30 days of admission and updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #235 – skin integrity, Individual #186 – other: hypothyroidism, and Individual #188 – constipation/bowel obstruction.										

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.	
Summary: This outcome requires attention be paid to psychiatric indicators regarding problematic symptoms of the psychiatric disorder, as well as psychiatric indicators regarding positive pro-social behaviors. Lubbock SSLC made progress in the former, but not yet the latter. This, however, was very encouraging and although these three indicators (4, 5, 6) will remain in active monitoring, it is likely	Individuals:

that good progress can be shown for the next review, especially in setting criteria for determining if the goal has been met. Of course, without good data on psychiatric indicators (indicator 7, which will also remain in active monitoring), progress cannot be determined and the good work of the psychiatry department in developing goals does not benefit the individual as much as it could.											
#	Indicator	Overall Score	27	233	82	322	131	320	174	236	197
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

4. The psychiatry department demonstrated very good progress in developing goals related to the individual's psychiatric status. Specifically, for six individuals (Individual #27, Individual #82, Individual #233, Individual #322, Individual #320, Individual #197), the annual PTP identified specific observable psychiatric indicators that were linked to the psychiatric diagnosis. This was very good to see and demonstrated the efforts of the psychiatry department. To fully meet the requirements of this monitoring indicator, however, the goals need to also specify the expected/desired criterion, such as "three or less occurrences over each quarter for the year that ends 12/31/16." One option might be to state the specific criterion for success in the "goal" box in the line of the psychiatry grid rather than only stating increase or decrease.

That being said, for Individual #233 and Individual #320, the requirements of this indicator were met for problem aspects of their psychiatric status in a goal(s) that was in the IHCP. That is, whoever developed the IHCP took the psychiatrist's suggested goals from the PTP and added some wording about criterion for success. The IHCP goal, however, did not appear again in any subsequent quarterly psychiatry clinic reports.

Also to meet the requirements of this indicator, there needs to be one or more goals for the positive behaviors that would indicate improvement in the individual's psychiatric status (it would not be productive to monitor only psychiatric indicators that measured the reduction of symptoms because, for example, this could be achieved with sedation). Thus, it will be important to also develop positive prosocial behaviors that can be directly linked to the core symptoms of the psychiatric disorder to demonstrate positive growth.

5. The goals for these individuals related to the reduction of negative behaviors were measurable (even though criterion for success was not specified). This was very good to see, but as noted above, corresponding measurable positive replacement behavior goals are also required to meet criterion for this indicator.

6. The negative monitored behaviors for these six individuals were derived from the psychiatric diagnostic assessment, which was also good to see, but this was not true for the positive behaviors to monitor.

7. The behavioral data that were generated at Lubbock SSLC were not shown to be reliable.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: Three of these indicators showed high and sustained high performance for this review and the last two review. Therefore, these three indicators (12, 13, 15) will be moved to the category of requiring less oversight. CPE content had improved (indicator 14), though consistency in diagnoses in the record had worsened (indicator 15). These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 27	233	82	322	131	320	174	236	197
12	The individual has a CPE.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
13	CPE is formatted as per Appendix B	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	CPE content is comprehensive.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	44% 4/9	0/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1

Comments:

12. All of the individuals had a CPE.

13. Each of these was formatted according to the required specifications.

14. The content of each section was appropriate for all of the individuals, except Individual #233 for whom the diagnosis of a schizoaffective disorder bipolar type was not fully supported by the discussion. This also negatively impacted the formulation, which was also deficient.

15. The only individual who had been admitted recently was Individual #236. The CPE was completed the following day and there was

an Integrated Progress Note from the medical department documenting his physical status.

16. The psychiatric diagnoses were consistent throughout the record for four of the individuals. For Individual #27 and Individual #320, the diagnosis was consistent in the behavioral and psychiatric sections, but the diagnoses in the medical section were different. The records of Individual #197 and Individual #236 had somewhat different diagnoses in the medical, psychiatric, and behavioral sections. The pattern for Individual #174 was different in that the diagnosis was consistent in the behavioral and medical sections, but the psychiatric section had a different diagnosis. This issue was discussed with psychiatric team. They indicated that when the electronic record system is fully implemented this should ensure consistent diagnoses in all sections of the record.

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

Summary: Annual documentation was done and was thorough and complete. This had been the case for the last two reviews, too. Therefore, indicators 17 and 18 will be moved to the category of requiring less oversight. With sustained high performance, indicator 19, regarding timely submission to the IDT, might move to the category of requiring less oversight after the next review. Indicators 20 and 21 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 27	233	82	322	131	320	174	236	197
17	Status and treatment document was updated within past 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	78% 7/9	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	56% 5/9	1/1	0/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1

Comments:
17-18. Each individual had a comprehensive clinical update within the last year. The title of this evaluation was changed from the Psychoactive Medication Treatment Plan (PMTP) to the Psychiatric Treatment Plan (PTP) during the course of the year, but the content remained the same. These were thorough documents that contained all of the required clinical information for all of the individuals.

19. This documentation was made available to the IDT prior to the ISP within the required time frame for each individual.

20. The psychiatrist or psychiatric nurse attended the ISP for six of the individuals. A member of the team did not attend the ISP for Individual #233, Individual #131, and Individual #320. For each of these, there was documentation in the ISP preparation meeting

notes that the IDT felt that the psychiatrist's attendance was not necessary and their assessment would suffice. This made sense for Individual #320 who was stable and whose presentation was relatively not complex. For the other two individuals, complex polypharmacy, crisis intervention chemical restraints, potential cardiac side effects, and/or diagnostic questions should have resulted in psychiatrist presence and participation at the ISP meeting, especially given that the ISP preparation meeting was three months prior to the annual ISP meeting. This issue was discussed with the psychiatric team during the onsite review.

21. The documentation contained in the ISP summaries contained the required information for five of the individuals. Two of these were Individual #233 and Individual #82 whose ISP meetings were directly observed during the onsite review. The direct observation of the screen on which the ISP document was displayed as the meeting progressed made it possible to follow the proceedings in a more complete manner than the review material that was available for those ISPs that had not been directly observed. The electronic printout for the two ISPs that were observed would not be available until 30 days after the review when they would be finalized. The other individuals whose ISPs met criteria were those of Individual #27, Individual #322, and Individual #236. The psychiatrist or psychiatric nurse had attended these. The ISP documentation for Individual #174, Individual #320, Individual #131, and Individual #233 were missing multiple elements, but a common finding was that the conclusions reached in the risk benefit analysis could not be supported by the available data.

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

Summary: The Monitoring Team reviewed PSPs for five individuals not part of the set of individuals otherwise reviewed by the Monitoring Team. All five met criteria. This was the case during the last review, too, and for all but one PSP in the July 2015 review. Given this overall sustained high performance, this indicator will be moved to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	27	233	82	322	131	320	174	236	197
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	100% 5/5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:

22. There were no individuals reviewed by the behavioral health monitoring team who had a Psychiatric Support Plan (PSP). The total number of individuals at the facility who had a PSP was 16. The five most recently completed PSPs were reviewed and were found to be acceptable. Following the last monitoring review the Behavioral Services Department began to require the completion of a Functional Behavioral Assessment prior to considering the appropriateness of a PSP. This was good to see.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.												
Summary: Performance was at 100% for all five indicators for all nine individuals. Performance was also high at the last review; with sustained high performance, all of these indicators might move to the category of requiring less oversight. They will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	27	233	82	322	131	320	174	236	197
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
32	HRC review was obtained prior to implementation and annually.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

28. The consents for each of the medications prescribed for the individuals had been obtained within the last year and were done individually.

29. The information provided to the guardian related to medication side effects was adequate and understandable.

30. Risk versus benefit discussions were present for all individuals.

31. There was a reference to alternate non-pharmacological treatments for each medication consent.

32. The documentation of the HRC Review for each medication accompanied the consent signed by the guardian and was signed by the members of the HRC.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.	
Summary: Lubbock SSLC ensured that any individual who needed a PBSP had one. This was an improvement from the last two reviews. All individuals had goals and objectives that were measurable. This was the case for this review and for the last	Individuals:

two reviews, too. Therefore, these two indicators (2, 3) will be moved to the category of requiring less oversight. Ensuring that the goals are fully based on assessments (e.g., including all relevant behaviors) and ensuring that reliable data are available are areas for focus. These three indicators (1, 4, 5) will remain in active monitoring.

#	Indicator	Overall Score	27	233	82	322	131	320	174	236	197
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 15/15	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	44% 4/9	1/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

1. All nine individuals reviewed by the behavioral health monitoring team had PBSPs. At the time of the document request, five of the six individuals reviewed by the physical health monitoring team (Individual #186, Individual #6, Individual #235, Individual #8, Individual #188) had PBSPs. It was concerning that the plans for Individual #6 and Individual #235 had not been updated/revised in over one year. Individual #182 was not included on the master list of individuals with a PBSP. However, during the onsite visit, the Monitoring Team learned that a recent PMR-SIB plan had been implemented (1/25/17). When the director of behavioral health services was asked about this, she indicated that a functional assessment had been completed and a PBSP had been developed. Although the PBSP was implemented on 1/13/17, the direct support professionals reported that he did not have a PBSP. Further, his All About Me Book included a note indicating he did not have a PBSP. It is imperative that BHS staff adequately communicate changes in supports to the direct support professionals and ensure that all relevant training and implementation occur.

2-3. All nine individuals reviewed by the behavioral health monitoring team had measurable goals related to behavioral health services.

4. Four of the nine individuals (Individual #27, Individual #233, Individual #82, Individual #197) had goals that were based upon their assessments. However, even for these individuals, there were concerns regarding the problem behaviors addressed in their PBSPs.

- The PBSPs for Individual #27, Individual #233, and Individual #82 referenced problem behaviors (inappropriate display of

affection, licking others, and pulling the fire alarm, respectively) that were not addressed.

- Although Individual #197's plan did address her self-injurious behaviors, these were included in the definition of outbursts. It is suggested that this particularly risky behavior be addressed separately.

For the remaining five individuals, either there was no objective for one of their targeted behaviors or behaviors identified in the assessment were not addressed in the PBSP.

- An objective was not provided for Individual #131's inappropriate toileting and Individual #320's unauthorized departure.
- The direct observation completed for Individual #322's assessment included descriptions of her banging her head or biting herself, but self-injury was not addressed in her plan.
- Individual #174's assessment included descriptions of his throwing items, flipping furniture, and slamming doors, but none of these behaviors were addressed in his plan.
- Individual #236 was reported to engage in low to moderate rates of self-injury and property destruction. Because he resided at the facility for approximately six months, it is suggested that these should have been addressed in his plan.

5. Although there were IOA reports for eight of the nine individuals, the data were not considered reliable due to continued challenges as the facility implemented the new electronic data collection system. The assessment of data timeliness remained a particular challenge.

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

Summary: Attention needs to be paid to these indicators, which form the foundation for good behavioral treatment and programming. All three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 27	233	82	322	131	320	174	236	197
10	The individual has a current, and complete annual behavioral health update.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
11	The functional assessment is current (within the past 12 months).	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
12	The functional assessment is complete.	11% 1/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1

Comments:

10. While all nine individuals had a current behavioral health assessment, only Individual #236's was considered complete. For the remaining individuals, there was no review of their physical health over the previous year.

11. The functional assessment was current for eight of the nine individuals. The exception was Individual #131. Although his report was dated within the past 12 months, the report contents were a review of an assessment completed on 6/17/15. While the functional assessment should be updated at least annually, this was particularly important in Individual #131's case in light of the frequent application of physical restraint.

12. The functional assessment for Individual #320 was considered complete. Most assessments lacked a clear summary statement based on the hypothesized antecedent and consequent conditions that affect the target behavior. It was positive to note that in some cases (e.g., Individual #322 and Individual #197), multiple observations occurred, at least one of which was two hours in duration.

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

Summary: Almost all PBSPs were implemented within 14 days and all were current. This was good improvement from the past two reviews. With sustained high performance, these two indicators might move to the category of requiring less oversight after the next review. The Lubbock SSLC PBSPs, however, still needed improvement in content, especially regarding some of the basic components typically seen, and always required, in a PBSP. All three indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	27	233	82	322	131	320	174	236	197
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
14	The PBSP was current (within the past 12 months).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

13. For eight of the nine individuals, there was evidence that their PBSPs had been implemented within 14 days of necessary consents. The exception was Individual #174.

14. All nine individuals had a current PBSP.

15. None of the PBSPs were considered complete. Absent from most plans were the use of positive reinforcement in a manner that was likely to be effective, a clear description of data collection procedures, sufficient opportunities for replacement behaviors to occur, and baseline or comparison data.

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

Summary: Lubbock SSLC ensured that individuals who were referred for counseling received counseling. This was the case for some time now and, therefore, indicator 24 will be moved to the category of requiring less oversight. With sustained high performance, indicator 25, regarding treatment planning and

Individuals:

documentation, might also be moved to the category of requiring less oversight. It will remain in active monitoring.											
#	Indicator	Overall Score	27	233	82	322	131	320	174	236	197
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/1	N/A
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/1	N/A
Comments: 24-25. Two of the nine individuals (Individual #236, Individual #131) were participating in counseling services at the time of the onsite visit. Each had a complete treatment plan with corresponding progress notes. Individual #197 had been referred by her IDT and had been receiving services, but as reported by the facility, she chose to discontinue this service in August 2016.											

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Given that over the last two review periods and during this review, individuals reviewed had timely medical assessments (Round 9 – 100%, Round 10 – 100%, and Round 11 -100%), Indicators a and b will move to the category requiring less oversight. Indicator c for this Outcome will be assessed once the ISPs reviewed integrate the revised periodic assessment process.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	100% 2/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	1/1
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	N/A
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	Not Rated (N/R)									
Comments: c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.											

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Although some additional work was needed, the Center had made progress with regard to the quality of medical assessments. Given that over the last two review periods and during this review, individuals reviewed generally had diagnoses justified by appropriate criteria (Round 9 – 94% for Indicator 2.e, Round 10 – 100% for Indicator 2.e, and Round 11 -100% for Indicator 3.b), Indicator b will move to the category of requiring less oversight. Indicator c for this Outcome will be assessed once the ISPs reviewed integrate the revised periodic assessment process.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	Individual receives quality AMA.	33% 3/9	0/1	0/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	N/R									

Comments: a. It was positive that three individuals' AMAs (i.e., Individual #182, Individual #8, and Individual #186) included all of the necessary components, and addressed individuals' medical needs with thorough plans of care. Problems varied across the remaining medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, family history, social/smoking histories, past medical histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Most, but not all included childhood illnesses, complete interval histories, and updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments include plans of care for each active medical problem, when appropriate.

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

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

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188

a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review i.e., Individual #174 – circulatory, and falls; Individual #197 – diabetes, and osteoporosis; Individual #6 – respiratory compromise, and gastrointestinal (GI) problems; Individual #182 – respiratory compromise, and seizures; Individual #8 – cardiac disease, and osteoporosis; Individual #235 – weight, and osteoporosis; Individual #102 – GI problems, and seizures; Individual #186 – cardiac disease, and osteoporosis; and Individual #188 – cardiac disease, and weight].

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

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: Over this review and the last one, improvement was noted with regard to the timely completion of annual dental summaries. If the Center sustains this progress, Indicator a.iii might move to the category requiring less oversight after the next review. The Center should continue its focus on completing timely annual dental exams, as well as improving the quality of dental exams and summaries.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
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.	50% 1/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	0/1
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	14% 1/7	0/1	0/1	0/1	0/1	0/1	1/1	0/1	N/A	N/A
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	86% 6/7	1/1	1/1	1/1	1/1	0/1	1/1	1/1	N/A	N/A
b.	Individual receives a comprehensive dental examination.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1

c.	Individual receives a comprehensive dental summary.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. For seven of the nine individuals reviewed, successful/completed annual dental exams did not occur in a timely manner. In some cases, individuals did not have exams and/or treatment since 2014 (i.e., Individual #6, and Individual #182). On a positive note, though, the new Dental Director was taking steps aimed at improving the rate of timely annual dental exams and the completion of needed restorative work.

For one of the newly-admitted individuals, a dental summary was completed prior to his initial ISP meeting. It was positive that dental summaries were completed no later than 10 working days prior to the ISP meeting for six of the seven individuals reviewed.

b. It was positive that for Individual #186, the dental exam included all of the required components. As noted above, some individuals reviewed had not had full dental exams completed in some time (i.e., Individual #6, Individual #182, and Individual #8). Dental exams that were out-of-date were scored negatively for this indicator. Most of the dental exam template was blank for Individual #235. No annual dental exam was submitted for Individual #188 (i.e., the response to the document request stated: "not available for this individual"). In other instances, blanks were found for sections such as number of teeth present/missing, and x-ray information.

c. On a positive note, all of the dental summaries included the following:

- Provision of written oral hygiene instructions;
- Recommendations for the risk level for the IRRF; and
- Dental care recommendations.

Most included:

- Treatment plan, including the recall frequency.

Moving forward the Facility should focus on ensuring dental summaries include the following, as applicable:

- Recommendations related to the need for desensitization or another plan;
- A summary of the number of teeth present/missing, which is important due to the fact that odontograms might be difficult for IDTs to interpret;
- Effectiveness of pre-treatment sedation;
- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health; and
- A description of the treatment provided.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.	
Summary: Due to an issue with IRIS, full physical assessments were not documented for a number of individuals (i.e., assessments of genitalia were missing). This was unfortunate, because the Center had achieved scores of 100% for these indicators for the past two reviews. If this issue is corrected by the time of	Individuals:

the next review and the Center maintains the timeliness and quality of these assessments, Indicator a likely will move to the category requiring less oversight. The remaining indicators require continued focus to ensure nurses complete timely quarterly reviews, nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice.											
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
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.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	0/1
	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.	71% 5/7	0/1	1/1	0/1	1/1	1/1	1/1	1/1	N/A	N/A
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	38% 3/8	0/1	1/1	1/1	0/1	0/1	0/1	1/1	0/1	N/A
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/17	0/2	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/8	0/1	0/1	0/2	0/1	0/2	0/1	0/1	N/A	0/1

Comments: a. Complete physical assessments were not completed for Individual #186 or Individual #188 within 30 days of their admission. A quarterly physical was not submitted for Individual #186. At the time of the document request, a quarterly nursing review was not yet due for Individual #188.

Due to an issue with IRIS, full physical assessments were not documented for a number of individuals (i.e., assessments of genitalia were missing). The Center had achieved scores of 100% for these indicators for the past two reviews. The nurses on the Monitoring Team have discussed this issue with the State Office Nursing Discipline Lead. If this issue is corrected by the time of the next review, this indicator likely will move to the category requiring less oversight.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #174 – falls, and dental; Individual #197 – fractures, and weight; Individual #6 – dental, and GI problems; Individual #182 – falls, and weight; Individual #8 – dental, and skin integrity; Individual #235 – dental, and skin integrity; Individual #102 – falls, and constipation/bowel obstruction; Individual #186 – other: hypothyroidism, and UTIs; and Individual #188 – falls, and constipation/bowel obstruction).

At the time the annual nursing assessment was completed, skin integrity was not an issue for Individual #8. None of the nursing assessments sufficiently addressed the risk areas reviewed. Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

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

- According to an IPN on 9/14/16 at 4:55 p.m., Individual #174 slipped and hit his head re-opening an old wound. The nursing assessment did not include specifics regarding if he fell, where, what he hit his head on, a description of wound, neurological assessments, or respirations. An IPN indicated his gait was unsteady, but it did not include what was being done to prevent additional falls.
- On 10/15/16, the PCP noted that Individual #197's left foot was discolored. No nursing assessment was found addressing this issue, which was concerning because she had a diagnosis of osteoporosis and a past fracture.
- On 12/28/16, a nurse documented in an IPN that Individual #6 vomited. However, the nurse did not conduct and/or document an assessment of lung sounds for this individual at risk for aspiration.
- On 9/4/16, an IPN indicated that direct support professional staff reported Individual #182 had an unsteady gait and was feeling weak. A nursing IPN noted he was unable to stand, had a non-productive cough, and his skin felt warm, but his hands and feet were cold to the touch. The note indicated he was put on clinic list for the morning. The nurse did not notify the PCP of the individual's change in status. No follow-up nursing notes were found for the 9/5/16, 9/6/16, 9/7/16, or 9/8/16. On 9/9/16 and 9/10/16, nursing IPNs noted Individual #182 had an unsteady gait and had not had a bowel movement for three days. On 9/11/16, he was sent to the hospital and admitted.

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

Summary: Given that over the last three review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	6% 1/18	0/2	0/2	1/2	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).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: b. The IHCP that included preventative measures was for Individual #6 – dental.											

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: It was positive that as needed, a Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results. Since the last review, the scores during this review generally showed improvement with regard to timely referral of individuals to the PNMT. The Center should focus on sustaining its progress in this area, as well as improving referral of all individuals that meet criteria for PNMT review and timely completion of the PNMT initial review, completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT comprehensive assessments.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	67% 4/6	0/1	0/1	1/1	1/1	1/1	N/A	N/A	1/1	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	50% 2/4	0/1	0/1	1/1	N/A	N/A			1/1	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	60% 3/5	0/1	N/A	0/1	1/1	1/1			1/1	
d.	Based on the identified issue, the type/level of review/assessment	50%	0/1	0/1	0/1	1/1	1/1			1/1	

	meets the needs of the individual.	3/6									
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 5/5	1/1	N/A	1/1	1/1	1/1			1/1	
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	33% 2/6	0/1	0/1	0/1	1/1	0/1			1/1	
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/2	0/1	0/1	N/A	N/A	N/A			N/A	
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/5	0/1	N/A	0/1	0/1	0/1			0/1	

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

- It was not until 8/16/16 that Individual #174 was referred to the PNMT. This was after multiple injuries and a continued decline in status since February 2016. The PNMT discussed him according to their minutes, but did not provide direct intervention in the form of a comprehensive assessment despite falls continuing to occur. The PNMT concluded that it did not need to conduct a comprehensive assessment. However, given he had a significant and ongoing decline in status and the IDT had not resolved the issue, a PNMT assessment was warranted. Given Individual #174's complex needs, in conducting its review, the PNMT should have sought input from Behavioral Health Services, Psychiatry, and Pharmacy, but did not.
- On 4/6/16, Individual #197 fractured her humerus. According to PNMT policy, when an individual experiences a fracture of a long bone, the PNMT is required to conduct a review. Although PNMT minutes indicated a brief discussion, no evidence was found to show the PNMT conducted a review, or that a formal referral was made. The PNMT discussion that was documented lacked all the components needed for a review. There was no clear assessment provided outside of a single observation that the PT conducted. This observation noted decreased balance, but provided no further assessment or review.
- Individual #6 was referred timely to the PNMT, and the PNMT conducted a timely review, which was good to see. However, the PNMT did not provide a comprehensive assessment. Individual #6 was having ongoing issues with reflux and vomiting. Due to the ongoing nature of the emesis and the impact on his life in multiple areas, a PNMT comprehensive assessment was warranted. Such an assessment should have focused on all areas of activities of daily living (ADL), and incorporated input from Behavioral Health Services, Pharmacy, and the PCP. In its comments to the draft report, the State contended that because the PNMT had previously assessed the individual, a comprehensive assessment was not warranted. The last PNMT comprehensive assessment of this individual occurred five years prior in 2012. Given the length of time and the potential changes that can occur over a five-year period, the PNMT should have conducted a comprehensive assessment.

- Individual #182 did not require a review, because the PNMT immediately began a comprehensive assessment, which was completed timely. Of note, Individual #182 returned from the hospital with a recommendation for a ground diet with nectar thick liquids. This recommendation was based on a modified barium swallow study (MBSS), but based on interview, the PNMT did not know this, because the hospital did not provide a copy. It was unclear why Center staff did not request this information. Individual #182 continued to receive an inappropriate diet texture and fluid consistency for approximately 30 days. The Speech Language Pathologist (SLP) noted coughing during meals, but provided no recommendation to downgrade the individual's diet texture.
- Individual #8 did not require a review, because the PNMT immediately began a comprehensive assessment, which was completed timely. Although the PNMT assessment indicated that the individual's behaviors impacted progress and implementation of treatment, there was no evidence that the PNMT included Behavioral Health Services in the completion of the assessment.
- The PNMT reviewed and assessed Individual #188 timely in relation to dehydration and weight loss.

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

h. As noted above, two individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #174, and Individual #6). The following summarizes some of the concerns noted with the three assessments that the PNMT completed:

- As noted above, Individual #182 returned from the hospital with a recommendation for a ground diet with nectar thick liquids. This recommendation was based on a modified barium swallow study (MBSS), and there was no evidence that the SLP requested this specific information upon his return to LBSSLC. Individual #182 continued to receive an inappropriate diet texture and fluid consistency for approximately 30 days. The SLP noted coughing during meals, but provided no recommendation to downgrade the individual's diet texture. In addition, the PNMT assessment lacked clear evidence of assessment of the individual's swallow status. Posture and alignment were listed as being not applicable, but positioning plays a vital role in aspiration prevention. Other weak components of this assessment included: discussion of medications that might be pertinent to the problem, and discussion of relevance to PNM supports and services; evidence of observation of the individual's supports at his/her program areas; identification of the potential causes of the individual's physical and nutritional management problems; recommendations, including rationale, for physical and nutritional interventions; and recommendations for measurable goals/objectives, as well as indicators and thresholds.
- As noted above, although the PNMT assessment for Individual #8 indicated that the individual's behaviors impacted progress and implementation of treatment, there was no evidence that the PNMT included Behavioral Health Services in the completion of the assessment. As a result, the PNMT assessment was lacking analysis and/or recommendations related to this important area of need. Other weak components of this assessment included: evidence of observation of the individual's supports at his/her program areas; identification of the potential causes of the individual's physical and nutritional management problems; and recommendations for measurable goals/objectives, as well as indicators and thresholds.
- Overall, Individual #186's assessment included many of the required components. However, the key components that were missing from the assessment were: discussion of his medications that included a summary of whether any of them were noted to have a negative impact on him (i.e., while the assessment discussed the impact Valproic Acid was having, missing from the assessment was the potential impact of other drugs, such as Haloperidol, and Clonazepam); and observation/assessment of

skin turgor and integrity, and the potential impact of dehydration on skin health.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: No improvement was seen with regard to these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
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% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	11% 1/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	28% 5/18	0/2	1/2	0/2	0/2	0/2	2/2	2/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	30% 3/10	0/1	1/1	0/1	0/2	0/1	N/A	2/2	N/A	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/18	0/2	0/2	0/2	0/2	0/2	2/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: aspiration, and falls for Individual #174; gastrointestinal (GI) problems, and falls for Individual #197; choking, and GI problems for Individual #6; choking, and aspiration for Individual #182; weight, and fractures for Individual #8; weight, and GI problems for Individual #235; aspiration, and choking for Individual #102; GI problems, and other: dehydration for Individual #186; and choking, and aspiration for Individual #188.

a. and b. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP, and/or include preventative physical and nutritional management interventions to minimize the individuals' risks.

c. All individuals reviewed had PNMPs and/or Dining Plans. The PNMP for Individual #235 included all of the necessary components to meet the individual's needs. Problems varied across the remaining PNMPs and/or Dining Plans. For example, triggers for Individual #174 did not include meal refusals, despite the fact that they were listed as being an indicator of sickness; the risk of dehydration was

not listed for Individual #186; some PNMPs did not include photos of the individual in bed with the correct elevation (e.g., Individual #197, Individual #182, and Individual #186); Individual #174's PT consult mentioned the need for a gait belt, but there was no meeting to discuss its use or reason provided as to why the gait belt was not listed in the PNMP; with regard to medication administration, Individual #8's PNMP indicated that she needed to be elevated, but did not specify the degree of elevation; and a number of PNMPs did not describe the individuals' receptive language ability.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for falls for Individual #197; weight, and GI problems for Individual #235; and aspiration, and choking for Individual #102.

f. The IHCPs that identified triggers and actions to take should they occur were those for GI problems for Individual #197; and aspiration, and choking for Individual #102.

g. Often, the IHCPs reviewed did not include the frequency of PNMP monitoring.

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	174	197	6	182	8	235	102	186	188
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.	50% 1/2	N/A	N/A	1/1	0/1	N/A	N/A	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% 0/2			0/1	0/1					

Comments: a. and b. While the return to oral intake might not be possible for Individual #6, there is a good possibility that he would benefit from dysphagia therapy to address decreased oral musculature. Improvement in this area could help improve his ability to handle secretions, etc. However, such discussion was not found in his ISP/IRRF/assessments.

For Individual #182, the PNMT minutes noted that the SLP would evaluate his ability to return to oral feeding in February 2017. His current IRRF/ISP did not provide a clear path to oral intake. No justification or rationale was provided regarding why the SLP was not working on oral motor functioning in the interim to help prepare Individual #182 for oral intake.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied. The quality of OT/PT assessments continues to be an area on which Center staff should focus. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	1/1
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	1/1
	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.	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports;	N/A									

	• Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/6	0/1	0/1	0/1	0/1	N/A	N/A	N/A	0/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/3	N/A	N/A	N/A	N/A	0/1	0/1	0/1	N/A	N/A

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

- For Individual #174, although consults were provided in response to falls, a thorough assessment was not provided that addressed all locations in which the falls were occurring. An example was that the risk of falls while bathing was not assessed until August, even though falls and balance issues had been problematic since February 2016. In addition, consults often provided a single trial and not multiple trials across days. On 3/31/16, Habilitation Therapies staff completed a consult for a walker, and on 4/1/16, staff conducted a consult for a wheelchair. Individual #174 refused both, but Habilitation Therapies staff provided no further recommendations. It was only after the IDT requested another trial over a month and a half later that the Habilitation Therapy staff offered the individual a second trial and then a third trial. On 5/19/16, he tolerated the chair for one minute, and on 5/26/16, he tolerated it for 10 minutes. This provided further evidence that the Habilitation Therapies staff should have trialed the wheelchair multiple times after the initial failure on 4/1/16.
- On 7/7/16, Individual #102's IDT held an ISPA meeting to address falls that occurred on 7/3/16 and 7/4/16. During the meeting, the IDT requested that Habilitation Therapies staff look at the individual's walker and bed. While Habilitation Therapies staff assessed the walker in a timely manner, they did not assess the bed until almost a month later, on 8/5/16.

d. The Monitoring Team reviewed comprehensive OT/PT assessments for six individuals. The following summarizes some of the problems noted:

- The individual's preferences and strengths were used in the development of OT/PT supports and services: Some individuals' strengths were not reflected in the development of skills (e.g., Individual #6's strengths in upper extremity range of motion and motor skills could have been, but were not used to expand participation in adaptive living skills);
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: In a number of instances, the assessors did not discuss whether or not medications were potentially impacting an OT/PT problem (e.g., Individual #174's gait, Individual #186's gait or slumping forward/fatigue, and/or Individual #188's overall functioning);
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living: Individual #197's assessment discussed basic activities of daily living skills, such as toileting, bathing etc., but it lacked discussion of more high-level skills, such as cooking, and high-end safety skills. Having this information for Individual #197 was important, in part because the IDT had recommended transition to the community. In its response to the draft report, the State contended that the assessment addressed her cooking skills. However, based on the passage the State quoted, the OT/PT had not provided the IDT with a full

assessment of her cooking skills along with recommendations for next steps is skill acquisition in this important area of independent living;

- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale): For Individual #186 and Individual #188, while at times adaptive mealtime equipment was listed in the annual assessments, the assessments did not clearly delineate the rationale for the use of the various equipment;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings: The assessments for Individual #197 and Individual #6 did not review or include monitoring findings related to the effectiveness of current supports. Although Individual #182's assessment listed monitoring percentages, it did not provide discussion of the content of the monitoring findings. Individual #174's assessment discussed his refusal to use a wheelchair as well as a walker, but these findings were based on inadequate trials, as they were limited in exposure and time. Individual #174 was offered minimal opportunity outside of the initial trial. The need for multiple trials was confirmed when the IDT had to request a second trial for the wheelchair, and the second trial was effective;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services: Individual #197's assessment did not provide an assessment of adaptive living skills that were relevant to her, so it was unclear whether or not she would benefit from OT/PT supports and services. Four of the remaining five assessments identified OT and/or PT needs for which supports or services were not recommended, but clinical justification was not offered for not making such recommendations. The exception was Individual #182; 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: As noted above, recommendations that should have been made to address individuals' needs were not.

On a positive note, all of the comprehensive OT/PT assessments the Monitoring Team reviewed included, as applicable:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports; 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.

e. The following summaries some examples of concerns noted with regard to the required components of OT/PT assessments:

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: For all three individuals, the updates provided limited discussion of the impact of medications on OT/PT supports, and/or failed to identify whether or not the individual experienced potential side effects;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day: Individual #8's update lacked detail with regard to her oral motor status, and used words such as "good" with no objective information to substantiate the finding (i.e., no definition was provided for "fair" or "good lip closure," or a "fair pace");
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services: Because individuals often did not have goals/objectives that were clinically relevant and measurable, the updates did not include evidence regarding progress, maintenance, or regression. In other instances, justification was not

provided for not developing OT/PT supports to address identified needs (e.g., Individual #235 to improve his foot clearance, and Individual #102 to improve adaptive living skills); and

- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: As noted above, two updates did not include recommendations to address strategies, interventions, and programs necessary to meet individuals' needs. The only exception was for Individual #8.

On a positive note, as applicable, all of the updates reviewed provided:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments; and
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings.

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

Summary: It was good to see improvement from the last review with regard to IDTs reviewing and making changes, as appropriate, to individuals' PNMPs and/or Positioning schedules at least annually. The Monitoring Team will continue to review these indicators.

#	Indicator	Overall Score	Individuals: 174	197	6	182	8	235	102	186	188
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	33% 3/9	0/1	0/1	0/1	0/1	1/1	1/1	1/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	55% 6/11	0/1	1/1	1/2	0/1	2/2	1/1	1/1	0/1	0/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or	60%	0/1	N/A	0/1	N/A	2/2	N/A	1/1	N/A	N/A

	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.	3/5									
Comments: c. and d. Examples of concerns noted included: • Individual #174's ISP/ISPAs did not include evidence of discussion and IDT determination regarding whether a weighted belt would be used, as well as a gait belt. Discussion also was lacking about the leg brace and/or taping. • The IDT for Individual #6 did not appear to hold an ISPA meeting to discuss issues with the current cushion and the occurrence of a pressure sore. • For some individuals, PNMP details were not clearly included as part of the ISP (e.g., Individual #186, and Individual #188).											

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 2/2	N/A	N/A	N/A	N/A	N/A	N/R	N/A	1/1	1/1
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	100% 2/2	N/A	N/A	N/A	N/A	N/A		N/A	1/1	1/1
	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.	67% 4/6	1/1	1/1	1/1	1/1	0/1		0/1	N/A	N/A
b.	Individual receives assessment in accordance with their individualized needs related to communication.	75% 6/8	1/1	1/1	1/1	1/1	0/1		0/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and	N/A									

	receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/5	0/1	0/1	0/1	N/A	N/A		N/A	0/1	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/3	N/A	N/A	N/A	0/1	0/1		0/1	N/A	N/A

Comments: Individual #235 had functional communication skills and was part of the outcome group, so these indicators were not reviewed for him.

a. and b. The following provides information about problems noted:

- Individual #8's last communication assessment was completed in 2014. Individual #8 had many communication deficits, and naming and increasing vocabulary were two areas noted in the 2014 assessment on which skill building could be focused. However, there had been no goals/objectives developed and/or reassessment.
- Since 2014, Individual #102 experienced a decrease in cognitive functioning secondary to dementia, but the Speech Language Pathologist (SLP) had not conducted an assessment.

d. The following describes some of the concerns with the five assessments:

- The individual's preferences and strengths are used in the development of communication supports and services: Although preferences and strengths were incorporated for Individual #174, Individual #186, and Individual #188, preferences such as the stated desire to learn to read (i.e., Individual #197) or comic book characters and superheroes (i.e., Individual #6) were not incorporated into recommendations for the remaining two individuals;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services: Although the assessments listed the individuals' medications and potential side effects, they lacked discussion of whether such side effects had been noted for the individual being assessed;
- 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: In some cases, assessments primarily focused on existing skills and did not provide an in-depth analysis of individuals' potential for expansion or development of skills (e.g., Individual #197, and Individual #6);
- A comparative analysis of current communication function with previous assessments: For Individual #197, no comparative

analysis from previous assessments was noted. This was not applicable to the two individuals that were newly admitted;

- The effectiveness of current supports, including monitoring findings: This was not applicable to the two individuals that were newly admitted. For the remaining three individuals, results of monitoring/observations over the previous year were not cited, and/or the assessors concluded that supports were effective, but provided no data to support this conclusion;
- 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: Individual #188's assessment met criterion for this sub-indicator. Individual #174's assessment reviewed potential communication boards as well as expansion of signs, which were already in his repertoire, but did not explore options for him to express pain or discomfort. Individual #6's assessment restated that AAC was not appropriate based on the previous assessment's findings, but did not provide sufficient justification for why it was not trialed again;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated: Evidence to show compliance with this sub-indicator was present for Individual #174, Individual #197, and Individual #6. However, for Individual #186, and Individual #188, the SLPs indicated they met with Behavioral Health Services staff and provided input, but the assessment included no information regarding the input provided; 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: Given that complete assessments were not completed of individuals' communication needs, it was unclear whether or not the assessments included a full set of recommendations to address individuals' needs. In addition, SAPs recommended did not address identified needs and/or preferences (e.g., for Individual #174, Individual #197, and Individual #6).

On a positive note, all five assessments provided:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication.

e. As noted above, Individual #8 and Individual #102 should have had updates completed, at a minimum, but did not. The following provides examples of concerns noted with regard to the required components of the communication update for Individual #182:

- The individual's preferences and strengths are used in the development of communication supports and services: The assessment identified Individual #182's ability to identify objects as a strength, and stated that this could be expanded through use of the "all-shared devices." However, the all-shared devices listed on the Communication dictionary utilized pictures and sign language, which are not considered strengths of this individual;
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills: The inconsistency between the description of Individual #182's functional receptive skills and the recommendation to expand his expressive skills called into question the accuracy of this description;
- The effectiveness of current supports, including monitoring findings: The assessment did not include monitoring findings, and/or review the individual's past use of all-shared devices; 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: The assessment indicated that object identification was a strength and that the individual's communication could potentially be expanded

through increased exposure to object cue boards, but then recommended non-object-based devices.

On a positive note, the update did sufficiently address:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services; and
- Assessment of communication needs (including AAC, EC, or language-based) in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services.

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

Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	75% 6/8	1/1	0/1	1/1	1/1	0/1	N/R	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	67% 4/6	1/1	1/1	1/1	0/1	0/1		1/1	N/A	N/A
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	71% 5/7	1/1	0/1	1/1	0/1	N/A		1/1	1/1	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: a. For two individuals, their ISPs did not provide complete functional descriptions of their communication skills (e.g., an accurate description of Individual #197's reading and writing skills, or a description of Individual #8's receptive skills).

Skill Acquisition and Engagement

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

Summary: It was good to see that SAPs were written in measurable terms. All individuals had at least one SAP, resulting in the high score for indicator 1, but given the small number of SAPs; the many that were not based on assessments and were not practical, functional, and meaningful; and problems with adequately tracking progress because of problems with data collection, all five indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 27	233	82	322	131	320	174	236	197
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	100% 22/22	3/3	2/2	2/2	2/2	3/3	3/3	3/3	1/1	3/3
3	The individual's SAPs were based on assessment results.	50% 11/22	2/3	0/2	1/2	1/2	2/3	0/3	3/3	1/1	1/3
4	SAPs are practical, functional, and meaningful.	36% 8/22	2/3	0/2	1/2	1/2	2/3	0/3	1/3	1/1	0/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/22	0/3	0/2	0/2	0/2	0/3	0/3	0/3	0/1	0/3

Comments:

1. Although everyone had a skill acquisition plan, these were often quite limited in number (this was the case for about half of the individuals). One individual (Individual #236) had one SAP, and three others (Individual #233, Individual #82, Individual #322) had two SAPs. Given the learning needs, and learning potential, of these individuals (as well as the given the types of skills chosen as noted in indicator 3 below), more IDT work on identifying important SAPs was warranted.

2. All of the SAPs that were reviewed were measurable.

3. Eleven of the 22 SAPs were based on assessments. Exceptions included skills that had been identified as mastered in the individual's functional skills assessment (e.g., Individual #27 – cooking; Individual #131 – cooking; Individual #320 – expressive communication, printing name, and caring for adaptive equipment; and Individual #197 – using a phone). In other cases, it was noted in the SAP that the individual could already perform the skill (e.g., Individual #233 – walking and using remote).

4. Eight of the 22 SAPs were considered practical, functional, and meaningful. In addition to those skills that had been identified as mastered, exceptions included the following:

- It would be more meaningful for Individual #174 to learn to operate a radio/CD player or play a piano rather than limiting his access to music by teaching him to drum.
- Rather than learning to record her earnings in a ledger, it would be more meaningful for Individual #197 to open and use a bank account.

5. Based upon the SAP integrity system that was in place at the time of the visit, the data cannot be considered reliable or valid.

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: These assessments were available to the IDT as required for all individuals for this review and the last two reviews, with one exception at the last review. Given this performance, indicator 11 will be moved to the category of requiring less oversight. The assessments were current for most but not all individuals for this and the previous reviews, too. There was no improvement in the percentage of assessments that included recommendations for skill acquisitions. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 27	233	82	322	131	320	174	236	197
10	The individual has a current FSA, PSI, and vocational assessment.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	33% 3/9	0/1	0/1	1/1	0/1	1/1	1/1	0/1	0/1	0/1

Comments:

10. Eight of nine individuals had a current FSA, PSI, and vocational assessment. The exception was Individual #174 who did not have a vocational assessment. It should be noted that a day program assessment was completed for him.

11. For each individual, all of his/her completed assessments were available to the IDT 10 days prior to the ISP meeting.

12. Three individuals (Individual #82, Individual #131, Individual #320) had assessments that included recommendations for skill development, however, these were limited to one recommended SAP. Staff are advised to consider the utility of assessments in guiding functional and meaningful skill development for all individuals. A broad range of potential SAPs should be recommended to ensure the team reviews all domains of development.

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

This domain contains 40 outcomes and 176 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Twenty-two of these, in restraints, psychiatry, psychology/behavioral health, medical, pharmacy, and OT/PT, had sustained high performance scores and will be moved the category of requiring less oversight. This included the entirety of Outcomes 1, 8, and 12 for psychiatry.

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

Goals/Objectives and Review of Progress

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

Without measurable psychiatric goals and/or without good data on psychiatric indicators, progress could not be determined. Even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. Quarterly reviews were held as required for all individuals, though documentation content was insufficient, perhaps due in part to the recent change to the electronic health record. Psychiatric clinics the Monitoring Team observed were thorough and complete. Interim clinics were provided as needed.

Problems in data collection and data summarization for PBSPs led to poor performance on the related indicators. Improvement in data collection, summarization, and response to status of progress are areas for focus that, if addressed, will likely lead to improved scores. Progress notes were complete as per criteria. Improvements in graphing and scheduling and conducting of peer reviews are needed.

Acute Illnesses/Occurrences

With regard to acute illnesses/occurrences, improvement was needed with regard to nursing staff's assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis until the issue resolved; timely notification of the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification; the development of acute care plans for all relevant acute care needs; and development of acute care plans that are consistent with the current generally accepted standards.

It was positive that the individuals reviewed with acute illnesses or injuries received medical treatment and/or interventions. It was also good to see that for the individuals reviewed with Emergency Department (ED) visits or hospitalizations, upon their return to the Center, IDTs held ISPA meetings to address follow-up medical and healthcare supports to reduce risks and promote early recognition, as appropriate, and that the PCPs conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of the acute illness. The Center should focus on ensuring that individuals with acute issues have quality assessments documented in the IPNs, and the PCP or nurse communicates necessary clinical information with hospital staff should the individual require transfer out of the Center.

When dental emergencies occur, better nursing and/or dental documentation is needed with regard to the onset of symptoms. It was good to see, though, that once the dentist saw the individuals with dental emergencies that treatment was provided. Pain management and documentation of it is an area on which the Center should focus.

Variables that were identified as potentially playing a role in the occurrence of behaviors that often led to more than three restraints in any rolling 30-day period were identified and actions to address these variables were developed and taken for some, but not yet for all individuals in all cases.

Implementation of Plans

The Center had a good system for ensuring psychiatrist participation in PBSP development. The collaboration between psychiatry and neurology continued to be that of a high standard. Polypharmacy management activities were meeting criteria.

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

Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. On a positive note, documentation generally was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs. Although additional work is needed, it was also positive that the Center had made progress on ensuring individuals with chronic conditions or at high or medium risk for health issues received medical assessment, tests, and evaluations consistent with current standards of care, and for a number of individuals reviewed that PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible. The Center is encouraged to continue its efforts in this regard. However, these treatments, interventions, and strategies need to be included in IHCPs, and PCPs need to implement them timely and thoroughly.

It was positive that over the last two review periods and during this review, for the non-Facility consultations reviewed, the PCPs generally reviewed consultations and indicated agreement or disagreement, and did so in a timely manner. This resulted in two indicators moving to the category requiring less oversight. During this review, the Center also showed progress with regard to providers ordering agreed-upon recommendations. The Center needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate.

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

Vacancies and staff changes as well as individuals' refusals to participate in dental treatment contributed to lapses in dental care. With the new Dental Director, the Center should continue to focus on the provision and quality of dental treatment

Based on the individuals reviewed, practitioners reviewed Quarterly Drug Regimen Reviews (QDRRs) timely. As a result, one indicator will be placed in the category requiring less oversight. The timeliness and quality of QDRRs are areas in which the Center needs to continue to improve its performance.

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

Based on observations, there were still numerous instances (60% of 40 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Restraints

<table>
<tr><td colspan="2">Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.</td></tr>
<tr><td>Summary: Lubbock SSLC met criteria for all individuals for four of these indicators. Two of these four (24 and 27) were met for all individuals across the last two reviews, too (with one exception in July 2015). Therefore, these two indicators will be moved to the category of requiring less oversight. For one individual, Individual #27, all indicators were met (except for the development of a CIP) showing that the facility had the capability to meet the criteria for all individuals. All of the other indicators will remain in active monitoring.</td><td>Individuals:</td></tr>
</table>

#	Indicator	Overall Score	27	131	320						
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	33% 1/3	1/1	0/1	0/1						
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	67% 2/3	1/1	0/1	1/1						
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 3/3	1/1	1/1	1/1						
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	67% 2/3	1/1	0/1	1/1						
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	33% 1/3	1/1	0/1	0/1						
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	33% 1/3	1/1	0/1	0/1						
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 3/3	1/1	1/1	1/1						
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	67% 2/3	0/1	1/1	1/1						
26	The PBSP was complete.	N/A	N/A	N/A	N/A						
27	The crisis intervention plan was complete.	100% 2/2	N/A	1/1	1/1						
28	The individual who was placed in crisis intervention restraint more	100%	1/1	1/1	1/1						

	than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	3/3									
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	67% 2/3	1/1	0/1	1/1						

Comments:

18-19. Of the nine individuals reviewed, three (Individual #27, Individual #131, Individual #320) had experienced more than three crisis intervention restraints in a rolling 30-day period. For Individual #27, there was evidence that his IDT had met within the required time frame. For both Individual #27 and Individual #320, there was evidence of that the IDT had held a sufficient number of meetings. There were also a sufficient number of meetings of each individual's team. Neither of these requirements were met by Individual #131's team.

20. As reflected in the ISPA minutes, the IDTs for all three individuals had discussed the potential role of adaptive skills, and biological, medical, and psychosocial issues. Individual #131's team recommended continuing his medication regimen and involvement with counseling. Individual #320's team recommended training from the speech therapist to ensure staff could understand his communication.

21. Potential environmental variables were discussed by both Individual #27's and Individual #320's teams. In Individual #320's case, one plan to address this was to ensure a consistent and predictable schedule for tobacco use.

22-23. The IDTs for Individual #27 and Individual #320 discussed potential antecedents and consequences that may have contributed to the use of restraint. Although it was hypothesized that conflict with peers, and staff redirection, were antecedents for Individual #27, plans to address these were not identified. For Individual #320, strategies to reduce restraint included providing him choices and access to other preferred items when tobacco was not available.

24. All three individuals had a current PBSP.

25. Individual #131 and Individual #320 had Crisis Intervention Plans at the time of the repeated restraints that were reviewed. In Individual #27's case, the IDT determined that due to his ability to escape restraint and thus the need for repeated restraints, he did not meet criteria for a CIP. Because he had twice met the criteria for more than three restraints in a rolling 30-day period, a CIP should have been developed.

26. Review of the individual's PBSP can be found elsewhere in this report (Psychology/Behavioral Health, outcome 4, indicator 5).

27. Individual #131 and Individual #320 had complete crisis intervention plans. Staff are advised to consider expanding the termination criteria for Individual #131 because he may stop struggling without verbalizing that he is okay.

28. Although treatment integrity had been assessed regularly over a six-month period for all three individuals, assessment was

completed primarily through staff interview. Assessment was consistently over 80%.

29. There was evidence that the IDT had reviewed the PBSPs for Individual #27 and Individual #320.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
Summary: Reiss screens were conducted at Lubbock SSLC for some time now. Further, Reiss screens are regularly conducted for all individuals not already receiving psychiatric services. Therefore, these three indicators will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	182								
1	If not receiving psychiatric services, a Reiss was conducted.	100% 1/1	1/1								
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A	N/A								
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A	N/A								

Comments:

1. Fifteen of the 16 individuals reviewed by both Monitoring Teams were receiving psychiatric services. The only individual who was not followed by psychiatry was Individual #182 who was administered the Reiss screening tool on 7/3/14 and received a score of zero.

2. Individual #182had not had a change in status since that time. The facility repeated the Reiss every three years for the individuals who were not prescribed psychotropic medications and the Reiss was scheduled to be repeated again for Individual #182in April 2017.

3. Individual #182's score of zero indicated that no further evaluation was required.

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.										
Summary: Without measurable goals and/or without good data on psychiatric indicators, progress could not be determined. The Monitoring Team, however, acknowledges that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	27	233	82	322	131	320	174	236	197

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

Comments:
8-9. In the absence of measurable goals for both positive and negative behaviors, as well as the absence of good data, it was not possible to assess the individual's progress toward defined goals.

10. Although the goals were not suitable for assessing progress, there was documentation in the record of each of the individuals that, when there was a change in their status that required intervention, the psychiatrists responded. The documentation of these interventions appeared in the integrated progress notes and/or interim psychiatric clinics that occurred in between the quarterly reviews.

11. The recommendations that were discussed in these interim notes were uniformly implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary: Lubbock SSLC showed good progress on these two indicators regarding psychiatry and behavioral health. The facility had a good system for ensuring psychiatrist participation in PBSP development, resulting in scores of 100% for this review and the last review. The system was initiated at the time of the July 2015 review and showed good maintenance. Therefore, indicator 24 will be moved to the category of requiring less oversight. With sustained high performance, indicator 23 might move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	27	233	82	322	131	320	174	236	197
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
23. The psychiatric documentation discussed the behavioral contributions for each individual and was routinely updated in the psychiatric quarterlies and the annual PTP. The Behavioral Health Assessments and Functional Behavioral Assessments also referenced the psychiatric biological contributions to the individual's behavioral presentation.

24. There was evidence of the psychiatrist's participation for each individual. This documentation could be found in the annual PMTP/ PTP where the target behaviors that were related to the symptoms of the psychiatric diagnosis were identified.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.

Summary: The collaboration between psychiatry and neurology continued to be that of a high standard. Scores of 100% for all three indicators were obtained for all three indicators for this and the last two reviews, too. Therefore, all three indicators of this outcome will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 27	233	82	322	131	320	174	236	197
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 2/2	N/A	1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A
26	Frequency was at least annual.	100% 2/2	N/A	1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 2/2	N/A	1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A

Comments:
25. Two individuals, Individual #233 and Individual #322, were prescribed medications for the treatment of both a neurological condition and for psychiatric purposes. During the onsite review, the neurology clinic that occurred on 2/8/17 was directly observed. The clinic was attended by the psychiatrist, the primary care provider, a nurse from the individual's residential unit, the clinic nurse, and the clinical pharmacist. This was the standard format for the conduct of the neurology consultations at Lubbock SSLC. It set the occasion for direct communication between the disciplines at the time of the consult. The neurologist dictated a note at the time of the clinic and the psychiatrist subsequently prepared an integrated progress note. The neurology clinic visit was also noted and summarized in the next psychiatric quarterly review. Documentation of this collaboration was found in the record of both Individual #322 and Individual #233.

26. This documentation also indicated periodic follow-up visits at least annually.

27. Both the neurology and the psychiatry notes referenced plans for future treatment.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: Quarterly reviews were held quarterly for this review for all individuals and for the last two reviews, too. Therefore, indicator 33 will be moved to the category of requiring less oversight. Challenges with the new electronic health record resulted in decreased performance with some of the content (indicator 34). Psychiatric clinic contained the required components (indicator 35) and with sustained high performance, might move to the category of requiring less oversight after the next review. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	27	233	82	322	131	320	174	236	197
33	Quarterly reviews were completed quarterly.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
34	Quarterly reviews contained required content.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:

33. The review of the psychiatric quarterlies indicated that they were held on a quarterly basis for each individual.

34. The documentation of the quarterly reviews contained the required content with two notable exceptions. The vital signs that previously appeared in the quarterly review documentation were now filed and recorded in a different section of the electronic record and did not appear in the quarterly review format. The symptoms that supported and justified the psychiatric diagnosis also no longer appeared in the electronic format for the quarterly reviews. This documentation did appear in the annual psychiatric treatment plan, but did not carry over to the quarterly reviews. This information was discussed with the psychiatric team during the onsite review and they are going to explore possible remedies.

35. The psychiatric clinic for Individual #233 was observed on 2/8/17. It was attended by the psychiatrist, the QIDP, behavioral health specialist, nurse case manager, and members of the direct care staff. The behavioral data were discussed as well as an update on her general health. The direct service professionals were involved in the discussion. On that day, the psychiatric clinics for four additional individuals were also reviewed and met the same standards.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: Overall, criteria were met, except for one evaluation that was not completed and one evaluation that was completed late. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	27	233	82	322	131	320	174	236	197

36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1

Comments:
36. The facility's policy was to complete the MOSES evaluations every six months in the months of January and July for all of the individuals who were prescribed psychotropic medications. The prescribing psychiatrists performed the AIMS evaluations themselves every three months. The review of these data indicated that both the MOSES and the AIMS had been completed and reviewed for seven of the individuals as required, that is, all except for Individual #174 and Individual #197. The July 2016 MOSES had not been completed for Individual #197 and the AIMS for Individual #174 that was due in November 2016 was not completed until February 2017.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.

Summary: The availability, provision, and documentation of emergency/urgent and/or follow/up interim clinics met the criteria required for these indicators for a number of years. These three indicators will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 27	233	82	322	131	320	174	236	197
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
37. There was documentation in the medical record of each individual that indicated that the treating psychiatrist had performed interim or urgent clinical assessments and interventions.

38. The context and documentation for these clinical interventions indicated that when the treatment teams made a request for such an intervention, the psychiatric team responded. During the onsite review, members of the treatment teams told the Monitoring Team that the psychiatrists were always responsive when a clinical intervention was requested.

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

Summary: These indicators met criteria during this review and the previous two reviews, too. They will, however, remain in active monitoring. Some may be considered for less oversight after the next review.

#	Indicator	Overall Score	Individuals: 27	233	82	322	131	320	174	236	197

40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
40. There was no indication that the dosages of medication used at the facility were excessive or suggested that the medications were being used to produce sedation.

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

42. Each individual had a Positive Behavior Support Plan in addition to pharmacological treatment.

43. There were no administrations of PEMA this review period. There were instances of chemical restraint for Individual #131 and Individual #322 as reviewed in outcome 15.

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

Summary: Indicators 45 and 46 will be moved to the category of requiring less oversight. With sustained high performance, indicator 44 might be moved to the category of requiring less oversight after the next review.

#	Indicator	Overall Score	Individuals: 27	233	82	322	131	320	174	236	197
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 4/4	1/1	1/1	1/1	N/A	1/1	N/A	N/A	N/A	N/A
45	There is a tapering plan, or rationale for why not.	100% 4/4	1/1	1/1	1/1	N/A	1/1	N/A	N/A	N/A	N/A
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 4/4	1/1	1/1	1/1	N/A	1/1	N/A	N/A	N/A	N/A

Comments:

The observation of the polypharmacy clinic on 2/9/17 indicated that the meeting was attended by the psychiatrist, the medical director, the psychiatric nurse, and the clinical pharmacist. Each month this group reviewed the update of the polypharmacy spreadsheet and they met together quarterly.

44. Four individuals had pharmacological profiles that met the criteria for polypharmacy. The review of the extensive data contained in the historical summaries presented at the meeting and contained in the spreadsheet indicated that the use of the prescribed medications could be justified.

45. These four individuals either had active tapering plans for some of their prescribed medications or such plans had been implemented in the past and then halted due to clinical deterioration.

46. The minutes of the polypharmacy committee meetings confirmed the quarterly review meetings of the full committee and paper reviews during the intervening months.

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: Problems in data collection and data summarization for PBSPs led to poor performance on all of these indicators. Moreover, performance had deteriorated on indicators 8 and 9. These two indicators are scored based upon the facility's own reports. Improvement in data collection, summarization, and response to status of progress are areas for focus that, if addressed, will likely lead to improved scores for this outcome's indicators. All four indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 27	233	82	322	131	320	174	236	197
6	The individual is making expected progress	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	0% 0/3	N/A	N/A	0/1	N/A	0/1	N/A	0/1	N/A	N/A
9	Activity and/or revisions to treatment were implemented.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
6. Although information included in the progress notes for six individuals (Individual #27, Individual #233, Individual #322, Individual #320, Individual #236, Individual #197) suggested progress in the majority of their targeted problem and replacement behaviors, this indicator is rated as zero due to the identified problems with data timeliness and the lack of confidence in the accuracy of the data

following the introduction of the electronic data collection system. For instance, it was noteworthy that there were marked changes in the rates of targeted problem and/or replacement behaviors for Individual #233, Individual #320, and Individual #174 when the data cards were discontinued and there was full reliance on the electronic data system. Staff also reported concerns with possible artificially inflated rates of replacement behaviors as a result of the new data collection system.

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

8-9. There was no evidence that corrective actions had been suggested to address the lack of progress in the plans supporting Individual #82, Individual #131, or Individual #174.

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

Summary: Lubbock SSLC had now been using summaries for float staff and had certified staff write or oversee all (but one) PBSP. With sustained high performance, these two indicators might move to the category of requiring less oversight after the next review. More focus needs to be paid to staff training as per the criteria for this indicator. All three indicators of this outcome will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 27	233	82	322	131	320	174	236	197
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.	33% 3/9	0/1	1/1	0/1	0/1	0/1	1/1	1/1	0/1	0/1
17	There was a PBSP summary for float staff.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1

Comments:

16. For three of the nine individuals (Individual #233, Individual #320, Individual #174), there was evidence that more than 80% of their assigned staff had been trained on the PBSP.

Several behavioral health services staff were observed by the Monitoring Team to be on the homes, interacting with staff and with individuals. Additionally, several of these staff had offices on the homes. This was good to see. Behavioral health staff presence is a required setting condition for good implementation of behavioral health treatments and supports.

17. For all nine individuals, a PBSP summary had been developed to help familiarize float staff with the individual's needs and supports.

18. For eight of the nine individuals, the functional assessment and PBSP had been written by a BCBA or behavior health specialist who

was enrolled in coursework, participating in supervision, or was eligible to sit for the exam. The exception was Individual #197.

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

Summary: Progress notes were complete as per criteria and for the last two reviews (with one exception in July 2015). Therefore, indicator 19 will be moved to the category of requiring less oversight. Improvements in graphing and scheduling and conducting of peer reviews are needed and if done, will likely result in improved scores for these indicators. Indicators 20-23 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 27	233	82	322	131	320	174	236	197
19	The individual's progress note comments on the progress of the individual.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The graphs are useful for making data based treatment decisions.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	Not rated	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	80% 4/5	1/1	N/A	N/A	N/A	1/1	0/1	1/1	1/1	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0%									

Comments:

19. For all nine individuals, their progress notes commented on their progress or lack thereof.

20. It was positive that graphs depicted weekly occurrences of targeted problem and replacement behaviors. However, none of the graphs were found to be useful for making data-based treatment decisions. This was because phase change lines were not always included for important events, including changes in medication, hospitalization, or change in data collection systems. Further, the graphs were (for the most part) very small, making them difficult to read.

21. During this onsite visit, the Monitoring Team was unable to attend any clinical meetings.

22. There was evidence that five individuals (Individual #27, Individual #131, Individual #320, Individual #174, Individual #236) had been reviewed in either the behavior support, internal peer review, or external peer review committee over the six-month period prior to the Monitoring Team's visit. There was also evidence that recommended changes had been made to the assessments or plans for

four of the five individuals. The one exception was Individual #320. A review of his PBSP and CIP did not reflect the recommended changes (nor was there any documentation indicating that the changes were considered and rejected).

23. There was evidence over a six-month period that external peer review meetings were held monthly. However, during this same period, internal peer review meetings did not occur three times each month.

Outcome 8 – Data are collected correctly and reliably.

Summary: Lubbock SSLC was struggling with meeting criteria with these indicators. As a result, performance decreased since the last review. Much focused attention needs to be paid so that data can be collected and used to assess individuals' status, make changes in treatment, and overall improve services and supports. Also, improvements need to be made to the treatment integrity process so that it validly assesses treatment integrity. All five indicators of this outcome will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 27	233	82	322	131	320	174	236	197
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
26-27. Based upon the concerns noted with the electronic data collection system, it was determined that there were not adequate systems for measuring target and/or replacement behaviors.

28. It was concerning that the instructions for inter-observer agreement noted that BHS staff should inform the direct support professionals that they are there to observe them document events in CareTracker. Further, instructions suggested that at the end of the observation, BHS staff were to instruct the direct support professionals to complete the documentation. When conducting assessments of treatment integrity, BHS staff were told to first provide each staff member with a copy of the PBSP or PBSP summary. Staff were then provided scenarios and interviewed to determine their competency in implementing the PBSP.

There was no indication that staff were observed on-the-job as they implemented the PBSP. Data timeliness instructions suggested that

identifying names of targeted behaviors did not always match the operational definition, possibly increasing the difficulty of accurate recording of data.

29. For all nine individuals, their PBSPs indicated that IOA should be assessed at a minimum of once each month. For eight of the nine individuals, treatment integrity was also to be assessed once each month. The exception was Individual #197. There were no established goal frequencies for assessing data timeliness.

30. For nine of the individuals, goal frequencies and levels were achieved for treatment integrity. It was concerning, however, that this was assessed largely by interviewing staff rather than observing them implementing the PBPS on-the-job.

For eight of the nine individuals, IOA frequencies and levels were achieved. The exception was Individual #27 for whom IOA was not assessed over a six-month period. In the majority of assessments, however, targeted problem and/or replacement behavior were not observed.

Because there were not established goal frequencies for assessing data timeliness, this indicator was not met.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.

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

#	Indicator	Overall Score	Individuals: 174	197	6	182	8	235	102	186	188
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	17% 3/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	2/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #174 – circulatory, and falls; Individual #197 – diabetes, and osteoporosis; Individual #6 – respiratory compromise, and GI problems;

Individual #182 – respiratory compromise, and seizures; Individual #8 – cardiac disease, and osteoporosis; Individual #235 – weight, and osteoporosis; Individual #102 – GI problems, and seizures; Individual #186 – cardiac disease, and osteoporosis; and Individual #188 – cardiac disease, and weight).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #102 – seizures; and Individual #188 – cardiac disease, and weight.

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

Outcome 4 – Individuals receive preventative care.

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

Individuals:

#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	Individual receives timely preventative care:										
	i. Immunizations	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
	ii. Colorectal cancer screening	80% 4/5	N/A	1/1	0/1	1/1	1/1	N/A	N/A	1/1	N/A
	iii. Breast cancer screening	50% 1/2	N/A	1/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	vi. Osteoporosis	83% 5/6	N/A	1/1	N/A	1/1	0/1	1/1	1/1	1/1	N/A
	vii. Cervical cancer screening	50% 1/2	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	N/A

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

- For Individual #6, documentation indicated that he had not had a colonoscopy, because the "risks outweigh the benefits." However, the documentation did not include an explanation of the risks. In addition, during discussion on site, it was stated that another attempt would be made on 2/15/17.
- Individual #8 had a DEXA scan on 7/13/12 that indicated a T-score of -1.8, but this was reported incorrectly in the AMA as +1.8. On 9/5/13, she had a mammogram with a recommendation for a follow-up ultrasound, which was scheduled for 10/2/13. However, it appeared this did not occur due to a lack of cooperation. According to the AMA, dated 4/15/16, another mammogram was ordered, but it had not been completed at the time of the Monitoring Team's visit.
- For Individual #188, no cervical cancer screening or order for a screening was found. With regard to immunizations, it appeared she had only one dose of varicella on 12/8/10, and varicella consent on 9/28/16, but no evidence it was administered. She had a Td/Tdap consent on 9/28/16, and on 10/18/16, a Td was given. As an adult, she had not received any Tdap vaccination. It also was unclear why the pneumovax was being repeated (i.e., she had one on 11/16/12, but a consent was also dated 9/28/16).

Comments: 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.

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
Summary: The Monitoring Team will continue to review this indicator.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: None.

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Given that over the last two review periods and during this review, prior to the transfer to the hospital or ED, individuals reviewed received timely treatment and/or interventions for the acute illness requiring out-of-home care (Round 9 – 92% for Indicator 4.e, Round 10 – 88% for Indicator 4.e, and Round 11 - 92% for Indicator 6.e), Indicator e will move to the category requiring less oversight. The Monitoring Team will continue to review the remaining indicators.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
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.	47% 7/15	2/2	2/2	0/2	0/1	1/2	N/A	1/2	1/2	0/2
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	100% 6/6	1/1	1/1	1/1	N/A	2/2		N/A	1/1	N/A
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	85% 11/13	1/2	N/A	1/2	2/2	2/2	1/1	2/2	2/2	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	67% 4/6	N/A		N/A	0/1	2/2	1/1	N/A	1/2	
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	92% 12/13	2/2		2/2	1/2	2/2	1/1	2/2	2/2	
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	46% 6/13	1/2		1/2	0/2	2/2	0/1	1/2	1/2	
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	100% 7/7	N/A		2/2	1/1	1/1	1/1	N/A	2/2	
h.	Upon the individual's return to the Facility, there is evidence the PCP	100%	2/2		2/2	2/2	2/2	1/1	2/2	2/2	

	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.	13/13									

Comments: a. and b. For eight of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 15 acute illnesses addressed at the Center, including the following with dates of occurrence: Individual #174 (scalp laceration on 12/24/16, and swollen nose on 12/28/16), Individual #197 (reactive airway disease on 12/16/16, and pseudo-seizure on 12/13/16), Individual #6 (stomal irritation/drainage on 12/27/16, and red eye on 12/12/16), Individual #182 (lesion on right forearm on 7/28/16), Individual #8 (skin breakdown on 8/16/16, and rash on 9/12/16), Individual #102 (dermatitis on 9/10/16, and fever on 9/6/16), Individual #186 [urinary tract infection (UTI) on 12/20/16, and fall on 12/8/16], and Individual #188 (bruises on 12/1/16, and bruise on 10/31/16).

The acute illnesses for which documentation was present to show that medical providers assessed the individuals according to accepted clinical practice were for Individual #174 (scalp laceration on 12/24/16, and swollen nose on 12/28/16), Individual #197 (reactive airway disease on 12/16/16, and pseudo-seizure on 12/13/16), Individual #8 (rash on 9/12/16), Individual #102 (fever on 9/6/16), and Individual #186 (UTI on 12/20/16). For many of the remaining acute illnesses treated at the Facility that the Monitoring Team reviewed, medical providers did not cite the source of the information (e.g., nursing, activities/workshop staff, PT, OT, etc.) in assessing them. No physical exam was documented for Individual #102 (dermatitis on 9/10/16).

It was positive that for the acute illnesses/occurrences reviewed for which follow-up was needed, documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized.

For seven of the nine individuals reviewed, the Monitoring Team reviewed 13 acute illnesses requiring hospital admission, or ED visit, including the following with dates of occurrence: Individual #174 (ED visit for fall hitting head on 8/14/16, and ED visit for scalp laceration on 10/2/16), Individual #6 (hospitalization for vomiting and GI bleed on 8/1/16, and hospitalization for UTI on 12/17/16), Individual #182 (hospitalization for abdominal distension and lethargy on 9/11/16, and ED visit for GI issues on 12/8/16), Individual #8 (ED visit for right lower extremity swelling on 7/26/16, and ED visit for left hip rotated internally on 9/1/16), Individual #235 (ED visit for abscess in mouth on 7/26/16), Individual #102 (ED visit for abdominal pain on 8/8/16, and ED visit for fall on 7/3/16), and Individual #186 (hospitalization for dehydration, acute renal failure, and UTI on 10/20/16, and hospitalization for dehydration and acute kidney injury on 10/10/16).

c. For Individual #174 (ED visit for fall hitting head on 8/14/16) and Individual #6 (hospitalization for UTI on 12/17/16), PCP IPNs were not completed on the next business day.

d. Seven of the acute illnesses reviewed occurred after hours, on a weekend/holiday, or off-grounds. Vital signs were not documented in the IPNs for Individual #182 (hospitalization for abdominal distension and lethargy on 9/11/16) and Individual #186 (hospitalization for dehydration, acute renal failure, and UTI on 10/20/16).

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

exception was Individual #182 (ED visit for GI issues on 12/8/16) for which IPNs were not found with regard to staff actions/treatment prior to the ED visit.

f. The individuals that were transferred to the hospital for whom documentation was not submitted to confirm that the PCP or nurse communicated necessary clinical information with hospital staff were Individual #174 (ED visit for scalp laceration on 10/2/16), Individual #6 (hospitalization for vomiting and GI bleed on 8/1/16), Individual #182 (hospitalization for abdominal distension and lethargy on 9/11/16, and ED visit for GI issues on 12/8/16), Individual #235 (ED visit for abscess in mouth on 7/26/16), Individual #102 (ED visit for abdominal pain on 8/8/16), and Individual #186 (hospitalization for dehydration, acute renal failure, and UTI on 10/20/16).

g. It was positive that IDTs met to conduct post-hospitalization reviews. In several cases, IDT developed a number of action steps to address follow-up medical and healthcare supports to reduce risks and promote early recognition.

h. It was good to see that for the individuals reviewed, upon their return to the Center, there was evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.

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

Summary: Given that over the last two review periods and during this review, for the consultations reviewed, the PCPs generally reviewed consultations and indicated agreement or disagreement (Round 9 – 88%, Round 10 – 94%, and Round 11 – 88%), and did so in a timely manner (Round 9 – 81%, Round 10 – 75%, and Round 11 – 94%), Indicators a, and b will move to the category requiring less oversight. It was good to see improvement with regard to PCPs writing orders for agreed-upon recommendations. The Center needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

#	Indicator	Overall Score	Individuals: 174	197	6	182	8	235	102	186	188
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	88% 14/16	2/2	2/2	1/2	2/2	1/2	2/2	N/A	2/2	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	94% 15/16	2/2	2/2	2/2	2/2	2/2	1/2		2/2	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to	50% 8/16	2/2	1/2	0/2	2/2	0/2	1/2		2/2	0/2

	the IDT.										
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	77% 10/13	1/1	1/1	2/2	1/1	2/2	1/2		0/2	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/8	N/A	N/A	0/2	N/A	0/2	0/1		0/1	0/2

Comments: For eight of the nine individuals reviewed, the Monitoring Team reviewed a total of 16 consultations. The consultations reviewed included those for Individual #174 for orthopedics on 7/7/16, and surgery on 7/18/16; Individual #197 for cardiology on 7/19/16, and orthopedics on 8/2/16; Individual #6 for endocrinology on 11/30/16, and gastroenterology (GI) on 8/18/16; Individual #182 for GI on 11/8/16, and pulmonology on 11/21/16; Individual #8 for endocrinology on 10/15/16, and orthopedics on 9/22/16; Individual #235 for endocrinology on 8/30/16, and GI on 12/14/16; Individual #186 for urology on 9/30/16, and urology on 11/2/16; and Individual #188 for neurology on 9/28/16, and endocrinology on 10/25/16.

a. It was positive that PCPs generally reviewed and initialed the consultation reports reviewed, and indicated agreement or disagreement with the recommendations. The exceptions were the consultations for Individual #6 for GI on 8/18/16, and Individual #8 for orthopedics on 9/22/16.

b. Only one of these reviews did not occur timely (i.e., the one for Individual #235 for GI on 12/14/16).

c. Half of the PCP IPNs related to the consultations reviewed included all of the components State Office policy requires. The exceptions were for Individual #6 for endocrinology on 11/30/16, and gastroenterology (GI) on 8/18/16, Individual #8 for endocrinology on 10/15/16, and orthopedics on 9/22/16, Individual #235 for GI on 12/14/16, and Individual #188 for neurology on 9/28/16, and endocrinology on 10/25/16, which did not state whether or not there was a need for referral to the IDT; and Individual #197 for orthopedics on 8/2/16, for which an IPN was not found.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, with the exceptions of the following: Individual #235 for GI on 12/14/16 (i.e., for which written orders were not provided for the following labs: ferritin, anti-nuclear antibodies, and acute hepatitis panel), and Individual #186 for urology on 9/30/16 (i.e., evidence of order for lab testing was missing), and urology on 11/2/16 (i.e., timed voiding every one to two hours was not submitted).

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
Summary: Although additional work was necessary, it was positive that for a number of individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188

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.	78% 14/18	0/2	2/2	2/2	2/2	1/2	2/2	1/2	2/2	2/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #174 – circulatory, and falls; Individual #197 – diabetes, and osteoporosis; Individual #6 – respiratory compromise, and GI problems; Individual #182 – respiratory compromise, and seizures; Individual #8 – cardiac disease, and osteoporosis; Individual #235 – weight, and osteoporosis; Individual #102 – GI problems, and seizures; Individual #186 – cardiac disease, and osteoporosis; and Individual #188 – cardiac disease, and weight).

a. It was positive that for a number of individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate. The following summarizes concerns noted:

- Individual #8 was diagnosed with osteopenia. She had a hysterectomy in the past, and was prescribed estrogen replacement therapy until she developed a pulmonary embolism. At the time of the Monitoring Team's review, she was prescribed Alendronate. However, in 2013, a Vitamin D supplement at a relatively high dose of 2000 International Units (IUs) daily, and a calcium supplement were discontinued when she developed hypercalcemia. Sine 2/9/15, her Vitamin D level had not been reported. A DEXA scan from 2007 resulted in a T-score of -1.8, but the AMA recorded this as +1.8. The AMA stated that further DEXA scans would not be ordered, because treatment would not change, and because of her refusal to cooperate with testing. However, it is important to use serial DEXA scans every two to three years to determine efficacy of treatment. No information was submitted indicating the IDT had developed a desensitization plan or other strategy to decrease her refusals. In approximately July 2016, she sustained a hip fracture, which was diagnosed on 9/2/16, resulting in hip surgery on 9/5/16. She currently was able to ambulate short distances with her walker, and a gait belt was used with the assistance of one staff member. She also propelled herself in a wheelchair. However, her recent hip fracture resulted in a reduced ability to cooperate with any exercise program. The lack of monitoring Vitamin D levels, the lack of serial DEXA scan reports to determine efficacy of the Alendronate, and the lack of behavioral intervention to improve compliance with testing were problematic.
- Individual #102 had a seizure disorder that was treated with Dilantin and Tegretol. The most recent levels prior to his death were obtained on 7/28/16 (Dilantin 13.7, and Tegretol 2.8). On 6/16/16, he had been hospitalized for hyponatremia of 117. This was in part due to psychogenic polydipsia. On the day of his death, he drank considerable amounts of fluid, although the amount was not provided. There was notation about the high ambient temperature, and his apparent sweating perhaps in part due to overexertion during participation at a community event. Despite his recent hospitalization for electrolyte imbalance, there appeared to be no plan to ensure adequate hydration with instructions for the specific type of fluid to be ingested for rehydration in high environmental temperatures. A post-hospital ISPA, dated 6/21/16, included information concerning hydration and fluids to be administered, but did not specify how staff should apply this to offsite events. His most recent Tegretol level was sub-therapeutic. His seizure and subsequent death was not expected. The autopsy indicated vomiting and aspiration followed the seizure, as opposed to aspiration leading to hypoxia and seizure activity. The Center did not submit any documentation that might have discussed alternate choices of seizure medication, given that Tegretol is associated with or might aggravate hyponatremia and he had a history of psychogenic polydipsia. He had had no neurology consultation in the time period that the document request covered.
- The potential causes (e.g., vertigo, akathisia, cerumen impaction, a vena cava abnormality such as a stricture or other anatomic

anomaly, a behaviorally-based etiology, etc.) of Individual #174's many falls (i.e., 2013 - 29, 2014 - 48, and 2016 - 55) as well as his behavior suggesting discomfort remained numerous and unresolved. The etiology of his extensive bruising of his buttocks also remained elusive. Specific coagulation deficiencies had not been considered. He was prescribed Valproic Acid, which can be associated with low platelets, but it was determined that he did not have thrombocytopenia. He had not been able to cooperate for consultant evaluations and tests in which he needed to remain still. His situation might require consultation across organizations (e.g., hospital anesthesiology and the SSLC) to develop a safe approach to ensuring his health yet completing necessary tests. Additionally, having consultations arranged on campus by such specialties as physiatry might provide additional guidance and new information. Overall, a methodical approach to his behavioral and medical challenges needs to be created and tracked. An interdisciplinary approach with specific steps taken to address the differential diagnosis will be important to assist in improving his quality of health.

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

Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. However, documentation was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs/ISPs. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.

#	Indicator	Overall Score	Individuals: 174	197	6	182	8	235	102	186	188
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	100% 12/12	1/1	N/A	2/2	2/2	N/A	1/1	2/2	2/2	2/2

Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed generally were implemented.

Pharmacy

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

Summary: N/R

#	Indicator	Overall Score	Individuals: 174	197	6	182	8	235	102	186	188
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	N/R									

b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
	Comments: The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.										

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
Summary: In it comments to the draft report, the State explained that the transition to the IRIS system played a role in the completion of QDRRs outside the quarterly timeframe (i.e., Indicator a). Given that the Center received 100% scores for this indicator during the last two reviews, if this issue is corrected during the next review, this indicator will likely move to the category requiring less oversight. Given the timely practitioner review of QDRRs during this review and the past two reviews (Round 9 – 100%, Round 10 – 100%, and Round 11 - 100%), indicator c will be placed in the category requiring less oversight. Improvement is needed with regard to the timely completion of QDRRs, as well as the quality of the QDRRs.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	QDRRs are completed quarterly by the pharmacist.	63% 10/16	1/2	1/2	1/2	1/2	1/2	1/2	2/2	1/1	1/1
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	50% 8/16	1/2	1/2	1/2	1/2	1/2	0/2	2/2	0/1	1/1
	ii. Benzodiazepine use;	100% 9/9	N/A	N/A	2/2	2/2	N/A	2/2	2/2	1/1	N/A
	iii. Medication polypharmacy;	88% 7/8	N/A	N/A	N/A	2/2	N/A	2/2	2/2	1/1	0/1
	iv. New generation antipsychotic use; and	0% 0/9	N/A	0/2	0/2	N/A	0/2	N/A	0/2	N/A	0/1
	v. Anticholinergic burden.	94% 15/16	2/2	2/2	2/2	2/2	2/2	2/2	2/2	1/1	0/1
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical										

	justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 16/16	2/2	2/2	2/2	2/2	2/2	2/2	2/2	1/1	1/1
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 14/14	2/2	2/2	2/2	N/A	2/2	2/2	2/2	1/1	1/1
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	100% 4/4	1/1	1/1	1/1	N/A	1/1	N/A	N/A	N/A	N/A
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	N/R									

Comments: a. In it comments to the draft report, the State explained that the transition to the IRIS system played a role in the completion of QDRRs outside the quarterly timeframe. Given that the Center received 100% scores for this indicator during the last two reviews, if this issue is corrected during the next review, this indicator will likely move to the category requiring less oversight.

b. For a number of individuals, the most recent lab data available had not been incorporated into the QDRR reports.

For individuals with metabolic syndrome or at risk for metabolic syndrome, including data for each of the five risks would clarify the presence or risk for this concern. The individual's waist circumference should be specifically included, but was not in many cases.

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

d. When prescribers agreed to recommendations for the individuals reviewed, documentation was presented to show they implemented them.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including	13%	0/1	0/1	0/1	0/1	0/1	0/1	1/1		0/1

	timeframes for completion;	1/8									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1

Comments: a. and b. Individual #186 was edentulous, but was part of the core group, so a full review was conducted. The Monitoring Team reviewed eight individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental.

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #102's goal/objective for an annual dental exam and teeth cleaning every six months.

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

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: These are new indicators, which the Monitoring Team will continue to review.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	Individuals have no diagnosed or untreated dental caries.	13% 1/8	0/1	0/1	0/1	0/1	0/1	1/1	0/1	N/A	0/1
b.	Since the last exam:										
	i. If the individual had gingivitis (i.e., the mildest form of periodontal disease), improvement occurred, or the disease did not worsen.	50% 1/2	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	0/1
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	17% 1/6	0/1	1/1	0/1	0/1	0/1	N/A	0/1	N/A	N/A
c.	Since the last exam, the individual's fair or good oral hygiene score was maintained or improved.	N/R									

Comments: a. and b. Individual #186 was edentulous. For many individuals reviewed, because up-to-date dental exams were not completed, evidence was not available to confirm that they had no untreated dental caries, and/or determine the status of their periodontal condition.

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

Outcome 5 – Individuals receive necessary dental treatment.

Summary: As Center staff are aware, vacancies and staff changes as well as individuals' refusals to participate in dental treatment contributed to lapses in dental care. With the new Dental Director, the Center should continue to focus on the provision and quality of dental treatment.

#	Indicator	Overall Score	Individuals: 174	197	6	182	8	235	102	186	188
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.	13% 1/8	0/1	0/1	0/1	0/1	0/1	1/1	0/1	N/A	0/1
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	38% 3/8	0/1	1/1	1/1	0/1	0/1	1/1	0/1		0/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	50% 4/8	1/1	1/1	0/1	1/1	0/1	1/1	0/1		0/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	17% 1/6	N/A	0/1	0/1	0/1	0/1	1/1	0/1		N/A
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		N/A
f.	If the individual has need for restorative work, it is completed in a timely manner.	17% 1/6	N/A	0/1	N/A	0/1	0/1	1/1	0/1		0/1
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 2/2	N/A	1/1	N/A	N/A	N/A	1/1	N/A		N/A

Comments: a. through f. Individual #186 was edentulous. A number of individuals reviewed had not had needed dental treatment. As noted above, the new Dental Director was working to address individuals' dental needs, but the backlog of needed care was significant.

f. On 5/11/15, Individual #197 presented with non-restorable tooth #9, needing extraction. This tooth was not extracted until 11/3/16. Additionally, on 5/11/15, tooth #3 also was considered for possible restoration (i.e., crown), but was not treated then, and later on 3/8/16, Individual #197 had pain from this tooth, and on 5/6/16, this tooth was found to be grossly decayed and non-restorable. A three-month holiday of Alendronate was needed before the scheduling of an extraction. She was subsequently seen three times for emergency dental visits due to dental pain/discomfort, with final resolution on 11/3/16, via extraction of both tooth #9 and tooth #3. There was considerable delay in restorative treatment for tooth #9, along with the prolonged discomfort of tooth #3 before definitive treatment occurred.

Outcome 7 – Individuals receive timely, complete emergency dental care.

Summary: When dental emergencies occur, better nursing and/or dental documentation is needed with regard to the onset of symptoms. It was good to see, though, that once the dentist saw the individuals with dental emergencies that treatment was provided. Pain management and documentation of it is an area on which the Center should focus.

#	Indicator	Overall Score	Individuals: 174	197	6	182	8	235	102	186	188
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	11% 1/9	N/A	0/6	N/A	N/A	N/A	1/3	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 9/9		6/6				3/3			
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	44% 4/9		2/6				2/3			

Comments: a. through c. Due to a lack of documentation related to the onset of symptoms, the timeliness of emergency dental care often could not be confirmed. However, based on documentation reviewed, once the dentist saw the individuals, treatment was provided. Although individuals clearly received pain management in some instances, in others, it was unclear whether or not pain management was ordered/provided, and in other instances, contradictions were found with regard to the assessment of pain. For example, on 7/25/16, Individual #235 came in to the Dental Office with a complaint of pain and was able to point to the tooth that hurt, but the numeric pain scale was rated a 0. On 11/29/16, Individual #197's pain was rated an eight out of 10, but no pain management was noted.

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.

Summary: The Monitoring Team will continue to review all of these indicators.

#	Indicator	Overall Score	Individuals: 174	197	6	182	8	235	102	186	188
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of	50% 1/2	N/A	N/A	1/1	0/1	N/A	N/A	N/A	N/A	N/A

	suction tooth brushing.										
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.	100% 2/2			1/1	1/1					
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: b. Although some information was provided on Medication Administration Records (MARs), it was incomplete. In the response to the document request, the Center referenced "Care Management Orders." However, the Center was unable to provide the documentation, based on an onsite request. c. It was positive that Dental Department staff were monitoring staff's implementation of suction tooth brushing for quality, as well as safety.											

Outcome 9 – Individuals who need them have dentures.										
Summary: Improvements were needed with regard to the dentist's assessment of the need for dentures for individuals with missing teeth.		Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	14% 1/7	N/A	0/1	0/1	0/1	0/1	0/1	N/A	1/1	0/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: For the individuals reviewed with missing teeth, the Dental Department often did not provide recommendations regarding 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: Nursing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis for acute illnesses/occurrences remained areas on which the Center needs to focus. It is also important that nursing staff timely notify the practitioner/physician of such signs and symptoms in accordance with the	Individuals:

nursing guidelines for notification. Nursing staff were not developing acute care plans for all relevant acute care needs, and those that were developed needed significant improvement. These indicators will remain in active oversight.											
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	20% 2/10	0/2	0/1	1/1	0/1	0/2	N/A	0/1	1/2	N/A
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	11% 1/9	0/2	0/1	1/1	0/1	0/2		0/1	0/1	
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/10	0/2	0/1	0/1	0/1	0/2		0/1	0/2	
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0% 0/5	0/1	N/A	0/1	0/1	0/1		N/A	0/1	
e.	The individual has an acute care plan that meets his/her needs.	0% 0/10	0/2	0/1	0/1	0/1	0/2		0/1	0/2	
f.	The individual's acute care plan is implemented.	0% 0/10	0/2	0/1	0/1	0/1	0/2		0/1	0/2	

Comments: The Monitoring Team reviewed 10 acute illnesses and/or acute occurrences for seven individuals, including Individual #174 – skin integrity/infection on 10/3/16, and laceration with staples on 8/17/16; Individual #197 – dental issues on 9/13/16; Individual #6 – urinary tract infection (UTI) on 12/21/16; Individual #182 – percutaneous endoscopic gastrostomy (PEG) tube placement, aspiration pneumonia, and edema related to renal failure post hospitalization on 9/2/16; Individual #8 – infections/skin integrity on 12/20/16, and fractured hip in September 2016; Individual #102 – cellulitis of the nose on 7/26/16; and Individual #186 – UTI on 12/20/16, and dehydration and UTIs in October 2016.

a. The acute illnesses/occurrences for which nursing assessments (physical assessments) were performed were for Individual #6 – UTI on 12/21/16, and Individual #186 – UTI on 12/20/16.

b. The acute illness/occurrence for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms in accordance with the DADS SSLC nursing protocol entitled: "When contacting the PCP" was: Individual #6 – UTI on 12/21/16. For other illnesses/occurrences, sometimes nurses had not completed IPNs at the time of the initial onset of symptoms, even though the PCP wrote a corresponding note and/or the individual was sent to the ED.

e. For a number of acute issues, the Center did not submit acute care plans (i.e., Individual #182 – PEG tube placement, aspiration

pneumonia, and edema related to renal failure post hospitalization on 9/2/16; Individual #8 – infections/skin integrity on 12/20/16, and fractured hip in September 2016; and Individual #186 – dehydration and UTIs in October 2016). Common problems with the acute care plans that were submitted included a lack of: instructions regarding follow-up nursing assessments that were consistent with the individuals' needs; alignment with nursing protocols; specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; clinical indicators nursing would measure; and the frequency with which monitoring should occur.

The following provide some examples of concerns noted with regard to this outcome:

- On 9/2/16, Individual #182 returned from the hospital with a new PEG tube, and diagnoses of aspiration pneumonia and edema related to renal failure. Acute care plans were not developed and/or implemented for these significant occurrences/illnesses.
- In September 2016, it was discovered that Individual #8 had a fractured hip. The Center provided no acute care plan to address this major health issue. Such a plan should have defined the care staff were to provide, the expected nursing assessments, as well as preventative measures to avoid complications.
- For Individual #8, in response to the Monitoring Team's request for acute care plans for the review period, the Center provided an "Infections, Skin Integrity IHCP," initiated on 12/20/16. However, no IPN was found on 12/20/16, or 24 hours before and/or after this date noting an infection and/or skin issue. IPNs going back to 11/23/16 indicated a friction blood blister to the individual's right heel with a black-looking scab, and on 11/25/16, an IPN noted she was bleeding from her buttocks and "had a couple ongoing open areas to buttocks." The Center did not provide an acute care plan addressing these issues. It appeared that the term "Acute Care Plan" was added to the "LTC" (it was unclear what this meant) IHCP, but the IDT did not identify the acute issue the plan was designed to address and/or how this plan was different from the IHCP. Individual #8 had a number of skin issues, and the ISPAs indicated that the IDT met to talk about them, but the Center did not submit any evidence that nursing staff developed acute care plans to address her acute skin breakdown issues since her discovered hip fracture. In addition, the nursing IPNs did not include regular, specific clinical criteria assessing and documenting her skin or skin issues.
- On 9/13/16, Individual #197 complained of a broken front tooth and pain. The nursing assessment did not include vital signs, or include an assessment of the individual's mouth mucosa, pain, odor, sensitivity to cold/heat, and/or ability to eat and chew. The IPN noted that the individual had broken a tooth previously. The individual was prescribed an antibiotic, but nursing staff did not conduct ongoing assessments. The acute care plan the Center provided was written as an IHCP with the goal: "oral hygiene rating will improve from fair to good in the coming year." No nursing assessments were included in the plan of care. This did not meet the criteria for an acute care plan.
- On 7/24/16 at 6:45 a.m., an IPN noted that Individual #102 was "stuffy" when he spoke and his nose was slightly swollen, "however he was diagnosed with a fracture on 7/3/16." Nursing staff put him on the list to see the PCP that morning. An IPN at 4:00 p.m. noted that a direct support professional reported Individual #102 felt warm. The only nursing assessment data was a temperature of 100, but the nurse did not note how the individual's temperature was taken (i.e., orally, temporal, rectal). The next IPN at 7:30 p.m. indicated the individual's temperature was still 100 (again no site was provided), but nursing staff conducted and/or documented no further assessment. On 7/25/16, a PCP note indicated that antibiotics were started for the possible beginning of cellulitis around the peri-nasal area. The only related IPN addressing nursing assessments following this diagnosis was on 7/26/16 at 11:30 a.m., and it included an assessment of rhinitis. The acute care plan provided did not include any assessment criteria, the frequency of assessments, where they should be documented, and/or who should review the

documentation.

- Following Individual #186's hospitalization in October 2016, nursing staff did not develop acute care plans for the significant medical issues of dehydration, and/or UTI. On 12/20/16, he again was diagnosed with a UTI, and the acute care plan nursing staff developed did not include specific assessment criteria, the frequency of assessments, daily intake requirements, measurement of actual intake, and/or hygiene teaching (i.e., e coli was found in the urinalysis). The assessments found in IPNs did not use consistent criteria, and IPNs frequently noted that vital signs were "WNL" (within normal limits) as opposed to noting actual values. IPNs provided no indication of his fluid intake or output.

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

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

#	Indicator	Overall Score	Individuals: 174	197	6	182	8	235	102	186	188
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	6% 1/18	0/2	0/2	0/2	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/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #174 – falls, and dental; Individual #197 – fractures, and weight; Individual #6 – dental, and GI problems; Individual #182 – falls, and weight; Individual #8 – dental, and skin integrity; Individual #235 – dental, and skin integrity; Individual #102 – falls, and constipation/bowel obstruction; Individual #186 – other: hypothyroidism, and UTIs; and Individual #188 – falls, and constipation/bowel obstruction).

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #182 – weight.

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the

IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provision of nursing supports and services to these nine individuals.

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

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

#	Indicator	Overall Score	Individuals: 174	197	6	182	8	235	102	186	188
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/15	0/2	0/1	0/2	0/2	0/2	0/2	0/2	0/1	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).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

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

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

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

#	Indicator	Overall	Individuals: 174	197	6	182	8	235	102	186	188

		Score									
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R									
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	88% 7/8	1/1	1/1	1/1	1/1	0/1	1/1	N/A	1/1	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	N/A									
	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.	50% 1/2	N/A	N/A	1/1	0/1	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.	88% 7/8	1/1	1/1	1/1	1/1	0/1	1/1		1/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	88% 7/8	1/1	1/1	1/1	1/1	0/1	1/1		1/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the	N/R									

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

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of eight individuals, including Individual #174, Individual #197, Individual #6, Individual #182, Individual #8, Individual #235, Individual #186, and Individual #188.

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

- The medication nurse administered eye drops with Individual #8 sitting up in her wheelchair with the headrest inhibiting the individual from being able to tilt her head back. The dropper touched the corner of the individual's left eye during administration, which is an infection risk, and the eye drop to right eye fell on the individual's cheek. The nurse did not attempt to re-administer it. After the medication pass was complete, the nurse member of the Monitoring Team pointed out that the dropper touched the individual's left eye and the right eye drop did not go into the eye, and asked the nurse why she did not attempt the right eye drop again. The nurse did not provide any rationale. The Chief Nurse Executive (CNE) then prompted the nurse to try to re-administer the medication to the right eye before the timeframe for medication administration lapsed. Nursing staff should collaborate with Habilitation Therapy staff regarding alternative positions for eye drop administration to ensure the drops are consistently and safely administered.

d. The CNE reported that nursing staff completed training regarding lung sounds during medication administration in alignment with the indicators.

- Before and after medication administration, the medication nurse appropriately assessed the lung sounds for Individual #6, who has a jejunostomy-gastrostomy (J/G) tube.
- For Individual #182, the nurse obtained lung sounds before and after administering medications. However, the completion of lung sounds was not defined in the IHCP.

f. It was positive that for most individuals observed, the nurses followed their PNMPs during medication administration. The only exception was the nurse administering medications to Individual #8, who needed prompting to check the position of the individual in her wheelchair.

g. For the individuals observed, nursing staff generally followed infection control practices, which was good to see. The exception was

the nurse that touched the eyedropper to Individual #8's eye, as discussed in more detail above.

l. and m. Due to issues with IRIS documentation, the Monitoring Team could not fully assess these indicators, and therefore, is not scoring them. However, of concern, medication variance forms the Center submitted indicated that for each individual reviewed multiple medications were not given or were found in their bins. For most individuals, these omissions or unknown returns occurred over multiple days (e.g., Individual #8 with 51 doses across five days, or Individual #186 with 76 doses across seven days). The IRIS variance forms provided did not indicate if the PCPs were notified or if there were any clinical issues related to the medications not administered. In addition, the forms provided no explanation as to why the variances occurred.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: It was good to see some improvement with regard to individuals being referred to the PNMT, when needed (i.e., during the review, the Center's score was 0%). Overall, though, IDTs and/or the PNMT did not have a way to measure outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
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	0/1	0/1	0/1	0/1	0/1	0/2	0/2	0/1	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	42% 5/12	0/1	0/1	1/1	0/1	0/1	2/2	1/2	0/1	1/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	8% 1/12	0/1	0/1	0/1	0/1	0/1	1/2	0/2	0/1	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/12	0/1	0/1	0/1	0/1	0/1	0/2	0/2	0/1	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/12	0/1	0/1	0/1	0/1	0/1	0/2	0/2	0/1	0/2
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										

	i.	If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	67% 4/6	0/1	0/1	1/1	1/1	1/1	N/A	N/A	1/1	N/A
	ii.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	0/1	0/1	0/1	0/1	0/1			0/1	
	iii.	Individual has a measurable goal/objective, including timeframes for completion;	17% 1/6	0/1	0/1	0/1	1/1	0/1			0/1	
	iv.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/6	0/1	0/1	0/1	0/1	0/1			0/1	
	v.	Individual has made progress on his/her goal/objective; and	0% 0/6	0/1	0/1	0/1	0/1	0/1			0/1	
	vi.	When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/1	0/1	0/1	0/1	0/1			0/1	

Comments: The Monitoring Team reviewed 12 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: aspiration for Individual #174; GI problems for Individual #197; choking for Individual #6; choking for Individual #182; weight for Individual #8; weight, and GI problems for Individual #235; aspiration, and choking for Individual #102; GI problems for Individual #186; and choking, and aspiration for Individual #188.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: choking for Individual #182; weight, and GI problems for Individual #235; choking for Individual #102; and choking for Individual #188.

b.i. The Monitoring Team reviewed six areas of need for six individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: falls for Individual #174, falls for Individual #197, GI problems for Individual #6, aspiration for Individual #182, fractures for Individual #8, and other: dehydration for Individual #186.

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

- It was not until 8/16/16 that Individual #174 was referred to the PNMT. This was after multiple injuries and a continued decline in status since February 2016. The PNMT discussed him according to their minutes, but did not provide direct intervention in the form of a comprehensive assessment despite falls continuing to occur.
- On 4/6/16, Individual #197 fractured her humerus. According to PNMT policy, when an individual experiences a fracture of a long bone, the PNMT is required to conduct a review. Although PNMT minutes indicated a brief discussion, no evidence was found to show the PNMT conducted a review.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT did not develop clinically relevant, achievable, and measurable goals/objectives for these individuals. Although the following goal/objective was measurable, because it was not clinically relevant, the

related data could not be used to measure the individual's progress or lack thereof: aspiration for Individual #182.

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

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

Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
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.	6% 1/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	0% 0/8	0/1	0/1	0/1	0/2	0/2	N/A	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.	0% 0/2	N/A	N/A	N/A	0/1	N/A	N/A	N/A	0/1	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, the IHCP for which documentation was found to confirm the implementation of the PNM action steps that were included was for weight for Individual #235.

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

- Individual #186's IDT did not develop an IHCP for dehydration, despite two episodes in one month.
- Individual #8's IDT did not update her IHCP after a fracture was treated in September 2016 that was approximately two months old when it was detected. Although Individual #8 was overweight and listed at medium risk, she had no IHCP related to weight.
- Individual #182 returned from the hospital with a recommendation for a ground diet with nectar thick liquids. This recommendation was based on a modified barium swallow study (MBSS), but the IDT did not implement it. Individual #182 continued to receive an inappropriate diet texture and fluid consistency for approximately 30 days, which placed him at extremely high risk.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
Summary: During numerous observations, staff failed to implement individuals' PNMPs as written. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	40% 16/40
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.	50% 2/4
Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during nine out of 19 observations (47%). Staff followed individuals' dining plans during seven out of 21 mealtime observations (33%). Given the number of staff who did not implement PNMPs correctly, it should be noted that during one meal, the Monitoring Team member asked the PNMP Coordinator how staff were trained on the PNMPs of individuals with whom they were not familiar. The PNMP Coordinator stated that she provided the training. When asked if the training was competency-based, the PNMP Coordinator stated: "yes." Upon review of the training, however, it was in-service training and did not include return demonstration. Given that the individual observed was in a different home than usual (i.e., while recovering from a fracture), return demonstration competency-based training was warranted. In addition, the individual's dining plan included what appeared to be detailed individualized strategies.		

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	174	197	6	182	8	235	102	186	188
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.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
Comments: a. Although Individual #182 was expected to return to oral eating, his IDT had not developed a measurable plan.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: It was good to see that some OT/PT goals/objectives developed for individuals reviewed were clinically relevant, and measurable. However, for the individuals reviewed, IDTs overall did not have a way to measure outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	27% 3/11	0/1	0/2	1/1	0/1	2/2	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	27% 3/11	0/1	0/2	1/1	1/1	1/2	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	9% 1/11	0/1	0/2	0/1	1/1	0/2	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/11	0/1	0/2	0/1	0/1	0/2	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/11	0/1	0/2	0/1	0/1	0/2	0/1	0/1	0/1	0/1
Comments: a. and b. The goals/objectives that were clinically relevant and achievable, as well as measurable were those for Individual #6 (i.e., pressing a button to activate a remote), and Individual #8 (i.e., ambulation). Although Individual #197's goal/objective for direct therapy (i.e., performing pendulum exercises) was clinically relevant and measurable, it was not included in the ISP or incorporated through an ISPA. Individual #182 had a goal/objective to wash his chest, which was measurable, but given that his assessment indicated he could already perform this task, it was not clinically relevant. c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. The Monitoring Team conducted full reviews for all nine individuals.										

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188

a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	44% 4/9	0/1	1/1	0/1	1/1	2/2	N/A	0/1	0/1	0/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	33% 1/3	N/A	0/1	N/A	N/A	1/2	N/A	N/A	N/A	N/A
Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that supports were implemented. For the individuals that scored positively on this indicator, evidence was found in the OT/PT IPNs.											

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: Given that over the last two review periods and during this review, individuals observed generally had clean adaptive equipment (Round 9 – 95%, Round 10 – 90%, and Round 11 - 95%) that was in working order (Round 9 – 98%, Round 10 – 100%, and Round 11 - 88%), Indicators a and b will move to the category requiring less oversight. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's varying scores (Round 9 – 88%, Round 10 – 79%, and Round 11 - 52%), 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	217	183	195	269	161	226	196	139	293
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	95% 25/26	1/1	1/1	1/1	1/1	2/2	1/1	2/2	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	88% 23/26	1/1	1/1	1/1	1/1	2/2	1/1	2/2	0/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	52% 13/25	0/1	1/1	1/1	0/1	2/2	1/1	0/2	0/1	1/1
		Individuals:									
#	Indicator		6	89	225	317	190	238	260	23	109

a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	2/2	1/1	0/1	2/2	1/1	1/1	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/2	1/1	0/1	2/2	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	0/2	1/1	1/1	2/2	0/1	0/1	1/1	N/A
		Individuals:									
#	Indicator		181	37	258	130					
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1					
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	1/1					
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	0/1	0/1	0/1					

Comments: a. The Monitoring Team conducted observations of 29 pieces of adaptive equipment. The individuals the Monitoring Team observed generally had clean adaptive equipment, which was good to see. The exception was Individual #317's palm protector.

b. Issues with regard to equipment being in working order were noted for Individual #139 (headrest), Individual #89 (headrest), and Individual #317 (palm protector).

c. Based on observation of Individual #217, Individual #196, and Individual #260 (i.e., chest strap loose) in their wheelchairs, the outcome was that they were not positioned correctly. Individual #269's heel protectors, Individual #196's elbow splint, Individual #89's heelbos, and Individual #258's heel protectors did not appear to fit correctly. Individual #139 and Individual #89's headrests were tilted back and not in place to support the individuals' heads. Individual #238 and Individual #37 appeared to have insufficient supports to maintain their positioning in their recliners. Individual #130's walker did not appear to provide adequate support (i.e., it was used inefficiently and did not provide the individual support to maintain an upright position). 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.

In addition, it should be noted that a number of individuals' (e.g., Individual #186, Individual #223, and Individual #160) pants were falling down while the individuals were walking, which placed individuals at increased risk of falls.

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

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition. None of the indicators had sustained high performance scores to warrant being moved 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.

Regarding ISPs, one of the three goals that met criteria with indicator 1 and that were measurable (indicator 2) and had reliable date (indicator 3) was determined to be making progress.

Action steps were not regularly implemented for many goals and/or action plans, with the exception of one individual.

None of the SAPs were considered complete and, for all SAPs, progress could not be determined with certainty due to the lack of reliable data. SAPs that the Monitoring Team observed were not implemented as written.

Overall, engagement levels were low. New initiatives were in place, however, to develop on-campus and community programming activities.

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

It was concerning that often individuals' AAC devices were not present or readily accessible, and that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them. The Center should focus on improvements in these areas.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: One of the three goals that met criteria with indicators 1, 2, and 3 was determined to be making progress. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	197	174	27	320	182	188			
4	The individual met, or is making progress towards achieving his/her	0%	0/6	0/6	1/6	0/6	0/6	0/6			

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

Comments:
4-7. Overall, personal goals did not meet criterion as described above, therefore, there was no basis for assessing progress in these areas. See Outcome 7, Indicator 37, for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans.

For the personal goals that met criterion with indicators 1 and 2, there was no evidence that action plans to support those goals were consistently implemented because reliable and valid data were not available. For the personal goals that also met criterion with indicator 3, progress could not be determined or the data did not show any progress for two of the three.

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: Both indicators showed some improvement since the last review. Both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	197	174	27	320	182	188			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	33% 2/6	0/1	1/1	0/1	1/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			

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

40. The action steps were not consistently implemented for many goals and/or action plans, as noted above. Individual #174 was the only individual with documentation of consistent implementation of his ISP.

- Per Individual #197's ISP preparation document and QIDP monthly reviews, goals were not consistently implemented.
- For Individual #27, many action plans were not fully implemented, including his recreation/leisure, work and greater independence action plans.
- Per Individual #320's QIDP monthly reviews, his action plans had not been consistently implemented.
- Individual #182's ISP was not being implemented due to a change in medical status. Per observations, he was not involved in training or active treatment through most of his day. Interviews indicated that staff were not following recommendations to

ensure that he spent time each day out of his wheelchair or recliner. His IDT did meet when the Monitoring Team was onsite to discuss revising his goals to include active treatment on the home.

- Per QIDP monthly reviews, Individual #188's action plans were not being consistently implemented.

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: Attending to SAP implementation, data collection, and actions if SAPs are, or are not, progressing is an area of general focus for Lubbock SSLC. These four indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 27	233	82	322	131	320	174	236	197
6	The individual is progressing on his/her SAPS	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/3	0/2	0/1	0/2
7	If the goal/objective was met, a new or updated goal/objective was introduced.	50% 1/2	N/A	N/A	N/A	N/A	1/1	0/1	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	24% 4/17	0/2	0/2	1/2	1/2	0/1	0/2	2/3	0/1	0/2
9	Decisions to continue, discontinue, or modify SAPs were data based.	95% 21/22	3/3	2/2	2/2	2/2	2/3	3/3	3/3	1/1	3/3

Comments:

6. Although two SAPs (Individual #82 – hair care; and Individual #131 – SAMS) had data that suggested progress, neither had been monitored for integrity of implementation. Progress could not be assessed for four SAPs, either because there were not three months of data (Individual #27 – cooking; Individual #174 – signing; and Individual #197 – money management) or no data were reported (Individual #131 – sweeping). For all of the SAPs, progress could not be determined with certainty due to the lack of reliable data.

7. It was determined that Individual #131 had met his SAMS objective. Therefore, it was recommended that the IDT meet to identify another SAMS SAP. The monthly review from September 2016 noted that Individual #320 had met his hearing aid objective, however, the reported data did not support this determination. No replacement SAP was recommended.

8. The IDT for Individual #82 determined that her hair care SAP would be discontinued after she had cut her hair short. Individual #322's team recommended changing her SAP from learning to use a CD player to learning to use a DVD player as they believed she would be more interested in this activity. Individual #174's team determined that two SAPs would be discontinued at his upcoming ISP meeting due to lack of progress.

9. With one exception, there was evidence of data-based decisions for all SAPs. Individual #131's monthly reports from July 2016 to December 2016 did not include data on his sweeping program.

Outcome 4- All individuals have SAPs that contain the required components.												
Summary: Much continued work is needed in this area. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	27	233	82	322	131	320	174	236	197
13	The individual's SAPs are complete.	0% 0/22	0/3	0/2	0/2	0/2	0/3	0/3	0/3	0/1	0/3

Comments:
13. None of the SAPs were considered complete. The most typical omissions were those that included objectives that did not identify the conditions under which the behavior was to occur, teaching schedules that did not include the number of expected trials, and the absence of the use of individual-specific reinforcement.

As a practical matter, staff are advised to increase the font and to ensure that all printed instructions are visible (i.e., in several SAPs the last few lines of instructions were covered by dates).

It was positive to note that baseline was often assessed and independent or prompted performance was specified in the objective.

Outcome 5- SAPs are implemented with integrity.												
Summary: SAPs that were observed by the Monitoring Team were not done correctly and the facility did not have a good plan to regularly assess the quality of implementation. Without correct implementation, learning is not likely to occur and instead, valuable staff and individual personal time are wasted. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	27	233	82	322	131	320	174	236	197
14	SAPs are implemented as written.	0% 0/4	N/A	N/A	N/A	N/A	0/1	0/1	N/A	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.	0% 0/22	0/3	0/2	0/2	0/2	0/3	0/3	0/3	0/1	0/3

Comments:
14. Four SAPs were observed by the Monitoring Team, but none were implemented as written.
- When Individual #131 completed his blood glucose reading, the chart was not readily available to him as indicated in the SAP.
- Although the discriminative stimulus in the signing SAP for Individual #320 is to ask him what he wants to do, the staff member asked him who he wanted to call. (It should be noted this question was actually better related to the SAP).
- Individual #236's reinforcer was not readily available as he completed his shaving SAP.

- Although Individual #197 independently completed many of her medication routines, she did not ask for her medications by name as the SAP indicated.

15. As explained by the director of residential services, two staff members were to review one SAP for six individuals each month. She acknowledged that this was not a sufficient system for assessing all SAPs at a minimum of twice annually. The facility is working on a plan to involve residential coordinators to expand assessment of SAP integrity. Integrity is expected to be 80% or better.

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

Summary: Both indicators showed low performance and will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 27	233	82	322	131	320	174	236	197
16	There is evidence that SAPs are reviewed monthly.	27% 6/22	0/3	0/2	2/2	2/2	0/3	1/3	0/3	1/1	0/3
17	SAP outcomes are graphed.	0% 0/22	0/3	0/2	0/2	0/2	0/3	0/3	0/3	0/1	0/3

Comments:

16. QIDP monthly reports from July 2016 through December 2016 were reviewed. Based upon the information presented, there was evidence that six of 22 SAPs were reviewed monthly. These included the following: Individual #82 – hair care and medication; Individual #322 – hair care and radio/CD player; Individual #320 – hearing aids; and Individual #236 – shaving. While most reviews were completed the month after data were collected, several reviews were completed on the same day months later. These included Individual #82's and Individual #322's monthly reviews from July 2016 through November 2016, completed in January 2017. Conversely, Individual #236's monthly reviews from July 2016 and October 2016 were completed before the month had ended.

17. Although the facility had begun graphing SAP data in November 2016, these graphs were not helpful in determining progress. Only one month of data were presented as bar graphs indicating daily level of independent or prompted (verbal, gestural, physical, or manipulation) performance on a single trial of the SAP. This did not allow for a determination of progress over time. Further, refusals were not depicted on the graph.

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

Summary: Overall, engagement levels were low, as evidenced by indicator 18, which also scored the same as at the last review. The facility was regularly measuring engagement and had set goals. Therefore, with sustained high performance, indicators 19 and 20 might move to the category of requiring less oversight after the next review. Achieving those goals had improved since the last review. All four indicators will remain in active monitoring.

#	Indicator	Overall	Individuals: 27	233	82	322	131	320	174	236	197

		Score									
18	The individual is meaningfully engaged in residential and treatment sites.	13% 1/8	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	56% 5/9	1/1	0/1	1/1	0/1	1/1	1/1	0/1	0/1	1/1

Comments:

18. The Monitoring Team was able to observe eight of the nine individuals who were reviewed. The exception was Individual #27 who had recently transitioned to the community from the facility. Repeated observations revealed only one individual, Individual #197, to be consistently engaged in meaningful activities. She was observed on her job in the diner and later in the ceramics workshop. She also reported that she worked in one of the workshops.

Although observed engagement was not good, it should be noted that the facility had begun involving seniors in community-based programs and was pursuing opportunities for individuals to become involved with an educational program operated by Texas Tech University. In addition, an art studio and ceramics program had been established on campus.

19. It was positive to determine that the facility had assessed engagement each month in eight of the nine individuals' residential and primary day program sites over a six-month period. The exception was Individual #131. Engagement in his home had been assessed five times over this same six-month period.

20. The facility had established a goal of 80% engagement.

21. Engagement of 80% or better in both the residential and primary day treatment sites had been achieved for Individual #27, Individual #82, Individual #131, Individual #320, and Individual #197. For the remaining four individuals (Individual #233, Individual #322, Individual #174, Individual #236), the majority of their programming occurred on the home. Therefore, only residential engagement was used when assessing this indicator.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: Community outings occurred, but did not meet criteria for this indicator. With additional work, it is likely that the facility can make progress on these indicators, all of which had the same scores as last review. All three will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	27	233	82	322	131	320	174	236	197

22	For the individual, goal frequencies of community recreational activities are established and achieved.	22% 2/9	0/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A

Comments:
22. Three individuals (Individual #233, Individual #82, Individual #131) had goal frequencies for community recreational activities clearly identified in their ISPs. However, these frequencies were achieved for only Individual #233 and Individual #82. It should be noted that all nine individuals did participate in community-based activities over the six-month period from July 2016 through December 2016.

23. None of the individuals had goal frequencies of SAP training in the community identified in their ISPs. Documentation provided by the facility did indicate that some community-based training had occurred for Individual #233, Individual #131, Individual #320, and Individual #174.

24. There were no plans identified to address any barriers to Individual #131's frequency of community-based recreational activities.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
Summary: Only one individual at Lubbock SSLC qualified for and attended public school. He was a new admission and began school only a few weeks before the onsite review. Therefore, this outcome and indicator did not apply to any individuals at Lubbock SSLC. It will remain in active monitoring for the next review.			Individuals:								
#	Indicator	Overall Score									
25	The student receives educational services that are integrated with the ISP.	N/A									

Comments:

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.	
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals. These indicators will remain in active	Individuals:

oversight.											
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/5	0/1	0/1	N/A	N/A	0/1	0/1	0/1	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	20% 1/5	1/1	0/1			0/1	0/1	0/1		
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/5	0/1	0/1			0/1	0/1	0/1		
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/5	0/1	0/1			0/1	0/1	0/1		
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/5	0/1								
Comments: For four of the five individuals that had refused dental services, IDTs had not developed specific goals/objectives related to their refusals. Although Individual #174's IDT had developed a goal, it did not address the underlying cause of the dental refusals.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Since the last review, although more communication goals/objectives the Monitoring Team reviewed were measurable, fewer were clinically relevant. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	14% 1/7	0/1	0/1	0/1	0/1	0/1	N/A	0/1	1/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	43% 3/7	1/1	0/1	1/1	0/1	0/1		0/1	1/1	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	29% 2/7	1/1	0/1	1/1	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. and b. Individual #235 and Individual #188 had functional communication skills.

The goal/objective that was clinically relevant, as well as measurable was Individual #186's goal/objective related to identifying the correct meaning of safety signs.

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #174 (i.e., sign "more"), and Individual #6 (i.e., matching colors).

c. through e. QIDP reviews included analysis of data for Individual #174 (i.e., sign "more"), and Individual #6 (i.e., matching colors). For Individual #186's goal/objective to identify the correct meaning of safety signs, although data were submitted to show it was implemented, no evidence was found to show the QIDP had reviewed or analyzed the data.

As noted above, Individual #235 and Individual #188 had functional communication skills. Individual #235 was part of the outcome group, so further review was not conducted for him related to communication. Individual #188 was part of the core group, so a full review was conducted for her. For the remaining seven individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.

Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	174	197	6	182	8	235	102	186	188
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	40% 2/5	1/1	N/A	1/1	0/1	N/A	N/R	0/1	0/1	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									

Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. Examples of concerns included:

- No evidence was found of review of Individual #182's use of the all-shared devices.
- The QIDP monthly reviews for Individual #102 continually restated that the SLP would provide icons for the schedule, but provided no further detail regarding whether or not the SLP provided them.
- Although from data sheets provided, it appeared Individual #186's SAP for identifying street safety signs was implemented, no evidence was found of QIDP review and/or analysis for the IDT.

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
Summary: The Center should focus on ensuring individuals have their AAC devices with them, and that staff prompt individuals to use them in a functional manner. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	133	160	238	190	320	33	315		
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	43% 3/7	0/1	0/1	0/1	1/1	0/1	1/1	1/1		
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	29% 2/7	0/1	0/1	0/1	1/1	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.	0% 0/4									
Comments: a. and b. It was concerning that often individuals' AAC devices often were not present or readily accessible, and/or that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them.											

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

This Domain contains five outcomes and 20 underlying indicators. At this time, none will be moved to the category requiring less oversight. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. In addition, earlier in 2016, the Center began additional post-move monitoring responsibilities, and had begun to follow individuals in the community for a year as opposed to 90 days.

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

More work was needed to make supports in the CLDPs measurable. In addition, a number of essential supports were missing from the CLDPs reviewed, and this should be a focus for Center staff.

It was positive that the Post-Move Monitor conducted timely monitoring for the individuals reviewed. The Center should focus on the PMM basing decisions about supports on reliable and valid data, the PMM providing clear documentation to substantiate the findings, and IDTs following up in a timely and thorough manner when the PMM notes problems with the provision of supports.

Both individuals reviewed had experienced PDCT events, including five ER visits and the death of one individual, and police contact with transport to the hospital, and police contact with incarceration for the other individual. For both individuals, there were failures 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. In neither case did their IDTs conduct thorough post-event reviews.

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

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.	
Summary: More work was needed to make supports in the CLDPs measurable. In addition, a number of essential supports were missing from the CLDPs reviewed, and this should be a focus for Center staff. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement	Individuals:

requirements related to transition to the most integrated setting. These indicators will remain in active oversight.											
#	Indicator	Overall Score	36	273							
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1							
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1							

Comments: 1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how needs and preferences must 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 adjustments as needed. Overall, Lubbock SSLC needed to be more precise in defining supports, as described below:

- The IDT developed 11 pre-move supports and 19 post-move supports for Individual #36. Pre-move supports primarily focused on exchange of information, in-service training, transportation, and ensuring that equipment requirements were in place. Pre-move supports for training provided no specific criteria to confirm competence of staff in any area, stating only that staff would receive competency-based training. The IDT also did not specify how direct support staff would receive training on his health care needs. Post-move supports were not consistently measurable. Examples included:
  - The IDT required no staff knowledge interviews for his Positive Behavior Support Plan (PBSP) and defined no other related staff competencies.
  - The CLDP included a support to have his blood pressure checked twice daily prior to taking atenolol, but it did not provide criteria or any action to be taken based upon results. Per the CLDP narrative, provider staff should have held the medication and contacted the nurse if his blood pressure was less than 90/60. Even this was not clear, as his diastolic pressure was often in the upper 50s per his Integrated Risk Rating Form (IRRF.)
- The IDT developed ten pre-move and 17 post-move supports for Individual #273. Pre-move supports for training provided no specific criteria to confirm competence of staff in any area, stating only that staff will receive competency-based training. Post-move supports for implementation of key needs, such as positioning, transfers, bathing, assistive technology, suction tooth brushing, gastric residual checks, assistive devices, and his PBSP required no evidence of staff competence, either by observation or interview. Rather, they only required review of home logs and nursing notes.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for it to be scored as meeting criterion. Neither of these CLDPs comprehensively addressed support needs and did not meet criterion, as described below:

- Past history, and recent and current behavioral and psychiatric problems: For both individuals, supports called for pre-move training related to behavioral needs, but did not specify the training methodologies or competency demonstration criteria. Supports did not sufficiently reflect the individual's past history, and recent and current behavioral and psychiatric problems in a consistent manner. Examples included:
  - Individual #36 had a PBSP that targeted verbal and physical aggression, property destruction, inappropriate sexual behavior (taking off clothes, showing genitals in public), and SIB (breaking a CD and using it to scrape the inside of his

elbow). Prior to transition, on 6/28/16, the IDT held an ISPA meeting for suicidal threats and decided to add this as a target behavior to the PBSP. The Center provided no evidence this had been accomplished, and the CLDP did not address it with a support.

- Individual #36's PBSP included appropriate refusals and scheduling meetings with staff as replacement behaviors, but the CLDP support called only for following the PBSP when challenging behaviors arose. It did not include a support to interview for staff knowledge, only requiring that home and day habilitation staff would receive competency-based training.
- It was very concerning the IDT did not develop any supports requiring specific staff knowledge of Individual #36's past history of elopement and fire-starting, or the recent history, including physical aggression, frequent restraint in the past year, threats to cause great bodily harm to staff, and law enforcement involvement.
- Individual #36 had been using smokeless tobacco for three years or more. The IDT discussed the need to work with provider on a use schedule, but did not develop a related support.
- Individual #273 had a PBSP at the Center with target behaviors of outbursts (irritably vocalizing, grabbing and throwing items), SIB (biting his wrist, hand, arm, causing redness or injury), and pain notification. The PBSP also called for encouraging participation in his daily schedule. The IDT developed a support to continue the PBSP for the target behaviors, but it did not define any specific competency criteria for staff. In particular, the support did not reference participation in his daily schedule using an object cue or relevant object card.
- Individual #273's IDT did not include side effects monitoring as a support because the provider nurse indicated they did that as a matter of routine for individuals who take psychoactive medications. The IDT should develop supports necessary to ensure a successful transition, regardless of the standard practices described by the provider. This ensures provider staff are aware of all important needs and provides a benchmark for the PMM to assess implementation.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: For both individuals, the IDTs did not address significant needs in these areas with specific supports. Examples included:
  - For Individual #36:
    - The IDT developed a support for supervision stating he needed 24-hour awake staff in case of emergency. The CLDP Profile indicated he was on routine supervision on campus and was able to walk around campus with little to no supervision, but "may require additional supervision until he is accustomed to his surroundings" in the community. The support did not include this.
    - Individual #36 had glasses, which he frequently refused to wear. The CLDP noted three new pairs had been ordered, but the IDT was not sure they would be available prior to transition and might need to be sent. The CLDP did not include a support related to this or to any vision exams or follow-up needed.
    - Individual #36 was at high cardiac risk and had a history of pericardial effusion. The Integrated Health Care Plan (IHCP) required a quarterly cardiac assessment by a nurse and for staff to immediately report weakened radial or pedal pulses, changes in heart sounds, irregular heartbeat, etc. Per the IHCP, direct support professionals (DSPs) should also report clinical indicators, including headache, chest pain, shortness of breath, or abnormal sweating, as these could signify a cardiac event. The CLDP did not address any of these.
    - Individual #36 was significantly overweight, which was an added risk factor for cardiac disease, but the CLDP had no weight loss support. It only called for monitoring for weight changes. The CLDP contained no specific

support related to diet, but an IHCP action plan indicated he was prescribed a heart healthy diet with no concentrated sweets due to a diagnosis of hypertension and hyperlipidemia. It also noted he should not have grapefruit or grapefruit juice due to an interaction with Seroquel, and should have limited caffeine due to an interaction with Perphenazine. The CLDP did not include a staff training support for diet or nutrition.
    - The CLDP included a support for Individual #36's blood pressure to be checked twice daily prior to taking atenolol, but it included no parameters that would require holding the medication and/or notifying the nurse.
- For Individual #273, the Monitoring Team found it particularly concerning that the IDT did not identify specific and detailed supports about his many health care needs. In his ISP, most disciplines were opposed to community referral based on his medical and health instability, but the referral was made anyway due to LAR choice. This should have prompted the IDT to take extra care in developing supports that would clearly specify how his needs were to be addressed and, if necessary, to delay transition until it could be assured that all support needs could be met. Examples of concerns included:
    - Per the CLDP narrative, Individual #273's level of supervision at the Center was routine, indicating that staff were available to assist him throughout the day. It also included a contingency plan for enhanced supervision when he had a urinary tract infection (UTI) to assist in preventing injuries from tugging at his feeding pump. The narrative identified 24-hour awake staff should be available at the group home to monitor and assist with activities of daily living (ADLs) and that for activities outside of the home, he should travel with provider staff who were well trained regarding his daily needs. The CLDP support only indicated 24-hour awake staff to assist with emergencies and egress.
    - The PBSP noted Individual #273 might alert staff of pain by wailing/moaning/screaming, grabbing and throwing items, and/or gesturing towards the painful area. In the past, this could have indicated a UTI, dry mouth, or a developing pressure wound. The CLDP contained no specific support for staff to have knowledge of these signs and symptoms or related reporting requirements.
    - Per the IRRF, Individual #273 had many physical and nutritional management needs. These included, but were not limited to, recurrent skin breakdown, a recent history of aspiration pneumonia and respiratory failure, a requirement for a head-of bed-elevation, a requirement to check residuals twice a day, a need to be repositioned every 1.5 hours, and brittle bone precautions. The CLDP supports did not include specific details about these needs.
    - Per the ISP narrative, the Physical and Nutritional Management Team (PNMT) saw him continuously from 2014 through April 2016, with monitoring at least monthly and IDT meetings every four to six weeks. Despite the frequent monitoring by PNMT, the CLDP included no supports for occupational therapy (OT), physical therapy (PT), or nursing oversight. It also included no supports that required observation or interview of provider staff related to his many physical and nutritional management needs.
    - The ISP noted weekly visits to the dentist as well as other strategies related to increasing tolerance of tooth brushing, but the CLDP contained no specific supports in this regard. The dental department did not provide a full dental assessment or update. Instead, it provided only a dental progress note, dated 9/13/16. This noted he had severe erosion of all his teeth with pulpal involvement likely in several and that he would require general anesthesia for treatment. It also indicated several reports of blood in his mouthwash likely due to bruxing gingiva with eroded teeth. The CLDP narrative stated he received oral suction tooth brushing daily

and used a bite block for better gum line brushing. The only related CLDP support was for annual recall for oral care.

- What was important to the individual: The IDT did develop supports for some things that were important to each individual, but did not address other key areas of importance.
    - Per the CLDP, things important to Individual #36 included social gatherings with his family; attending church with his mother; using the telephone to keep in touch with important people, for which he needed help dialing the telephone; animals; grilling out; earning money; and, privacy. The CLDP did include a support to maintain current relationships with family, staff, and peers and to develop a healthy relationship with a girlfriend, but did not address needing help to dial the telephone or attending church with his mother. His desire to earn money was not assertively addressed, as detailed further below under the need/desire for employment.
    - For Individual #273, moving to be closer to his family was an important outcome, which was achieved. Other outcomes identified in the CLDP as important were broad and not individualized in many cases. Examples were to have a successful transition, have the best possible health, and to have transportation to day habilitation, outings, and appointments. Outcomes also included continuing to increase his functional living skills through his daily routine, but the CLDP contained no specific supports related to increasing functional living skills and the only support related to his daily routine was for staff to receive competency-based training on his daily schedule. This was included as one item in a broad pre-move training support for provider staff. Individual #273's ISP focused on strengthening his relationship with a long-term friend, but the CLDP did not include any supports for maintaining this or establishing any new stable friendships. The ISP also listed many specific preferences, but the CLDP did not include supports for any of these to occur; rather, it only defined a support that included training about his preferences.
- Need/desire for employment, and/or other meaningful day activities:
    - Individual #36 had worked in supported employment and liked to earn money. His Preferences and Strengths Inventory (PSI) indicated he was interested in working at an animal shelter. The CLDP included a broad support to obtain employment within six months of transition. This timeframe took into account that he was going to have hammertoe surgery and the LAR wanted him to recover from that before beginning work. At his ISP meeting, it was noted the Transition Specialist was working on a Department of Assistive and Rehabilitation Services (DARS) referral, but no referral was included in CLDP. The ISP also included a service objective to get his Texas identification card updated to facilitate a job search; this was referenced in the CLDP review of assessments but not included in the supports.
    - Individual #273 had one support to attend a day habilitation program. The support included no detail as to how often he should attend or what he should be engaged in while there. Per his ISP, he had attended the work center at Lubbock SSLC, and had expressed to a friend that he wanted to work by saying "work." The CLDP did not include any other supports for meaningful day activities in the community.
- Positive reinforcement, incentives, and/or other motivating components to an individual's success:
    - For Individual #36, the IDT did identify some motivating components, but missed others of importance. Supports called for him to have a daily schedule that allowed leisure time and for him to know what activities to expect, as well as opportunities to visit at least twice monthly with his mother and grandfather. This was positive. Another support indicated his PBSP should be followed when his challenging behavior arose, but it did not reference the replacement behaviors which should be worked on even when, and perhaps especially when, there were no challenging behaviors

in evidence.
    - For Individual #273, the PSI noted he enjoyed being able to make choices and do things for himself, but the CLDP included no supports for choice-making or increasing independence to do things for himself. It also did not have any supports related to his special friend, who was noted to have a positive impact on both his mood and behaviors.
- Teaching, maintenance, participation, and acquisition of specific skills: The respective IDTs did not identify any pre- or post-move supports for the teaching, maintenance, participation, and acquisition of specific skills based upon individual needs and preferences, such as in the areas of personal hygiene, domestic, community, communication, and social skills.
- All recommendations from assessments are included, or if not, there is a rationale provided: Recommendations from assessments were not consistently addressed. There was a tendency by the IDTs toward deferring many recommendations for health care to the community primary care provider (PCP), who had no previous experience with the individual. This was concerning and particularly so because there was no support for the Center's medical staff to communicate with the community PCP. The IDT also did not consistently identify needed supports based upon recommendations, because the provider stated they typically did those things anyway or could include them in one of their standard protocols. For example, the IDT did not develop a support for monitoring psychotropic medication side effects, monthly vitals, and oxygen levels for Individual #273. The CLDP documented a discussion in the narrative, but did not include a specific support because the provider indicated this could be documented on the weight log.

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

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

Individuals:

#	Indicator	Overall Score	36	273							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	0% 0/2	0/1	0/1							
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1							
5	Based on information the Post Move Monitor collected, the individual 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	0% 0/2	0/1	0/1							

	justification is provided as to why it is no longer necessary.										
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/R	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A	N/R	N/A							

Comments: 3. Post-move monitoring was completed at required intervals for both individuals. Each of these post-move monitoring visits were within the required timeframes, included all locations where the individual lived or worked, and were completed in the proper format. For Individual #36, the PMM provided little detail for many comments at the time of the seven-day PMM visit. For Individual #273, the details and comments sometimes provided a clear indication of the presence or absence of some supports, including the evidence upon which the PMM based her determination, but this was not consistent. At a minimum, the PMM should document the review of all prescribed evidence for each respective support, including observation, interview, and/or documentation. The PMM did not consistently address each type of evidence a support required.

4. Reliable and valid data availability was not consistent as a result of the lack of consistent documentation identified above.

5. Based on information the Post Move Monitor collected, neither of the individuals had consistently received supports as listed and/or described in the CLDP. For example, the provider had not yet obtained the services of a BCBA to monitor, and modify as needed, Individual #36's PBSP. It was also not always possible to ascertain whether Individual #36's supports were in place as needed due to a lack of detail in the PMM's documentation. Similarly, for Individual #273, the limited evidence provided by the PMM did not document he was consistently receiving supports as listed and/or described in the CLDP. For example, the community BCBA had not yet reviewed Individual #273's PBSP at the time of the 45-day PMM visit, due to being behind on her work.

6. Based on the supports defined in the CLDP, the evidence did not always support the PMM's scoring, in particular because it did not provide a level of detail that allowed for such an analysis. Examples included:

- For Individual #36, the PMM documented receiving a copy of the staffing schedule to confirm the presence of a support calling for him to be provided with 24-hour awake staff to assist with emergencies and egress, but provided no evidence that staff were knowledgeable of the support needs. Likewise, for a support to have a schedule that allowed him leisure time and to know what activities to expect, the comment noted only that the PMM obtained the schedule prior to transition and that staff said nothing had changed. The PMM did not provide any evidence that the schedule allowed leisure time or whether Individual #36 knew what activities to expect.
- The Additional Questions section of the CLDP included the following question: "Is the individual satisfied with day program?"

The PMM documented Individual #36 told her he really didn't like the day habilitation program, although he liked the staff and what they were working on interview practice and filling out applications. He went on to state he really wanted a job in the community. The PMM documented that he was satisfied.

- For Individual #273, the limited evidence the PMM provided at the time of the seven-day PMM visit made it difficult to determine whether the PMM had scored correctly. Examples included:
  - The PMM's comments did not provide clear evidence that staff were knowledgeable or competent regarding the purpose and intent of his 24-hour staff requirement; daily schedule; likes/dislikes; abilities/challenges; daily living skills; programming; communication skills; and, strategies to increase his independence in self-help skills. This was also true for supports related to the PNMP; transfers; mobility; positioning; range of motion exercises; the PBSP and behavioral issues; medical diagnoses; health status; and, specialty physicians. Each of these had pre-move competency-based training prescribed, but no competency criteria were identified. Post-move supports called for observation of proper positioning, transfers, bathing, assistive equipment, and mobility. While the PMM checklist documented interview of staff and observation of positioning and affirmed the supports were in place, this broad statement did not indicate specific evidence that each and every one of the many support needs was addressed. Other documentation and the circumstances of a PDCT event identified at the time of the seven-day PMM visit also called into question whether this affirmation could be correct. The PDCT ISPA acknowledged concerns related to staff knowledge of positioning and wheelchair issues, requiring Lubbock SSLC PT staff to make a trip to the new settings, yet related supports had been marked as being in place.
  - A pre-move support to continue the PBSP called for interview and observation, but the PMM did not document any interview to affirm staff knowledge at either the seven-day or 45-day PMM visits.
- At the time of the 45-day PMM visit for Individual #273, the PMM marked as in place a support to have weekly communication with his mother/brother, but referenced documentation indicated there was no information about family visits and staff said he had not seen the family in several weeks.

7. and 8. It could not be reliably determined the IDT/Center consistently implemented, for either individual, corrective actions in a timely manner for the many supports that were not being provided as needed. The Post Move Monitor was diligent in her efforts, but there were issues that should have been more assertively addressed.

- For Individual #36, the Monitoring Team found it concerning that behavioral issues were not addressed as needed following the PDCT events in December. For example, at the 45-day PMM visit, the PMM was not able to confirm provider staff had been in-serviced on the additional guidance the Lubbock SSLC BCBA provided following the PDCT, nearly one month after the event. In addition, the provider still did not have a BCBA in place to address Individual #36's behavioral needs. The PMM did not include the in-service issue as requiring follow-up.
- It was positive the IDT sent the PT out to work with Individual #273's provider after the 10/5/16 PDCT, an emergency room (ER) visit related to a pressure wound that had developed. It was concerning the IDT did not take similarly assertive action following PDCTs for ER visits on 10/17/16, 11/5/16 and 11/6/16 related to catheter issues and UTI. These were followed by another ER visit on 12/6 for a UTI, but the IDT did not meet before Individual #273 died on 12/12/16. More information is provided in relation to Indicator #11 below.

9. and 10. A member of the Monitoring Team attended the residential portion of the 90-day PMM visit for Individual #36. Scoring for

these indicators was not possible, because the Monitoring Team member was unable to attend the second component of the PMM visit, which included a visit to the day program and provider offices, where a good portion of the document review would be conducted.

The Monitoring Team member shared feedback with the PMM after the residential portion of the visit. The PMM was well organized, and had developed her own check sheet to ensure she reviewed each support included in the CLDP. It was also good to see that the Post-Move Monitor adapted her interview to meet the needs of the individual who was a little reluctant to participate at the beginning of the review. The Post-Move Monitor asked necessary questions in a respectful manner. The Monitoring Team recommended that as appropriate, the PMM consider conducting interviews privately, as opposed to in a larger group, to allow questions to be asked of both the individual and staff in a way that elicits frank discussion, particularly with issues that might be sensitive.

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

Summary: Both individuals had experienced PDCT events. For both individuals, there were failures 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. In neither case did their IDTs develop a full list of necessary supports to reduce the likelihood of negative events recurring.

Individuals:

#	Indicator	Overall Score	36	273							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	0% 0/2	0/1	0/1							

Comments: 11. Both individuals had experienced PDCT events.

- For Individual #36, two PDCT events had occurred.
  - The ISPA documentation indicated he had called 911 from a cell phone, but provided no description of why he made the call, other than to state he was upset about tobacco. The police arrived, spoke with him, and took him to the hospital. There was no description of why the police felt this to be necessary. The following day, Individual #36 did not want to go to day habilitation, removed a pole for hanging clothes from his closet, tried to harm himself, and threatened staff. Police were called and took him into custody.
  - The IDT had not developed assertive, clear, and detailed supports related to Individual #36's behavioral and psychiatric needs. Supports included provider and day habilitation program staff to receive competency-based training on his PBSP and behavioral issues, but did not require demonstration of staff knowledge or competence.
  - The Monitoring Team found this particularly concerning, given the events of his site visit with another provider in March of 2016, when he threatened staff with a knife and a police report was filed due to resulting injury to staff. At that time, he was left with pending charges. The pre-move training did not address this. Provider staff indicated at the

PDCT ISPA that they were just learning what his behaviors really looked like and that "sometimes it's hard to capture in writing" what the actual experience looks like. His history as well as the nature of his behaviors at the initial provider's home called for a more assertive approach to staff preparation.

- Individual #273 experienced five ER visits and then passed away.
    - Individual #273 was at high risk for skin integrity. On 10/11/16, he was taken to the ER and diagnosed with a Stage 2 pressure ulcer, possibly related to difficulties with his wheelchair footrests. At the ISPA meeting, the IDT noted provider staff had been competency trained on his PNMP in August when he went on an overnight visit. The IDT decided to send a Habilitation Therapies staff to look at the chair, observe positioning, and make adjustments to the Roho cushion and footrests. This was positive. Per the PMM Checklists, this was completed on 10/28/16. The IDT did not, however, identify the lack of detailed and specific supports related to his positioning needs and the lack of a requirement for confirming staff competence through interviews and observation as issues that should be better addressed for future transitions. It did not revise the supports to ensure staff competence would be monitored for Individual #273 going forward. As noted above, the IDT had not originally included specific PNM supports in the CLDP, and did not modify the CLDP at the ISPA meeting to address this significant oversight.
    - On 10/18/16, Individual #273 was taken to the ER because his bladder catheter was leaking. The PDCT ISPA meeting held on 10/26/16 stated preventive measures included cleaning the site three times a day, correct positioning of the catheter (which was not specifically defined in the CLDP), and changing the catheter once per month. Per the review of the CLDP, it included the support for monthly changing, but there were no other supports specific to the catheter. The ISPA recommendations included "continuing" to clean the site three times a day and positioning the bag, but the supports were not updated to include these specific instructions. The PMM did not then document confirmation this was being done as needed at the 45-day PMM visit.
    - Two PDCT events occurred on 11/5/16 and 11/6/16. Both were for ER visits due to issues with his catheter and he was diagnosed with a UTI. On 11/14/16, the IDT met to review the events and considered these not to be preventable. The IDT took no action to revise the supports or consider whether additional training should have been provided prior to the transition or was currently needed based on these recent events.
    - On 12/6/16, the provider took Individual #273 to the ER to have his catheter replaced. He was diagnosed with a UTI at that time and treatment was provided. The evidence provided did not indicate whether the Center was notified of the 12/6/16 PDCT event at that time or whether they took any action. On 12/12/16, he was found unresponsive and not breathing at his home. An autopsy and police investigation were ordered. The cause of death was not yet known at the time of the Monitoring Team's visit. On 12/21/16, the IDT held a PDCT ISPA meeting. The ISPA indicated this event was anticipated and that in-services that the RN Case Manager completed in August included many details that were not evident in the actual CLDP supports. No post-move evidence documented this staff knowledge. The Monitoring Team found it very concerning the IDT had not earlier considered making revisions to CLDP supports that did not specify details for catheter care, other than to be changed monthly, or identify the need for any additional training related to his catheter care.

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.											
Summary: Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of transition assessments. Although Center staff provided training to community provider staff, the CLDPs did not define the training well, and the training did not appear to meet the individual's needs. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	36	273							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	0% 0/2	0/1	0/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	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 collaborates with the Local	100%	1/1	1/1							

	Authority staff when necessary to meet the individual's needs during the transition and following the transition.	2/2									
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

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

- Assessments updated with 45 days of transition: Examples of assessments that were not updated within 45 days included:
  - The Center did not review or update the IRRF for Individual #273, but should have, or should have indicated that the IRRF was reviewed and no updates were required. The IRRF for Individual #36 was updated within 45 days of transition, but not reviewed as a part of the CLDP, per the documentation. The IRRF section of the ISP typically contains a great amount of information. The APC should ensure that the IDTs review the status of the IRRF as part of the transition assessment process.
  - For Individual #36, the Functional Skills Assessment (FSA) was dated 11/2015. The annual medical assessment (AMA) was dated 2/22/16 and noted some information was from the previous physical because Individual #36 refused to cooperate. An addendum was dated 11/7/16, but included no updated information except to delete two recommendations. It still did not document a physical exam. The assessment provided no reference to a podiatry consult and pending surgery for hammertoe.
  - For Individual #273, the FSA was dated 2/8/16 and the dental assessment consisted only of a progress note.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Available assessments did not consistently provide a summary of relevant facts of either individual's stay at the facility and the lack of needed updates described above also negatively impacted compliance in this area.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments did not consistently include a comprehensive set of recommendations needed for successful transition.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not consistently focus on the new community home and day/work settings, and/or identify supports that might need to be provided differently or modified in a community setting.
  - For Individual #36, recommendations related to his upcoming surgery and its impact were general and provided no detail from either the vocational staff or habilitation therapies staff about his recovery, any accommodations he might need, when he might be able to return to work, or the potential impact on his risk for falls.
  - For Individual #273, social work recommendations included to have frequent communication with his mother, continue his daily schedule, and go on community outings with staff. Recommendations did not include anything specific to the community, such as opportunities for increased interaction with his mother due to the move, opportunities to update his daily schedule based on the rhythms of daily life in a small home in the community, or opportunities for types and frequency of community outings in the new setting that would facilitate community integration.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator, including the following: 1) There was documentation to show IDT members actively participated in the transition planning

process; 2) the CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed; and 3) the CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting. Documentation showed the individual and LAR were involved in the decision-making process, but IDT members did not consistently participate in the transition process as needed for Individual #273. His IDT did not participate as needed in the provision of pre-move training. The Center did not consistently identify the specific SSLC staff responsible for transition actions, but needed to do so.

14. IDTs should focus on the development of provider training supports that include the identification of staff to be trained, specific competencies to be achieved, the methodologies required to achieve those competencies and how staff competencies will be measured and/or demonstrated. Training supports for these two CLDPs were broad and did not consistently include these components. The Monitoring Team had particular concerns about the level of SSLC staff participation in pre-move training for Individual #273. Per the Transition Specialist transition log, the IDT indicated that Habilitation Therapies staff should provide pre-move training, but Center administration would not allow those staff to participate. Instead, the Transition Specialist received what was described as competency-based training from Habilitation Therapies staff and, in turn, provided this training to provider staff. Given the extent of Individual #273's needs in this area and the IDT's reluctance for the transition to occur, it would have been prudent to ensure that provider training be completed by staff with clinical expertise.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: Both CLDPs included a support for a nurse-to-nurse conversation regarding medical diagnoses, medications, health status, and specialty physicians. The Monitoring Team reviewed the documentation of these conversations to evaluate whether they were completed in such a manner as to accomplish these purposes. The documentation was sparse and did not clearly substantiate this support had been met. For Individual #36, the nursing documentation indicated a nursing report was given and that medical diagnoses, medication, and medical history were reviewed. It did not indicate that health status and specialty physicians were discussed. For Individual #273, the Monitoring Team requested documentation of this conversation, but received only a pre-move training competency quiz completed by all provider staff, including the provider nurse. It did not address medical diagnoses, medications, health status, and specialty physicians. In addition, for Individual #273, the IDT deferred a number of medical recommendations to the PCP in the community without considering whether it would have then been prudent to have the SSLC medical staff who knew Individual #273 well communicate directly with the receiving physician.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results. Neither of the CLDPs provided evidence the IDT made such a consideration.

17. The CLDP should provide a specific statement about the types and level of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences. Examples include provider direct support staff spending time at the Center, Center direct support staff spending time with the individual in the community, and Center and provider direct support staff meeting to discuss the individual's needs. The CLDPs for Individual #36 and Individual #273 did not provide evidence of this consideration.

18. Both CLDPs met criterion for collaboration between the Center and the LIDDA.

19. The Monitoring Team found it was not consistently possible to confirm that all needed supports were in place at the time of the pre-move site review (PMSR) due to the lack of specificity in supports and the lack of detail in the PMM comments. For Individual #36, the PMM indicated all supports were in place, but a number of pre-move needs described in the narrative did not have corresponding supports identified. Supports not identified included a sample menu to be provided on the day of move, updated calendar pictures for use at the day habilitation and employment program, and a tobacco use schedule. Individual #273's CLDP required pre-move competency-based training, which occurred at the time of his pre-move trial visit, nearly two months before his transition. The PMSR provided no evidence that staff were able to demonstrate competency on his many needs at the time of transition. The CLDP called for the respective provider and Center nurses to have a conversation addressing Individual #273's medical diagnoses, medications, health status, and specialty physicians, and the PMM documented she was provided with documentation from their conversation on 10/4/16. The Monitoring Team requested this documentation, but was provided only with copies of completed competency quizzes that did not include all of the required information.

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary: This indicator will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	36	273								
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	0% 0/2	0/1	0/1								
Comments: 20. Both transitions exceeded 180 days and transition logs reflected an approximately two-month delay on the part of the APC's office in initiating the development of the Profile, a first step necessary to begin transition activity. In interview, APC staff indicated they had identified this issue and had begun implementing a plan to prioritize timely initiation of referral documentation.												

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

c. Medical
d. Nursing
e. Pharmacy
f. Dental

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

The individual-specific documents listed below:

- ISP document, including ISP Action Plan pages
- IRRF, including revisions since the ISP meeting
- IHCP
- PNMP, including dining plans, positioning plans, etc. with all supporting photographs used for staff implementation of the PNMP
- Most recent Annual Medical Assessment, including problem list(s)
- Active Problem List
- ISPAs for the last six months
- QIDP monthly reviews/reports, and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request
- QDRRs: last two, including the Medication Profile
- Any ISPAs related to lack of progress on ISP Action Plans, including IHCP action plans
- PNMT assessment, if any
- Nutrition Assessment(s) and consults within the last 12 months

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

- For individuals who received TIVA or medical and/or dental pre-treatment sedation, copy of informed consent, and documentation of committee or group discussion related to use of medication/anesthesia
- ISPAs, plans, and/or strategies to address individuals with poor oral hygiene and continued need for sedation/TIVA
- For any individual with a dental emergency in the last six months, documentation showing the reason for the emergency visit, and the time and date of the onset of symptoms
- Documentation of the Pharmacy's review of the five most recent new medication the orders for the individual
- WORx Patient Interventions for the last six months, including documentation of communication with providers
- When there is a recommendation in patient intervention or a QDRR requiring a change to an order, the order showing the change was made
- Adverse Drug Reaction Forms and follow-up documentation
- PCP post-hospital IPNs, if any
- Post-hospital ISPAs, if any
- Medication Patient Profile form from Pharmacy
- Current 90/180-day orders, and any subsequent medication orders
- Any additional physician orders for last six months
- Consultation reports for the last six months
- For consultation reports for which PCPs indicate agreement, orders or other documentation to show follow-through
- Any ISPAs related to consultation reports in the last six months
- Lab reports for the last one-year period
- Most recent colonoscopy report, if applicable
- Most recent mammogram report, if applicable
- For eligible women, the Pap smear report
- DEXA scan reports, if applicable
- EGD, GES, and/or pH study reports, if applicable
- Most recent ophthalmology/optometry report
- The most recent EKG
- Most recent audiology report
- Clinical justification for Do Not Resuscitate Order, if applicable
- For individuals requiring suction tooth brushing, last two months of data showing implementation
- PNMT referral form, if applicable
- PNMT minutes related to individual identified for the last 12 months, if applicable
- PNMT Nurse Post-hospitalization assessment, if applicable
- Dysphagia assessment and consults (past 12 months)
- IPNs related to PNMT for the last 12 months
- ISPAs related to PNMT assessment and/or interventions, if applicable
- Communication screening, if applicable
- Most recent Communication assessment, and all updates since that assessment
- Speech consultations, if applicable
- Any other speech/communication assessment if not mentioned above, if any within the last 12 months

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

The individual-specific documents listed below:

- ISP document
- IRRF, including any revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment
- Active Problem List
- All ISPAs for past six months
- QIDP monthly reviews/reports (and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request)
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- These annual ISP assessments: nursing, habilitation, dental, rights
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment

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

- A list of all injuries for the individual in last six months.
- Any trend data regarding incidents and injuries for this individual over the past year.
- If the individual was the subject of an injury audit in the past year, audit documentation.

For specific individuals who have moved to the community:

- ISP document (including ISP action plan pages)
- IRRF
- IHCP
- PSI
- ISPAs
- CLDP
- Discharge assessments
- Day of move checklist
- Post move monitoring reports
- PDCT reports
- Any other documentation about the individual's transition and/or post move incidents.

APPENDIX B - List of Acronyms Used in This Report

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

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

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