United States v. State of Texas

Monitoring Team Report

Lubbock State Supported Living Center

Dates of Onsite Review: August 6th to 10th, 2018

Date of Report: October 29, 2018

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Table of Contents

Background

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

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

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

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

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

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

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

Methodology

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

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

Organization of Report

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

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

Executive Summary

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

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at 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. At the time of the last review, 21 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, six additional indicators in the areas of restraint, and abuse, neglect, and incident management will move to the category of less oversight. One indicator in the area of abuse, neglect, and exploitation will return to active oversight.

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

Restraint

The overall usage of crisis intervention restraint at Lubbock SSLC showed an increasing trend over this review period (and even when looking at the trend over the past five review periods as a whole). The Center's census-adjusted rate was now the second highest across all of the Centers. Center staff hypothesized that this was due to new admissions. Ascending trends were occurring in crisis intervention physical restraints and chemical restraints.

The frequency of crisis intervention chemical restraint also showed an ascending trend. On the positive, the average duration of a crisis intervention physical restraint remained low (at about two and one-half minutes). There were no instances of crisis intervention mechanical restraint, and there were no individuals for whom protective mechanical restraint for self-injurious behavior was being used.

Review of the data regarding the use of non-chemical, pre-treatment sedation, and TIVA for medical and dental procedures is warranted.

Documentation, not including nursing-related documentation, was at criteria for all restraints. Numerous problems were noted with regard to nurses' administration of chemical restraints and monitoring of individuals after the administration of chemical restraints, which placed individuals at significant risk of harm. Some of the other areas in which nursing staff need to focus with regard to restraint monitoring include: providing detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and clearly documenting an assessment for and findings related to restraint-related injuries, and if the nurse cannot determine the cause of an injury, stating so.

Reviews occurred as required for all but one restraint. The Center, however, could not provide documentation to show that any recommendations were carried out.

Abuse, Neglect, and Incident Management

As also discussed at the start of the Abuse/Neglect/Exploitation (ANE) Incident Management (IM) review of preliminary scores, there were a number of areas that were showing ascending trend lines [some were presented in the Executive Safety Committee (ESC) meeting minutes in data graphs]:

- Confirmed allegations,
- Restraints,
- Peer-to-peer aggression,
- Injuries, and
- Falls.

The Center generated a number of directives for IDTs from the ESC meeting. These were primarily/solely focused on the individual and his or her circumstances. This is good a good practice. In addition:

- The Center should be looking at these issues center-wide, systemically.
- There were a number of safety/protection from harm examples that the Monitoring Teams observed during the onsite review week. These were shared with Center management (e.g., based on the Monitoring Team's multiple observations, an individual with pica for whom a pica-safe environment was not available; an individual foraging for food in unlocked dumpsters).

Three investigations (25%) did not meet all of the criteria of indicator 1 (regarding protections being in place to reduce the likelihood of the incident occurring). One was due to absence of a current duty to report form. The other two were due to some supports not being in place. This was a decrease in performance compared to the last review.

Every investigation contained recommendations, sometimes many (one had 17; most had three to seven recommendations). The Center was able to produce extensive documentation to demonstrate completion of all recommendations for the investigations reviewed (though see below regarding mortality reviews).

Regarding investigations: Unusual Incident Reports (UIRs) were well done. Information was presented logically and sequentially. All investigations met criteria for the collection and analysis of evidence and the conclusions drawn.

Two investigations did not fully explore issues around what appeared to be late reporting. Most staff could not correctly describe proper reporting procedures. Most said that allegations had 24 hours to be reported and some did not state how they would make a report.

The Center's supervisory review of investigations did not identify the same issues identified by the Monitoring Team. Thus, some attention to the quality and process of supervisory/review authority is needed. Some investigations were not completed within the required timeline (or with the required extension approvals).

Lubbock SSLC was correctly conducting non-serious injury investigations for all individuals for the first time.

Of significant concern from a protection from harm perspective, mortality reviews, including Center investigations, did not identify the full set of serious issues contributing to at least two of the deaths reviewed, and even when reasonable corrective actions were identified, delayed or incomplete responses potentially placed other individuals at continued risk of harm. As described elsewhere in this report, two deaths exemplified the need for enhanced interdisciplinary coordination, and improvements in basic healthcare services (i.e., nursing, medical, and physical and nutritional management), as well as thorough investigations and review of the healthcare provided to individuals prior to their deaths:

- At the time of one individual's death, he had a Stage 4 pressure ulcer with osteomyelitis. The individual became septic and died, probably from the osteomyelitis. From the magnetic resonance imaging (MRI), the coccyx had been destroyed and was no longer present due to the decubitus and osteomyelitis, and the decubitus had impinged into the sacrum and surrounding bilateral buttocks. Although records the Monitoring Team reviewed showed potential lapses in care regarding, for example, ongoing assessment of the original pressure ulcer, completion of a computed tomography (CT) scan, purchasing recommended equipment, the quality of PNMT review, ongoing nurses' assessments, and notification of the PCP of potential issues/changes, neither the Center's death investigation, nor the clinical death reviews identified these lapses in care, and sufficient recommendations were not put forward to address them.
- Another individual died after experiencing severe dehydration. During the brief hospitalization prior to his death, he had sepsis with pneumonia, but his extreme dehydration probably initiated the cascade into sepsis. Again, records showed problems related to adaptive equipment and Habilitation Therapy staff's monitoring to ensure its effectiveness, Dietary's oversight of the known dehydration issues, direct support professionals' (DSPs') training and role in monitoring and reporting signs and symptoms of illness, nursing assessments and related reporting, and medical staff's monitoring of this risk in an individual who had been hospitalized for dehydration in June 2017. In this case, although not complete, the investigation and clinical death reviews identified some of the important issues that potentially contributed to the death or impacted the individual's healthcare prior to his death. However, follow-up on some important and basic issues was still pending as of early August 2018, for this death that occurred in mid-March 2018.

<u>Other</u>

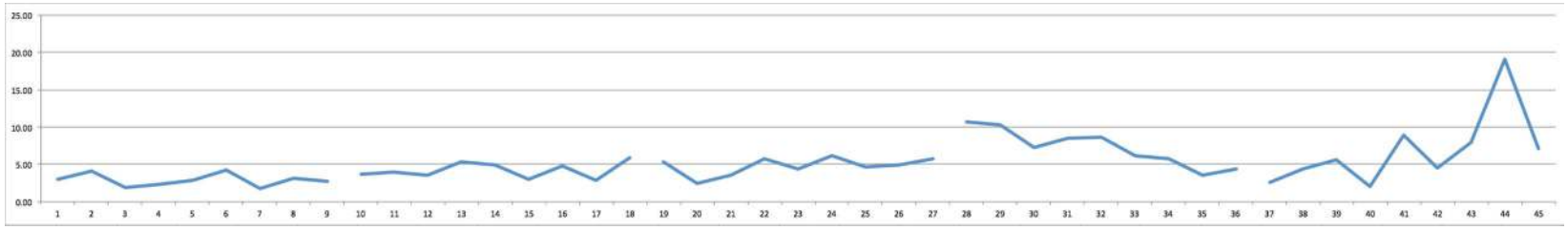
In conducting its review, the Monitoring Team identified potential adverse drug reactions (ADRs) that staff should have reported, but did not.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.												
Summary: The overall usage of crisis intervention restraint at Lubbock SSLC showed an increasing trend over this review period (and even when looking at the trend over the past five review periods as a whole). The Center's census-adjusted rate was now the second highest across all of the Centers. Center staff hypothesized that this was due to new admissions. Ascending trends were occurring in crisis intervention physical restraints and chemical restraints. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	276	319	26	322	237	220	278	224	408
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.	78% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (October 2017 through June 2018) were reviewed. The overall usage of crisis intervention restraint at Lubbock SSLC showed an increasing trend over this review period (and even when looking at the trend over the past five review periods as a whole).



The Center's census-adjusted rate was now the second highest across all of the Centers. Center staff hypothesized that this was due to new admissions. Data weren't presented to support this, however, the Center could consider creating a secondary graph that pulls out crisis intervention restraints for the first three or so months of admission. One of the other data sets, related to this, showed an ascending trend in the number of different individuals who had one or more crisis intervention restraints each month.

The rate of crisis intervention physical restraints also was ascending, paralleling the overall usage of crisis intervention restraint (because most of the crisis intervention restraints were crisis intervention physical restraints). The average duration of a crisis intervention physical restraint, however, decreased to about two and one-half minutes, one of the lowest in the state. The usage of

crisis intervention chemical restraint also showed an ascending trend. There was no usage of crisis intervention mechanical restraint and no usage of protective mechanical restraint for self-injurious behavior. Few injuries were reported to have occurred during or as a result of restraint implementation, though see below regarding nursing's implementation of post-restraint assessments.

The Center was moving towards using the SUR and Ukeru programs and protocols. They were discontinuing usage of the boat pads, described in more detail in the previous report.

There was one occurrence of non-chemical restraint for a medical or dental procedure. There were few instances of pretreatment sedation or TIVA for dental procedures, due, in part, to the Center not having dental services on campus for some time during this review period. There was an increase in use of pretreatment sedation for medical appointments/procedures due, in part, to the Center discovering they were behind in medical consultations for many individuals and they were catching up on these. The Monitoring Team recommends that the Center include a review of these four data sets in their quality and/or executive safety committee review of restraints.

Thus, facility data showed low/zero usage and/or decreases in seven of these 12 facility-wide measures (i.e., use of crisis intervention mechanical restraint, average duration of a crisis intervention physical restraint, use of protective mechanical restraint for self-injurious behavior, injuries during restraint, pretreatment sedation and TIVA for dental procedures; and non-chemical restraint for dental or medical procedures).

2. Six of the individuals reviewed by the Monitoring Team were subject to restraint. Six received crisis intervention physical restraints (Individual #276, Individual #319, Individual #322, Individual #220, Individual #278, Individual #408), three received crisis intervention chemical restraint (Individual #319, Individual #220, Individual #408), and one received object retrieval (Individual #278). Data from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for four of these six. The other three individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period.

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.	
Summary: Restraint, when implemented, was documented to meet almost all of these indicators. Indicator 10, regarding a graduated usage of restraint, met criteria for this and the previous reviews, too. The exceptions this time had to do with some confusion in the IRIS recording of when behavioral health services was contacted, but based on the overall documentation, the Monitor will move this indicator (10) into the category of requiring less oversight. Protections regarding restraint were not in place for Individual #319. Indicators 9 and 11 will remain in active monitoring. Also, see the comments regarding indicator 7. This documentation conflicting information needs to be corrected in future restraint documents in order for this indicator to continue to remain in this category, too.	Individuals:

#	Indicator	Overall Score	276	319	322	220	278	408			
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The restraint was a method approved in facility policy.										
5	The individual posed an immediate and serious risk of harm to him/herself or others.										
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.										
7	There was no injury to the individual as a result of implementation of the restraint.										
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.										
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	50% 1/2	Not rated	0/1	Not rated	Not rated	1/1	Not rated			
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	80% 8/10	1/1	2/2	1/1	1/2	2/2	1/2			
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	83% 5/6	1/1	0/1	1/1	1/1	1/1	1/1			

Comments:
The Monitoring Team chose to review 10 restraint incidents that occurred for six different individuals (Individual #276, Individual #319, Individual #322, Individual #220, Individual #278, Individual #408). Of these, six were crisis intervention physical restraints, three were crisis intervention chemical restraints, and one was an objective retrieval. 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.

7. For two restraints, Individual #220 6/12/18 and Individual #278 4/7/18, the IRIS form says yes to the query, Crisis Injury Restraint, but also says no to the query, Restraint Cause Injury. Additional documentation provided while onsite did not clarify this confusing/conflicting information.

9. Because criterion for indicator #2 was met for four of the individuals, this indicator was not scored for them. Criteria for this indicator were met for Individual #278. Criteria were not met for Individual #319. Various aspects of her ISP were not implemented, goals were not updated, and there were no SAPs.

10. For two of the three crisis intervention chemical restraints, Individual #220 5/10/18 and Individual #408 2/16/18, IRIS forms showed that pre-restraint consultations with behavioral health services were completed after the restraints, and they also showed that they were contacted before the restraints.

11. There was nothing in Individual #319's IRRF about whether there were or were not any restrictions on restraints.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.												
Summary:			Individuals:									
#	Indicator	Overall Score										
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments:												

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.												
Summary: Indicator 14 will remain in active monitoring for possible review at the next onsite visit.			Individuals:									
#	Indicator	Overall Score	276	319	322	220	278	408				
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
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: Numerous problems were noted with regard to nurses' administration and monitoring of individuals after the administration of chemical restraints, which placed individuals at significant risk of harm. Some of the other areas in which nursing staff need to focus with regard to restraint monitoring include: providing detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and clearly documenting an assessment for and findings related to restraint-related injuries, and if the nurse cannot determine the cause of	Individuals:

an injury, stating so. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	276	319	322	220	278	408			
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	30% 3/10	1/1	1/2	1/1	0/2	0/2	0/2			
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	50% 5/10	1/1	2/2	1/1	0/2	0/2	1/2			
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	40% 4/10	1/1	1/2	1/1	0/2	0/2	1/2			

Comments: The restraints reviewed included those for: Individual #276 on 4/21/18 at 7:25 p.m.; Individual #319 on 5/8/18 at 2:10 a.m., and 6/3/18 at 2:14 a.m. (chemical); Individual #322 on 3/12/18 at 12:40 p.m.; Individual #220 on 5/10/18 at 9:45 a.m. (chemical), and 6/12/18 at 11:47 a.m.; Individual #278 on 4/7/18 at 11:55 a.m., and 5/4/18 at 8:32 p.m.; and Individual #408 on 2/16/18 at 10:03 a.m. (chemical), and 5/23/18 at 8:35 p.m.

a. through c. For Individual #276 on 4/21/18 at 7:25 p.m., Individual #319 on 5/8/18 at 2:10 a.m., and Individual #322 on 3/12/18 at 12:40 p.m., the nurses performed physical assessments, documented whether there were any restraint-related injuries or other negative health effects, and took action, as needed to meet the needs of the individuals.

In addition to the three restraints listed in the paragraph above, for the following restraint, the nurse documented whether or not the individual sustained restraint-related injuries of other negative health effects: Individual #408 on 5/23/18 at 8:35 p.m.

The following provide examples of additional findings:

- For most of the restraints reviewed, documentation showed nurses initiated monitoring within 30 minutes. The two exceptions were for:
  - Individual #220's physical restraint on 6/12/18 at 11:47 a.m., for which the Center presented no documentation of a nursing assessment; and
  - Individual #408's chemical restraint on 2/16/18 at 10:03 a.m., for which a number of problems were noted including:
    - An IPN, entitled Emergency Restriction, dated 2/16/18 at 3:39 p.m., noted that the individual told his QIDP and Residential Coordinator (RC) that his sister had been shot, and he wanted to go to visit her. The note indicated that they told him his request could not be met and that they would have to talk to their supervisors. Individual #408 then asked if the police could take him and they said no. The note indicated that the individual said if he could not see his sister he would "kill everyone here." At this point, his physical aggression began, and staff made a few attempts to restrain him that were unsuccessful. The documentation provided no indication of whether or not the team members attempted to work with Individual #408 to investigate this issue when he reported it, which might have avoided the need for restraint. (There was a note on the Flowsheet that his grandmother reported the incident did not happen.)
    - During the incident, the Behavioral Health Services Specialist made a call to the PCP for a chemical restraint, and the PCP noted in an IPN, dated 2/16/18 at 5:10 p.m., that he spoke with the Registered Nurse Case

Manager (RNCM) and gave a verbal order for Haldol 5 milligrams (mg) intramuscular (IM) and Ativan 2 mg IM. No related RNCM IPN was found in the documents provided.
    - The Center did not provide an order from the PCP for the chemical restraint.
    - The Center did not provide an IPN documenting the administration of the chemical restraint, including who administered it.
    - An addendum IPN, dated 2/16/18 at 5:10 p.m., from the PCP indicated that an RN (not the RNCM) called him and that the nurse had given Individual #408 the wrong dose of Ativan (i.e., he gave 5 mg IM, rather than 2 mg IM). There was no indication why the nurse who received the order for the chemical restraint did not document the conversation in the IPNs, enter the verbal order into the system, and/or administer the medications herself.
    - An IPN, dated 2/24/18 at 10:38 p.m., from the nurse (RN) who administered the medications indicating that he "received the order from [the RNCM] who received it from [the PCP]. It was an emergency, so she requested me [sic] to prepare the medication and advice [sic] we cannot wait for the home nurse to arrive. I ask the orders [sic] of [PCP] from her because she's the one who received the order. I asked how many milligrams is the Lorazepam [sic]. She mention [sic] it was 5 mg instead of 2 mg. She may have meant the Haloperidol dose but I ask [sic] the Lorazepam dose." It is not an acceptable standard of practice for nurses to accept a verbal order for medications from another nurse without seeing the order or talking to the PCP directly.
    - The Medication Administration Record (MAR) documentation provided only noted the Haldol administration, and as is discussed in further detail below, the format made it unclear specifically what medication nursing staff administered. However, under Action Details on the form, an LVN was listed. Thus, based on the documents provided, it was not possible to verify who actually wrote the order and who actually gave the medication. The Center provided no MAR documentation for the Ativan.
    - Lastly, according to the PCP's IPN, the PCP ordered the administration of both Haldol 5 mg IM and Ativan 2 mg IM. This would require two injections, since not more than three to five mg should be injected using the same syringe, and the medications should not be mixed together in the same syringe. There was no documentation provided that indicated that the nurse administered two injections.
- For Individual #319's chemical restraint on 6/3/18, the IPN, dated 6/3/18, did not include justification for the administration of the chemical restraint, and did not indicate whether or not staff needed to physically restrain her or if she was cooperative for the injection. An IPN (late entry), dated 6/4/18 at 12:30 p.m., noted that the individual refused full assessments and vital signs during the shift and had been "very noncompliant." However, the IPN also indicated later in the note that "she has been asleep for the entire shift," which created a discrepancy with the previous statement that she was noncompliant. The MAR indicated the medication name: "LORazepam" and Ingredients: "lora2inj1 2 mg 1 ml." This document did not clearly indicate that lorazepam 2 mg IM was given. During past reviews, documentation provided was clearer regarding the medication and dosage that was ordered and administered.
- For Individual #220's chemical restraint (Ativan 2 mg IM) on 5/10/18 at 9:45 a.m., the Center provided no PCP order. In the IPN, the nurse did not indicate if the individual was cooperative for the injection or had to be restrained for administration. Also, the nurse did not describe the individual's mental status at the time of the chemical restraint or right afterwards. In addition, in the IPN, the nurse did not state where the chemical restraint was administered and/or when the individual was

assisted to his home, but other documentation (i.e., the face-to-face debriefing form) indicated Individual #220 was outside at the Administration building breaking glass. The flow sheets provided for vital signs/assessments did not indicate the name of the nurse conducting the assessments. Information was cut off of this form. It looked similar to the face-to-face debriefing form submitted, but perhaps printed out differently. In the "flowsheets" provided, the nurse(s) did not provide descriptions of the individual's mental status or respiratory rates for times the individual refused an assessment. The IPN indicated that the individual had blood on his chin, but did not note if it was a result of the restraint/chemical restraint procedure. The MAR document indicated the medication name: "LORazepam" and Ingredients: "lora2inj1 2 mg 1 ml." This document did not clearly indicate that lorazepam 2 mg IM was given.

- For Individual #278's restraint on 4/7/18 at 11:55 a.m., the Center provided no order for the restraint. The IPN provided did not address a restraint that occurred at 11:55 a.m., only the episode from 11:48 a.m. until 11:51 a.m. However, vital signs were conducted within the appropriate time frames related to the previous restraint episode noted from 11:48 a.m. until 11:51 a.m. The nurse provided no indication in the IPN if the individual sustained any injuries due to the restraint episode.
- For Individual #278's restraint on 5/4/18 at 8:32 p.m., the events were not well documented in the nursing IPNs. Details were missing, for example, regarding the behavior warranting the notification of the police department, her mood, statements made, and when the individual left with the police. The IPN only noted the individual verbalized suicidal threats at approximately 8:30 p.m., staff implemented a modified basket hold restraint from 8:32 p.m. to 8:36 p.m., and the "nurse unable to perform further assessment due to client being arrested by LPD for homicidal threats." The Center provided no IPN upon the individual's return from the arrest.
- For Individual #408's restraint on 5/23/18 at 8:35 p.m., the Center did not provide documentation from the nurse of the individual's mental status. However, other nursing assessment were completed as required.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary: Documentation, not including nursing-related documentation was at criteria for all restraints. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	276	319	322	220	278	408			
15	Restraint was documented in compliance with Appendix A.	100% 10/10	1/1	2/2	1/1	2/2	2/2	2/2			
Comments:												

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.	
Summary: Reviews occurred as required for all but one restraint. Many of the individuals had a crisis intervention plan in place. The Center, however, could not provide documentation to show that any recommendations were carried out for those reviews that contained recommendations. These indicators will remain in	Individuals:

active monitoring.												
#	Indicator	Overall Score	276	319	322	220	278	408			
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	89% 8/9	0/1	2/2	N/A	2/2	2/2	2/2			
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	0% 0/2	N/A	0/1	N/A	0/1	N/A	N/A			
Comments: 16. For Individual #276 4/21/18, he did not have a crisis intervention plan and there was not a post restraint ISPA. 17. For Individual #319 6/3/18 and Individual #220 5/10/18, there was no documentation provided to substantiate that the five and 17 recommendations, respectively, were carried out.												

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:			Individuals:									
#	Indicator	Overall Score										
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
48	Multiple medications were not used during chemical restraint.											
49	Psychiatry follow-up occurred following chemical restraint.											
Comments:												

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.												
Summary: Three investigations (25%) did not meet all of the criteria of this outcome and indicator. One was due to absence of a current duty to report form. The other two were due to some supports not being in place to have reduced the likelihood of the incident occurring in the first place. This was a decrease in performance compared to the last review. The Center and HHSC PI were following protocols for the sole individual that made frequent unfounded allegations. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	276	319	322	237	220	278	224	408	309

1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	75% 9/12	1/1	1/1	1/2	1/1	1/2	1/2	1/1	1/1	1/1

Comments:

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

- Individual #276, UIR 18-146, HHSC PI 46431578, unconfirmed allegation of physical abuse, discovered injury, multiple fractures, 2/18/18
- Individual #319, UIR 18-245, sexual incident, 5/30/18
- Individual #322, UIR 18-164, HHSC PI 46598850, inconclusive allegation of physical abuse, confirmed allegation of verbal abuse, 3/8/18
- Individual #322, UIR 18-226, discovered injury, 5/16/18
- Individual #237, UIR 18-121, HHSC PI 46309789, unconfirmed allegation of verbal abuse, 2/1/18
- Individual #220, UIR 18-243, HHSC PI 47037789, administrative referral of an allegation of verbal abuse, 5/29/18
- Individual #220, UIR 18-150, witnessed injury, peer aggression, 2/26/18
- Individual #278, UIR 18-173, HHSC PI 46653114, unconfirmed allegations of verbal and sexual abuse, 3/21/18
- Individual #278, UIR 18-216, law enforcement encounter, 5/7/18
- Individual #224, UIR 18-251, HHSC PI 47064976, unconfirmed allegation of physical abuse, 6/6/18
- Individual #408, UIR 18-232, HHSC PI 47014089, unconfirmed allegation of physical abuse, 5/23/18
- Individual #309, UIR 18-204, HHSC PI 46830316, clinical referral of an allegation of neglect, 4/23/18

1. For all 12 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes (a) the occurrence of staff criminal background checks and signing of duty to report forms, (b) facility and IDT review of trends of prior incidents and related occurrences, and the (c) development, implementation, and (d) revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator and other facility staff met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

For all investigations, criminal background checks were completed, but for one staff member, a current duty to report form was not completed, therefore, that investigation did not meet criteria with this indicator (Individual #322 UIR 18-164). For eight of the 12, the investigation was regarding allegations of staff misconduct and, for each of these, there were no relevant individual-related trends to be reviewed.

For two of the other four, trends/prior occurrences were being addressed by the IDTs and plans were developed and implemented, which were primarily PBSPs or changes in levels of supervision. For the other two, one was the victim of peer to peer aggression, but there were no plans in place that effective protected him (Individual #220 UIR 18-150), and one had repeated instances of peer to peer

aggression, but less than 20% of staff were properly trained in the PBSP (Individual #278 UIR 18-216).

In addition, see the comments in outcome 10 (indicators 19-23) below regarding center-wide data trends and systems for ensuring supports are in place (implemented correctly, updated when necessary, maintained).

One individual at Lubbock SSLC was designated for streamlined investigations by DFPS (Individual #154). This was the same as at the last review. The individual made frequent calls. For instance, in the tier 1 document that listed all allegations during the previous six months, 752 were made by this individual and most were subjected to the streamlined investigation protocol. HHSC PI reviewed the individual within the past quarter (6/22/18) and it appeared that he was discussed during the Center's regularly occurring meeting with HHSC PI. The SSLC requirement was also met because there was a plan in place to address his frequent calling (within his PBSP). Further, the Center reported that they recently conducted a root cause analysis review of this behavior.

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

Summary: One investigation did not fully explore issues around what appeared to be late reporting. This indicator will remain in active monitoring, however, with sustained high performance, it might be moved to the category of requiring less oversight after the next review.

Individuals:

#	Indicator	Overall Score	276	319	322	237	220	278	224	408	309
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	92% 11/12	1/1	1/1	2/2	1/1	2/2	2/2	1/1	1/1	0/1

Comments:

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

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

- For Individual #309 UIR 18-204, the UIR noted that the incident occurred on 4/23/18 and was reported to the Center on 4/27/18 and to the facility director/designee also on 4/27/18. The HHSC PI report also noted that there was a failure to report. This was not explored or explained in the UIR.

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: Most staff could not correctly describe proper reporting procedures. Most said that allegations had 24 hours to be reported and some did not state how

Individuals:

they would make a report (e.g., phone call). Therefore, indicator 3 will be returned to active monitoring. Indicator 4 will also remain in active monitoring.											
#	Indicator	Overall Score	276	319	322	237	220	278	224	408	309
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. However, due to low performance, it will be returned to active monitoring.									
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	89% 8/9	1/1	1/1	0/1	1/1	1/1	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments: 3. Because indicator #1 was met for many of the individuals, this indicator was not scored for them. For the three individuals for whom this indicator was applied, staff for two of the three provided incorrect information about reporting requirements. All of the staff stated that suspected abuse/neglect needed to be reported within 24 hours (not one hour) or they needed repeated re-wording of the question with extra prompting from the Monitoring Team regarding the call in number and timeline. In response to the draft version of this report, the State highlighted the various activities the Center had engaged in, and will continue to engage in, to address this. After the next onsite review, this indicator may be returned to the category of requiring less oversight. 4. The reporting information poster was not present in Individual #322's home.											

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.											
Summary: Given that the alleged perpetrator reassignment issues that occurred at the last review were no longer occurring, and given that high performance was again achieved, indicator 6 will be moved to the category of requiring less oversight.		Individuals:									
#	Indicator	Overall Score	276	319	322	237	220	278	224	408	309
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	92% 11/12	1/1	1/1	1/2	1/1	2/2	2/2	1/1	1/1	1/1
Comments: 6. For Individual #322 UIR 18-226, the typical detail on date and time of alleged perpetrator reassignment was no in the UIR.											

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

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
Summary: All investigations met criteria for the collection and analysis of evidence and the conclusions drawn. Including this review, Lubbock SSLC scored 100% on indicators 9 and 10 for three of the four reviews. Therefore, indicators 9 and 10 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	276	319	322	237	220	278	224	408	309
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 12/12	1/1	1/1	2/2	1/1	2/2	2/2	1/1	1/1	1/1
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	100% 12/12	1/1	1/1	2/2	1/1	2/2	2/2	1/1	1/1	1/1
Comments: 9-10. Individual #322 UIR 18-226 was a very extensive investigation.											

Outcome 7– Investigations are conducted and reviewed as required.											
Summary: Some investigations were not completed within the required timeline or with the required extension approvals. Problems with investigations were not detected in one-third of the investigations. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	276	319	322	237	220	278	224	408	309
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
12	Completed within 10 calendar days of when the incident was	83%	0/1	1/1	2/2	1/1	2/2	1/2	1/1	1/1	1/1

	reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	10/12									
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.	67% 8/12	0/1	1/1	0/2	1/1	2/2	1/2	1/1	1/1	1/1

Comments:

12. For Individual #276 UIR 18-146, the incident was reported to DFPS intake on 2/18/18 and the investigation was completed on 3/8/18 (18 days). The first staff (alleged perpetrator) interview was 2/26/18 (day 8), and the next staff interview was 3/5/18 (day 15). The extension request was on 2/28/18 requesting additional time needed for interviews.

For Individual #278 UIR 18-173, the incident was reported on 3/21/18 and completed on 4/1/18 (day 11); no extension provided. The requirement is completion within 10 calendar days.

13. The supervisory review did not detect the various problems identified in the investigations, such as late reporting, alleged perpetrator reassignment, and/or late completion of the investigation. 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.

Lubbock SSLC continued with some positive practices: The Center's review process included a review by the Assistant Independent Ombudsman. Also, the Center used a Case Review Checklist, showing Review Authority members, IMC, Investigator, unit director, ADOP, QA director, and facility director.

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: Lubbock SSLC was correctly conducting non-serious injury investigations for all individuals for the first time. Indicator 15 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	276	319	322	237	220	278	224	408	309
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.												
Summary:			Individuals:									
#	Indicator	Overall Score										
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.											
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.											
Comments: 17. There were four investigations that included a confirmed physical abuse category 2. In all cases, the employment of the involved staff was terminated (or was in the process of being terminated). Every investigation contained recommendations, sometimes many (one had 17; most had three to seven recommendations). The Center was able to produce extensive documentation to demonstrate completion of all recommendations for the investigations reviewed. As discussed below, this was not the case for all mortality reviews that the Monitoring Team reviewed.												

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.												
Summary: This outcome consists of facility indicators. Lubbock SSLC collected various data and tracked/trended it. This has been the case for three consecutive reviews. As a result, indicators 19 and 20 will be moved to the category of requiring less oversight. Executive Safety Committee generated many individual-specific actions for IDTs for follow-up. This was good to see. There were not, however, any actions regarding any center-wide systemic needs. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score										
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes										
20	Over the past two quarters, the facility's trend analyses contained the required content.	Yes										

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

Comments:
21-23. The Center did much of its review of data for abuse/neglect and incident management via the Executive Safety Committee. Monthly minutes showed a lot of different data being presented. The Center reported that it was in the process of revising the Executive Safety Report, primarily drawing more from the IRIS systems.

Executive Safety Committee generated a number of directives for IDTs for follow-up regarding the various topics reviewed during the meeting (e.g., injuries). These plans were detailed and there was evidence of implementation. This was good to see.

The program, however, did not identify any center-wide systemic issues or actions.

For instance, during the review of preliminary scoring meeting while onsite, the Monitoring Team referred to the Executive Safety Committee report graphs that showed ascending trends/graph lines for confirmations of abuse/neglect, peer to peer aggression, crisis intervention restraints, falls, and injuries.

In addition, during the review week, and as indicated in various sections of this report, executive safety committee, IDTs, and other forums may generate reasonable actions, but they were often not implemented, not implemented fully, or not maintained. Examples included staff being aware of the need for a safe environment for individuals with pica behaviors, but a box of rubber gloves and other items being readily within reach. Another example was the expectation of trashcans being emptied/locked every hour, but turning out it was being done at the end of the work shift. In other examples, it did not become apparent to IDTs that supports were not in place (or not in place correctly) until a subsequent similar incident occurred.

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A

	are followed.										
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 created, expanded, and/or 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 the use of TIVA with Individual #197 on 1/23/18, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, and post-operative vital sign flow sheets were submitted showing nurses monitored the individual according to the requirements of the policy. However, an operative note defining the procedures and assessment completed was not available.

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

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									

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

Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
Summary: Monitoring of this outcome and its indicators is put on hold while the State develops instructions, guidelines, and protocols for meeting criteria with this outcome and its indicators.			Individuals:								
#	Indicator	Overall Score									
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.										
2	If PTS was used over the past 12 months, the IDT has either (a)										

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

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	139	205	141	269					
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.	75% 3/4	0/1	1/1	1/1	1/1					
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1					

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

- On 12/13/17, Individual #139 died at the age of 45 with causes of death listed as urinary tract infection (UTI), acute coronary syndrome, and ventricular fibrillation. The clinical death review was completed 23 days after the individual's death.
- On 2/9/18, Individual #205 died at the age of 52 with causes of death listed as acute respiratory failure, cardiopulmonary arrest, bilateral pneumonia, and sepsis.
- On 3/12/18, Individual #141 died at the age of 62 with causes of death listed as septic shock, cardiogenic shock, and multi-organ failure.
- On 4/21/18, Individual #269 died at the age of 69 with cause of death listed as pneumonia.

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

- As indicated in previous reports, overall, the nursing reviews of deaths were not sufficient to identify problems with nursing care that required remediation. For each death, the Center provided a Quality Assurance Death Review of Clinical Services. It included a narrative of events occurring in the 72 hours prior to death. Overall, the reports did not reflect comprehensive reviews of essential areas, such as risk areas, the quality and implementation of IHCPs, ISPs, ISPAs, implementation of Acute Care Plans, nursing assessments and documentation, and the IDT's response to issues.
- The Monitoring Team identified significant problems with regard to the care provided to Individual #205, and Individual #141 but the Center's clinical and administrative death reviews had not identified and/or addressed many of the identified issues. At times, even when the Center's reviews identified an issue, the clinical and administrative death review teams did not develop and require implementation of strategies to correct the issues and/or monitoring to ensure that problematic practices changed. For example:
    - For Individual #205, the recommendations from the clinical and administrative death reviews did not address the root cause of this likely preventable death. He had a Stage 4 decubitus that then developed into osteomyelitis, which placed him in a greatly weakened state (with ineffective cough or inability to cough) associated with rapid terminal complications, including sepsis, and pneumonia with only a brief hospitalization of 24 hours prior to his death. The osteomyelitis was likely long-standing. On 9/23/17, the coccyx was radiographically present, but by 2/5/18, was destroyed and no longer radiographically present, with additional spread of the infection to the sacrum.
        - Although the clinical death review included a recommendation to train PCPs on osteomyelitis, the death reviews included no information to suggest that the PCPs would be trained on the diagnosis, treatment, and preventive steps for decubitus ulcers/pressure sores.
        - The Center needed a policy/procedure and flow chart on the treatment of pressure sores/decubitus ulcers. Such a policy/procedure should define the participation and roles of all departments to ensure timely and thorough treatment of decubiti, including, for example, treatments, as well as training of staff, ongoing assessments (i.e., nursing, medical, and habilitation therapies), measuring with accuracy the size and depth of the ulceration, additional tests, and frequency of documentation of each discipline (daily, weekly, etc., including the PCP).

- Due to the continued reopening of the wound, the medical team should have suspected osteomyelitis, and investigated the possibility far earlier. Osteomyelitis can impact the healing of a wound and result in a wound healing from the top down rather than bottom up, which is how a wound normally heals. The infection penetrates the surrounding tissues resulting in the tissues not healing appropriately or in a manner that prevents reopening of the wound or delays its healing. Based on documentation provided, on 8/3/17, a PNMT note indicated that Individual #205 would be referred to the wound care specialist, and a computed tomography (CT) scan was needed to rule out tunneling of the decubitus. The medical staff did not provide an order for the CT scan until 8/24/18, three weeks later. No rationale for this delay was offered. While on 9/15/17, PNMT minutes did state that the results were pending, there was no ISP, PNMT minutes, or OT/PT consults that showed discussion of the results or what the results were. It was not until 1/25/18, that osteomyelitis was diagnosed after the wound, which was originally a Stage 2 ulcer, had reached Stage 4 status.
- Based on the documentation reviewed as well as interviews with staff, significant concerns existed in the communication between the medical and nursing departments, as well as residential services. Although the Monitoring Team did not complete a full investigation into these issues to allow it to draw definitive conclusions with regard to the underlying causes of the problems, the Lead Monitor spoke with the Center Director about the need to identify and address the factors that appeared to impact the provision of needed care to the individuals served, such as Individual #205. Of note, the Center's mortality reviews did not uncover and/or address these concerns.
- A delay occurred in obtaining a recommended bed for Individual #205, which possibly related to a decision to wait for insurance approval of the cost. As far back as 5/15/17, the PNMT recommended an alternating pressure mattress. On 11/30/17, a PNMT note indicated the individual's current mattress still did not meet his needs. An OT/PT consult, dated 1/26/18, stated: OT/PT follow up with medical supply for bed. Wound declining. STAGE IV wound with tunneling and Osteomyelitis. Medial supply brought out same mattress he currently has." Per OT, "[Individual #205] would benefit from a true alternating/rotating pressure bed for wound healing."

  If one did not already exist, the Center needed a protocol to address requests for additional resources (e.g., one-to-one staffing, specialized mattresses, etc.) with tracking until they are in place. Such a protocol also should address circumstances when Center administration does not approve such requests, including documenting the reason, and the alternative plan implemented to address the identified need, with a date of implementation. Such a system should include an appeal process to ensure that when a clinician believes a resource is needed to address an individual's health and safety, a mechanism exists to appeal a denial up the chain of command.
- On 12/7/17, the wound care reportedly was placed on hold due to a fracture of his arm. The orthopedist stated in a consult that: "the fracture will be ok; the wound will KILL him if not cared for correctly." It was not until 12/29/17, that he returned to wound care. During the delay, the wound increased from Stage 2 to Stage 4.
- The nursing review did not comprehensively review nursing staff's planning, and care for this individual with a Stage 4 pressure ulcer, and as a result, the clinical and administrative death reviews did not include a full set

of recommendations to remediate issues. If not already in place, Lubbock SSLC should explore the potential for a part-time or full-time nurse with wound care certification as either an employee or consultant.

- Although not reflected in the causes of death listed, severe dehydration contributed to Individual #141's death.
  - It was positive that the administrative death review included a recommendation that read: "Work group will be developed to review individuals at high risk for dehydration at the facility. Workgroup will focus on reviewing supports for current individuals developing a process for improved communication between DSP [direct support professionals] and nursing staff and developing a system to ensure that processes in place are being implemented." However, given the seriousness of Individual #141's dehydration, and its impact on his death, the Center should have considered this a high-priority recommendation (e.g., the equivalent of "immediate jeopardy"), but instead, two and a half months after the individual's death, the workgroup did not have a final product, and the workgroup scheduled its next meeting for close to two months later (i.e., 7/27/18).
  - Although the nursing Quality Assurance Death Review of Clinical Services did not represent a comprehensive review, it identified some significant problems, but did not generate related recommendations. Findings included, for example: 1) There was no documentation indicating that the individual was offered six ounces of fluids every hour or that nursing informed DSPs how much fluid he received with medication passes (it was not clear why nursing staff would have to notify DSPs, because all intake should have been documented); 2) No evidence was found to show that the Registered Nurse Case Manager (RNCM) monitored fluid intake weekly (of note, weekly would not have been frequent enough for this individual's status and health issues); 3) Nursing assessments for dehydration were not found in IView and the care plan did not define the frequency for these assessments (of note, it should have been at least daily); and 4) the nursing care plan for dehydration was initiated, but not implemented. Some of the concerns the Monitoring Team noted included:
    - A Dehydration Workgroup was established, and the minutes, dated 4/24/18, indicated that 14 individuals either had an ED visit and/or hospitalization related to dehydration and two additional individuals were at high risk for dehydration. It was concerning that this number of individuals were significantly dehydrated. As discussed above, action to address this issue were not immediate enough to reduce individuals' risk.
    - The review did not mention training for the RNCM who did not follow through with the interventions that could have prevented this individual's dehydration, and potentially his death.
    - The review did not include recommendations related to the lack of nurses' notification of the PCP when intake was significantly below 51 to 55 ounces per day and/or had no urination in 12 hours.
    - A recommendation that was listed was to obtain a basic metabolic panel (BMP) more frequently than every three to six months "as this would be a more accurate indicator of whether or not interventions are effective or being implemented as ordered." A lab test should not be the only validation that an individual who had hospitalizations due to dehydration is receiving daily fluids as the physician ordered. This is a tragic example of how the lack of simple and regular monitoring, nursing assessments, and documentation played a significant role in the Center's failure to protect individuals from harm up to and including death.
  - Even after multiple reviews indicating inadequate intake, the Dietician continued to offer the primary

recommendation to "encourage" fluid intake. The Dietitian chose to end monthly reviews after the September 2017 monthly note despite the individual continuing to have less than ideal fluid intake. The Dietitian continued to change estimated fluid intake needs without providing a rationale for doing such. The various mortality reviews did not address these issues.

- Similarly, the mortality reviews did not address concerns related to Habilitation Therapies services and supports:
  - In July 2017, after Individual #141 was hospitalized for dehydration, the PNMT completed a review. The PNMT noted that DSPs stated that they had been notifying nursing staff of the individual's meal refusals, but upon chart review only one meal had been refused. The PNMT did not further pursue this issue.
  - On 7/10/17, the Speech Language Pathologist (SLP) recommended a change from a Spout cup to a Vacuum Cup, which had a larger opening that would allow fluids to flow more freely while remaining safe. However, monitoring of this support did not occur to assess its effectiveness.

- For Individual #269, the administrative death review included a recommendation that: "RN Case Managers will review the frequency of PCP reviews to determine if frequency is appropriate based on health issues." This is not clinically appropriate, because it is outside of the scope of nursing practice.

e. For two or more recommendations from each of the four individuals' clinical and/or administrative death reviews, the Center did not submit documentation to substantiate their completion.

The recommendations generally were not written in a way that ensured that Center practice had improved. For example, a recommendation that read: "Floor nurse and DSP staff should communicate regarding fluid intake recommendations/orders." resulted in an in-service training to nurses and direct support professionals. 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 necessary communication was occurring.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: In conducting its review, the Monitoring Team identified two potential ADRs that staff should have reported, but did not. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	ADRs are reported immediately.	0% 0/2	N/A	N/A	N/A	N/A	0/1	0/1	N/A	N/A	N/A
b.	Clinical follow-up action is completed, as necessary, with the individual.	0% 0/2					0/1	0/1			

c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	0% 0/2					0/1	0/1			
d.	Reportable ADRs are sent to MedWatch.	0% 0/2					0/1	0/1			

Comments: a. through d. Center staff had not identified and/or reported potential adverse drug reactions for any of the individuals reviewed. However, in conducting a review of other documents provided, the Monitoring Team identified two potential ADRs that staff should have reported, including:

- During Individual #12's hospitalization from 3/28/18 to 4/2/18, Zosyn might have worsened her seizure disorder.
- Individual #197 is prescribed Tramadol, and on 5/8/18, she complained of diarrhea.

In it comments on the draft report, the State disputed the findings for both individuals and provided lengthy analyses of why neither was an adverse drug reaction and why reporting to MedWatch was not necessary. After reviewing the State's comments, the Monitoring Team did not change its original findings. Staff should have reported both instances as potential adverse drug reactions. The wealth of information the State provided about each should have been included in the ADR deliberation process and presented to the P&T Committee for final decision-making regarding whether modifications were needed to the individuals' records to show an allergy, sensitivity, or other statement to alert practitioners to a history of a side effect in the individual to the medication. The P&T Committee should have deliberated and reached agreement on whether or not the incidences were actual ADRs, as well as whether Center staff needed to make a report to MedWatch. Whether a medication should be reported to MedWatch is not an initial step to dismiss whether the ADR process should be followed, as implied in some of the State's comments.

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: 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.	Due to the Center's sustained performance, this indicator moved to the category of requiring less oversight.
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	N/A
Comments: b. Since the last review, Lubbock SSLC completed three DUEs, but none generated recommendations for follow-up.		

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the time of the last review, 18 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, nine additional indicators in the areas of ISPs, psychiatry, behavioral health, physical and nutritional management, and skill acquisition will move to the category of less oversight.

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

The Monitoring Team observed many positive interactions among staff and the individuals whom they were assigned to support.

Assessment

For the ISPs, most IDTs did not consider what assessments the individual needed and would be relevant to the development of an individualized ISP. IDTs arranged for and obtained all needed, relevant assessments prior to the IDT meeting for half of the individuals.

In psychiatry, about half of the CPEs met criteria for content and about half met criteria for diagnostic consistency in the record.

Behavioral health/PBSP goals were based upon assessments for all individuals. Most annual behavioral health updates were missing any information related to relevant physical health. Functional assessments were current for most individuals, but were complete in content for about one-third.

About half of the SAPs were based on assessment results; even fewer were practical/functional/meaningful. None of the SAPs met criteria for having reliable data. For all individuals reviewed, the FSA included SAP recommendations.

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 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.

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

During this review, none of the individuals reviewed had timely dental exams, and half of the individuals reviewed had timely annual dental summaries, most of which were based on outdated information. However, the dentist position was vacant for a portion of the review period, and this likely contributed to these findings. At the time of the onsite review, a dentist had been hired, and recognized the need to improve the timeliness and quality of dental exams and summaries.

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.

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. This has been a consistent finding for a few reviews, so the related indicator will move to the category of less oversight. However, the IDTs of a number of individuals reviewed should have made referrals to the PNMT, or the PNMT should have made self-referrals, but this did not occur. The Center should focus on improving the referral of all individuals that meet criteria for PNMT review, completion of PNMT comprehensive assessments for individuals needing them, and improvement in the quality of the PNMT reviews and comprehensive assessments.

Since the last review, the Center's performance with regard to the timeliness of OT/PT assessments improved. The quality of OT/PT assessments continues to be an area on which Center staff should focus.

It was positive that for most individuals reviewed, Speech Language Pathologists (SLPs) completed timely communication assessments. However, significant work is needed to improve the quality of communication assessments in order to ensure that SLPs provide IDTs with clear understandings of individuals' functional communication status; AAC options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated.

<u>Individualized Support Plans</u>
For the ISPs, overall, IDTs had established goals that were more individualized (and based on known preferences) than in the past. The exceptions were the work/day goals. Most were related to compliance with attending day or work sites rather than being aspirational or providing opportunities to learn new skills.

Action plans would not likely lead to accomplishment of these more individualized goals. The Monitoring Team recommends that Lubbock SSLC develop a plan to address the quality components of action plans that are monitored in outcomes 3 and 4 (i.e., indicators 8 through 29).

Most action plans had not been fully implemented, and there was little evidence that individuals were making progress towards greater independence and learning new skills.

QIDP monthly reviews were occurring, but were not generating any meaningful analyses or resultant actions. QIDPs need additional training on completing monthly reviews that provide a good summary of status, progress, and/or regression.

In psychiatry, Lubbock SSLC made progress in that, for most individuals, some psychiatric indicators were identified in one or more documents. For some individuals, some sub-indicators met criteria. The next steps, of defining these indicators in observable terminology, ensuring they relate to the diagnosis, and then collecting data were needed. Also, putting these indicators into goals and then including them in the IHCP section of the ISP was also needed.

The number of individuals with a psychiatric support plan (PSP) decreased at Lubbock SSLC to 14, the fewest in the past few years. In looking at the most recent four PSPs, however, a decrease in quality was seen. That is, although each PSP contained a great deal of information about the individual, they were missing the information regarding how the staff were to collect and report the behavioral data and how staff were to respond to the individual when these symptoms/behaviors occurred.

PBSPs contained some important components, but each plan was missing other important components and/or aspects were not updated. The Center was unable to show that the data being collected for goals were reliable. Moreover, the Monitoring Team directly observed six occurrences of problem behavior, five of which were never entered into the data collection system.

Regarding SAPs, same as at the last review, all (but one) individuals had at least one SAP, but there remained a small number of SAPs for many individuals who could have benefited from more skill training.

Overall, the IHCPs of the individuals reviewed were not sufficient to meet their needs. For example:

- Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.
- Although much work is needed, some improvement was seen with regard to including preventative nursing interventions in individuals' IHCPs. The Center should continue to focus on developing IHCPs that fully address individuals' health risks and chronic conditions.
- Some improvement was seen with regard to the inclusion in IHCPs of physical and nutritional management (PNM) clinical indicators, as well as triggers and actions to take if they occur. Overall, though, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs.

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

It was good to see that the ISPs of individuals reviewed provided good functional descriptions of their communication skills. It also was positive that IDTs included recommended communication strategies, interventions, and programs in the ISPs reviewed.

ISPs

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

Summary: Lubbock SSLC maintained performance, which means that more work needs to be done to develop individualized goals in all six goal areas (especially regarding work/day and health/wellness), ensure they are written in measurable terms, and collect data on the individual's status on each. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	276	319	26	237	12	23			
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	3/6	2/6	2/6	2/6			
2	The personal goals are measurable.	0% 0/6	2/6	2/6	3/6	2/6	2/6	2/6			
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	1/6	0/6	0/6	0/6	1/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #319, Individual #237, Individual #26, Individual #276, Individual #23, and Individual #12. 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. The ISP relies on the development personal goals as a foundation. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

None of the six individuals had individualized goals in all six goal areas. Therefore, none had a comprehensive set of goals that met criterion. For this set of individuals, however, the IDT had defined/chosen some personal goals that met criterion for being individualized, based on the individual's preferences and strengths. Overall, 15 of 36 personal goals met criterion for this indicator. This was about the same as the last review when 16 goals met criterion. Goals that met criterion were:

- Individual #319's goals for recreation, relationships, and living options.
- Individual #237's goals for recreation and greater independence.
- Individual #26's goals for relationships, greater independence, and living options.
- Individual #276's goals for recreation/leisure, relationships, and greater independence.
- Individual #23's goal for recreation/leisure and relationships.
- Individual #12's relationship and greater independence goals.

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

Individual #26's ISP preparation meeting was observed. The IDT failed to develop a vision for Individual #26 that would lead to greater independence and a more meaningful life based on his preferences. New goals suggested by the team were based on compliance with facility expectations and increasing participation in activities that were already available to him. For instance, his suggested work goal for the upcoming year was for improved attendance at the sheltered workshop on campus. The IDT failed to consider other work opportunities based on his preferences. His suggested relationship goal was to eat in the community with his peers. There was no discussion regarding skills that he might learn while in the community.

2. Of the 18 personal goals that met criterion for indicator 1, 13 also met criterion for measurability (an improvement from the last review). The two that did not were Individual #319 and Individual #12's relationship goals.

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

3. Two of the goals had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals (also similar to the last review). This was Individual #276's recreation/leisure goal and Individual #12's greater independence goal.

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

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: This set of indicators speaks directly to the overall quality of the ISP for the individual's upcoming year. The Monitoring Team looks across the entire ISP when scoring each of these indicators. Performance remained about the same as at the time of the last review, indicating that some focus or specialized approach to improvement is warranted. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	276	319	26	237	12	23			
8	ISP action plans support the individual's personal goals.	0% 0/6	1/6	0/6	0/6	0/6	1/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	33% 2/6	1/1	1/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
8. Fifteen of the personal goals met criterion in the ISPs, as described above in indicator 1, therefore, those action plans could be evaluated in this context. 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.

Two of the goals had action plans that were likely to lead to the accomplishment of the goal. Individual #276's action plans to support his recreation/leisure goal, and Individual #12's greater independence goal had reasonable action plans to support these goals.

For the most part though, IDTs were not developing action steps that would lead to measurable progress towards goals. Although the facility acknowledged that IDTs needed additional training on developing action plans to support goals at the last review, there had been no identifiable progress in developing action plans to support goals.

Skill acquisition programs did not include enough information to ensure that staff could consistently implement them and determine what progress was made. Most of the action plans were written as service objectives and did not include staff instructions or implementation strategies that would ensure staff could consistently teach a new skill or accurately collect data on progress.

9. None of the ISPs had action plans that integrated preferences and opportunities for choice. IDTs were not identifying preferences in a way that might guide the development of activities that would offer opportunities to learn new skills and build on developing a plan for meaningful days. For the most part, ISPs listed general preferences related to food, music, TV, and activities routinely offered at the facility.

10. None of the ISPs clearly addressed strengths, needs, and barriers related to informed decision-making. A basis to making informed decisions is offering individuals exposure to a variety of new experiences and opportunities to make choices throughout their day. These opportunities were rarely included in action plans in any substantial way.

11. One of six ISPs met criterion for this indicator to support the individual's overall independence. Individual #276 had action plans for reading and money management, however, per observations, these SAPs were not functional for him. For the other five individuals, it was not clear how their chosen action plans would support them to gain independence.

12. None of the ISPs integrated strategies to minimize risks in ISP action plans. While risks were addressed through action plans included in the IHCP, supports were not integrated into other action plans when relevant, and risks were not always identified by the IDT. Rarely were SAPs written to provide staff with strategies for implementing plans and, when SAPs were written, they did not include specific mobility, behavioral, and safe eating supports. Four of the six individuals were involved in peer to peer aggression incidents over the past year. Protections did not appear to be effective and were not revised when not effective. For example, Individual #276's ISP indicated that he had been the aggressor in peer to peer incidents 23 times in the past year and the victim in 20 separate incidents. His ISP did not adequately address his risk for injury or protections for other individuals in his home.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well integrated in ISPs. In most cases, supports were fragmented, with little

evidence that IDT members were sharing data and collaborating on developing supports. Some examples of this lack of integrated supports included:

- Individual #319's psychiatry, neurology, and behavioral supports were not well integrated.
- Individual #237's IDT had not considered his medical prognosis when revising his ISP. Consequently, his goals had all been discontinued or placed on hold due to his change in medical status.
- Individual #26's communication, occupational therapy, and nutritional supports were not integrated into his skill acquisition plan for cooking pizza.
- Communication strategies were not well integrated into Individual #276's ISP goals and action plans. Staff reported that most of his behavioral incidents related to his inability to express his frustration.
- Individual #23 and Individual #12's ISPs did not integrate communication and mobility/positioning strategies into goals and action plans.

14. Meaningful and substantial community integration action plans were absent from the ISPs for these individuals, with no specific, measurable action plans for community participation that promoted any meaningful integration.

Individuals were rarely given opportunities to utilize community resources that might support them to be more independent and integrated into the community. Individuals did not have goals for banking, volunteering, getting haircuts, joining a church, or joining a gym in the community. Outings were limited to specific events, such as eating out, going to the movie, or attending a sporting event. While these types of activities support community exposure, they are unlikely to lead to meaningful integration.

15. Two ISPs included action plans to support opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Day and work opportunities were particularly limited for most individuals. Vocational training was not focused on building skills that might lead towards employment in a more integrated setting.

- Individual #319 was working in the sheltered workshop, however, her ISP included an action plan to complete a community employment exploration assessment.
- Individual #276 was working at a nursing facility in the community rolling silverware for two hours per week through the supported employment program.

Training opportunities were limited and rarely individualized. Individuals had few opportunities to learn new skills and experience new things. Individual #237, Individual #23, and Individual #12 did not spend a majority of their day outside of their homes engaged in meaningful programming.

16. For the most part, ISPs did not support substantial opportunities for functional engagement described with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Overall, the ISPs provided limited opportunities for learning and functional skill development. During observations, activities were rarely functional and did not provide opportunities to experience new things and learn new skills. IDTs need to expand the preference assessment to offer more opportunities to try new things and identify new interests. Individual #276 was the one individual who was engaged throughout much of the day in meaningful activities.

17. ISPs did not adequately address barriers to achieving goals and learning new skills. Goals were not consistently implemented, and IDTs did not address barriers to implementation. A review of ISP preparation documents indicated that some goals that either had not been implemented or the individual failed to make progress were continued from the previous ISP without addressing barriers.

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

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

Summary: Performance remained about the same as at the last review. The Monitoring Team recommends that Lubbock SSLC develop a plan to address the quality components that are monitored in this outcome and outcome 3 above (i.e., overall, indicators 8 through 29). The indicators in outcome 4 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	276	319	26	237	12	23			
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).	33% 2/6	0/1	1/1	0/1	1/1	0/1	0/1			
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.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	83% 5/6	1/1	1/1	1/1	0/1	1/1	1/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	33% 2/6	0/1	1/1	0/1	1/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	83% 5/6	1/1	1/1	1/1	0/1	1/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	N/A	N/A	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	33% 2/6	0/1	1/1	1/1	0/1	0/1	0/1			

	referred, to transition.										
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	N/A	N/A	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.	0% 0/4	0/1	N/A	0/1	N/A	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:

19. Two ISPs included a description of the individual's preference for where to live and how that preference was determined by the IDT.

- Individual #26's ISP indicated that he has not expressed any likes or dislikes. His only preference was noted to be a smaller home.
- Individual #276's ISP noted that he liked his current home. There was no discussion documented of preferences in his living environment. His ISP did note that he had limited exposure to other living options.
- Individual #23's ISP noted that he seems happy in his current home. His exposure to other living options was limited.
- Individual #12's ISP indicated that she did not have a preference of where she lives.

21. Five ISPs included the opinions and recommendation of the IDT's staff members. Individual #237's psychiatrist and PCP were not present at his meeting to provide input on supports that he would need. Without their input, it was unlikely that the IDT had information that they would need to make an informed decision.

22. Six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR.

23. Two of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths. For the most part, ISPs did not document discussion regarding placement options that might support current support needs, preferences, and strengths

24. 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 #237's ISP noted that his medical and behavioral needs were barriers to community living options, however, as noted above, his psychiatrist and PCP were not available for input and the IDT did not specify supports needed that could not be provided in the community.

26. Two of the individuals had individualized, measurable action plans to address obstacles to referral, or were referred if obstacles were not identified. Barriers to referral were addressed in Individual #319's and Individual #26's positive behavior support plans.

28. Four individuals did not have individualized and measurable action plans to educate the individual and/or LAR on living options

that might be available to support their needs. Individual #319 and Individual #237's ISPs indicated that they had recently lived in the community and were aware of living options.

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

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

Summary: ISPs were developed within 30 days for new admissions. This was the case for all individuals over the past few reviews. Therefore, indicator 31 will be moved to the category of requiring less oversight. ISP action plans, however, were then not implemented in a timely manner, or at all (indicator 32). Most individuals and their LARs attended ISP meetings, but some important IDT members were absent from the annual meeting of two-thirds of the individuals. These three indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	276	319	26	237	12	23			
30	The ISP was revised at least annually.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	67% 4/6	1/1	1/1	N/A	1/1	N/A	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.	33% 2/6	0/1	1/1	0/1	0/1	0/1	1/1			

Comments:

31. Individual #319 was admitted within the past year. She had an ISP that was developed within 30 days of admission.

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

33. Four individuals attended their ISP meetings. Individual #26 and Individual #12 did not attend their ISP meeting.

34. Two of the individuals had an appropriately constituted IDT (Individual #319, Individual #23), based on the individual's strengths, needs, and preferences, who participated in the planning process.

- Individual #237's psychiatrist and PCP did not attend his ISP meeting. He had complex medical and psychiatric needs. The IDT

had little information regarding his medical diagnosis and his prognosis.
- Individual #26's psychiatrist and PCP did not attend his ISP meeting.
- Individual #276's PCP did not attend his IDT meeting.
- It was not evident that Individual #12's team was addressing the fact that she was sleeping through most of her day. The team needs to have an interdisciplinary discussion to determine what supports might be needed to make her day more meaningful.

Overall, QIDPs and other team members had little expectation for growth or greater independence. The IDT members were not tracking progress towards goals or addressing barriers when individuals were not making progress.

IDTs need a better understanding of the ISP process and how to develop a good vision statement, then how to support individuals to achieve that vision.

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

Summary: Various assessments were not obtained or were submitted late. Both indicators decreased in performance from the last review. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	276	319	26	237	12	23			
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.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	50% 3/6	0/1	1/1	1/1	1/1	0/1	0/1			

Comments:

35. Five IDTs did not consider what the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting.
- Individual #237's IDT needed to consider a comprehensive health/neurological assessment that would determine a current baseline for his progressive diagnosis and facilitate the IDT in developing supports based on his prognosis.
- Individual #26's IDT did not consider an explorational vocational or preference assessment that might guide the team in developing vocational supports to lead towards more meaningful day opportunities.
- Individual #276 had a communication screening without recommendations for expanding/improving his expressive and receptive language. There was no consideration by the team for further assessment.
- Per observations and interviews, Individual #23 spent a majority of his day in a transport wheelchair. The IDT needed to consider a wheelchair assessment to determine if this was appropriate for his mobility needs. He also needed a more comprehensive communication assessment to determine if signs he routinely used were functional for his needs.
- Individual #12 needed a more comprehensive preference and functional assessment to guide the team in providing supports that might increase her independence and provide more meaningful activities.

36. IDTs did not arrange for and obtain all needed, relevant assessments prior to the IDT meeting for three of the individuals.
- Individual #276's dental and FSA assessments were not submitted timely prior to his ISP meeting.
- Individual #23's communication assessment was not adequate for planning.
- Individual #12's nursing assessment was not submitted 10 days prior to his annual meeting and was not adequate for planning.

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

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

Summary: IDTs met often and often they made recommendations. There was, however, little follow-up to ensure implementation and effectiveness. QIDP monthly reviews were occurring, but were not generating any meaningful analyses or resultant actions. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	276	319	26	237	12	23			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

37. IDTs met routinely to review supports, services, and serious incidents. This was good to see, however, when recommendations were made or supports were revised, IDTs rarely met again to ensure that recommendations were implemented. Furthermore, reliable and valid data were rarely available to guide decision-making.

IDTs rarely revised goals when progress was not evident. ISPs were not fully implemented for any individual.

Examples where IDT members did not provide adequate follow-up and revision of supports when needed included:
- Individual #237's IDT had placed a hold on implementation of his goals following a significant change in health status. The IDT had met several times to revise some supports, however, he did not have a comprehensive ISP in place to address all of his current support needs or review the efficacy of revised supports.
- Facility data indicated that from 5/1/18 through 7/31/18, Individual #276 was involved in 22 incidents of peer to peer aggression. He was the aggressor in 20 of those incidents. His IDT met twice during that time period (5/3/18 and 6/21/18). At both meetings, the recommendation was to continue his PBSP and remind staff to redirect him without consideration regarding the effectiveness of current supports.

38. Consistent implementation and monitoring of ISP action steps remained areas of concern. ISP action plans were not regularly

implemented for any of the individuals.

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

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

The Monitoring Team attended a number of meetings while onsite to review the IDT process and the facility's response to incidents. In most cases, the facility reviewed incidents and assigned follow-up action for staff to complete to ensure any contributing factors identified were addressed. The Monitoring Team, however, could not determine whether actions for staff to complete were ever implemented and reviewed.

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

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

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

#	Indicator	Overall Score	Individuals: 237	319	227	321	12	197	269	176	23
a.	The individual's risk rating is accurate.	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	50% 9/18	0/2	0/2	1/2	2/2	1/2	1/2	1/2	2/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #237 – skin integrity, and other: Pompe disease; Individual #319 – constipation/bowel obstruction, and weight; Individual #227 – falls, and choking; Individual #321 – fractures, and cardiac disease; Individual #12 – urinary tract infections (UTIs), and constipation/bowel obstruction; Individual #197 – falls, and cardiac disease; Individual #269 – constipation/bowel obstruction, and other: Alzheimer's

dementia; Individual #176 – fractures, and constipation/bowel obstruction; and Individual #23 – choking, and fractures].

a. The IDT that effectively used supporting clinical data, and used the risk guidelines when determining a risk level was for Individual #321 – fractures.

b. Individual #319's IDT did not complete a timely IRRF within 30 days of her admission (i.e., the IRRF form was incomplete, and appeared not to have been finalized). However, for the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. It was concerning, though, 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 #227 – choking; Individual #321 – fractures, and cardiac disease; Individual #12 – constipation/bowel obstruction; Individual #197 –cardiac disease; Individual #269 – constipation/bowel obstruction; Individual #176 – fractures, and constipation/bowel obstruction; and Individual #23 – fractures.

Psychiatry

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

Summary: Lubbock SSLC made progress in that, for most individuals, some psychiatric indicators were identified in one or more documents. For some individuals, some sub-indicators met criteria. The next steps, of defining these indicators in observable terminology, ensuring they related to the diagnosis, and then collecting data were needed. Also, putting these indicators into goals and then including them in the IHCP section of the ISP was also needed. Additional specific comments are provided below.

Moreover, the Monitoring Team has revised the wording and sub-indicators for indicators 4, 5, and 6 in order to provide more guidance and specific feedback to the Centers. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	276	319	26	322	237	220	278	224	408
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
5	The individual has goals related to psychiatric status.	0% 0/9	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2
6	Psychiatry goals are documented correctly.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
7	Reliable and valid data are available that report/summarize the	0%	/2	/2	/2	/2	/2	/2	/2	/2	/2

	individual's status and progress.	0/9									

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

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

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

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

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

The Monitoring Team looks for:

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

4a. Each of the individuals had at least one psychiatric indicator for decrease. Aggression was identified as a psychiatric indicator to decrease for all of the individuals. Self-injury was an additional indicator for Individual #319, Individual #26, and Maria. Property destruction was also a psychiatric indicator to decrease for Individual #276, Individual #220, Individual #224, and Individual #408. Suicidal ideation was an additional indicator for Individual #319 and Individual #220. Seeking attention in an adverse manner was also identified for Individual #319 and Individual #220. Five individuals had psychiatric indicators to increase. These were Individual #276 - socially appropriate behavior, Individual #26 - choice board, Individual #322 - accepting own wheelchair, Individual #237 - appropriate communication, and Individual #220 - requesting a meeting.

4b. The review of the records with the lead psychiatrist indicated that there was not sufficient documentation to link the indicator to decrease to the individual's psychiatric diagnosis for any of these individuals. For the indicators for increase, all were positive behaviors, but there was no explanation as to how they were linked to any of the individual's psychiatric diagnosis or diagnoses.

4c. There was one individual for whom the indicator was described with sufficient clarity. It was Individual #322 for whom the physical aggression was defined as an episode lasting longer than three minutes. None of the indicators to increase were described with specific enough terminology that they could be operationalized.

Thus, none of the individuals met criteria for all three sub-indicators for psychiatric indicators for decrease. Specifically, though, nine met criteria with sub-indicator a, none met criteria with sub-indicator b, and one met criteria for sub-indicator c. For psychiatric indicators for increase, five met criteria with sub-indicator a, none met criteria with sub-indicators b or c.

5. Psychiatric goals:
The Monitoring Team looks for:

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

5d. There were three individuals for whom there were defined goals for an indicator to decrease. For Individual #276, this was less than three episodes of aggression per month for the next 12 months by 6/11/19. Individual #322's goal was less than 19 episodes of aggression per month over the next 12 months ending by 7/2/19. The goal for wheelchair seeking was less than five per month over the next 12 months ending on 7/2/19. However, seeking wheelchair was simply defined as being in a wheelchair that was not her own. Individual #220 had three goals to decrease. The goal for suicidal behavior was less than three per month over the next 12 months ending in 3/18/19. Suicidal behavior was not well defined. For physical aggression, the goal was less than three per month over the next year ending in 3/18/19. The corresponding goal for verbal aggression was written in a similar manner, but the criterion was less than 12 per month. Thus, these goals satisfied the requirement for written goals, but they did not contain detailed information about how the behavior was to be defined and collected. One individual had a specific goal related to an indicator to increase. This was Individual #220 for whom the goal for requesting a meeting was equal or greater than 80 episodes per month for the next 12 months ending 3/18/19.

5e. The type of data and how to collect them were not specified for the psychiatric indicators and there was no specific definition regarding the term episode. There was one exception; Individual #220 had a goal for increase and for it, the data collection system for a psychiatric indicator for increase was adequately specified.

Thus, none of the individuals met criteria for both sub-indicators for psychiatric indicators for decrease or for increase. Though one individual did meet criteria for both sub-indicators for the psychiatric indicator for increase only. Overall, three individuals met criteria for sub-indicator d for psychiatric indicators for decrease and none met criteria with sub-indicator e for decrease. For psychiatric indicators, one individual met criteria with both sub-indicators.

6. Documentation:
The Monitoring Team looks for:

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

6f. None of the individuals had psychiatry goals identified in their ISP.

6g. None of the individuals had goals that were updated during the course of the year.

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

At Lubbock SSLC, the psychiatric indicators were not defined with sufficient specificity to allow for the accurate recording of the data, which is necessary to summarize the individual's status and progress. Data were not being collected on psychiatric indicators.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: Performance remained identical to that last review. That is, about half of the CPEs met criteria for content and about half met criteria for diagnostic consistency in the record. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 276	319	26	322	237	220	278	224	408
12	The individual has a CPE.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B										
14	CPE content is comprehensive.	56% 5/9	0/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1	0/1
15	If admitted within two years prior to the onsite review, and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses	44% 4/9	1/1	0/1	0/1	1/1	0/1	0/1	1/1	1/1	0/1

	relevant to psychiatric treatment are referenced in the psychiatric documentation.										

Comments:
14. The CPEs of Individual #276, Individual #322, Individual #220, and Individual #408 did not contain all of the required information.

16. The psychiatric diagnoses were not consistent in the records of five individuals. For Individual #319, the diagnoses were consistent in the psychiatric and medical sections, but not behavioral documentation. The discrepancies for Individual #26, Individual #237, Individual #220, and Individual #408 were in the medical sections as the diagnoses in the behavioral and psychiatric sections were congruent.

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

Summary: All four indicators met criteria for one individual. Overall, performance increased slightly for indicators 18, 19, and 20; and decreased for indicator 21. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 276	319	26	322	237	220	278	224	408
17	Status and treatment document was updated within past 12 months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	78% 7/9	1/1	1/1	0/1	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.	1/9 11%	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1

Comments:
18. These documents contained the required information with the exception of Individual #408 whose admission CPE did not contain sufficient information about his admission medical work-up.

19. The annual psychiatric treatment plans were submitted to the IDT at least 10 days prior to the ISP.

20. The psychiatrist's name appeared on the attendance sheet for all of the individuals, except Individual #26 and Individual #237. The psychiatrist has been attempting to attend all of the ISP meetings for the individuals followed by psychiatry.

21. The final ISP documentation referenced the participation of the psychiatrist for one individual, Individual #220. None of the others mentioned the psychiatrist's participation and contained limited discussions of the psychiatric aspects of the individual's treatment. In

addition, there was no combined discussion of the behavioral and psychiatric aspects of their treatment.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.											
Summary: The number of individuals with a PSP decreased at Lubbock SSLC to 14, the fewest in the past few years. In looking at the most recently written four PSPs, however, a decrease in performance and quality was seen. That is, although each PSP contained a great deal of information about the individual, they were missing the information regarding how the staff were to collect and report the behavioral data and how staff were to respond to the individual when these symptoms/behaviors occurred. Given the Center's long-standing quality of PBSPs, this indicator will remain in the category of requiring less oversight, however, improvement/correction needs to occur if this is to remain in this category after the next review.			Individuals:								
#	Indicator	Overall Score									
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments:											

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
Summary: Given sustained high performance over this and the previous two reviews, indicators 29 and 30 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	276	319	26	322	237	220	278	224	408
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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/or non-pharmacological interventions that were considered.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
32	HRC review was obtained prior to implementation and annually.										

Comments:
29. The information contained in the consent was understandable and covered the side effects of each medication.

30. A risk benefit discussion was in each consent. These discussed both the potential side effects of the medication as well as the risk presented by the individual's psychiatric disorder.

Psychology/behavioral health

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

Summary: All individuals who needed a PBSP had one. This has been the case at Lubbock SSLC for this and the previous two reviews, too. Similarly, behavioral health/PBSP goals were based upon assessments for all individuals (except one at the last review) for three of the last four reviews. Therefore, indicators 1 and 4 will be moved to the category of requiring less oversight. On the other hand, the Center was unable to show that the data being collected for these goals were reliable (indicator 5). Moreover, the Monitoring Team directly observed five occurrences of problem behavior, none of which were ultimately entered into the data collection system. This is a serious problem that needs attention from the Center. Indicator 5 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 276	319	26	322	237	220	278	224	408
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% 12/12	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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
3	The psychological/behavioral goals/objectives are measurable.										
4	The goals/objectives were based upon the individual's assessments.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	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 a Positive Behavior Support Plan (PBSP). Individual

#319's was an interim plan, however, the facility reported that a new plan was soon to be reviewed by the Behavior Support Committee. Of the six individuals reviewed by the physical health monitoring team, documentation indicated that Individual #227, Individual #23, and Individual #197 had a PBSP. After meeting the individuals and speaking with staff, it was determined that this was appropriate. Behavioral health services staff are encouraged to complete a functional behavior assessment for Individual #321 because staff reported that he occasionally engaged in self-injurious and aggressive behavior.

4. All nine individuals had measurable goals related to their psychological/behavioral health. This included goals to reduce identified problem behaviors and increase replacement/alternative behaviors, including those identified in counseling services. All goals were based upon the individuals' assessments.

5. Due to problems with data timeliness and inter-observer agreement, reviewed in detail later in this report, it was determined that the data were not reliable or valid. Further, during the onsite review, several individuals were observed engaging in identified problem behavior. A check of their PBSP data revealed the following on each of the four days of the onsite week:

- On Monday, Individual #4 was observed dropping to the floor at approximately 4:10 pm. The next day, he was again observed engaging in this response at approximately 2:55 pm. The first event was documented (which was good to see); the second was not (which was a concern).
- On Tuesday, Individual #100 was observed with his hand in his mouth at approximately 3:42 pm. This was not documented.
- On Wednesday, Individual #224 and Individual #408 were observed exchanging profanities at approximately 9:49 am. Neither of these behaviors was documented.
- On Thursday, Individual #23 was observed hitting his head at approximately 5:50 pm. This response was not documented.

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

Summary: Criteria for all three indicators were met for one individual. Most annual behavioral health updates were missing any inclusion of information related to relevant physical health. Functional assessments, although complete in content for about one-third of the individuals, were updated and current for all individuals but one. Functional assessments were current for all but one individual over the previous two reviews, too. Therefore, indicator 11 will be moved to the category of requiring less oversight. Indicators 10 and 12 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	276	319	26	322	237	220	278	224	408
10	The individual has a current, and complete annual behavioral health update.	22% 2/9	0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1
11	The functional assessment is current (within the past 12 months).	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
12	The functional assessment is complete.	38% 3/8	0/1	N/A	1/1	0/1	0/1	0/1	1/1	0/1	1/1

Comments:
10. Although all nine individuals had a current behavioral health assessment, two (Individual #26, Individual #237) were considered complete. It was good to see that Individual #237's provided detailed information about his physical health history. For the other seven individuals, there was no information about the individual's physical health over the previous 12 months. Individual #319's behavioral health assessment also did not include information regarding her cognitive skills or adaptive behavior. It would be beneficial for the facility to contract with an outside professional with training and experience in psychometric testing with individuals with intellectual disabilities and/or mental health issues. This is particularly important as the profile of new admissions changes over time.

11. For eight of the nine individuals, there was a current functional behavior assessment (FBA). The exception was Individual #319 for whom an FBA had not yet been completed. She had been in residence at the facility since late April 2018. It was reported that her behavior health specialist would be presenting an assessment at the Behavior Support Committee meeting scheduled for the week after the onsite visit.

12. The FBAs for Individual #26, Individual #278, and Individual #408 were considered complete. Although direct observations were completed for Individual #276, Individual #322, Individual #237, and Individual #224, no target behaviors were observed. There was no explanation provided as to why additional observations were not necessary. The FBA for Individual #220 noted the dates and times of observation, but provided no summary of what occurred.

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

Summary: Performance reduced for indicator 13 and remained at 0% for indicator 15. PBSPs contained some important components, but each plan was missing other important components or aspects were not updated. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	276	319	26	322	237	220	278	224	408
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	78% 7/9	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
14	The PBSP was current (within the past 12 months).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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. Based upon the documents provided, there was evidence that the PBSP was implemented within 14 days of all consents. The exceptions were Individual #319, whose plan was implemented before approval by the Human Rights Committee, and Individual #237, whose plan was implemented more than 14 days after all consents were obtained.

The most recent PBSP for Individual #276 did not include consent from the Human Rights Committee. His plan included two

restrictions: first, he would not be allowed to travel off campus if he had displayed aggression or property destruction; second, he would be expected to provide restitution for any damage to a peer's property. These restrictions required the approval of the HRC.

14. All nine individuals had a current PBSP. As noted elsewhere in this report, it is important that the interim PBSP for Individual #319 be replaced with a comprehensive plan based upon a complete functional behavior assessment.

15. While none of the PBSPs were considered complete, most included these three components:
    - operational definitions of targeted problem behaviors and replacement/alternative behaviors.
    - guidelines for training functionally equivalent replacement behaviors.
    - clear interventions to reduce problem behaviors.

Specific comments are outlined below.

- Staff are advised to ensure that the individual is clearly identified in the document header.
- As the facility had trained staff and switched from PMAB to the Safe Use of Restraint (SUR), all plans should be updated to reflect this change.
- Although several plans referenced the use of tokens, only the PBSP for Individual #278 provided clear guidelines for awarding these tokens.
- The plans for Individual #319, Individual #26, Individual #322, and Individual #408 referenced the use of boat cushions to ensure protection. These cushions are not designed for this use, nor are they part of the SUR program. Further, the manner in which staff were to use these cushions was not always described in detail. For example, in Individual #408's PBSP, staff were advised to be prepared to use it. Further guidelines were not provided.
- As has been noted in the past, staff are advised to eliminate the use of the term "junk" behavior. Further comments regarding this term can be found in the restraint section of this report.
- Plans should also be updated when an individual transitions from one home to another. The plans for both Individual #220 and Individual #224 referenced a reinforcement system in place on the Birch home, but they were living at Rose at the time of the onsite visit.
- Plans should also be updated when a major change occurs in the individual's daily activity schedule. Individual #408's plan referenced token reinforcement for attending school, yet he had graduated in May 2018.
- Several individuals had targeted behaviors of undressing (Individual #319, Individual #322, Individual #278). It will be important to add directions to ensure that the individual's privacy is protected at all times.
- Individual #276, Individual #220, Individual #278, and Individual #224 had clothing identified as a reinforcer in their plans. As clothing is a basic right, this needs to be deleted or clarified. Individual #276 also had toiletries as an identified reinforcer in his plan. Again, it is a basic right to have access to these materials. Either omit this from his plan or provide further clarification.
- One simple antecedent strategy that staff are advised to consider is to offer the individual a choice whenever possible. As this provides the individual with a degree of control over what he or she wears, what activities he or she engages in, or when to complete required activities of daily living, it can be effective in helping to reduce problem behaviors.

Individual specific comments are below.

- Individual #276's plan includes a statement that staff should never befriend him. There should be guidelines for how staff can develop a positive relationship with him. His PBSP also noted that he can participate in the token store and/or a behavioral contract, but neither of these strategies was outlined in sufficient detail for implementation.
- As noted, Individual #319's PBSP was an interim plan developed upon her admission. Because she engaged in serious physical aggression, among other targeted problem behaviors, the completion of a functional behavior assessment and comprehensive PBSP should have been a priority.
- Individual #26's PBSP included a targeted behavior of self-injury, however, it is suggested that hand biting and head banging be measured separately, because the latter could result in serious harm. It is also suggested that he be assessed for a personal augmentative communication device because he was observed readily using a common device located in the diner. It was noted that problem behavior might occur when he is asked to wait for a meal or snack, but these situations were not addressed under preventative or antecedent strategies. Lastly, there was no treatment objective for physical aggression.
- Individual #322's plan included guidelines to hold doors closed from the outside to prevent her from leaving a building when not appropriately dressed or to seek out wheelchairs. When concerns were brought to the attention of the Center and State Office, a response was provided. They indicated that, as currently written, there may be confusion as to when this restriction of movement can be applied. The Center indicated that the PBSP would be clarified to ensure this was only applied when Individual #322 was not wearing appropriate clothing, including shoes, sock, and pants. While the Center staff are commended for taking quick action, other revisions are suggested.
    - First, greater emphasis should be placed on shaping and reinforcing Individual #322 for wearing clothing, including shoes and socks.
    - Second, her replacement behavior is to accept the use of a loaner wheelchair. Current guidelines note that she should be offered the wheelchair when she begins to display removal of her clothing. This may serve to (inadvertently) reinforce this undesirable behavior. Further, as she reportedly had good mobility skills, staff are advised to fade this strategy to avoid her becoming dependent upon a chair and losing her skills.
    - Third, as holding the door closed to prevent her movement from a building is a form of restrictive practice, staff are advised to document each time this is applied.
    - Fourth, it would be advisable to present her functional behavior assessment, PBSP, SAPs, and daily schedule to the External Peer Review Committee.
    - Fifth, there are guidelines for responding to self-injury, but this was not a targeted behavior. If this behavior occurs, even infrequently, staff should be addressing this in her plan.
- There were similar concerns raised for Individual #23. He frequently used a wheelchair, although he was observed to have fairly good mobility skills. Perhaps the use of a wheelchair, with a waist belt, was a way to manage his pica behavior.
- One of Individual #237's targeted problem behaviors, Serious Adverse Attention Seeking, included in its definition false medical complaints. It was unclear how staff would know these complaints were false. Further, his replacement behavior included many of the same statements indicating that he was not feeling well.
- Staff are advised to operationally define Individual #220's nonverbal communication referenced in his replacement behavior.
- It was noted in Individual #278's plan that she may report to staff that she is hungry. Staff are advised to not give her food, but rather to remind her of meal and snack times. It is suggested that the IDT work with the dietician and Individual #278 to determine whether there are alternative foods she could have outside of these scheduled times to eat. The training objectives did not include an anticipated date of completion.

- Individual #224's PBSP noted that objectives for property destruction and attending work would be established after 90 days of baseline data collection. The plan should have been updated to include these as 90 days passed by mid-May 2018.
- One component of Individual #408's PBSP was a contract to reinforce appropriate behavior. As written, this included reinforcement for attending school. As he had graduated from school in May 2018, the contract should have been updated to reflect this change in his daily schedule. When an updated contract was requested, behavioral health services staff reported that this would be completed in August 2018, nearly three months after he had stopped attending school. This should have been addressed in a more timely manner.

It was not always evident that recommendations identified in an ISPA meeting were addressed or implemented. For example, staff were advised to empty trashcans in the home every hour to reduce Individual #26's food foraging behavior. When staff were interviewed, it was reported that trash receptacles were emptied at the end of the shift if full or near full. Other examples included a reinforcement program for Individual #237 to help him leave his wheelchair, a behavioral contract for Individual #220 to address increasing aggression, and a point system for Individual #224 to address his aggression (i.e., none were implemented, or reviewed again in an ISPA meeting).

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

Summary: Documentation (and provision) of counseling/psychotherapy treatment was much improved since the last review, resulting in 100% performance on indicator 25. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 276	319	26	322	237	220	278	224	408
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 4/4	N/A	1/1	N/A	N/A	N/A	1/1	1/1	1/1	N/A

Comments:

25. For the four individuals who were receiving counseling services, it was determined that each had a complete treatment plan that included measurable, goal directed services. Plans included a data-based criterion for triggering review and identified strategies for the individual to generalize his/her learned skills. Cognitive Behavior Therapy was the identified approach. Progress notes included both a narrative and data based review of the individual's progress.

In the progress notes for Individual #224, it was noted that if he did not attend any sessions in July 2018, he would be removed from counseling. There was no clear summary of what other steps had been taken to encourage his participation. For Individual #319, and possibly Individual #278 and Individual #224 both of whom have a diagnosis of borderline personality disorder, it may be important for the team to consider counseling with a professional who has training and experience in Dialectical Behavior Therapy.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Medical Department staff should continue to focus on ensuring the timely completion of annual medical assessments. Center staff also should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on the severity of the individual's risk, as well as current standards of practice, and accepted clinical pathways/guidelines. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	75% 6/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	0/1	0/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." Interim reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interim reviews will need to occur more frequently. The IHCPs reviewed did not define the frequency of medical review, or, as discussed in further detail below, included frequencies that were not consistent with current standards of practice, and/or accepted clinical pathways/guidelines, and did not reflect the severity of the individual's risk.											

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Center staff should continue to improve the quality of the medical assessments. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	Individual receives quality AMA.	11% 1/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their	0%	0/2	N/A	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	individualized needs, but no less than every six months.	0/16									

Comments: a. It was positive that Individual #319's AMA included all of the necessary components, and addressed the individual's 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 social/smoking histories, past medical histories, complete interval histories, 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 pre-natal histories, family history, childhood illnesses, allergies or severe side effects of medications, 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.

c. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #237 – cardiac disease, and other: Pompe disease; Individual #319 – diabetes, and seizures; Individual #227 – falls, and aspiration; Individual #321 – osteoporosis, and gastrointestinal (GI) problems; Individual #12 – seizures, and urinary tract infections (UTIs); Individual #197 – diabetes, and falls; Individual #269 – respiratory compromise, and GI problems; Individual #176 – respiratory compromise, and GI problems; and Individual #23 – osteoporosis, and other: pica].

Individual #319 was newly-admitted, and so this indicator did not yet apply to her. As noted above, the remaining ISPs/IHCPs reviewed did not define the frequency of medical review, based on the severity of the individuals' level of risk, as well as current standards of practice, and accepted clinical pathways/guidelines.

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. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 237	319	227	321	12	197	269	176	23
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.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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 #237 – cardiac disease, and other: Pompe disease; Individual #319 – diabetes, and seizures; Individual #227 – falls, and aspiration; Individual #321 – osteoporosis, and GI problems; Individual #12 – seizures, and UTIs; Individual #197 – diabetes, and falls; Individual #269 – respiratory compromise, and GI problems; Individual #176 – respiratory compromise, and GI problems; and Individual #23 – osteoporosis, and other: pica). None of the IHCPs reviewed included a comprehensive set of medical action steps/interventions sufficient to address the individuals' at-risk or chronic conditions.

b. As noted above, the ISPs/IHCPs reviewed generally did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. Although the following individuals' ISPs/IHCPs defined the frequency as six months, given the severity of the individuals' level of risk, this frequency was not sufficient to meet their needs: Individual #12 – seizures, and UTIs; Individual #269 – respiratory compromise, and GI problems; and Individual #176 – respiratory compromise, and GI problems.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: During this review, none of the individuals reviewed had timely dental exams, and half of the individuals reviewed had timely annual dental summaries, most of which were based on outdated information. However, the dentist position was vacant for a portion of the review period, and this likely contributed to these findings. At the time of the onsite review, a dentist had been hired, and recognized the need to improve the timeliness and quality of dental exams and summaries. As a result, Indicator a.iii will continue in less oversight, but if problems are noted at the next review, it might return to active oversight. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight. During this review, half of the individuals reviewed did not have timely annual dental summaries. However, the dentist position was vacant for a portion of the review period, and this likely contributed to this finding. At the time of the onsite review, a dentist had been hired, and recognized the need to improve the timeliness of dental exams and summaries. As a result, this indicator will continue in less oversight, but if problems are noted at the next review, it might return to active oversight.									

b.	Individual receives a comprehensive dental examination.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	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. At times, individuals reviewed did not have dental exams completed within 365 days of the previous one (i.e., Individual #227, Individual #197, and Individual #269), and a number of individuals did not have dental exams completed within the last year (i.e., Individual #237 – 4/12/17, Individual #321 – 4/18/17, Individual #12 – 2/6/17, Individual #176 – 11/5/15, with an attempt 12/21/17, and Individual #23 – 4/5/17).

On a positive note, though, the new Dental Director was taking steps aimed at improving the rate of timely annual dental exams and summaries.

b. The most recent dental exams for Individual #321 and Individual #12 included all of the required components, but they were well over a year old, dated 4/18/17, and 2/6/17, respectively. As a result, these individuals had not had recent quality dental exams. As noted above, other individuals had not had dental exams within the last year (i.e., Individual #237 – 4/12/17, Individual #176 – 11/5/15, with an attempt 12/21/17, and Individual #23 – 4/5/17), so their exams scored 0 (although review of these exams showed similar strengths and problems to those discussed below). No specific exam information was available for Individual #197 or Individual #269. For Individual #319 and Individual #227, their dental exams included the following:

- A description of the individual's cooperation;
- An oral hygiene rating completed prior to treatment;
- Periodontal condition/type;
- Caries risk;
- Periodontal risk;
- A summary of the number of teeth present/missing;
- Treatment provided/completed; and
- A treatment plan.

One, but not the other included:

- The recall frequency;
- An oral cancer screening;
- Information regarding last x-ray(s) and type of x-ray, including the date;
- Sedation use;
- An odontogram; and
- Periodontal charting.

c. Many of the annual dental summaries were based on outdated dental exam information. In addition, although most of them included other required components, none of the dental summaries reviewed included: dental conditions that could cause systemic health issues or are caused by systemic health issues.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.											
Summary: Since the last review, some improvement was noted with regard to the completion of timely annual and quarterly nursing record reviews and physical assessments. In some cases, assessments were missing fall risk scores or a physical assessment. Significant work is needed to improve the review and analysis of information in nursing assessments related to individuals' at-risk and chronic conditions. In addition, when individuals experience changes of status, nurses need to complete assessments in accordance with current standards of practice. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	50% 4/8	0/1	N/A	0/1	1/1	1/1	1/1	1/1	0/1	0/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	38% 3/8	0/1	N/A	0/1	1/1	1/1	1/1	0/1	0/1	0/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/8	0/2	0/1	0/2	N/A	0/1	0/1	0/1	N/A	N/A

Comments: a. For the assessments that scored negatively, fall risk scores were missing. In addition, Individual #23's annual nursing assessment did not contain a physical assessment.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #237 – skin integrity, and other: Pompe disease; Individual #319 – constipation/bowel obstruction, and weight; Individual #227 – falls, and choking; Individual #321 – fractures, and cardiac disease; Individual #12 – UTIs, and constipation/bowel obstruction; Individual #197 –

falls, and cardiac disease; Individual #269 – constipation/bowel obstruction, and other: Alzheimer's dementia; Individual #176 – fractures, and constipation/bowel obstruction; and Individual #23 – choking, and fractures).

Overall, none of the annual comprehensive nursing assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. However, on a positive note, for about a quarter of the risk areas reviewed, nurses included status updates, including relevant clinical data (i.e., Individual #227 – choking; Individual #321 – fractures; and Individual #23 – choking). Unfortunately, nurses had not analyzed this information, including comparisons with the previous quarter or year, and/or made recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

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:

- For Individual #237, a nursing IPN, dated 2/21/18, noted a Stage 2 pressure ulcer on his left hip area. The nurse did not complete and/or document an assessment of drainage, odor, skin temperature, depth, or describe the exact location of the breakdown. From the note, it was unclear if this was when it was initially found. The note provided no specific details, such as whether direct support professional staff reported it.
- Individual #237's IDT did not have a system in place to measure the progression of the Pompe Disease. As a result, nurses were not documenting assessments related to changes in status, such as loss of mobility, strength to his extremities, or loss of independence, such as requiring more assistance with activities of daily living (ADLs).
- An IPN, dated 5/16/18, noted Individual #227 tripped and fell. However, the nurse did not complete and/or document in the IPN an assessment of pain, gait, range of motion to the injured left knee, swelling, or mental status.
- An IPN, dated 1/17/18, indicated that Individual #227 choked, requiring abdominal thrusts. The note did not indicate that the nurse notified the PCP or Habilitation Therapy staff of the incident.
- On 4/3/18, nursing staff did not write an IPN showing an assessment in response to the diagnosis of a UTI.
- An IPN, dated 4/13/18, noted Individual #197 fell in the shower and complained about pain to the neck of the right arm and leg. The note stated the nurse asked the individual to stand up, but individual said she was in too much pain. The nurse did not complete and/or document an initial neurological check, and did not document how the individual was moved to transfer to the hospital. The nurse also did not document the individual's status when she transferred to the ED, the time of the transfer, and/or who transferred her.
- Individual #269 had a diagnosis of Alzheimer's dementia, but her IDT had not defined what a change in status would entail. The AMA, dated 3/23/18, noted she was previously prescribed Namenda and Aricept, but they were discontinued because it was felt they were not helping her dementia (the AMA did not include dates regarding when these medications were prescribed). However, the documentation provided no information regarding what symptoms nurses or other staff measured to allow the IDT to determine if the individual's Alzheimer's dementia symptoms were "better" or "worse."

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: Although much work is needed, some improvement was seen with regard to including preventative nursing interventions in individuals' IHCPs. The Center should continue to focus on developing IHCPs that fully address individuals' health risks and chronic conditions. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 237	319	227	321	12	197	269	176	23
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.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	39% 7/18	0/2	0/2	0/2	2/2	0/2	0/2	1/2	2/2	2/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	17% 3/18	0/2	0/2	0/2	1/2	0/2	0/2	1/2	1/2	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).	17% 3/18	0/2	0/2	0/2	1/2	0/2	0/2	1/2	1/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	28% 5/18	1/2	0/2	0/2	2/2	0/2	0/2	0/2	1/2	1/2

Comments: a. through f. Although significantly more work was needed, it was positive that some of the IHCPs reviewed included preventative nursing interventions. The following provide a few of examples of the strengths and weaknesses found in the IHCPs reviewed:

- Individual #269's IHCP related to constipation/bowel obstruction included an intervention for nurses to listen to bowel sounds and assess for abdominal distension/tenderness every shift. The assessment criteria were consistent with the applicable nursing guideline. The frequency of every shift assessments was appropriate for an individual with high risk in this area; according to Individual #269's IRRF, though, he was at medium risk.
- Individual #321's IHCP for cardiac disease included an important intervention for nurses to monitor his blood pressure daily and notify the PCP if it was out of range (i.e., <90/60>135/90 HR >100<60). Although blood pressures are not the only assessment criteria for an individual with an abdominal aortic aneurism, this was a good intervention for the IDT to include. Other interventions that the IDT should have considered including in the IHCP were circulation checks to the individual's extremities due to possible blood clots; checks to determine if he was avoiding saturated fat, trans fat, and salt in his diet, and

keeping stress low; assessments for back pain, sweating, vomiting, etc.

- Individual #321's IHCP for fractures included a promising intervention: RNCM will monitor transfers monthly and document correctness or any concerns. It needed specific criteria regarding the individual's transfer instructions to measure against (e.g., could be a simple auditing tool). In addition, nurses should implement the intervention more frequently than monthly for an individual with a high-risk rating. It also needed to indicate where nurses would document the monitoring results, and how often it would be reviewed.
- Individual #23's IHCP for choking included an intervention for the RNCM to monitor mealtime monthly to ensure he had the correct diet texture and adaptive equipment. This was a good start, but the IHCP needed to identify the monitoring criteria (such as direct support professionals' supervision and implementation of his specific meal plan). Additional interventions were needed to address his repeated pica episodes (e.g., gloves, metal objects, etc.) that could lead to a choking incident.
- Although Individual #227's choking IHCP included an intervention for nurses to monitor mealtime monthly, the IHCP provided no criteria for monitoring. In addition, monthly monitoring was not frequent enough for a high-risk area and for an individual that had a choking episode in January 2018, as well as an IPN that stated he coughed during medication pass and meals.
- Individual #12's UTI IHCP included one nursing assessment to obtain vital signs, which was not a complete assessment for UTIs. It also should have included, for example, observing urine, and monitoring fluid intake. An intervention assigned to residential staff to clean from front to back and use a new wipe every time was promising, but the IDT did not develop a monitoring system as part of the intervention to ensure staff implemented it, and to generate data that could be used when reviewing episodes of UTIs.
- A number of IHCPs reviewed still included no proactive nursing assessments (e.g., Individual #237 – other: Pompe disease; Individual #319 – constipation/bowel obstruction, and weight; Individual #227 – falls; Individual #197 – cardiac disease; and Individual #269 – other: Alzheimer's dementia).

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. This has been a consistent finding for this review and the previous two (Round 11 – 100%, Round 12 - 100%, and Round 13 – 100%). As a result, Indicator e will move to the category of less oversight. The Center should focus on improving the referral of all individuals that meet criteria for PNMT review, completion of PNMT comprehensive assessments for individuals needing them, and the quality of the PNMT reviews and comprehensive assessments. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23

a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	14% 1/7	N/A	N/A	0/1	0/1	0/1	1/1	0/1	0/1	0/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	0% 0/6			0/1	0/1	0/1	N/A	0/1	0/1	0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	25% 1/4			0/1	N/A	0/1	1/1	N/A	0/1	N/A
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	14% 1/7			0/1	0/1	0/1	1/1	0/1	0/1	0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 6/6			N/A	1/1	1/1	1/1	1/1	1/1	1/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/7			0/1	0/1	0/1	0/1	0/1	0/1	0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/4			N/A	0/1	0/1	N/A	0/1	N/A	0/1
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4			0/1	N/A	0/1	0/1	N/A	0/1	N/A

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

- On 1/18/18, Individual #227 choked on mashed potatoes. He had a history of swallowing problems with a modified barium swallow study (MBSS), dated 4/25/17, recommending that he receive nothing-by-mouth (NPO). Given his history and the recent choking event, at a minimum, the PNMT should have conducted a review.

  Similarly, Individual 227's IDT did not refer him to the PNMT despite falls on the following dates: 1/10/18, 1/22/18 x2, 1/28/18, 2/15/18, 3/20/18, 3/29/18, 4/5/18, 4/7/18, 4/18/18, 4/19/18, 5/14/18, 5/16/18, 5/21/18, 5/22/18, 5/23/18, 5/31/18, 6/22/18, 6/26/18, and 6/29/18. A PNMT note, dated 6/20/18, stated that toxic myoneural disorder might contribute and that the falls might have been behavioral in nature, but offered no formal review or assessment.
- On 2/6/18, and 3/21/18, Individual #321 was diagnosed with pneumonia. Given that his IDT already rated him at high risk for respiratory issues, his already complicated positioning needs, and his reliance on staff for mobility, these two pneumonias

within six weeks paired with a fecal impaction warranted at least a PNMT review.

- Individual #12 had a significant history of respiratory-related issues, including, but not limited to multiple episodes of respiratory distress and aspiration pneumonia in 2016, and aspiration pneumonia on 1/8/18, and 3/22/18. For these events, her IDT did not refer her to the PNMT, and the PNMT did not make a self-referral. On 4/6/18, another pneumonia occurred, which finally resulted in a PNMT assessment. At times, the PNMT cited the fact that the pneumonia occurred outside of the Center and at the hospital (e.g., stated in PNMT ISPAs, dated 2/1/18 and 3/21/18). Based on referral criteria, a pneumonia does not have to occur at the Center in order for it to need PNMT review and/or assessment. On 4/28/18, Individual #12 had a tracheostomy placed.
- For Individual #197, the PNMT conducted an assessment related to falls and fractures. On 4/13/18, she was hospitalized for a fracture of the right femoral neck, and on 4/14/18, underwent surgery. The PNMT proceeded directly to an assessment instead of first completing a review, which was appropriate (i.e., this information is provided to explain why Indicator b is scored as N/A).
- Due to Individual #269's significant medical history and overall medical complexities, in conjunction with pneumonia on 1/1/18, and observation of tube feeding substances around her nostrils, at a minimum, the PNMT should have conducted a review. The PNMT stated no referral was needed due to the pneumonia occurring away from the Center, and as a result of the flu. However, the impact on the lungs is similar and due to her history could have had a significant impact on functioning. As a result, a review of all PNMP-related systems and supports was warranted. On 4/21/18, the individual died at the age of 69 with cause of death listed as pneumonia.
- On 2/17/17, the PNMT conducted its last review of Individual #176. Since that time, he had six pneumonias (i.e., 6/2017, 8/8/17, 10/10/17, 1/5/18, 3/5/18, and 3/23/18). Due to his significant respiratory illness history and overall medical complexities, a comprehensive PNMT assessment was warranted.
- Due to Individual #23's history of pica, the recent removal of a bezoar (i.e., on 4/4/18), the surgical implications, and the potential medical impact of his continuing pica behaviors, a PNMT review was warranted. The PNMT minutes, dated 4/12/18, only stated that "supports are appropriate" and this was a behavioral issue, and therefore, no PNMT involvement was needed. Given that he continued to ingest items, supports were not "appropriate." A PNMT review would be an ideal interdisciplinary forum for aggregating all of the related information, and making recommendations to ensure consistent and comprehensive behavioral, medical, and habilitation therapy supports and services to address this longstanding, and potentially life-threatening issue.

f. As the Monitoring Team has discussed with State Office, without signature pages that include dates, it is not possible to determine which members of the PNMT participated in the PNMT assessments.

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 potentially should have had comprehensive PNMT assessments did not (i.e., Individual #227, and Individual #176). The following summarizes some of the concerns noted with the two assessments that the PNMT completed:

- For Individual #12, no assessment was noted regarding positioning, motor skills, activities of daily living (ADLs), and head-of-bed-elevation (HOBE). The PNMT assessment reflected more of a summary of what was done and not an assessment of current

status and what might be needed moving forward. In addition, the only observation noted occurred on 5/21/18. No evidence was found of observations of the individual throughout the day and in various situations. As a result of missing data and assessment information, the PNMT was not able to assess/identify the root cause(s). The assessment stated that the individual's supports were effective, and that the issue was implementation. However, the PNMT then offered no clear plan to improve implementation. Thresholds for referral back to the PNMT were not included.

- For Individual #197, the PNMT discussed her risks related to osteoporosis and falls, but did not review the impact of her fracture on other areas of risk, such as bowel obstruction and gastroesophageal reflux disease (GERD), due to decreased mobility. The PNMT identified potential causes (e.g., cerumen impaction, Charcot foot, hypoglycemia and/or hypertension), but the assessment did not contain analysis of data to determine if one or more of the hypotheses were correct. Thresholds for referral back to the PNMT were not included in the assessment. Objectives included were not measurable and not integrated into the IHCP.

On a positive note, both assessments reviewed included:

- The presenting problem;
- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs; and
- Discussion of medications that might be pertinent to the problem, and discussion of relevance to PNM supports and services.

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

Summary: Some improvement was seen with regard to these indicators, particularly in terms of the inclusion in IHCPs of clinical indicators, as well as triggers and actions to take if they occur. Overall, though, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. In addition, the PNMPs reviewed still had missing information. With minimal effort and attention to detail, though, the Habilitation Therapy staff could make the needed corrections to PNMPs, and by the time of the next review, the Center could make good progress on improving individuals' PNMPs. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 237	319	227	321	12	197	269	176	23
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).	13% 2/16	0/2	N/A	1/2	0/2	0/2	0/2	1/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	17% 3/18	0/2	2/2	1/2	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	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	11% 2/18	0/2	1/2	1/2	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.	83% 15/18	2/2	2/2	2/2	0/2	2/2	2/2	2/2	2/2	1/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	69% 9/13	1/1	1/1	2/2	0/2	1/1	1/1	0/1	2/2	1/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	28% 5/18	1/2	2/2	2/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: aspiration, and falls for Individual #237; GI problems, and weight for Individual #319; choking, and falls for Individual #227; aspiration, and GI problems for Individual #321; skin integrity, and aspiration for Individual #12; GI problems, and falls for Individual #197; aspiration, and skin integrity for Individual #269; skin integrity, and aspiration for Individual #176; and aspiration, and choking for Individual #23.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMPs. The exceptions were the IHCPs for choking for Individual #227, and aspiration for Individual #269.

b. Overall, the ISPs/IHCPs reviewed also did not sufficiently include preventative physical and nutritional management interventions to minimize the individuals' risk. The exceptions were the IHCPs for GI problems, and weight for Individual #319; and choking for Individual #227.

c. All individuals reviewed had PNMPs and/or Dining Plans. It was positive that Individual #319's Dining Plan included all of the necessary components. Problems varied across the remaining PNMPs and/or Dining Plans reviewed.

- It was positive that all of the PNMPs, as applicable to the individuals' needs included:
  - Descriptions of assistive/adaptive equipment;
  - Transfer instructions;
  - Bathing instructions;
  - Toileting/personal care instructions;
  - Handling precautions or moving instructions;
  - Mealtime instructions; and
  - Medication administration instructions.
- As applicable to the individuals, most, but not all of the PNMPs reviewed included:
  - Positioning instructions (i.e., Individual #321's PNMP did not clearly provide mealtime and after mealtime positioning instructions, and Individual #176's PNMP did not mention the need for a nurse to monitor his vital signs during right sidelying due to his history of desaturation when in this position);
  - Mobility instructions (Individual #237's PNMP had not been updated to reflect his current mobility status);
  - Oral hygiene instructions (i.e., Individual #176's oral care section did not address the findings of the HOBE completed on 2/22/17).
- The components of the PNMPs on which the Center should focus on making improvements include:
  - Ensuring they are reviewed and/or updated within the last 12 months (i.e., four of the nine plans had not been

updated to reflect the individuals' current status and/or supports).
- Up-to-date information about the individuals' risks (i.e., three PNMPs included out-of-date information);
- Photographs (i.e., four PNMPs/Dining Plans were missing some pictures, and/or did not include the individual in pictures, when appropriate, for example, for head-of-bed elevation photos); and
- Complete communication strategies (i.e., most were incomplete), particularly information about the individuals' receptive language and practical strategies to aid with communication.

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

e. It was positive that many of the IHCPs reviewed included action steps to regularly measure relevant clinical indicators. The IHCPs reviewed that did not identify the necessary clinical indicators were those for aspiration, and GI problems for Individual #321, and choking for Individual #23.

f. Although more work was needed, a number of the IHCPs reviewed identified triggers and actions to take should they occur. Those that did not were for aspiration, and GI problems for Individual #321; aspiration for Individual #269; and choking for Individual #23.

g. The IHCPs that defined the necessary PNMP monitoring were those for falls for Individual #237; GI problems, and weight for Individual #319; and choking, and falls for Individual #227.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: Since the last review, improvement was noted with regard to IDTs' discussion and documentation of the medical necessity for continued enteral nutrition for the applicable individuals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	100% 3/3	N/A	N/A	N/A	1/1	1/1	N/A	1/1	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.	N/A				N/A	N/A		N/A		

Comments: a. and b. For the three individuals reviewed with enteral nutrition, their IRRFs documented IDT discussion of the clinical justification for the medical necessity of the enteral nutrition, as well as the risks-benefits of the individuals' potential return to oral intake. For all three individuals, the IDTs provided clinical justification for not currently developing a plan to move the individual along the continuum to oral intake.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: Since the last review, the Center's performance with regard to the timeliness of OT/PT assessments improved. 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	237	319	227	321	12	197	269	176	23
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture;	N/A									

	▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	N/A									

Comments: a. and b. Nine of the nine individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status. For example, it was positive that the therapists conducted an assessment after Individual #12 received a tracheostomy.

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

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: For all individuals reviewed, the assessors did not discuss whether or not medications were potentially impacting an OT/PT problem(s);
- 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 three individuals, evidence of a head-of-bed elevation (HOBE) evaluation was not present to justify the recommended levels of elevation. For another individual, justification for the use of a foot box at mealtime was not provided; and
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings: None of the assessments met this criterion. Problems included a lack of monitoring findings or specific and discreet data to confirm the conclusions that supports had good or fair effectiveness, and/or a lack of discussion about and/or revisions to supports that were not effective at minimizing or preventing PNM issues, such as falls, etc.

Most included:

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: The exception was Individual #23's assessment, which did not address his choking risk associated with his ongoing pica behavior;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living: The exception was for Individual #23, for whom some assessment findings were not justified (e.g., description of tone);
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments: The exception was that Individual #227's assessment did not mention the toxic myoneural disorder and its impact on ambulation;

- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

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; and
- The individual's preferences and strengths were used in the development of OT/PT supports and services.

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

Summary: Given that over the last two review periods and during this review, IDTs reviewed and made changes, as appropriate, to individuals' PNMPs and/or Positioning schedules at least annually (Round 11 – 100%, Round 12 – 89%, and Round 13 - 88%), Indicator b will move to the category requiring less oversight. It was positive to see that IDT addressed the recommendations included in the OT/PT assessments. The remaining indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 237	319	227	321	12	197	269	176	23
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	88% 7/8	1/1	N/A	1/1	1/1	1/1	0/1	1/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	100% 5/5	1/1	N/A	1/1	N/A	1/1	1/1	N/A	N/A	1/1

Comments: a. The ISPs reviewed did not include concise, but thorough descriptions of individuals' OT/PT functional statuses. Therapists should work with QIDPs to make improvements.

c. and d. It was positive that for most individuals reviewed, ISPs/ISPAs included recommended strategies, programs, and interventions.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: It was positive that for eight out of nine individuals reviewed, SLPs had completed timely communication assessments, and they were provided the correct type of communication assessment. If the Center sustains its performance in these areas, after the next review, Indicators a.iii and b might move to the category of less oversight. However, significant work is needed to improve the quality of communication assessments in order to ensure that SLPs provide IDTs with clear understandings of individuals' functional communication status; AAC options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
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.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals;	N/A									

	• Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	N/A									

Comments: a. and b. It was positive that for nine out of nine individuals reviewed, SLPs had completed timely communication assessments.

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

- 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 individuals 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: Five of the nine assessments did not meet this criterion. Various problems were noted, including, for example, incomplete information with sections left blank, lack of investigation/testing related to cognitive functioning (e.g., problem-solving or other more complex functioning), lack of discussion of ways to expand the individual's communication skills, information that was inconsistent with other sections of the same assessment, etc.
- The effectiveness of current supports, including monitoring findings: This was not applicable to the newly-admitted individual. For the remaining individuals, results of monitoring, observations, and/or interviews with staff over the previous year were not cited. In addition, SAP or direct therapy goal/objective data usually were not cited. Often, 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: For three individuals, this was not applicable. Individual #269's assessment met criterion for this sub-indicator. Problems varied for the remaining individuals. For example, for one individual, the assessor concluded AAC was not appropriate based on the previous assessment's findings, but did not provide sufficient justification for why it was not trialed

again. For a few individuals, the assessors did not appear to consider the full set of AAC options currently available that would potentially address individuals' needs. For Individual #237, the assessment did not address his future communication needs. Due to the progressive nature of his disease and its anticipated impact on his ability to speak, it is essential that his SLP and IDT focus now on identifying and teaching him alternate methods of communication (high tech) that can be modified as the disease progresses and his ability to vocalize declines; 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: Although many of the assessments included a number of recommendations, given that thorough 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.

Most assessments included:

- The individual's preferences and strengths are used in the development of communication supports and services: Those that did not do this fully were for Individual #12, and Individual #23; and
- A comparative analysis of current communication function with previous assessments: Those that did not were for Individual #237 (given his progressive disease, this should have been a focus), and Individual #227 (i.e., cognitive skills). This was not applicable to Individual #319, who was newly admitted.

On a positive note, all nine assessments provided:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication; and
- As applicable, evidence of collaboration between Speech Therapy and Behavioral Health 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: It was good to see that the ISPs of individuals reviewed provided good functional descriptions of their communication skills. It also was positive that IDTs included recommended strategies, interventions, and programs in the ISPs reviewed. More work is needed to describe IDTs' discussions about Communication Dictionaries in ISPs. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 237	319	227	321	12	197	269	176	23
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate,	0%	0/1	N/A	N/A	0/1	0/1	N/A	0/1	0/1	0/1

	and it comprehensively addresses the individual's non-verbal communication.	0/6									
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: a. and c. It was good to see that the ISPs of individuals reviewed provided good functional descriptions of their communication skills. It also was positive that IDTs included recommended strategies, interventions, and programs in the ISPs reviewed.

b. Simply including a stock statement such as "Team reviewed and approved the Communication Dictionary" did not provide evidence of what the IDT reviewed, revised, and/or approved, and/or whether the current Communication Dictionary was effective at bridging the communication gap.

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: Same as at the last review, all (but one) individuals had at least one SAP, resulting in the high score for indicator 1, but there remained a small number of SAPs for five of the individuals who could have benefited from more skill training. As a result, indicator 1 will remain in active monitoring. Lubbock SSLC, however, wrote SAPs in measurable terminology for this and the previous reviews, too. Therefore, indicator 2 will be moved to the category of requiring less oversight. About half of the SAPs were based on assessment results and even fewer were practical/functional/meaningful. None of the SAPs met criteria for having reliable data. Indicators 3, 4, and 5 will also remain in active monitoring.

Individuals:

#	Indicator	Overall Score	276	319	26	322	237	220	278	224	408
1	The individual has skill acquisition plans.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	100% 19/19	3/3	No SAPs	3/3	3/3	2/2	2/2	2/2	3/3	1/1
3	The individual's SAPs were based on assessment results.	53%	3/3	No	0/3	3/3	1/2	1/2	0/2	1/3	1/1

		10/19		SAPs							
4	SAPs are practical, functional, and meaningful.	16% 3/19	1/3	No SAPs	0/3	1/3	0/2	0/2	0/2	1/3	0/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/19	0/3	No SAPs	0/3	0/3	0/2	0/2	0/2	0/3	0/1

Comments:
1-2. Of the nine individuals reviewed by the behavioral health monitoring team, eight had at least one skill acquisition plan (SAP). Although Individual #319 had resided at the facility for over three months, no SAPs had been developed and/or implemented for her. Between one and three SAPs were reviewed for those who had them. All 19 of the SAPs reviewed were found to be measurable.

3. Ten of the 19 SAPs were found to be based on assessment results. These were the following: Individual #276 learning to operate a remote-control car, calculate his pay, and answer questions after he read a story; Individual #322 matching her socks, using a DVD remote control, and signing necklace; Individual #237 completing math problems; Individual #220 choosing his medications; Individual #224 administering his asthma medication; and Individual #408 labeling the strings on a guitar.

All others either did not include baseline information on the specific SAP and/or had Functional Skills Assessments that indicated they had already acquired the targeted skill.

4. Three of the 19 SAPs were considered practical, functional, and/or meaningful. These were Individual #276's operating a remote-control car, Individual #322 learning to use a DVD remote, and Individual #224's learning to administer his asthma medication.

Regarding the others:

- Individual #276's FSA noted that he could add multiple digits, use a calculator, and read simple books and magazines.
- Individual #26 was reportedly able to use a microwave, match numbers to a sample, and use a roller knife. Respectively, one SAP addressed his waiting for foods to cool down rather than his ability to prepare snacks, one had him choosing between two or more numbers presented (not a skill needed to use a microwave), and one he readily performed with preferred staff, making this a matter of generalization.
- Individual #322 could better learn to coordinate her wardrobe by choosing from an array of outfits depicted in photographs. Her learning to sign necklace was not related to her goal of selling her jewelry at crafts shows.
- Individual #237 was to learn to read five very simple words that would not increase his ability to navigate his environment independently. It would be more meaningful to teach him environmental signs such as Men, Women, Exit, etc. He was learning to read aloud a simple addition problem, yet he could independently complete the calculation.
- Individual #220 was learning to choose his medications and calculate his work hours, but his FSA indicated he could read and use a calculator to complete single digit addition.
- Individual #278 was learning to match her medication name to its purpose, yet she reportedly read at an adult level. Similarly, she was learning to ensure that change received following a purchase matched that indicated on the receipt, but her FSA noted she had these skills. Neither of these SAPs addressed her reported interest in learning to cook more complex meals.
- Individual #224 had two SAPs related to his obtaining his driver's license, but both focused on skills well below his identified

ability to read at an adult level.

- Individual #408 was learning to label the strings on a guitar. Enrolling him in guitar lessons would have been more meaningful.

5. There was evidence that at least one assessment of SAP integrity had been completed for 16 SAPs. While this monitoring tool required a response about data recording (i.e., was documentation completed as listed in the SAP and did staff record data upon completion of training), it did not allow for a comparison of recorded data between two or more independent observers. As such, data reliability or inter-observer agreement was not assessed. Further, as reported, the two questions about data recording were scored in combination with seven other questions. As a result, one data question could be scored negatively, but the calculation on this section would still be at an acceptable level.

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: Lubbock SSLC assessments should recommend skill acquisition topics, at this point, about one-third did so. Also, one-third of the FSAs were submitted late to the IDTs. This needs to improve in order for indicator 11 to remain in the category of requiring less oversight after the next review. Indicator 12 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 276	319	26	322	237	220	278	224	408
10	The individual has a current FSA, PSI, and vocational assessment.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.										
12	These assessments included recommendations for skill acquisition.	33% 3/9	1/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1

Comments:

11. All PSIs and vocational assessments were available to the IDT at least 10 days prior to the ISP meeting. The FSA was late for Individual #276, Individual #319, and Individual #278. This was based upon a review of documents and the QIDP report on timely submission of assessments.

The vocational assessment for Individual #278 was completed for her 30-day ISP following her admission in October 2017. At the time, it was noted that the assessment was not comprehensive because she had experienced a medical event that necessitated surgery. Once she had recuperated, a full vocational assessment was anticipated. This had not been completed by the time of the onsite visit, over nine months after the medical event.

12. For all nine individuals, the FSA included one (Individual #26, Individual #224, Individual #408), two (Individual #319, Individual #322, Individual #220, Individual #278), or three (Individual #276, Individual #237) SAP recommendations. As has been noted in previous reports, the FSA assesses skills across 13 domains. As such, consideration should be given to recommending SAPs across all

applicable skill areas with emphasis on the individual's interests and needs, particularly as related to enhancing his/her independence and quality of life. One SAP recommendation was provided in the vocational assessment for Individual #276, Individual #319, and Individual #220. For all others, there were not recommendations regarding the acquisition of work skills.

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 related to the provision of clinical services. At the time of the last review, 27 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, four additional indicators in the areas of restraint, psychiatry, pharmacy, and dental will move to the category of less oversight. One in medical will return to active 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.

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, integrated progress reports with data and analysis of the data generally were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

A positive practice at Lubbock SSLC was that the psychiatrists routinely attended the neurology clinic for all of the individuals they followed regardless of whether or not the medications were considered to be dual use.

Acute Illnesses/Occurrences

Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected. The Monitoring Team recognizes that Center staff were working with State Office to correct this issue.

For acute issues addressed at the Center, it was good to see that PCPs generally assessed individuals according to accepted clinical practice. However, often, PCPs/providers did not complete the necessary follow-up. When individuals were transferred to the hospital, PCPs or nurses did not consistently communicate necessary clinical information with hospital staff. It was positive that these individuals generally had quality assessments documented in the IPNs. However, follow-up upon individuals' return from the hospital was often lacking.

Work is still needed to ensure that individuals with dental emergencies receive timely evaluation and treatment, including pain management.

When an individual had frequent restraints, Lubbock SSLC was not correctly providing all of the protections and treatment planning required. Specifically, indicators 20-23 require the review of variables surrounding the restraints and a determination of actions to be (or not be) taken by the IDT.

When individuals were clearly experiencing problems with their psychiatric condition, psychiatrists (and IDTs) took action.

Implementation of Plans

In psychiatry, quarterly psychiatric review documentation contained the required content for all individuals. The MOSES and AIMS evaluations were completed as required for all of the individuals and the reviews by the prescriber occurred within the specified time frame.

Lubbock SSLC took action after a potential atypical usage of Zyprexa was identified across the Center at the last monitoring review. To that end, a drug utilization evaluation was conducted and the psychiatry department and IDTs reviewed/studied medication regimens and, as a result, high dosages of the medication were justified or reduced and, in one case, eliminated.

In behavioral health, assurance of PBSP data reliability was needed. If data are not reliable and if Center staff are not recording occurrences of target behaviors and replacement behaviors, the available data become meaningless. More attention needs to be paid to training all staff on individuals' PBSPs. The low percentage of staff trained on many of the plans might be a contributing factor in the poor collection of data that was occurring.

Graphs needed improvement in order to be useful for making treatment decisions. Up-to-date data needed to be presented in clinical meetings, even if the monthly progress note was not yet due. Peer review was not occurring as often as required and follow-up to peer review recommendations was not occurring for most individuals.

Individuals and staff reported high rates of peer-to-peer aggression. The environment was not free of non-edible items that can be ingested.

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

For the majority of individuals' chronic or at-risk conditions reviewed, medical assessment, tests, and evaluations consistent with current standards of care had not been completed, and/or the PCP had not identified the necessary treatment(s), interventions, and strategies, as appropriate. Moreover, IHCPs did not include a full set of action steps to address individuals' medical needs.

Although documentation often was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs, until IHCPs include a full set of action steps related to medical interventions, this is not a true measure of the Medical Department's success (i.e., a false positive).

Based on the review of consultation documentation for other indicators, PCPs did not consistently review non-facility consultation reports within five business days. As a result, the related indicator will return to active oversight. In addition, the Center needs to focus on ensuring PCPs write IPNs that include all of the required components, and write orders for agreed-upon recommendations, including follow-up appointments.

Individuals reviewed had teeth extractions only when restorative options were exhausted. As a result, the related indicator will move to less oversight. However, vacancies and staff changes as well as individuals' refusals to participate in dental treatment contributed to significant lapses in dental care. With the new Dental Director, the Center should continue to focus on the provision and quality of dental treatment. In addition, data was not available to confirm the provision of suction tooth brushing to applicable individuals according to the prescribed schedules.

Over the past three reviews, providers generally implemented agreed-upon recommendations from Quarterly Drug Regimen Reviews (QDRRs) for individuals reviewed. The related indicator will move to less oversight. Work is still needed to ensure QDRRs include the most recent lab information.

Proper fit of assistive/adaptive equipment was sometimes still an issue.

Based on observations, there were still numerous instances (55% 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 was not correctly providing all of the protections and treatment planning required by this outcome and its indicators. Specifically, indicators 20-23 require the review of variables surrounding the restraints and a determination of actions to be (or not be) taken by the IDT. The Monitoring Team has provided some detailed feedback in the comments below. The Center did,</td><td>Individuals:</td></tr>
</table>

however, put crisis intervention plans in place when needed for all individuals for this review and the three previous reviews (with one exception in February 2016). Therefore, indicator 25 will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.											
#	Indicator	Overall Score	319	220	278	408					
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.	25% 1/4	0/1	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.	75% 3/4	1/1	1/1	1/1	0/1					
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	50% 2/4	1/1	0/1	1/1	0/1					
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	75% 3/4	1/1	1/1	1/1	0/1					
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	0% 0/4	0/1	0/1	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.	0% 0/4	0/1	0/1	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 4/4	1/1	1/1	1/1	1/1					

26	The PBSP was complete.	N/A	N/A	N/A	N/A	N/A					
27	The crisis intervention plan was complete.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	75% 3/4	1/1	0/1	1/1	1/1					
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	50% 2/4	0/1	0/1	1/1	1/1					

Comments:

18. Individual #220's IDT met within 14 days to review potential variables that necessitated restraint.

Individual #319's IDT first met over one month after the fourth restraint had occurred. Individual #408's IDT met more than two months after he first experienced multiple restraints. Although the IDT for Individual #278 met within 14 days of her repeated restraint, these early meetings did not reflect a comprehensive review.

Staff are advised to review all ISPAs to ensure that correct dates are provided and consistent throughout the minutes (e.g., dates of admission were sometimes incorrect and reported to be different in the same report), and to ensure that the names of other individuals are not included.

19. There were a sufficient number of ISPAs for Individual #319, Individual #220, and Individual #278.

20-23. Feedback is provided below regarding each of the four individuals who experienced more than three restraints in a rolling 30-day period.

Individual #319's IDT completed a review of restraints on 7/7/18. This included a review of her adaptive behaviors, biological/medical factors, and psychosocial variables. Medication changes were noted, encouragement to attend counseling was reported, and opportunities to express anger were reviewed. Action plans did not address further pursuit of an appropriate counselor or an assessment of the efficacy of outlets for her anger, such as a punching bag, drawing, poetry, and painting. There was no discussion of the role nightmares may play, particularly in light of the more frequent use of restraint during the early morning hours. Staffing concerns were reviewed, including required overtime, reduced staff to individual ratios, and new/unfamiliar staff. These matters were addressed through the assignment of a behavior coach during the overnight hours, training of new and pulled staff, and the IDT working to identify triggers, particularly between the hours of 2:00 am and 5:00 am. Although the completion of a functional behavior assessment was recommended with a new PBSP to follow, this had not been completed by the time of the onsite visit. Lastly, while the minutes indicated a token economy was included in her interim PBSP, this was not found in the document provided to the Monitoring Team.

Individual #220's IDT met the day after he had experienced multiple restraints. The ISPA minutes reflected a discussion of multiple variables, including his mood, his observed difficulties with his girlfriend, his poor work attendance, a possible change of homes, a trip to visit his mother, and his participation in counseling. All of these were addressed in the recommendations section, including encouragement to attend work and to make better relationship choices. It is suggested that a more concerted effort be made by the team, with the lead taken by his behavioral health services staff, to address his poor attendance at work. Similarly, the team should follow up with the counselor to ensure that he is discussing healthy relationships with Individual #220. While at the time of the meeting, it was not recommended that he move to Rose, this did eventually take place. Some team members had speculated that when he was on respite there, he left the home more frequently to escape the presence of individuals who frightened him. Hopefully, the team has addressed this perceived fear to ensure that he feels safe in his new home.

Individual #278's IDT completed a thorough review of her restraints on 3/21/18 and again on 5/5/18. Medications were reviewed and adjusted when the prescribing psychiatrist determined this was appropriate. Staff also recognized that the presence of several staff could exacerbate the situation and, therefore, minimizing attention was recommended. While her participation in counseling was noted, it was reported that she had difficulties opening-up with her campus-based counselor. The team may want to explore other community-based counselors with whom she might develop a better rapport. Identified patterns involving restraints included her stating she was hungry, but then being denied food because it was not meal or snack time. The IDT should work with the dietician to determine whether there are appropriate alternatives that could be offered at these times. It was also noted that many of her restraints occurred in the evening or overnight hours. While engagement alternatives were recommended for the hours of 5:00 pm to 10:00 pm, there was no indication that repeated observations with assessment of treatment integrity and/or more intensive staff training would occur during these two shifts. It was also noted that limited staffing was an issue. Although behavior coaches were onsite 24 hours daily, there was no indication that one or more of these individuals would be assigned to her home. It was also suggested that Individual #278 might be exhibiting "junk" behavior and staff may be reinforcing and/or triggering challenging behavior. The IDT was expected to follow up on this matter, however, staff are again advised to operationally define all observed behaviors rather than referencing these as "junk" behavior. Restraint documentation essential information was often missing. The behavioral health services staff member was to follow-up on this matter. Although she had been in residence for over seven months, a functional behavior assessment had not been completed and she was still being supported with an interim behavior support plan. These were recommended within 30 days. One positive event was that a Crisis Intervention Plan involving a modified restraint had been approved by State Office and implemented in early May 2018.

When Individual #408's IDT met in February 2018, a review was conducted of seven restraints, although he had experienced an additional five restraints before the ISPA meeting. The team did review several variables that may have contributed to the use of restraint. Psychiatric medication was reviewed and adjusted when the prescribing psychiatrist determined this was appropriate. Although it was noted that he did not engage in challenging behaviors at school that warranted disciplinary action, there was no further assessment to determine strategies applied in school that might be useful at the facility. The first action recommended for his not taking medication was to consider a restriction to campus. There was no discussion of other strategies that could be applied before punitive measures were implemented. The team discussed the possibility of his cognitive abilities being better than what were reported, however, there was no suggestion of further assessment. Staff training was recommended, however, this should address behaviors that are operationally defined rather than "junk" behaviors. While verbal altercations with peers were identified as a possible environmental condition, efforts to improve peer relationships were not identified. Finally, although a functional behavior

assessment was recommended at this time, it was not completed until almost two months later, more than six months after his admission. He remained on an interim PBSP until a full PBSP was implemented in May 2018.

24-27. All four individuals had either a PBSP or an interim PBSP at the time of the visit. There were delays in developing PBSPs based upon the results of a functional behavior assessment. Three of the individuals had a Crisis Intervention Plan. The exception was Individual #319, for whom a draft CIP was provided. Review of the PBSPs can be found in the Psychology/Behavioral Health sections of this report. It was determined that all CIPs were complete.

Because the facility switched from using PMAB strategies to SUR strategies, staff are advised to check all CIPs to ensure these correspond to the current policy. Staff are also advised to provide guidelines regarding the provision of a substitute meal to Individual #278. There should be steps to ensure that the alternative meal is similar in quantity, quality (e.g., heated if appropriate), served in an appropriate setting, and consisting of food Individual #278 would typically consume.

28. Between December 2017 and May 2018, there was evidence that treatment integrity was assessed each month for Individual #220, Individual #278, and Individual #408. Acceptable levels were achieved for all, but Individual #220, because his April 2018 and May 2018 scores reflected poor implementation of his plan. Treatment integrity was assessed for Individual #319 for the first full month she was in residence.

29. There was evidence that the interim plans for Individual #278 and Individual #408 had been replaced in due time with a PBSP based on the findings of the functional behavior assessment. Not all recommendations regarding Individual #220's PBSP had been addressed following his move from one home to another.

Additional note: While onsite, the monitoring team was informed that Individual #46 had experienced multiple restraints in one day. It was positive to learn that the director and assistant director of behavior health services had responded the next day with a review of videotapes and the provision of written feedback to the IDT. Additional feedback was provided one day later. The feedback included several appropriate recommendations, including limiting the number of staff present in the immediate environment and calling a behavior crisis earlier in the episode. Other suggestions were implied, but it may be more appropriate to list these specifically, so that staff are clear on what is being advised. These could include minimizing verbal interactions with Individual #46 and not discussing the restraint in front of him. In the memo sent to staff, the term "junk behavior" was applied to stripping, spitting, and minor property destruction. As has been noted in previous reports, staff are advised to stop using this term in reference to behaviors that staff are advised to pivot. It would be more helpful to operationally define these observed behaviors. Further, the term conveys a level of disrespect for the individual for whom these behaviors, while socially inappropriate, likely serve some important function.

Psychiatry

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

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: As Lubbock SSLC creates indicators and goals for reduction and for improvement of individuals' psychiatric disorders, data can be collected, and progress determined. Even so, when individuals were clearly experiencing problems with their psychiatric condition, psychiatrists (and IDTs) took action. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	276	319	26	322	237	220	278	224	408
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
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 functional goals for either psychiatric indicators to decrease or increase it was not possible to determine if the individual was making progress. 10. Although there were no psychiatric goals, the documentation in the records of the individuals indicated that whenever members of the treatment team were concerned about a deterioration in an individual's status, the psychiatric team was consulted. This process											

was documented in the integrated progress notes and interim clinic notes.

11. These notes also documented the implementation of the recommendations.

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

Summary: Performance was about the same as at the last review. Plans were in place for psychiatrist participation in the development of the PBSPs. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 276	319	26	322	237	220	278	224	408
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.	8/9 89%	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1

Comments:

23. The psychiatric documentation routinely referenced the behavioral data for each of the individuals. The Behavioral Health Assessment described the psychiatric history, diagnoses, and medications for everyone, except Individual #319 for whom the psychiatric medications were listed, but there was not a description of the impact of the psychiatric disorder on her behavioral presentation.

24. The lead psychiatrist recently began attending the meetings of the Behavioral Support Committee on a regular basis. This was the meeting during which the individual's behavioral treatment plans are discussed and finalized. The Monitoring Team attended the meeting of the Behavioral Support Committee during the onsite review week. At this meeting, the treatment plan for Individual #408 was discussed and his name appeared on the attendance sheet. The behavioral treatment plans for the other individuals occurred prior to the psychiatrist's participation in the meetings.

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: A positive practice at Lubbock SSLC was that the psychiatrists routinely attended the neurology clinic for all of the individuals they followed regardless of whether or not the medications were considered to be dual use.

#	Indicator	Overall Score	Individuals:
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.	

26	Frequency was at least annual.	
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	
	Comments:	

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: Quarterly psychiatric review documentation contained the required content for all individuals. With sustained high performance, this indicator (34) might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring. Note that the psychiatry clinic for one individual did not contain up to date PBSP target and replacement behavior data (nor psychiatric indicator data) and the nurse did not present any medical/nursing related information. This needs to be corrected/improved if indicator 35 is to remain in the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	276	319	26	322	237	220	278	224	408
33	Quarterly reviews were completed quarterly.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
34	Quarterly reviews contained required content.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
35	The individual's psychiatric clinic, as observed, included the standard components.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

34. The documentation in the quarterly reviews was thorough and contained the required content.

35. The psychiatric clinic for Individual #276 on 8/7/18 was observed by the Monitoring Team. The behavioral data that were presented went through the end of June 2018. In response to a question about more recent data, the member of the behavioral health services team indicated that the July 2018 report had not been completed yet. In addition, the nurse did not provide any information, although his medical status was discussed by the psychiatrist. The same occurred for each of the five individuals reviewed in the 8/7/18 clinic. Clinic the following day for a different set of individuals, however, were more complete, including up to date data.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.												
Summary: 100% performance was obtained; given sustained high performance over the past three reviews (i.e., one absent evaluation in each of the last two reviews), this indicator will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	276	319	26	322	237	220	278	224	408
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 36. The MOSES and AIMS evaluations were completed as required for all of the individuals and the reviews by the prescriber occurred within the specified time frame.												

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

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.												
Summary: Lubbock SSLC took action after a potential atypical usage of Zyprexa was identified across the Center at the last monitoring review. To that end, a drug utilization evaluation was conducted and the psychiatry department and IDTs reviewed/studied medication regimens and, as a result, high dosages of the medication were justified or reduced and, in one case, eliminated. One individual receiving psychiatric medications did not have a full PBSP in place for many months after her admission. These indicators remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	276	319	26	322	237	220	278	224	408
40	Daily medications indicate dosages not so excessive as to suggest goal	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	of sedation.	9/9									
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.	8/9 89%	1/1	0/1	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. The dosages of the psychiatric medications did not suggest that the goal of treatment was to sedate the individuals.

Following the last monitoring review, the facility performed a DUE related to the use of Zyprexa as it had been noted that several individuals were receiving dosages greater than the usually accepted upper range of 20 mg. The DUE was dated 3/5/18. The report noted that 38 individuals were prescribed Zyprexa either alone or in combination with another medication. This represented 30 percent of the individuals prescribed psychotropic medications at the facility. The report also noted that following the last monitoring review, seven individuals had dosage reductions and, for one individual, the medication was discontinued. They also performed a more detailed review of a sub-sample of 10 individuals that included an analysis of the rationale for the use of Zyprexa as well as the presence of side effects. The results did not identify any significant issues with side effects. The facility developed a one page screening tool to review the sub-sample and it would appear that this could be useful for all of the individuals prescribed Zyprexa in higher dosages.

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

42. There was a treatment program in the record of each individual. However, Individual #319 had been admitted to the facility in April 2018 and the team was still using the interim behavior plan that had been developed on 5/8/18, soon after her admission. Given the severity of her behavioral presentation, an updated plan should have been developed.

43. The lead psychiatrist reported that the facility no longer used PEMA.

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.											
Summary:			Individuals:								
#	Indicator	Overall Score									
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
45	There is a tapering plan, or rationale for why not.										
46	The individual was reviewed by polypharmacy committee (a) at least										

	quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	
Comments:		

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: If data are not reliable and if Center staff are not recording occurrences of target behaviors and replacement behaviors, the data become meaningless. Moreover, if clinical staff (e.g., behavioral health services, psychiatry) are making treatment decisions based upon the [unreliable] data that are presented, incorrect treatment approaches and interventions could possibly be created and implemented. This set of indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	276	319	26	322	237	220	278	224	408
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% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	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 the Center's graphs for six individuals (Individual #322, Individual #237, Individual #220, Individual #278, Individual #224, Individual #408) suggested progress in all target behaviors, the data were not reliable (see indicator 5). While the graphs in the June 2018 progress note suggested improvement for Individual #276 and Individual #319, these are rated as not progressing due to verbal report from staff of worsening behavior in July 2018. Lastly, Individual #26's graphs suggested lack of progress in food seeking, self-injury, aggression, and his replacement behavior.

7. This indicator is rated as not applicable because none of the individuals had met their objectives.

8. This indicator could not be rated for Individual #276 and Individual #319 because their July 2018 progress notes were not available. Staff may suggest actions to take to address their worsening behavior. For Individual #26, there were no recommended corrective actions to address his worsening behavior.

9. This indicator is rated as not applicable because no action steps or revisions to PBSPs had been identified.

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

Summary: More attention needs to be paid to training of all staff on individuals' PBSPs. The low percentage of staff trained on many of the plans might be a contributing factor in the poor collection of data that was occurring (see indicator 5). This indicator (16) will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	276	319	26	322	237	220	278	224	408
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
17	There was a PBSP summary for float staff.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
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.										

Comments:
16. A comparison was made between a list of staff assigned to work with the individual and training rosters. This comparison revealed that in no case had 80% or more of assigned staff been trained. Calculations indicated that between 5% (Individual #237) and 79% (Individual #220) of assigned staff had received training on the PBSP.

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

Summary: Graphs needed improvement in order to be useful for making treatment decisions. Up to date data needed to be presented in clinical meetings, even if the monthly progress note was not yet due. Peer review was not occurring as often as required and follow-up to peer review recommendations was not occurring for most individuals. This set of indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	276	319	26	322	237	220	278	224	408
19	The individual's progress note comments on the progress of the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
20	The graphs are useful for making data based treatment decisions.	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.	0% 0/2	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of	25% 1/4	N/A	1/1	N/A	N/A	N/A	N/A	0/1	0/1	0/1

	recommendations made in peer review.										
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:

20. Although it was positive to review graphs that presented weekly data, none of the graphs were useful for making treatment decisions. For all but one (Individual #322), graphs were too small to read the dates or events identified under the horizontal axis. In the graph depicting physical and verbal aggression displayed by Individual #319, the legend indicated the same symbol for both behaviors. One graph in Individual #278's progress note depicted four measures, making this difficult to read. For all individuals, phase change lines were missing to indicate changes in medication, introduction of a new or revised PBSP, change in home, etc. Further, the vertical axis was not labeled accurately as many targeted behaviors were measured as episodes. This was not clear when the label was number per week.

21. During the onsite visit, an observation was conducted during Individual #276's psychiatric clinic and during the meeting of the Internal Peer Review Committee regarding Individual #408. In neither case were current data presented. The BCBA or Behavior Health Specialist presented data through June 2018, but no data from July 2018 or August 2018 were reviewed. It was reported that Individual #276's aggression had worsened in July 2018 and Individual #408's participation in activities remained a problem.

While progress notes may not have been due until later in the month, it is important that current data are presented at any clinical review meeting.

22. There was evidence that four individuals had been reviewed by the Internal and/or External Peer Review Committees. One recommendation was for Individual #319's staff to be trained in trauma-informed care. Behavioral health services staff reported that this had been completed through Ukeru training. Individual #224 had been reviewed by both committees. There was no evidence that his PBSP had been revised or updated following these reviews. For Individual #278 and Individual #408, the discussion focused on the possible use of a modified restraint in their Crisis Intervention Plans. It was determined that the emphasis should be placed on training staff to implement the PBSP, particularly antecedent and prevention strategies. This indicator was rated zero because documents indicated that 20% of Individual #278's staff and 64% of Individual #408's staff had been trained. Behavioral health services staff are advised to present Individual #319 to the External Peer Review Committee for further input regarding action steps to best meet her needs.

23. There was evidence that the Internal Peer Review Committee met between zero and three times each month between February 2018 and July of 2018 for a total of 12 times. This did not meet this indicator's criterion. However, the External Peer Review Committee did meet each month during this same time period, which did meet criterion.

Outcome 8 – Data are collected correctly and reliably.

Summary: Two indicators improved to 100% performance, compared with 0% scores for all five indicators for the two previous reviews. Changes (improvements) are needed in the data collection systems for PBSP target behaviors and in the methodology (and implementation) of reliability and integrity checks on those data and plans. This set of indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 276	319	26	322	237	220	278	224	408
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.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

26. For all nine individuals, at least one of their target behaviors was defined as an episode. Each episode was separated by the absence of the target behavior for one minute, two minutes, three minutes, five minutes, or 30 minutes. Clearly, episodes could vary greatly in length. Because this included target behaviors that could potentially cause significant harm to the individual (e.g., self-injury, suicidal threats/gestures) or to others (e.g., aggression, property destruction), a more sensitive measure is advised. It would be more helpful to utilize a duration measure or a partial interval recording of short intervals. Other behaviors that were not clearly defined as episodes included unauthorized departure or undressing. In both cases the event was considered over when the individual returned to campus or redressed, respectively. Again, a duration measure may be a more accurate of tracking these behaviors.

27. All of the replacement or alternative behaviors were measured adequately as each occurrence was recorded. Individual #319 did not have a replacement/alternative behavior in her plan, due in part to the plan being new and still in development. Therefore, it was not included in this indicator.

28. The behavioral health services staff were utilizing an assessment form that consisted of an interview covering 10 basic PBSP elements and an observation of staff working with the individual. Observed treatment integrity was determined by noting whether the staff member responded to the replacement behavior(s) and/or targeted behavior (s) as indicated in the PBSP. While this did not allow for assessment of prevention strategies along with consequent strategies, it was an acceptable method for determining the fidelity of plan implementation.

There were problems with the manner in which data timeliness and IOA were assessed and reported. Under data integrity, the behavioral health services observer was to note five events: (a) was the occurrence/nonoccurrence of the replacement behavior(s) documented, (b) did the documented count match the observed count, (c) was the occurrence/nonoccurrence of the target behavior(s) documented, (d) did the documented account match the observed count, and (e) was the time documented within two hours of the observed time. Data from these five measures were used to determine a percentage of data integrity. Although any one event could be recorded as not occurring, the data integrity score would still be at an acceptable level (i.e., 80%). This could result in an inflated reporting of adequate data timeliness and IOA measures. Staff are advised to separate this section into data timeliness (using the last question only), and inter-observer agreement (using the second and fourth questions only).

29. Assessment of data timeliness, IOA, and treatment integrity was expected to occur at least monthly. Expected assessment levels were established at 80% or better.

30. As staff had just recently begun assessing data timeliness, and due to the problems noted above, this indicator was scored zero for all individuals. Based on documentation provided by the facility summarizing IOA and treatment integrity measures between December 2017 and May 2018, goal frequencies and levels were achieved for seven individuals. The exceptions were Individual #26 and Individual #220. In Individual #26's case, it was noted that IOA and treatment integrity were not applicable in May 2018. There was no further explanation for this statement. In Individual #220's case, although IOA and treatment integrity were assessed each month over this six-month period, the average score fell below the established level of 80%.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/17	0/2	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	6% 0/17	0/2	0/2	0/2	0/2	1/1	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/17	0/2	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/17	0/2	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes	0%	0/2	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/2

	necessary action.	0/17									

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #237 – cardiac disease, and other: Pompe disease; Individual #319 – diabetes, and seizures; Individual #227 – falls, and aspiration; Individual #321 – osteoporosis, and GI problems; Individual #12 – seizures, and UTIs; Individual #197 – diabetes, and falls; Individual #269 – respiratory compromise, and GI problems; Individual #176 – respiratory compromise, and GI problems; and Individual #23 – osteoporosis, and other: pica).

These indicators were not applicable for Individual #12's seizures, because she is a passive participant in her care, and medications, which are the primary treatment, are given through her gastrostomy tube (G-tube). In other words, individual goals should either address an element of health promotion that the individual can improve upon or learn to do, or that staff need to do consistently to improve the individual's health and/or reduce risk to the extent possible. Neither of these were applicable in Individual #12's case, so a goal/objective was not necessary. For some individuals with seizures, goals/objectives would apply (e.g., related to learning to and/or avoiding situations that potentially trigger a seizure).

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 #12 – UTIs.

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

Outcome 4 – Individuals receive preventative care.

Summary: Three 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 improvement is noted, and 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 analyzed concerns related to 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	237	319	227	321	12	197	269	176	23
a.	Individual receives timely preventative care:										

	i. Immunizations	56% 5/9	1/1	0/1	1/1	0/1	0/1	1/1	1/1	0/1	1/1
	ii. Colorectal cancer screening	100% 3/3	N/A	N/A	N/A	1/1	1/1	1/1	N/A	N/A	N/A
	iii. Breast cancer screening	100% 2/2	N/A	N/A	N/A	N/A	1/1	1/1	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	78% 7/9	0/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
	vi. Osteoporosis	83% 5/6	0/1	N/A	1/1	1/1	1/1	1/1	N/A	N/A	1/1
	vii. Cervical cancer screening	50% 1/2	N/A	0/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	38% 3/8	0/1	N/A	1/1	1/1	0/1	0/1	0/1	1/1	0/1

Comments: a. The following problems were noted:

- Given Individual #237's increased sedentary status and decreased mobility at a young age, he was at increased risk for osteopenia/osteoporosis, but a DEXA scan was not completed. In its comments on the draft report, the State disputed this finding. The State's rationale was that on 8/13/18, the PCP ordered a DEXA scan. This was the Monday after the Monitoring Team's onsite review, and after the Monitoring Team member discussed this concern with the PCP.

  On 1/11/15, he had his last audiological exam, with a recommendation for a repeat every three years, which did not appear to have occurred.
- For Individual #319, a consent was signed for the administration of Prevnar 13, pneumovax, and varicella (she needed a titer), but the Center submitted no information to show whether or not they were given.

  On 7/12/18, she refused a scheduled pap smear. In its comments on the draft report, the State questioned this finding and stated: "Individual #319 refused a pap smear but attempt was made by PCP to complete this preventive screening. Should this be N/A instead?" As a follow up to a refusal, Center staff should have documented rescheduling the appointment. Additionally, the IDT should have addressed the refusal in an ISPA meeting with action steps to resolve the concern, such as counseling to inform the individual of the reason for the procedure, or the development of other individualized supports to assist the individual in completing the appointment.
- For Individual #321, documentation was not submitted of a Hepatitis B vaccine or titer.
- For Individual #12, no Tdap was submitted.

- On 12/12/16, Individual #197 had her last audiological exam, with a recommendation for a repeat every year, which did not appear to have occurred.
- For Individual #176, the Center did not submit documentation of a varicella vaccine or titer. On 8/10/18, after the Monitoring Team member discussed this with the PCP on site, the PCP ordered it.

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

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	100% 2/2	N/A	N/A	N/A	N/A	N/A	N/A	1/1	1/1	N/A
Comments: a. Both of the individuals reviewed with DNRs had clinical conditions that justified the order.											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: For acute issues addressed at the Center, it was good to see that PCPs generally assessed individuals according to accepted clinical practice. However, often, PCPs/providers did not complete the necessary follow-up. When individuals were transferred to the hospital, PCPs or nurses did not consistently communicate necessary clinical information with hospital staff. It was positive that these individuals generally had quality assessments documented in the IPNs. However, follow-up upon individuals' return from the hospital was often lacking. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
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.	82% 14/17	1/2	1/1	1/2	2/2	2/2	1/2	2/2	2/2	2/2
b.	If the individual receives treatment for the acute medical issue at the	53%	1/1	0/1	1/2	1/1	1/2	1/2	2/2	1/2	0/2

	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.	8/15									
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.	79% 11/14	2/2	2/2	N/A	2/2	1/2	1/2	1/2	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.	86% 6/7	2/2	N/A		2/2	1/1	0/1	1/1	N/A	
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	71% 10/14	1/2	0/2		2/2	2/2	2/2	2/2	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% 8/8	1/1	N/A		1/1	2/2	1/1	1/1	2/2	
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	60% 6/10	0/1	2/2		1/1	1/2	0/1	0/1	2/2	

Comments: a. For the nine individuals reviewed, the Monitoring Team reviewed 17 acute illnesses addressed at the Center, including: Individual #237 (right hip lesion on 1/5/18, and right-sided pain on 1/17/18), Individual #319 (swelling of hand on 4/30/18), Individual #227 (seizure on 2/12/18, and weakness/falls on 5/23/18), Individual #321 (flu on 2/6/18, and buttock lesions on 2/12/18); Individual #12 (tachycardia and elevated drug level on 2/10/18, and skin abscess on 2/16/18); Individual #197 (foot pain on 1/18/18, and toothache on 1/25/18), Individual #269 (cough on 3/28/18, and wheezing on 4/1/18), Individual #176 (fever on 3/6/18, and pneumonia on 6/4/18), and Individual #23 (cough on 3/15/18, and pica on 6/20/18).

It was good to see that PCPs assessed most acute issues reviewed according to accepted clinical practice. Those for which PCPs did not document the source of the information were for: Individual #237 (right hip lesion on 1/5/18), Individual #227 (seizure on 2/12/18), and Individual #197 (foot pain on 1/18/18).

b. Often, the PCPs did not conduct follow-up assessments and documentation at a frequency consistent with the individual's status and

the presenting problem until the acute problem resolved or stabilized.

The following provide examples of concerns noted:

- According to a PCP IPN, dated 4/30/18, the PCP saw Individual #319 for swelling of her right hand after she punched a window on 4/29/18. The IPN showed the PCP conducted an examination that revealed a small cut and superficial abrasions. The PCP ordered cleansing of the hand four times a day, topical antibiotic ointment four times a day, and an x-ray of the hand. However, based on documentation submitted, the PCP did not review the x-ray, or conduct follow-up to determine healing.

- Based on Tier I documentation, between December 2017 and 5/23/18, Individual #227 experienced at least 22 falls. On 5/23/18, a PCP IPN indicated the PCP saw the individual to assess weakness and falls. In addition to ordering lab work, the PCP recommended the use of a cane, and consideration of elbow and knee pads to provide some protection. The PCP documented no follow-up of lab results. Based on documentation the Center submitted, on 5/31/18, 6/22/18, 6/26/18, and 6/29/18, Individual #227 continued to fall.

- On 2/16/18, the PCP saw Individual #12 for a skin abscess, and ordered treatment. No follow-up was found.

- On 6/4/18, Individual #176's PCP saw him in relation to possible pneumonia. The PCP ordered a chest x-ray and complete blood count (CBC), and Levaquin. The IPN, dated 6/4/18, indicated the PCP would review the individual the next day. However, on 6/5/18, the PCP documented no follow-up. On 6/8/18, the PCP entered the next IPN, which indicated review of the labs confirming pneumonia.

- On 3/15/18, at 11:04 a.m., a nurse reported that Individual #23 had a dry cough. On the same day at 1:56 p.m., the PCP's IPN indicated the plan was to obtain a chest x-ray, CBC, and strep and influenza test. The PCP ordered vital signs every six hours for 24 hours, and then every shift for three days. Nursing staff were to report abnormal findings. The PCP also ordered guaifenesin 200 milligram (mg) syrup 10 milliliters (ml) four times a day for five days. The on-call PCP later changed this to Robitussin DM twice daily due to persistent cough. However, no PCP IPN was found reviewing the chest x-ray results, or the other ordered labs.

- On 4/4/18, Individual #23 was hospitalized and a bezoar was removed. On 6/19/18, at 7:40 a.m., nursing staff entered an IPN indicating a possible pica event. A PCP IPN, dated 6/20/18, at 4:56 p.m., indicated that a KUB (i.e., abdominal x-ray) was completed, and the report was pending. Based on the documentation submitted, the PCP did not review the results of the KUB.

c. For seven of the nine individuals reviewed, the Monitoring Team reviewed 14 acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #237 (ED visit for unresponsiveness on 4/16/18, and hospitalization for health care associated pneumonia on 6/11/18), Individual #319 (ED visit for head injury on 5/18/18, and ED visit for ingestion of broken glass on 6/3/18), Individual #321 (hospitalization for emesis on 3/21/18, and ED visit for Mickey button complication on 4/9/18), Individual #12 (hospitalization for sepsis on 1/8/18, and hospitalization for respiratory distress and UTI on 3/14/18), Individual #197 (hospitalization for fall on 4/13/18, and ED visit for hematoma on 4/20/18), Individual #269 (hospitalization for pneumonia on 1/1/18, and hospitalization for respiratory distress on 4/2/18), and Individual #176 (hospitalization for pneumonia on

1/5/18, and hospitalization for respiratory failure, and aspiration pneumonia on 3/23/18).

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

- It was positive to see that the following individuals displaying signs/symptoms of acute illness received timely acute medical care, and follow-up care, as needed: Individual #237 (ED visit for unresponsiveness on 4/16/18), Individual #321 (hospitalization for emesis on 3/21/18, and ED visit for Mickey button complication on 4/9/18), Individual #12 (hospitalization for respiratory distress and UTI on 3/14/18), Individual #269 (hospitalization for respiratory distress on 4/2/18), and Individual #176 (hospitalization for respiratory failure, and aspiration pneumonia on 3/23/18).

- On 6/11/18 at 9:15 p.m., Individual #237 went to the ED because he was nauseated, and needed oxygen to maintain oxygenation. The Center did not submit evidence that a provider or nurse contacted the ED to provide transfer information. He was hospitalized for pneumonia. On 7/9/18, he returned to the Center. Although nursing notes indicated that the PCP/a provider issued orders on 7/9/18, and 7/11/18, it was not until 7/12/18, that the PCP entered a post-hospital IPN, and it was the only follow-up note for the hospitalization.

- On 1/8/18, after Individual #12 did not respond to albuterol nebulizer treatments, she was transferred to the ED after hours. However, it was not until 1/10/18, that the PCP wrote an IPN. On 1/31/18, the individual returned to the Center. On 2/1/18, the IDT held an ISPA meeting and discussed the diagnosis of infected urinary stones, which led to respiratory distress and aspiration pneumonia, as well as the removal of bilateral stents. It was not until 2/2/18, that the PCP wrote an IPN. The IPN did not include a summary of hospital tests and results, and/or next steps.

- On 4/13/18, Individual #197 fell after hours and went to the ED. No PCP IPN was found reviewing the event. The individual was hospitalized for surgery to his right hip, and placement of three screws. On 4/17/18, she returned to the Center, and the PCP documented a doctor-to-doctor report. It was not until 4/20/18, that the PCP wrote the next IPN, in which it was explained the individual had gone back to the ED for an x-ray of the right hip.

- On 1/1/18, Individual #269 was hospitalized for pneumonia, but the PCP did not write a timely IPN reviewing the circumstances of the acute illness. In addition, upon her return on 1/16/18, the PCP/a provider did not conduct an exam/assessment. It was not until 1/18/18, that the PCP conducted an exam/visit, and it was documented in a late entry, dated 1/22/18.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.	
Summary: Based on the review of consultation documentation for other indicators, PCPs did not consistently review consultation reports within five business days. As a result, Indicator b will return to active oversight. In addition, the Center needs to focus on ensuring PCPs write IPNs that include all of the required components, and write orders for agreed-upon recommendations, including follow-up appointments. The remaining indicators will continue in active oversight.	Individuals:

#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight. However, based on the Monitoring Team's review of consultation documentation for other indicators, the Center regressed in its performance on Indicator b. Therefore, it will move back to active oversight.									
b.	PCP completes review within five business days, or sooner if clinically indicated.										
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	75% 12/16	2/2	0/2	2/2	2/2	1/1	2/2	2/2	1/1	0/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	45% 5/11	0/1	N/A	1/1	0/2	1/1	2/2	0/1	0/1	1/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 16 consultations. The consultations reviewed included those for Individual #237 for infusion services on 2/5/18, and ophthalmology on 2/16/18; Individual #319 for orthopedics on 6/14/18, and endocrinology on 6/26/18; Individual #227 for neurology on 11/15/17, and endocrinology on 11/28/17; Individual #321 for gastroenterology (GI) on 5/16/18, and endocrinology on 11/7/17; Individual #12 for oncology on 6/4/18; Individual #197 for endocrinology on 11/7/17, and endocrinology on 11/28/17; Individual #269 for hematology on 1/29/18, and pulmonology on 2/8/18; Individual #176 for vision on 2/15/18; and Individual #23 for GI on 4/4/18, and endocrinology on 6/26/18.

b. Five of these reviews did not occur timely (i.e., Individual #237 for ophthalmology on 2/16/18; Individual #319 for orthopedics on 6/14/18, and endocrinology on 6/26/18; and Individual #227 for neurology on 11/15/17, and endocrinology on 11/28/17). The reviews were overdue from between two business days and 13 business days.

c. Twelve of the PCP IPNs related to the consultations reviewed included all of the components State Office policy requires. The exceptions were for Individual #319 for orthopedics on 6/14/18, and endocrinology on 6/26/18; and Individual #23 for GI on 4/4/18, and endocrinology on 6/26/18.

d. When PCPs agreed with consultation recommendations, evidence was not submitted to show orders were written for all relevant recommendations, including follow-up appointments, for the following: Individual #237 for ophthalmology on 2/16/18 (i.e., follow-up appointment); Individual #321 for GI on 5/16/18 (i.e., topical Bacitracin to old PEG site), and endocrinology on 11/7/17 (i.e., follow-up appointment); Individual #269 for hematology on 1/29/18 (i.e., follow-up appointment); Individual #176 for vision on 2/15/18 (i.e., follow-up appointment); and Individual #23 for endocrinology on 6/26/18 (i.e., follow-up appointment with thyroid test).

In its comments on the draft report, the State asked for clarification for the finding for Individual #321. The State stated: "Individual #321was [sic] seen by GI on 5/16/18. He had an EGD on 5/24/18 (There is an order in IRIS for NPO after midnight for scheduled EGD). He was then followed in clinic by GI afterwards on 6/27/18 at which point the GI dr [sic] said to 'follow up PRN' only. No order is required when individual is to follow up on a PRN basis." As the Monitoring Team indicated in the draft report (see parentheses above), the missing order was for "topical Bacitracin to old PEG site."

e. For Individual #23's GI appointment, although the PCP did not include the need for IDT referral in the IPN related to the consultation, the PCP's post-hospital IPN did refer the issues to the IDT. According to an ISPA, dated 4/10/18, the IDT and PNMT met to discuss the concerns.

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

Summary: For the majority of individuals' chronic or at-risk conditions reviewed, medical assessment, tests, and evaluations consistent with current standards of care had not been completed, and/or the PCP had not identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.

#	Indicator	Overall Score	Individuals: 237	319	227	321	12	197	269	176	23
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	44% 8/18	1/2	2/2	0/2	1/2	1/2	1/2	1/2	1/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #237 – cardiac disease, and other: Pompe disease; Individual #319 – diabetes, and seizures; Individual #227 – falls, and aspiration; Individual #321 – osteoporosis, and GI problems; Individual #12 – seizures, and UTIs; Individual #197 – diabetes, and falls; Individual #269 – respiratory compromise, and GI problems; Individual #176 – respiratory compromise, and GI problems; and Individual #23 – osteoporosis, and other: pica).

a. For the following 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: Individual #237 – cardiac disease; Individual #319 – diabetes, and seizures; Individual #321 – GI problems; Individual #12 – seizures; Individual #197 – diabetes; Individual #269 – respiratory compromise; and Individual #176 – GI problems. The following provide examples of concerns noted:

- Individual#237 has a history of Pompe muscular dystrophy (alpha glucosidase deficiency). In earlier years, he had several diagnoses that likely were inaccurate. However, on 5/13/10, a magnetic resonance imaging (MRI) study of his lumbar spine showed severe atrophy of the muscles supporting his lumbar spine. On 2/19/15, a blood level of the enzyme alpha glucosidase was tested, and indicated an abnormally reduced level. On 1/10/17, he was started on serial infusions of Lumizyme to replace the deficit. On 3/2/17, he received a power wheelchair/scooter. On 9/13/17, further blood tests indicated elevated

inflammatory markers. More recently, he had several falls: 5/24/17, 6/17/17, 8/1/17, 9/12/17, 10/2/17, 1/6/18, 1/30/18, and 3/14/18. Several of these falls were associated with injury.

In June 2017, a pulmonology consult indicated he was able to walk for six minutes with stable oxygenation during exercise, with no oxygen saturation below 90%. In the past year, his pulmonary deterioration was significant. Reflective of this decline, although he had mainly used a walker, as of 1/9/18, he transitioned to more dependence on an adapted power wheelchair. Beginning on 1/17/18, he began to develop a decubitus ulcer on his right buttock. On 1/22/18, he underwent pressure mapping to his chair. He then developed pressure ulceration to his left hip. As his left hip ulceration continued to slowly increase in size, the IDT agreed to a low air loss pressure relieving mattress.

On 3/2/18, he was found on the floor, associated with attempts to get out of bed to use the restroom. An ISPA, dated 3/5/18, reviewed the plan to obtain a call bell, access a bedside urinal, and further discussed assistance in getting to the restroom. An ISPA, dated 3/7/18, discussed a behavioral contract to motivate him to move out of his power chair at least each shift. A PNMP, dated 3/8/18, included many updated recommendations. By 3/22/18, his left hip decubitus ulcer had healed. On 3/28/18, the IDT held an ISPA meeting to review a change in adaptive equipment while eating to accommodate his decline in function.

Although he had obstructive sleep apnea, and was provided CPAP with demonstrated improvement in clinical parameters, he often refused to use it. On 6/11/18, he developed hypoxia and was found to have a fecal load contributing to his respiratory compromise. He was admitted to the hospital for acute on chronic hypoxic hypercapnic respiratory failure. On 7/9/18, he returned to the Center. During his hospital stay, he required intubation. At the time of discharge, hospital specialists recommended CPAP at night and oxygen as needed during the day.

He had two significant indicators of poor prognosis, including needing a wheelchair for mobility, and respiratory compromise. As his condition declined over the past year, the IDT met several times to provide additional support. However, his PCP and IDT had not developed a plan to support him as he experiences the declines expected with this progressive disease. For example:

- All members of the IDT would benefit from access to education from the muscular dystrophy association and/or a national/local Pompe disease association.
- Likely, only a narrow window of time exists before his next respiratory exacerbation, during which time his wishes related to end-of-life decisions should be explored and documented (i.e., whether he wishes to have long-term ventilatory support). Given his carbon dioxide retention and recent respiratory failure requiring ventilator support, and ongoing oxygen needs, he meets the guidelines for having a terminal condition as well as hospice services, which should be discussed as part of this process. As he becomes hypophonic and less able to communicate, the PCP and IDT should address the end-of-life decision in the near future while he can understand his choices and articulate his wishes, with the assistance of his LAR/family members.
- The IDT should develop a mechanism for measuring whether the infusions are helping as well as how the disease is progressing. This will require a look back to determine a baseline, and then, testing to determine his current status, along with communication with the consultant.
- The PCP should work with the IDT to develop programming that would improve his quality of life as well as to keep up

his strength to the extent possible, for example, range of motion (ROM) exercises, and activities that keep him moving and meaningfully engaged as much as possible.
    - The PCP should consider the benefits of ordering respiratory therapy to maximize his lung capacity, and slow the degenerative process to the extent possible.
    - He will likely have ongoing skin integrity breakdowns, and access to a wound consultant or certified wound nurse would be advantageous.
    - He has demonstrated benefit from CPAP, but has been non-compliant with this apparatus, increasing his risk of hypoxia. The PCP should work with the IDT to identify possible options for encouraging his compliance with this treatment.
    - He also has a history of gastroesophageal reflux disease (GERD) and gastric emptying delays, which might contribute to reflux aspiration in the future, which would further imperil his fragile respiratory status. Treatment options should be maximized.

- With regard to Individual #227's risk of aspiration, on 5/31/06, he demonstrated moderate dysphagia on a modified barium swallow study (MBSS). An MBSS report, dated 6/10/14, recommended nothing-by-mouth (NPO) status. The individual's father did not consent to G-tube placement. On 4/6/15, 8/12/15, and 10/12/15, he choked while eating, requiring abdominal thrusts to clear his airway. On 10/21/15 and 4/25/17, repeat MBS studies continued to recommend NPO status. The individual's father has continued to decline G-tube placement. A trial of Vital Stim was ineffective, because Individual #227 refused to participate. On 1/17/18, he again choked on mashed potatoes, requiring abdominal thrusts. The 1/18/18 ISPA indicated that he had a tendency to overfill his mouth. Several instructions were revised on the dining plan, including: required to have one-to-one attention from staff during eating, encourage him to clear his mouth before speaking, use infant spoon with a white handle to be inscribed with his name on it to reduce confusion with a larger youth spoon, provide an extra spoon in order to break up sticky foods and scrape excess food from his spoon, add diet-specific actions such as "mashed potatoes should be moistened," and have him eat before or after others have eaten. The parent restated that he did not want his son to lose the ability to enjoy eating orally. On 1/19/18, the SLP completed monitoring and observed that staff offered him cake that was dry and that he had the wrong utensil. As of 4/17/18, the diet order was a ground diet with honey-thickened liquids, with no ice, ice cream, sherbet, or Jell-O, and to strain excess thin liquids from food items, and to moisten all dry foods including bread, rice and mashed potatoes with broth or gravy. The IRRF, dated 6/13/18, listed his adaptive equipment, including a chest bumper, a two-ounce nosey cup, plate guard, a dycem mat, an infant spoon with white handle, a positioning cushion, a box to elevate the plate to encourage an upright position, and an extra spoon. Individual #227's oral health rating was poor.

  The AMA, dated 4/30/18, indicated he "was doing well with no signs of aspiration." However, several areas of risk needed ongoing evaluation and attention. For example, the AMA plan of care should have focused on increased monitoring to ensure compliance with his diet, and use of adaptive equipment, as well as improved dental care, which will require an aggressive home tooth brushing SAP or SSO to accomplish, as well as frequent dental care visits.

- Individual #321 had a diagnosis of osteoporosis. A 10/13/10 DEXA scan report indicated a T-score of -5.2. On 5/8/14, a DEXA scan report indicated a T-score of -5.0. On 9/30/15, endocrinology was consulted for his hypothyroidism and hypovitaminosis

D. A DEXA scan report, dated 6/21/16, indicated a T-score of -4.3. A 9/22/17 vitamin D level was 38. An endocrine consult, dated 11/7/17, recommended no changes in medication. Current orders included Vitamin D supplementation and calcium supplementation. On 3/29/17, Individual #321 received his last Prolia dosage. He had no further Prolia administration, which should have been due every six months in September 2017 and March 2018. On 7/6/18, a DEXA scan was ordered. Although he continues to be monitored for vitamin D levels, and receives adequate calcium, his T-scores indicate the need for active treatment of osteoporosis, but for unclear reasons, he had not received Prolia administration in a timely manner as part of treatment of his osteoporosis.

- Individual #12 had a history of repeated urinary tract infections and urosepsis. From 1/30/16 to 2/8/16, she was hospitalized for seizures associated with urosepsis. From 3/8/16 to 3/21/16, she was hospitalized for a UTI. At that time, an ultrasound showed non-obstructive kidney stones. From 10/27/17 to 11/3/17, she was hospitalized for urosepsis. Blood cultures grew an extended spectrum bet lactamase resistant E coli. From 12/19/17 to 12/22/17, she was electively hospitalized for several urologic procedures, including left ureteroscopy, stent placement, laser lithotripsy, basket extraction of stones, and left ureteral stone exchange. She remained with right renal stones.

  From 1/8/18 to 1/31/18, she was hospitalized with urosepsis and aspiration pneumonia and acute respiratory failure, and was intubated. During the hospitalization, she underwent cystoscopy, ureteroscopy with bilateral ureteral stent placement, and retrograde pyelography bilaterally. On 1/12/18, the consultant neurologist tapered the Topamax. Topamax is associated with metabolic acidosis and renal stone formation. On 2/23/18, she developed a symptomatic UTI, and on 2/28/18, a catheter was placed through the ED for antibiotic therapy. An ISPA, dated 2/27/18, reviewed the need for monitoring of pericare, checking uric acid, and requesting dietary to adjust fluids. From 3/14/18 to 3/20/18, she was hospitalized again for a resistant UTI and developed aspiration pneumonia. She was given Zosyn IV. The submitted admitting ED information indicated she had still been on Topiramate at 100 mg twice daily. On 3/20/18, she was placed on nitrofurantoin for UTI suppressive therapy. From 3/22/18 to 3/23/18, she was hospitalized for a UTI associated with multiple seizures. Information from that ED admission continued to indicate she was on Topiramate, according to a home medication list. From 4/6/18 to 5/8/18, she was hospitalized for uncontrolled seizures and the hospital liaison note still listed that she was prescribed Topiramate at the time of admission. A 4/9/18 entry subsequently indicated "not taking." Topiramate was not listed on either QDRRs reviewed, dated 2/23/18 or 5/23/18. Pharmacy did not mention the need to review the use of Topiramate given the backdrop of renal calculi, and potential development of metabolic acidosis. Her metabolic acidosis appeared to have resolved after Topamax was discontinued, from a CO2 (bicarbonate) of 22 on a comprehensive metabolic panel (CMP) from 9/29/17, to 30 on a CMP, dated 6/20/18.

  It was not until the neurologist recommended a taper from Topiramate that this was considered. As noted above, also problematic was the lack of an accurate updated medication list at the time of arrival/admission to the ED, as the ED information continued to list Topiramate. It was approximately three months before the updated medication list indicated the Topamax had been removed from the ongoing treatment at Lubbock SSLC. It was unclear if the Center had a system to review the accuracy of medication lists when an individual was sent to the ED. Further, hospital documentation included a notation that Zosyn (an antibiotic) might have aggravated her seizure disorder. The Center's documentation did not show further review as an adverse drug reaction. Submitted documents, including the most recent QDRR, dated 5/23/18, did not list this as

a medication to avoid in the future should she be hospitalized or treated at the SSLC. She also had been prescribed Prolia, which might increase the risk of infections, but tracking of infections to determine any change in frequency over the past three to five years had not occurred prior to the Monitoring Team's visit, to guide the PCP on whether to continue Prolia or not. One consideration would be to change to IV Reclast, but this had not occurred in the time period of the submitted documents.

- Individual #197 had several falls. On 4/13/18, she fell in the shower, and broke her left hip, which required corrective surgery. A DEXA scan indicated a T-score of -2.8 (osteoporosis). On 4/20/18 she returned to the ED for an evaluation of hematoma formation at the surgical site. A 5/1/18 ISPA indicated that she had returned home, and received skilled PT. She was using a four-wheeled walker. She used a gait belt for ambulation and had use of a shower chair for bathing. On 5/8/18, she had an unwitnessed fall with no injury. She fell on her left side when she reportedly became dizzy while attempting to stand. Bilateral x-rays of the hips were ordered. At that time, she mentioned that tramadol, which was prescribed for pain, gave her diarrhea. It had been discontinued on 5/15/18, but later was reordered on 6/8/18. A 5/15/18 ISPA indicated that she was having dizzy spells. However, when the PCP, RN, and PT assessed her, she said she was no longer dizzy. Behavioral services indicated she appeared to have a manic episode. Risperdal was started. The PCP ordered nursing staff to obtain orthostatic blood pressures, and she was started on Tylenol for pain. Mats/shower decals were to be ordered for the shower. She had a follow-up appointment for a shoe fitting. An ISPA, dated 5/24/18, stated that she might have been embarrassed about slipping and instead stated she was having dizziness and black-out spells. By 5/30/18, she was using a four-wheeled walker and a single tip cane. She was discharged from PT. A 6/7/18 ISPA indicated the IDT and PNMT met to discuss her care. It was noted that orthostatic blood pressure had not been recorded. Nursing staff had recorded only one reading, dated 5/8/18. On 6/11/18, her left foot was swollen, but an x-ray was negative, and it was considered due to tight fitting shoes. On 7/2/18, she fell in the shower, and was sent to the ED. X-rays were negative. On 7/4/18, she fell while tripping over her shoes. She landed on her left hand and right hip. She appeared to have three episodes of brief seizure activity. She was sent to the ED, and x-rays were negative. A habilitation therapy note, dated 7/6/18, speculated that she might be seeking attention or medications, and that she might not want to move to a community setting. On 7/11/18, she fell, and was transferred to the ED. She had slipped getting out of the shower. A computed tomography (CT) scan of the cervical spine and head were negative. X-rays of the right shoulder, pelvis, and right knee were negative.

  These issues required interdisciplinary involvement with leadership from the PCP. Individual #197 continued to fall, but the submitted documentation included no information as to next steps. That orthostatic BPs were ordered, but not obtained in a timely manner was concerning. An evaluation or screening to address the dizziness was not reflected in the PCP IPNs. Although Tramadol had caused diarrhea, it was reordered, rather than listed as a medication with an adverse drug effect in her record. Pharmacy also did not pursue this concern with evaluation to rule out an adverse drug effect. Whether she actually had a seizure disorder was not clarified. It was concerning that these issues, including ongoing falls and a recent allegation of sexual assault in a community setting in the past, had not been resolved or addressed as she anticipated discharge to the community.

- Individual #269 had a history of dysphagia and GERD. In 2009, she had a G-tube placed to address aspiration per an MBSS. She also had an esophageal stricture. The PNMP included reflux precautions at all times. She had a hospital bed, a custom wheelchair, and recliner for positioning at 40 to 45 degrees, and the bathing trolley was to have a wedge to elevate her while

bathing. She also was on continuous feeding for 18 hours. She was prescribed Famotidine for the GERD. On 12/7/17, she completed a gastric emptying study, and this indicated she was 36% below the normal limit. There was a question of GERD at that time. On 12/18/13, her feeding tube was replaced with a mickey button.

During her hospitalization from 1/2/18 to 1/16/18, tube feeding was noted around her nose. On 1/18/18, it was noted that she continued to have a large amount of thick cream colored secretions, she also had thick cream colored secretions when deep suctioning occurred. A no-skid surface on the bed was placed to optimally position her. On 1/19/18, she again was noted with cream color nasal drainage. She also had a large amount of creamy secretions when suctioning. On 1/25/18, she developed wheezing and rhonchi after bathing, which resolved. With her known GERD, it appeared that she was refluxing into the pharynx, with aspiration into the lungs. She was known to have a delay in gastric emptying. There was no further information submitted that she had undergone an evaluation to confirm the severity of the GERD. As she had dementia associated with Down syndrome, she might not have been a candidate for a fundoplication or jejunostomy tube (J-tube) placement, but there was no discussion in submitted documentation concerning the next step to resolve her severe GERD, or to determine that she was not a candidate for surgical procedures. On 4/2/18, she received Reclast IV in the hospital, suggesting that she was not anticipated to die in the near future, and was not considered imminently terminal at that time. The clinical rationale for not following up on the severity of GERD was not documented.

- Individual #176 had severe restrictive lung disease due to severe kyphoscoliosis and pigeon chest. He had numerous bouts of acute respiratory distress, with many associated with aspiration pneumonia/hypoxia/lung infiltrate (e.g., 6/12/89, 11/30/95, 5/9/97, 2/18/99, 12/2/01, 3/25/02, 5/28/05, 10/26/06, 4/6/07, 1/13/10, 5/24/10, 7/20/10, 10/16/11, 4/22/15, 7/23/15, 10/20/15, 1/31/17, 6/12/17, 8/18/17, 10/10/17, 1/5/18, 3/6/18, 3/23/18, and 6/4/18).

  He was prescribed Albuterol, budesonide, and ipratropium nebulizer treatments, and loratadine for allergies. He received suction tooth brushing. There were PNMP instructions to never lie him flat, and he had HOBE instructions while in bed, and positioning instructions when he was in his wheelchair. He additionally used a pillow/wedge/bolster when bathing in order to maintain head elevation. He received his J-tube feeding, medication, and oral care while in the most upright position.

  Despite the frequent significant pulmonary infections, his PCP continued to prescribe Prolia for his osteoporosis without documentation of discussion of risk/benefit for this medication. During interview, the PCP indicated that the decision to use IV Reclast was in discussion. However, Prolia continued to be administered every six months, the most recent date of administration recorded was 4/9/18. From submitted documentation, it was unclear how long Prolia had been prescribed and whether there had been an increase in infections after it was initiated. Such information would guide the PCP in whether to continue Prolia or not. Additionally, the QDRR did not address the potentially significant side effects of Prolia. The QDRR did not even list this medication as being part of the drug regimen, which was a problem the Pharmacy Department had identified.

- Individual #23 had a significant history of completed pica events. Ingestions in the past included cloth material, gloves, a ball of toilet paper, a metal bolt, a windsock, training materials, feces, a coin, a rubber pad, a diaper/brief, a plastic streamer, a small game pieces, wrist bands, and the stuffing from a Santa hat. In June 1994, he has had an exploratory laparotomy for bowel obstruction and repair. In January 1998, he had an exploratory laparotomy for bowel obstruction. In July 2000, he had an

exploratory laparotomy with resection. In October 2011, he had an exploratory laparotomy to remove a foreign body in the stomach (EGD was not successful in removing the latex/plastic gloves). More recently, in January 2017, he attempted to eat paper at the workshop, and in May 2017 and again in August 2017, he successfully ingested paper at the work center. On 11/29/17, the IDT held an ISPA to discuss the one-to-one level of supervision (LOS). On 12/20/17, the IDT also held an ISPA meeting to discuss the LOS, and the IDT determined that if Individual #23 had no attempts in 26 consecutive weeks, the IDT would consider a reduction in LOS from one-to-one to a less restrictive staffing level. The ISPA, dated 1/31/18, indicated he was approaching the 26-consecutive week mark to potentially reduce the 1:1 LOS (he was reported to have had 23 pica-free weeks), but then on 2/1/18, a KUB indicated a radiopaque entity in the abdomen. On 3/26/18, a follow-up KUB continued to note a 10 centimeter (cm) by 5cm density in the stomach. At that point, the Medical Director requested an IDT meeting, but the QIDP indicated there was already a weekly meeting and another meeting was not indicated without new information. Due to the continued density on the serial KUBs, on 4/4/18, the gastroenterologist completed an EGD, but could not extract the plastic glove material. Subsequently, a repeat surgical EGD allowed the gastroenterologist to remove the material, and on 4/9/18, Individual #23 returned to the SSLC.

At a 4/10/18 ISPA meeting, his IDT changed his risk of pica from medium to high. An ISPA, dated 4/23/18, indicated the IDT agreed to order a pica blanket, and create a binder for the paperwork generated from his pica plan/observations. Steps included not taking the changing cart into his bedroom, home staff were to continue to use a form for counting gloves and wipes, staff were not to carry gloves in their pockets or clothing, hourly pica sweeps were scheduled, and a new pica sweep form was created for when he entered a new location or environment. From 6 a.m. to 10 p.m., he was assigned one-to-one staffing, and from 10 p.m. to 6 a.m., he was assigned enhanced staffing.

The IDT scheduled additional oversight pica sweeps for weekends and night shifts. Risk management and IDT members were to perform spot checks routinely. KUBs were to continue on a monthly basis, abdominal girth was to be checked daily on the day shift, labs were to be ordered for deficiencies, and quarterly in-services were to be held (unclear of audience). Many of these steps had been ongoing.

Subsequent QIDP monthly reports did not provide any data or concerns with regard to the action steps. Based on the documentation submitted, the IDT had not listed/discussed all potential sources of gloves (e.g., workshop, van, ambulance, ED, hospital room, outings, etc.). A more rigorous monitoring and counting system was indicated than that upon which the IDT agreed. As the Lead Monitor discussed with the Center Director, Individual #23's living environment and the Center grounds were not pica safe, and actually included many items that Individual #23 or others could ingest. Additional oversight was needed to make improvements.

The AMA did not include prior iron or zinc levels, but the PCP ordered recent levels and results indicated normal values. On 4/23/18, the IDT discussed his pica blanket at an ISPA meeting, but as of the 6/15/18 ISPA meeting, it had not arrived. At the time of the Monitoring Team's onsite visit, it was available, but there was a several-week delay in completing the order, for an individual who continued to be at high risk for further pica.

There was the need for Center staff to recognize that pica is usually lifelong. Given Individual #23's history of prior successful

	pica events requiring surgery, it was concerning that his IDT had lowered his risk to medium in the past. Additionally, the IDT appeared to believe that once he had 26 pica-free weeks, his supervision could be reduced, a highly unsafe consideration. The QIDP monthly review for May 2018 did not track the ongoing steps of pica prevention or provide evidence staff completed them. Given that he had ingested gloves again, his supervision and/or the other procedures in place were not successful. Training was needed for home staff, workshop staff, transport staff, etc. Based on the Monitoring Team's observations, a box of gloves, as well as bug spray were left unattended on the patio of his home, and objects in his home and room could have been dismantled and parts swallowed. His closet was a potential source of cloth and other material for ingestion. The pica plan needed considerable intensification and additional steps, given his multiple surgeries in the past. The Center might need to seek outside expertise for this ongoing challenging behavior, which places him at risk for additional surgeries and/or medical emergencies.

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 often was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs/ISPs. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	71% 5/7	1/1	N/A	N/A	N/A	N/A	2/2	0/2	2/2	N/A
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. Those action steps assigned to the PCPs that were identified for the individuals reviewed often 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			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and										

b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.										
	Comments: a. and b. 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: Given that during this review and the past two reviews, providers generally implemented agreed-upon recommendations from QDRRs for individuals reviewed (Round 11 – 100%, Round 12 – 88%, and Round 13 - 100%), indicator d will move to the category requiring less oversight. Work is still needed to ensure QDRRs include the most recent lab information.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	QDRRs are completed quarterly by the pharmacist.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
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;	78% 14/18	2/2	0/2	2/2	2/2	2/2	2/2	2/2	1/2	1/2
	ii. Benzodiazepine use;	100% 8/8	2/2	2/2	N/A	N/A	2/2	N/A	2/2	N/A	N/A
	iii. Medication polypharmacy;	100% 9/9	2/2	2/2	N/A	N/A	1/1	N/A	2/2	2/2	N/A
	iv. New generation antipsychotic use; and	100% 8/8	2/2	2/2	2/2	N/A	N/A	2/2	N/A	N/A	N/A
	v. Anticholinergic burden.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
	ii. When the individual receives psychotropic medications, the										

	psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	100% 3/3	N/A	1/1	1/1	1/1	N/A	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: b. For the QDRRs that scored negatively, some of the most recent lab data available had not been incorporated into the QDRR reports.

Of note, on 4/9/18, Individual #176 was administered Prolia, but the QDRR did not list it as a medication.

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

e. As noted with regard to Outcome #1, 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 and the Monitoring Team is able to identify the full scope of new medications requiring interventions, this indicator is not being rated.

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	237	319	227	321	12	197	269	176	23
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	13% 1/8	1/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	13% 1/8	1/1		0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/8	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%	0/1		0/1	0/1	0/1	0/1	0/1	0/1	0/1

		0/8									

Comments: a. and b. The Monitoring Team reviewed eight individuals with medium or high dental risk ratings. Individual #237 had clinically relevant, achievable, and measurable goals/objectives related to dental (i.e., cleaning his dentures, and wiping his gums).

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

c. through e. Unfortunately, Individual #237's QIDP integrated reviews did not include data related to his clinically relevant and measurable dental goals/objectives.

In addition to the goals/objectives not being clinically relevant, achievable, and measurable, integrated progress reports on existing goals with data and analysis of the data generally were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For all eight 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: N/A			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	Not rated (N/R)									

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

Outcome 5 – Individuals receive necessary dental treatment.	
Summary: Given that during past reviews and this review, individuals reviewed had extractions only when restorative options were exhausted (Round 11 – 100%, Round 12 – 100%, and Round 13 - 100%), Indicator f will move to the category requiring less oversight. However, as Center staff are aware, vacancies and staff	Individuals:

changes as well as individuals' refusals to participate in dental treatment contributed to significant lapses in dental care. With the new Dental Director, the Center should continue to focus on the provision and quality of dental treatment. The remaining indicators will continue in active oversight.											
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
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.	0% 0/7	N/A	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	14% 1/7	N/A	N/A	0/1	1/1	0/1	0/1	0/1	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.	40% 4/8	N/A	1/1	0/1	1/1	1/1	0/1	0/1	0/1	1/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	0% 0/4	N/A	N/A	0/1	0/1	N/A	0/1	0/1	0/1	N/A
e.	If the individual has need for restorative work, it is completed in a timely manner.	25% 1/4	N/A	N/A	N/A	N/A	0/1	1/1	0/1	0/1	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A
Comments: a. through f. Individual #237 was edentulous. Individual #319 was newly-admitted, so some indicators did not yet apply to her. Most 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.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: Work is still needed to ensure that individuals with dental emergencies receive timely evaluation and treatment, including pain management. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	50% 1/2	N/A	N/A	N/A	N/A	N/A	1/2	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	50% 1/2						1/2			

c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	50% 1/2						1/2			
Comments: a. through c. On 1/12/18, Individual #197 stated that a filling fell out, and she had some pain when eating. She was referred to the dental clinic the next day, when a dentist was present. The dentist found tooth #29 was non-restorable, and tooth #7 had a fractured filling with decay. Using TIVA, the dentist extracted tooth #29, and restored tooth #7. Although the dental note indicated the individual was experiencing some pain in the lower right side, the dentist included no information concerning pain management. On 1/25/18, Individual #197's PCP saw her concerning increased pain in her mouth after the recent dental extraction. When the dental office was called, no one was in the office, and the dentist never saw her. The PCP ordered increased Tylenol, and ordered salt water mouth rinses after each meal.										

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: It was good to see that for the applicable individuals, IDTs included suction tooth brushing strategies/plans in their ISPs/IHCPs. If the Center sustains this performance, after the next review, Indicator a might move to the category of less oversight. Unfortunately, data was not available to confirm the provision of suction tooth brushing to these individuals according to the prescribed schedules, and QIDP monthly reviews did not summarize and analyze related data. At the time of the last review, Indicator c, related to monitoring of suction tooth brushing, moved to the category of less oversight. However, during previous reviews, the Monitoring Team might have incorrectly scored this indicator. In order to sustain this indicator in the category of less oversight, IDTs should ensure that individuals with suction tooth brushing have IHCPs that define the frequency of monitoring (i.e., for quality as well as safety) and it is implemented according to the schedule. The Monitoring Team will continue to review the remaining indicators.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	100% 4/4	N/A	N/A	N/A	1/1	1/1	N/A	1/1	1/1	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/4				0/1	0/1		0/1	0/1	
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction	0% 0/4				0/1	0/1		0/1	0/1	

	tooth brushing.										

Comments: a. It was good to see that for the four applicable individuals, IDTs included suction tooth brushing strategies/plans in their ISPs/IHCPs.

b. For Individual #12 and Individual #269, the Center submitted no data related to suction tooth brushing. Based on documentation submitted, for each of other two individuals, lapses occurred in the provision of suction tooth brushing. Reasons were not provided for the days/times that staff did not provide individuals with the required tooth brushing support. In addition, the Center provided the raw data in a format that made interpretation difficult. Multiple tasks (e.g., medication administration, oxygen administration, suction tooth brushing, etc.) were included in the printout. It would be difficult to determine any trend of improvement in compliance with frequency of suction tooth brushing or duration of tooth brushing from the submitted data, which was not specific to suction tooth brushing, as well as the brief duration of the data (approximately three weeks), which would not allow for any trend analysis.

c. Although in the past the Center scored well on this indicator, and the indicator moved to the category of less oversight (i.e., the Center scored 100% during Rounds 10, 11, and 12), in reviewing ISPs for Indicator a, the Monitoring Team noted that ISP action plans did not define the frequency of monitoring expected to meet the individuals' needs. Since the inception of the Dental Audit Tool, in January 2015, the interpretive guidelines for this indicator have read: "Frequency of monitoring should be identified in the individual's ISP/IHCP, and should reflect the clinical intensity necessary to reduce the individual's risk to the extent possible." However, during previous reviews, the Monitoring Team might have incorrectly scored this indicator. In order to sustain this indicator in the category of less oversight, IDTs should ensure that individuals with suction tooth brushing have IHCPs that define the frequency of monitoring (i.e., for quality as well as safety) and it is implemented according to the schedule.

d. Sometimes, QIDP reports did not include specific data, but rather statements, such as "receives suction tooth brushing daily," or "suction tooth brushing offered daily." In other instances, QIDPs listed each tooth brushing event, but provided no summary. QIDPs need to summarize the frequency of sessions completed in comparison with the number anticipated (e.g., 60 out of 62 sessions). Additionally, a second data subset should provide data on the number of such events during which the individual completed two minutes of suction tooth brushing (e.g., of the 60 completed sessions, 12 sessions completed two minutes of suction tooth brushing).

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. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	50% 4/8	N/A	1/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									

Comments: For half of the individuals reviewed with missing teeth, the Dental Department did not provide recommendations regarding dentures, or did not provide a rationale for the recommendations not to pursue 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: Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected. The Monitoring Team recognizes that Center staff were working with State Office to correct this issue, and that during the next review, the Center will provide acute care plans for review. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0%									
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	0%									
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0%									
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%									
e.	The individual has an acute care plan that meets his/her needs.	0%									
f.	The individual's acute care plan is implemented.	0%									
Comments: a. through f. Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. At least in part, the conversion to the IRIS system complicated entry of acute care plans into the system. However, this is a substantial deviation from standard practice and needs to be corrected.											

The Monitoring Team has discussed this issue with State Office. Given that Center staff acknowledged that acute care plans have not been consistently developed and entered into the system, it was decided that the Monitoring Team would not search for needed acute care plans that might not exist. However, as a result of this systems issue, these indicators do not meet criteria. Center staff should continue to work with State Office to correct this issue.

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

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

#	Indicator	Overall Score	Individuals: 237	319	227	321	12	197	269	176	23
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.	39% 7/18	0/2	1/2	1/2	1/2	1/2	1/2	1/2	1/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT 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: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #237 – skin integrity, and other: Pompe disease; Individual #319 – constipation/bowel obstruction, and weight; Individual #227 – falls, and choking; Individual #321 – fractures, and cardiac disease; Individual #12 – UTIs, and constipation/bowel obstruction; Individual #197 – falls, and cardiac disease; Individual #269 – constipation/bowel obstruction, and other: Alzheimer's dementia; Individual #176 – fractures, and constipation/bowel obstruction; and Individual #23 – choking, and fractures).

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 #319 – weight, Individual #227 – choking, Individual #321 – cardiac disease, Individual #12 – UTIs, Individual #197 – cardiac disease, Individual #269 – constipation/bowel obstruction, and Individual #176 – constipation/bowel obstruction.

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports with data and analysis of the data generally were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. 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: Nurses often did not include interventions in IHCPs to address individuals' at-risk conditions, and even for those included in the IHCPs, documentation often was not present to show nurses implemented them. In addition, often IDTs did not collect and analyze information, and develop and implement plans to address the underlying etiology(ies) of individuals' risks. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 237	319	227	321	12	197	269	176	23
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	11% 2/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	1/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/10	0/2	0/1	0/2	0/1	0/1	0/1	0/1	N/A	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).	11% 2/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	1/2	0/2

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

a. and c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs often did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, or that nursing interventions were implemented thoroughly. Those for which such documentation was found were for Individual #321 – cardiac disease, and Individual #176 – constipation/bowel obstruction.

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

- The only ISPA, dated 2/26/18, that addressed skin breakdown for Individual #237 indicated that his pressure ulcer increased in size and that he should receive a low air loss/pressure relieving mattress. The IDT did not document recognition that skin issues could be an ongoing problem due to his decreases in mobility, strength, and independence and involvement in adaptive living skills, as well as possibly numbness related to his Pompe Disease. The ISPAs did not reflect any proactive planning to address his Pompe Disease, which his IRRF, annual and quarterly nursing assessments, ISP, PNMP, and AMA described as a "rare inherited neuromuscular disorder, which causes progressive muscle weakness." Knowing the progression of his disease, the IDT should proactively anticipate declines in his status and implement interventions to mitigate some of the possible

complications, rather than just reacting to his predictable health issues.

- Since her admission to the Center, Individual #319's IDT had not addressed her high risk related to weight, including, for example, developing and implementing interventions regarding her compliance with her prescribed 1800-calorie diet, her daily activity level, an analysis of her weights thus far, her appetite and percentage of meals consumed, and her participation in setting her weight goals.
- Based on the Center's response to Document Request TX-LB-1808-IV.1-20 as well as ISPAs, Individual #227 fell on the following dates: 1/10/18, 1/22/18 x2, 2/15/18, 3/20/18, 3/29/18, 4/18/18, 4/19/18, 5/14/18, 5/16/18, 5/21/18, 5/22/18, 5/23/18, 5/31/18, 6/22/18, 6/26/18, and 6/29/18. According to ISPAs, dated 1/24/18, 4/3/18, 4/24/18, and 5/29/18, his IDT met to review his recurring falls. According to the ISPA, dated 1/24/18, his IDT agreed to obtain new orthopedic shoes, to document his falls and report them to nursing staff, Individual #227 was supposed to be careful when walking and watch where he was going, and IDT would meet if he had increased falls. The next ISPA, dated 4/4/18, noted that on 2/2/18, he received his new shoes, and had two falls since then. However, the documentation indicated that he was not wearing the new shoes consistently and complained that they hurt his feet. The ISPA indicated that the fall that occurred on 3/20/18, was probably due to his not wearing the new shoes. It was not clear from the note if he had or had not been wearing them on the other days he fell. The documentation indicated that: "[Individual #227] knows he should be wearing his new shoes to determine if the shoes reduce his falls." The recommendations from this ISPA included staff reminding him to wear his orthopedic shoes, replacing his insoles/shoes as needed, and staff reminding him not to walk too fast.

  Although the ISPA, dated 4/24/18, indicated that the IDT conducted a "root cause analysis" (RCA), the team only reviewed the falls from 3/20/18 through 4/20/18. The documentation indicated that the IDT identified the root cause(s) of his falls as his "diagnosis and some behavior." However, it was unclear how the IDT identified these factors, to what specific diagnosis the IDT referred, and why the IDT used such a small sample of falls to conduct the RCA. Throughout the documentation in the ISPAs, the Monitoring Team found no indication that an OT/PT assessed him for balance issues that the QIDP identified as a potential cause of his falls in the ISPA note, dated 1/24/18. Lack of compliance with using his cane and walking fast were also noted as issues. In another ISPA, dated 4/24/18, the IDT noted that: "[Individual #227's] falls have been addressed previously and the plan was ineffective due to [the individual] not following redirection from staff to wear his shoes and not walk too fast." However, then, a note in the ISPA, 4/24/18, clearly indicated that Individual #227 had memory impairment from a Traumatic Brain Injury (TBI). In April 2018, when he did not have his cane, he fell (4/18/18 x2, and 4/19/18), and on 4/5/18, he fell when he was wearing another individual's shoes. At the time of the Monitoring Team's onsite review, he continued to experience falls. In summary, some of the issues included:
  - His IDT had not conducted a comprehensive review and analysis of his falls.
  - Without fully analyzing relevant data, the documentation showed the IDT had largely concluded that it was Individual #227's fault that he was falling recurrently.
  - When recommending interventions, his IDT had not taken into consideration his known memory loss.
  - His IDT had not raised his risk level for falls from medium to high. According to the IRRF and ISPA, dated 4/24/18, the IDT's reasoning was that he did not have osteoporosis and he had not had a serious injury from any of his falls. This lack of recognition of the seriousness of the issue was also reflected in the IDT's lack of urgency to aggressively address and prevent his falls. The documentation also did not show that when reviewing his risk level for falls, the IDT considered the fact that he had sustained a previous TBI and was at risk for additional head injuries.

    - The interventions the IDT put into place were not sufficient to keep him safe from falls. As a result, he continued to be at significant risk.
- Although Individual #227's team met to discuss a choking incident that occurred on 1/17/18, the ISPA, dated 1/18/18, did not reflect that the IDT conducted any analysis of why he choked. The documentation from the ISPA indicated that when staff performed abdominal thrusts, on the fifth thrust, what appeared to be mashed potatoes came out of his mouth. The dining plan at this time included the instructions: "Break apart sticky foods (like mashed potatoes/breads) before I start my meal." However, it did not appear that the IDT reviewed the incident to determine whether or not a breach occurred with regard to the existing dining plan/positioning, or if Individual #227 could still tolerate his current diet supports in light of the aspiration risk noted on the MBS studies conducted on 6/10/14, 10/21/15, and 4/25/17. All of these studies revealed aspiration and recommended nothing-by-mouth status, but his father declined G-tube placement, according to the IRRF. In addition, the IHCP only required that Habilitation Therapy staff monitor his meals quarterly and nursing staff monitor them monthly. This level of monitoring was not sufficient for an individual who already had four choking incidents requiring abdominal thrusts.
- In an ISPA, dated 4/6/18, the IDT noted Individual #321 had an abdominal aortic aneurism, but the IDT then only included a statement that it should be "monitored closely." There was no indication that the RNCM and/or PCP provided his IDT and home staff with an in-service (not a read-and-sign "training") addressing the signs and symptoms of this potentially life-threatening condition, if it were to rupture, and steps staff should take. This crucial medical information could be easily lost with staff turnover or floating staff, and the IDT needs develop a system for communicating it to all staff working with Individual #321.
- Based on the ISPAs provided, Individual #12's IDT met to discuss her recurrent UTIs. An ISPA, dated 2/27/18, described the IDT's RCA meeting. During this meeting, the IDT identified some factors that could contribute to her UTIs (e.g., staff's lack of compliance with every-two-hour brief changes, lack of compliance with appropriate peri-care, poor staff consistency, loose stools, changes in IDT membership, and kidney stones). Although the ISPAs documented that the IDT discussed fluid intake, they did not mention what her requirement for free water was, and if she had been actually receiving it in her formula and during medication administration. It was a positive finding that the IDT discussed the organism for some of her UTIs as part of the RCA. However, the IDT did not develop a monitoring system to ensure the consistent implementation of the agreed-upon interventions (i.e., changing her check-and-changes from every two hours to every hour, and if she was soiled, she would be changed and cleaned on a bath trolley and washed with soap and water from front to back). The note indicated that the "PNMT will monitor at the IDT level, via the morning medical meeting and clinic list." However, no documentation was found to show that this monitoring occurred. Also, the documentation indicated that the Residential Coordinator, a crucial person to ensure direct support professionals followed through on interventions, was not in attendance at the RCA meeting. Since the RCA meeting, Individual #12 had two additional UTIs (i.e., on 3/14/18, and 4/3/18). Even after these additional infections, the IDT did not implement a monitoring system to determine whether staff were implementing the new interventions.
- Although according to an ISPA, dated 5/24/18, Individual #197's IDT conducted a RCA, the team meeting occurred over a month after she fell in the shower with a resulting fracture to her right hip, on 4/13/18, and fell again on 5/7/18. The ISPA, dated 4/18/18, did not include any analysis to identify possible causes for the fall in the shower, resulting in a fracture, for someone who had no reported falls in the past year. The IPNs days prior to this incident noted she had been reporting blood in her stools. The RNCM and/or IDT conducted no analysis of her blood sugars, blood pressures, changes in sensation due to her diabetes, lab work, her reports of being dizzy and blacking out, hearing, vision, or changes in medications. The ISPA, dated 5/15/18, addressing the unwitnessed fall noted again she had been complaining of dizzy spells and "manic" behavior (her

Risperdal had been discontinued in the hospital and restarted on 5/8/18). At this time, the IDT recommended orthostatic blood pressures, as well as determining blood sugar trends. However, the documentation provided no indication that her IDT comprehensively reviewed her medication regimen to attempt to determine if any of the medications prescribed for her hip fracture, along with the discontinuation of her psychotropic medication could have precipitated mood swings/manic behaviors. The ISPA, dated 5/24/18, that described the team's attempt to conduct a RCA did not include any specific data related to her blood sugars, labs, etc., and noted that nurses had not obtained any orthostatic blood pressures. Consequently, the documentation did not support that the IDT actually conducted a comprehensive data-driven RCA. The Center's data provided in response to Document request TX-LB-1808-IV.1-20 indicated that she continued to fall, on 7/2/18, 7/4/18, 7/7/18, 7/17/18, and 7/24/18, and continued to be at risk of harm related to falls and fractures. It also was concerning that data from this same document request indicated that on 6/20/18, and 7/9/18, she had been a victim of peer-to-peer aggression.

- Individual #269 had a diagnosis of Alzheimer's dementia. However, the Center submitted no documentation addressing her cognitive baseline status and changes that had occurred to support the diagnosis. It did not appear the IDT had a system in place to monitor her symptoms. This was concerning, given that this diagnosis formed the basis for the justification for her DNR Order.
- In April 2018, Individual #23's IDT increased his choking risk from medium to high, but did not provide an explanation. In addition, the IDT did not revise his IHCP to address his increased risk.

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

Summary: For the three previous reviews, as well as this review, the Center did well with the indicators related to: 1) nurses administering medications according to the nine rights; and 2) nurses adhering to infection control procedures while administering medications. However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review these indicators 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 Center should focus on medication nurses following PNMPs, because some regression was noted. The remaining indicators will remain in active oversight as well.

#	Indicator	Overall Score	Individuals: 237	319	227	321	12	197	269	176	23
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R							N/A		
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1

	documentation).										
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.	75% 3/4	N/R	N/A	N/A	0/1	1/1	N/A	1/1	1/1	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.	83% 5/6	N/R	N/A	N/A	1/2	2/2	N/A	N/A	2/2	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.	75% 6/8	1/1	1/1	1/1	0/1	1/1	1/1		0/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
m.	If a medication variance occurs, documentation shows that	N/R									

	orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.										

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 #237, Individual #319, Individual #227, Individual #321, Individual #12, Individual #197, Individual #176, and Individual #23.

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

d. The following concerns were noted:

- In June 2018, Individual #237 had aspiration pneumonia. In its response to the draft report, the State indicated that the IDT met after the cutoff dates for the documents to revise the individual's IHCP to include regular lung assessments. Although the State indicated it attached documents to its response, no documents were attached. As a result, the Monitor chose not to rate these indicators for Individual #237.
- For Individual #321, during the onsite observation, the medication nurse checked the individual's lung sounds prior to medication administration, which was good to see. Although, his IHCP included an intervention to check lung sounds monthly, this was not frequent enough for this individual rated at high risk for aspiration/respiratory compromise, and with two recent diagnoses of pneumonia on 2/6/18, and 3/21/18.

f. For Individual #321 and Individual #176, the medication nurses asked direct support professionals if the individuals were in the correct position, rather than checking themselves to ensure the individuals were positioned in accordance with the PNMPs' instructions for medication administration.

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

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: The IDTs of a number of individuals reviewed should have made referrals to the PNMT, or the PNMT should have made self-referrals, but this did not occur. In addition, overall, 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	237	319	227	321	12	197	269	176	23
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;	11% 1/9	0/2	0/2	N/A	N/A	0/1	0/1	1/1	0/1	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	33% 3/9	0/2	1/2			1/1	0/1	1/1	0/1	0/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/7	0/2	N/A			0/1	0/1	0/1	0/1	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/7	0/2	N/A			0/1	0/1	0/1	0/1	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/7	0/2	N/A			0/1	0/1	0/1	0/1	0/1
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	11% 1/9	N/A	N/A	0/2	0/2	0/1	1/1	0/1	0/1	0/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9			0/2	0/2	0/1	0/1	0/1	0/1	0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	22% 2/9			1/2	0/2	1/1	0/1	0/1	0/1	0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	11% 1/9			0/2	0/2	0/1	0/1	0/1	0/1	0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/9			0/2	0/2	0/1	0/1	0/1	0/1	0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/9			0/2	0/2	0/1	0/1	0/1	0/1	0/1

Comments: The Monitoring Team reviewed nine goals/objectives related to PNM issues that seven individuals' IDTs were responsible for developing. These included goals/objectives related to: aspiration, and falls for Individual #237; GI problems, and weight for Individual #319; skin integrity for Individual #12; GI problems for Individual #197; skin integrity for Individual #269; skin integrity for Individual #176; and aspiration for Individual #23.

a.i. and a.ii. Individual #269's IHCP for skin integrity included a clinically relevant, achievable, and measurable goal/objective.

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: weight for Individual #319, and skin integrity for Individual #12.

b.i. The Monitoring Team reviewed nine areas of need for seven individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goals/objectives were included. These areas of need included: choking, and falls for Individual #227, aspiration, and GI problems for Individual #321, aspiration for Individual #12, falls for Individual #197, aspiration for Individual #269, aspiration for Individual #176, and choking for Individual #23.

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

- On 1/18/18, Individual #227 choked on mashed potatoes. He had a history of swallowing problems with a modified barium swallow study (MBSS), dated 4/25/17, recommending nothing-by-mouth (NPO). Given his history and the recent choking event, at a minimum, the PNMT should have conducted a review.

  Similarly, Individual 227's IDT did not refer him to the PNMT despite falls on the following dates: 1/10/18, 1/22/18 x2, 1/28/18, 2/15/18, 3/20/18, 3/29/18, 4/5/18, 4/7/18, 4/18/18, 4/19/18, 5/14/18, 5/16/18, 5/21/18, 5/22/18, 5/23/18, 5/31/18, 6/22/18, 6/26/18, and 6/29/18. A PNMT note, dated 6/20/18, stated that toxic myoneural disorder might contribute and that the falls might have been behavioral in nature, but offered no formal review or assessment.
- On 2/6/18, and 3/21/18, Individual #321 was diagnosed with pneumonia. Given that his IDT already rated him at high risk for respiratory issues, his already complicated positioning needs, and his reliance on staff for mobility, these two pneumonias within six weeks paired with a fecal impaction warranted at least a PNMT review.
- Individual #12 had a significant history of respiratory-related issues, including, but not limited to multiple episodes of respiratory distress and aspiration pneumonia in 2016, and aspiration pneumonia on 1/8/18, and 3/22/18. For these events, her IDT did not refer her to the PNMT, and the PNMT did not make a self-referral. On 4/6/18, another pneumonia occurred, which finally resulted in a PNMT assessment.
- Due to Individual #269's significant medical history and overall medical complexities, in conjunction with pneumonia on 1/1/18, and observation of tube feeding substances around her nostrils, at a minimum, the PNMT should have conducted a review. On 4/21/18, the individual died at the age of 69 with cause of death listed as pneumonia.
- On 2/17/17, the PNMT conducted its last review of Individual #176. Since that time, he had six pneumonias (i.e., 6/2017, 8/8/17, 10/10/17, 1/5/18, 3/5/18, and 3/23/18). Due to his significant respiratory illness history and overall medical complexities, a comprehensive PNMT assessment was warranted.
- Due to Individual #23's history of pica, the recent removal of a bezoar (i.e., on 4/4/18), the surgical implications, and the potential medical impact of his continuing pica behaviors, a PNMT review was warranted. The PNMT minutes, dated 4/12/18, only stated that "supports are appropriate" and this was a behavioral issue, and therefore, no PNMT involvement was needed.

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 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 #227, and aspiration for Individual #12.

a.iii. through a.v, and b.iv. through b.vi. Individual #319 was newly admitted to the Center, and, therefore, had a recently developed ISP. As a result, some indicators were not applicable to her.

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

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

Summary: Often, IDTs did not react to properly address increased risks or changes in individuals' PNM status. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 237	319	227	321	12	197	269	176	23
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/16	0/2	N/A	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	20% 2/10	0/1	N/A	0/2	0/1	1/2	1/1	0/1	0/1	0/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A

Comments: Individual #319 was newly admitted to the Center, and, therefore, had a recently developed ISP. As a result, some indicators were not applicable to her.

a. As noted above, most of IHCPs reviewed did not include all of the necessary PNM action steps to meet individuals' needs. In addition, documentation was generally not available to confirm the implementation of the PNM action steps that were included.

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

- Individual #237's was experiencing a decline in functional abilities due to the progression of his disease process. As a result, he had fallen at least three times (i.e., on 1/16/18, 1/30/18, and 3/2/18). Based on documentation provided, there was no evidence that his IDT had installed a call button for his use. It was not contained within the PNMP. The IDT also had not modified his risk ratings to recognize the changes occurring, and/or modify his IHCPs to plan for the future.
- On 1/18/18, Individual #227 choked on mashed potatoes. He had a history of swallowing problems with a MBSS, dated 4/25/17, recommending NPO. As discussed above, his IDT should have referred him to the PNMT, but did not. Moreover, according to OT notes, dated 3/21/18 and 4/17/18, he continued to cough during meals. Based on review of ISPA

documentation, his IDT did not address the continued coughing through a repeat MBSS that would fully assess pharyngeal phase, or continue enhanced monitoring due to ongoing coughing as stated above.

- Similarly, Individual 227's IDT did not refer him to the PNMT despite falls on the following dates: 1/10/18, 1/22/18 x2, 1/28/18, 2/15/18, 3/20/18, 3/29/18, 4/5/18, 4/7/18, 4/18/18, 4/19/18, 5/14/18, 5/16/18, 5/21/18, 5/22/18, 5/23/18, 5/31/18, 6/22/18, 6/26/18, and 6/29/18. Moreover, the IDT did not make a referral to the OT/PT to assist in identifying potential causes of the falls. On 1/24/18, the IDT met to discuss the falls. During this meeting, the QIDP read an email, dated 1/17/18, from the PT stating that orthopedic shoes should arrive in a couple of weeks and hopefully this would help. Another ISPA, dated 4/4/18, stated that he fell twice since the shoes arrived on 2/2/18, and those falls were related to peer-to-peer incidents. This, however, was inconsistent with the data the Center provided that identified three falls during this time period. On 4/24/18, the IDT met again regarding falls, which resulted in Habilitation Therapies adding Individual #227 to their caseload to train him on the use of a cane. The IDT did not refer him to PT for therapy until 4/24/18, after he experienced 11 falls. Considering the falls noted prior to the IDT meeting on 4/4/18, were all due to losing his balance, the IDT should have made a referral sooner. Additionally, there was no evidence of the IDT reviewing and updating the IHCP as it related to falls.
- To address Individual #321's GERD, the IDT did not address alternative positioning. His PNMP was not updated to include a photograph of his positioning in bed.
- Individual #12 had a significant history of respiratory-related issues, including, but not limited to multiple episodes of respiratory distress and aspiration pneumonia in 2016, and aspiration pneumonia on 1/8/18, and 3/22/18. For these events, her IDT did not refer her to the PNMT, and the PNMT did not make a self-referral. On 4/6/18, another pneumonia occurred, which finally resulted in a PNMT assessment. Based on review of ISPA documentation, her IDT did not update her PNMP to reflect a PNMT assessment recommendation to alternate positions every two hours. The PNMP stated every hour during the day. Prior to the PNMT assessment, the IDT met on 2/1/18, to discuss aspiration pneumonia, but only stated that the aspiration occurred at the hospital and that the PNMT would continue to monitor. However, the IDT offered no specifics with regard to what would be monitored. On 3/21/18, the IDT met again following an aspiration pneumonia, and again, it stated that the aspiration occurred at the hospital. No evidence was found of monitoring or root cause discussion. The ISPA only stated that the PNMT would continue to monitor, but again did not specify what would be monitored.
- On 1/1/18, Individual #269's was diagnosed with pneumonia and staff observed tube feeding substances around her nostrils. Due to her significant medical history and overall medical complexities, the IDT should have referred her to the PNMT, but did not. On 1/17/18, her IDT met, but simply stated that the pneumonia (1/8/18) occurred at the hospital and was probably due to vomiting, but Habilitation Therapy staff offered no review of her status or monitoring to ensure the plan remained sufficient to meet her needs. After respiratory events on 3/14/18 and 3/21/18, Habilitation Therapies again did not review or implement a monitoring plan. On 4/21/18, the individual died at the age of 69 with cause of death listed as pneumonia.
- On 2/17/17, the PNMT conducted its last review of Individual #176. Since that time, he had six pneumonias (i.e., 6/2017, 8/8/17, 10/10/17, 1/5/18, 3/5/18, and 3/23/18). His IDT did not refer him to the PNMT. On 1/11/18, the IDT met regarding the individual's return from hospital. The recommendation was that the PNMP date would be updated, but the IDT discussed no plan to conduct further review. On 3/28/18, the IDT met to discuss the individual's aspiration pneumonia, but offered no plan to monitor the implementation of supports or conduct further assessment. The ISPA simply stated that HOBE remained appropriate, but offered no data to support this conclusion.

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, including Habilitation Therapies as well as Residential and Day Program/Vocational staff, 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.	45% 18/40	
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.	67% 2/3	
Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 18 out of 31 observations (58%). Staff followed individuals' dining plans during zero out of six mealtime observations (0%). Staff completed transfers correctly during zero out of three observations (0%).			

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	237	319	227	321	12	197	269	176	23
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A				N/A	N/A		N/A		
Comments: a. None.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.

Summary: Since the last review, more individuals reviewed had clinically relevant, and measurable goals/objectives to address their needs for formal OT/PT services, which was good to see. However, QIDP interim reviews often did not include data related to existing goals/objectives. As a result, IDTs did not have information in an integrated format related to individuals' progress or lack thereof. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	57% 4/7	1/1	N/A	1/1	0/1	0/1	1/1	1/1	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	86% 6/7	1/1		1/1	0/1	1/1	1/1	1/1		1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	14% 1/7	0/1		0/1	0/1	1/1	0/1	0/1		0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/6	0/1		0/1	0/1	N/A	0/1	0/1		0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/6	0/1		0/1	0/1	N/A	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 #237 (i.e., to ambulate 15 feet with minimum assistance and a walker), Individual #227 (i.e., to use a single point cane), Individual #197 (i.e., to ambulate 200 feet with a walker and gait belt), and Individual #269 (i.e., to complete passive gentle motion exercises).

Individual #12 had a goal/objective to wash herself, which was measurable, but given that staff indicated she had no interest to perform this task, it was not clinically relevant. Similarly, Individual #23's goal objective to dry off his chest independently was measurable, but not clinically relevant, because since November 2017, he had shown no interest in it, which raised questions about its meaningfulness to the individual, but the IDT did not make any changes to the goal.

c. through e. For Individual #237, Individual #227, and Individual #197's direct OT/PT goals/objectives, although data were submitted to show they were implemented, no evidence was found to show the OTs/PTs worked with the QIDP to analyze the data and include it in the monthly integrated reviews for the IDT's consideration. For Individual #269, the ISP monthly reviews contained the raw data, but offered no analysis of data and whether there was improvement or regression in the mastery of the skill.

Some indicators were not applicable to Individual #12, because three months of data were not yet available due to the newness of the goal/objective.

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: For the individuals reviewed, evidence often was not found in ISP integrated reviews to show that OT/PT supports were implemented. It was positive that IDTs often held ISPAs to discuss the termination of OT/PT services. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/6	0/1	N/A	0/1	N/A	0/1	0/1	0/1	N/A	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.	75% 3/4	1/1	N/A	1/1	0/1	N/A	1/1	N/A	N/A	N/A
Comments: a. For Individual #237, Individual #227, and Individual #197's direct OT/PT goals/objectives, although data were submitted to show they were implemented, no evidence was found to show the OTs/PTs worked with the QIDP to analyze the data and include it in the monthly integrated reviews for the IDT's consideration. For Individual #269, the ISP monthly reviews contained the raw data, but offered no analysis of data and whether there was improvement or regression in the mastery of the skill.											

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the concerns noted during the onsite review, Indicator c 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	114	23	12	62	242	167	168	172	195
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they moved to the category requiring less oversight.									

b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	70% 28/40	0/1	0/1	1/2	2/2	0/1	2/2	1/1	1/1	0/1
		Individuals:									
#	Indicator		185	181	308	66	280	192	37	21	311
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/2	0/1	2/2	2/2	2/2	1/1	1/1	2/2
		Individuals:									
#	Indicator		6	258	104	317	161	89	322	58	201
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/2	1/2	1/1	2/2	0/1	1/1	0/1	2/2	0/1
		Individuals:									
#	Indicator		250								
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1								

Comments: c. The Monitoring Team conducted observations of 40 pieces of adaptive equipment. Based on observation of Individual #114, Individual #23, Individual #12, Individual #195, Individual #308, and Individual #37 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.

Individual #181's modified tennis shoes were not present. Individual #242's and Individual #161's palm protectors were not present.

Individual #6's heelbos were loose, and slid down around the individual's wrist. Similarly, Individual #258's heelbos slipped up, exposing his ankle, and Individual #201's heelbos were slid down on his forearms, so were not protecting his elbows.

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. At the time of the last review, one of these indicators moved to the less oversight category. Presently, one indicator in the area of engagement will move to the category of 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.

For ISP goals, without reliable useable data and/or without adequate implementation, it is impossible to determine progress. For the two goals for which reliable data were available, one was showing progress and one was not.

A positive organizational change was that engagement and SAP development moved to the behavioral health services department in April 2018.

Four SAPs met all criteria for component inclusion. All SAPs included relevant instructions. Some SAPs were implemented correctly when observed by the Monitoring Team, and some were not. The way that Lubbock SSLC assesses SAP integrity needs to be improved so that it is a more valid reflection of correctness of SAP implementation.

Lubbock SSLC regularly measured engagement in all sites on campus. There was concurrence between the Monitoring Team and the Center's scoring of engagement, that is, similar low scores. Unit directors and program supervisors now received feedback on engagement.

The Center found adaptive equipment to help an individual to be able to learn to play guitar. The Monitoring Team observed a dinner at Canna on Thursday of the onsite week. The meal was a prepared by staff and individuals and they dined family style.

Individual goals for community activities were set for about half of the individuals, but not yet for training skills in the community.

Performance improved to 100% for the first time regarding the collaborative work between Lubbock SSLC and the local school district, and integration of the IEP and ISP.

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

At times, individuals' AAC devices were present and readily accessible, but this is an area that requires continual focus. Most importantly, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Without reliable useable data or without adequate implementation, it is impossible to determine progress. For the two goals for which data were available, one was showing progress and one was not. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	276	319	26	237	12	23			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	1/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

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

For 11 of the 13 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 almost all of the goals (i.e., indicator 3).

For the two goals where reliable data were available:

- Data, observations and interviews confirmed that Individual #276 was making progress on his recreation/leisure goal.
- Data and staff interviews indicated that Individual #12 was not yet making progress on her greater independence goal. The team should review implementation of this goal and determine if the team needs to revise teaching and support strategies to support progress.

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

Outcome 8 – ISPs are implemented correctly and as often as required.												
Summary: It was good to see positive interactions between individuals and staff. Implementation of ISP action plans and steps needs to occur. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	276	319	26	237	12	23			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
Comments: 39. Direct support professional staff interviewed and observed throughout the week were knowledgeable about individual's preferences and support needs and very respectful and supportive to each individual in their interactions. Staff, however, were not fully implementing ISPs, so it was difficult to verify that they could exhibit competence in implementing support plans. ISPs rarely included detailed instructions to guide staff when implementing the ISP. 40. Action steps were not regularly and correctly implemented for all goals and/or action plans, as noted throughout this report. Going forward, IDTs need to monitor the implementation of all action plans and address barriers to implementation.											

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: These indicators will remain in active monitoring. Same as last time, attention to SAP development and implementation is required in order for the indicators of this outcome to make progress towards meeting criteria.			Individuals:								
#	Indicator	Overall Score	276	319	26	322	237	220	278	224	408
6	The individual is progressing on his/her SAPS	0% 0/16	0/3	No SAPs	0/3	0/2	0/2	0/2	0/2	0/1	0/1
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A	N/A	No SAPs	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	8% 1/12	0/3	No SAPs	1/3	0/2	0/2	0/1	0/1	N/A	N/A
9	(No longer scored)										
Comments:											

6. Based upon a review of the data presented in the QIDP monthly reports and/or the Client SAP Training Progress Note, the Center determined that progress was being made in four of 16 SAPs. Three SAPs were omitted from this analysis because either there were insufficient or no data to review (Individual #322 – DVD remote, and Individual #224 – SAPs related to driver's license). Progress was noted by the Center in the following SAPs: Individual #220's calculating his work (two months of data), Individual #278 counting her change, Individual #224 administering his medication, and Individual #408 learning the strings on the guitar. Without reliable data, however, (indicator 5), the Monitoring Team cannot make a determination of progress.

7. In no SAP, had the goal/objective been met.

8. In the case of Individual #26's using the microwave to make a snack, there was a note that the SAP had been revised to address his learning to wait for one minute to let the food cool down. There was no other evidence of actions taken to address limited progress.

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

Summary: Some, albeit small, progress was seen in SAP content. Four SAPs met all criteria for component inclusion. This was good to see. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 276	319	26	322	237	220	278	224	408
13	The individual's SAPs are complete.	21% 4/19	1/3 27/30	No SAPs	1/3 26/30	0/3 24/30	0/2 16/20	1/2 18/20	0/2 17/20	0/3 22/30	1/1 9/9

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

13. Four of the 19 SAPs were considered complete. These were the reading SAP for Individual #276, the set timer SAP for Individual #26, the work calculation SAP for Individual #220, and the guitar SAP for Individual #408.

In over 80% of the remaining SAPs, the following elements were present:

- a task analysis where appropriate;
- a behavioral objective;
- an operational definition;
- specific instructions for teaching the skill;
- consequences following correct and incorrect responding; and
- documentation methodology.

It was particularly good to read instructions that provided guidelines for the presentation of task materials. Another positive development since the last review was that SAP development, training, and monitoring had been moved to the behavioral health

services department.

A relevant discriminative stimulus was not always present and the number of trials was not always specified when appropriate.

Additional positive feedback and suggestions are provided below.

- The program developer had located a guitar stand to ensure that Joshua could continue to work on his SAP. This was very positive to see.
- The SAP that addressed Individual #220's learning to locate his medications did not correspond to the objective, which was to name the medications that help him stay calm. Nowhere in the SAP was he required to state the purpose of his medications.
- Several of the individuals were reported to have good academic skills. As such, it may be appropriate to run repeated baseline assessment because simple exposure to task materials may result in skill acquisition. A good example of this was Individual #408's learning to label the strings on a guitar. For these same individuals, the IDTs may have to consider different approaches to addressing and teaching new skills. Several examples are provided for staff members to consider.
    - Individual #319 had expressed an interest in obtaining her GED. Instead of teaching her to identify parts of speech (a proposed SAP), it may be more appropriate to obtain a GED study guide that she can proceed through as she demonstrates proficiency on each chapter or section test.
    - Similarly, Individual #224 had expressed an interest in obtaining his driver's license. Rather than developing two SAPs that focused on road signs (color, shape, and meaning), it may be more meaningful to obtain a study guide that he can progress through to obtain his learner's permit. This is particularly important because matching colors and shapes, and identifying traffic signs were below his reported abilities and may result in boredom and refusal to participate.
    - Lastly, Individual #408 was interested in learning to play songs on the guitar. Rather than teaching him rudimentary skills, with expected repetitive demonstration of skill acquisition, it would be more meaningful to have him learn specific songs with instruction from a qualified music teacher and/or videos. This too may alleviate potential boredom and loss of interest.
- Individual #276 had a goal to improve his reading skills, but the three books that were repeatedly presented addressed a much younger learner. Instead, staff are advised to explore high interest reading materials for readers who have lower level skills.
- Individual #237 should not be required to progress through a 13-step task analysis, several parts of which required him to verbally identify mathematical symbols. He clearly was able to complete the addition problems particularly when these were presented vertically. Requiring a man in his 40's to label the plus sign is not age appropriate, nor is it teaching him a new skill.

Outcome 5- SAPs are implemented with integrity.

Summary: Some SAPs were implemented correctly when observed by the Monitoring Team, and some were not. The way that Lubbock SSLC assesses SAP integrity needs to be improved so that it is a more valid reflection of correctness of SAP implementation. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	276	319	26	322	237	220	278	224	408
14	SAPs are implemented as written.	50%	0/1	Not	1/1	0/1	1/1	Not	0/1	Not	1/1

		3/6		rated				rated		rated	
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.	26% 5/19	0/3	No SAPs	3/3	1/3	0/2	0/2	0/2	0/3	1/1

Comments:
14. During the onsite visit, an observation was completed of one SAP for six individuals: Individual #276, Individual #26, Individual #322, Individual #237, Individual #278, and Individual #408. Although observations were scheduled for Individual #220 and Individual #224, both of these individuals refused to participate. Individual #319 did not have any SAPs at the time of the visit.

For three individuals (Individual #26, Individual #237, Individual #408), the SAPs were implemented as written. Individual #26's SAP was implemented correctly, but the timer did not work properly because he had set it for greater than one minute. This required the staff member to tell him that he had waited appropriately and could consume his pizza. A discussion ensued regarding different types of timers that might be better suited for this SAP.

Although Individual #276's staff member did a very nice job implementing the SAP, he did not record the level of prompting correctly, even though he acknowledged that he had helped a bit. Individual #322's staff member did not implement the verbal prompt as it was written and, in fact, she used multiple verbal prompts before increasing her prompting level. Although the staff member had a very positive interaction with Individual #278, the SAP noted that she would match the word Zoloft to its definition and earn two Canna tokens for successful completion. The staff member had her find the definition of Abilify and reinforced her with 100 tokens.

15. The expectation was for SAPs to be assessed for integrity once every six months at a level of 80% or better. While SAP integrity was reported for 16 SAPs, further review of the monitoring form revealed that the SAP had actually been implemented at an acceptable level by a direct support professional in five cases. These were Individual #26's SAPs, Individual #322's matching socks SAP, and Individual #408's guitar SAP.

Problems found in other monitoring forms included the individual refusing to participate (Individual #276 – calculating pay and reading; Individual #322 – using a DVD remote and signing necklace; and Individual #278 – medication), the individual was not present during the monitoring (Individual #237 – both SAPs), materials were not available (Individual #276 – reading), or the SAP was implemented by the program developer (Individual #278 – counting change). In other cases, although SAP monitoring was conducted with the direct support professional implementing the SAP, the scores were well below the established level (e.g., all of Individual #220's SAPs).

Outcome 6 - SAP data are reviewed monthly, and data are graphed.	
Summary: Performance on indicator 16 increased slightly and performance on indicator 17 decreased slightly. All that being said, not all SAPs were reviewed monthly and although graphs existed, some improvement is necessary for them to be more useful to the IDT and the QIDP reviews. These two indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	276	319	26	322	237	220	278	224	408
16	There is evidence that SAPs are reviewed monthly.	63% 12/19	3/3	No SAPs	2/3	2/3	0/2	1/2	2/2	1/3	1/1
17	SAP outcomes are graphed.	89% 17/19	3/3	No SAPs	3/3	2/3	2/2	2/2	2/2	2/3	1/1

Comments:
16. There was evidence that 12 of the 19 SAPs were reviewed monthly in the QIDP Monthly Report.

The exceptions were the following: no data related to setting a timer were provided in Individual #26's monthly report, there was no consistent review of data related to use of a DVD remote in Individual #322's monthly report, there was no review of Individual #237's two SAPs in his reports, there was no review of Individual #220's medication SAP in the June 2018 report, and there was no review of either of Individual #224's driver's license related SAPs.

17. Progress was reported in graphic format for 17 of the 19 SAPs. The exceptions were the DVD remote control SAP for Individual #322 and the road sign SAP for Individual #224.

Staff are advised to ensure accurate labeling of the vertical axis when presenting data graphically. In some cases, the graphs were labeled as percent of independent trials, but the vertical axis displayed the number of trials completed independently. It is important to note that when data were available for six consecutive months, it was clear that the expected number of training sessions were not consistently implemented for any of the SAPs.

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

Summary: Lubbock SSLC regularly measured engagement in all sites on campus. This has been the case for all individuals (with one exception) for this and the last two reviews, too. Therefore, indicator 19 will be moved to the category of requiring less oversight. There was concurrence between the Monitoring Team and the Center's scoring of engagement, that is, similar low scores on indicators 18 and 21. Those two indicators will remain in active monitoring. Also, as noted in the comments, one individual's clothing and appearance needs were not being addressed in a supportive manner.

Individuals:

#	Indicator	Overall Score	276	319	26	322	237	220	278		408
18	The individual is meaningfully engaged in residential and treatment sites.	33% 3/9	1/1	1/1	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

20	The day and treatment sites of the individual have goal engagement level scores.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	22% 2/9	0/1	0/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1

Comments:

18. Three of the nine individuals, Individual #276, Individual #319, and Individual #408, were found to be meaningfully engaged in both their homes and work sites during the onsite visit. For all others, meaningful engagement was not regularly occurring or adequately addressed.

Although not directly related to engagement, it is important to comment on circumstances observed during the week of the visit. In particular, Individual #322 and her presentation. She was observed on multiple occasions with her pants down around her hips, exposing her buttocks and brief, or with no pants on while seated in the living room. When staff did try to get her dressed, this activity was completed in the living area. It is recommended that staff complete a clothing inventory to determine whether better fitting clothing should be obtained. It is also recommended that any attempts to redress occur in her bedroom so that Individual #322 can learn to discriminate areas where clothing is essential (i.e., any public or group living environment).

19. As explained by the behavioral health services assistant director, engagement monitoring occurred multiple times each month in all settings. This monitoring had become part of the behavioral health services department's responsibilities. As of May 2018, engagement monitors had been retrained and the provision of feedback to unit directors and program supervisors had been initiated. The expected engagement goal was established at 80% at the time of the onsite visit.

21. Engagement goal frequencies and levels were achieved in the homes for eight of the nine individuals. The exception was Individual #237 as there was no reported engagement score for his home in April 2018. For those who had identified work or day program sites, acceptable scores were reported for Individual #26. This indicator requires that both/all settings meet the established goals.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: Individual goals for community activities were set for about half of the individuals, but not yet for training skills in the community. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	276	319	26	322	237	220	278	224	408
22	For the individual, goal frequencies of community recreational activities are established and achieved.	44% 4/9	1/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1
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	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	developed plans to correct.										

Comments:
22. Goal frequencies for community recreational activities were found in the ISP for four individuals. Expectations were weekly outings for Individual #276 and Individual #319, monthly outings for Individual #408, and quarterly outings for Individual #278 and her special friend. The five remaining individuals did not have action plans that specified the frequency of community outings. It should be noted, however, that multiple outings each month over a six-month period were reported for everyone, but Individual #26, Individual #322, and Individual #237.

23. Goal frequencies of community-based SAP training were not established for any of the nine individuals. However, the facility provided evidence that community training had occurred on at least one occasion for Individual #276, Individual #26, Individual #237, Individual #26, and Individual #278.

24. This indicator is rated as zero because either there were no established goals, or in the limited instance where recreational goals had been established and met, community training goals were not established.

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

Summary: Performance improved to 100% for the first time regarding the collaborative work between Lubbock SSLC and the local school district. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	408								
25	The student receives educational services that are integrated with the ISP.	100% 1/1	1/1								

Comments:
25. During the six-month period prior to the onsite visit, Individual #408 was enrolled and attending school. He graduated in May 2018. His ISP included actions plans to support his participation in school and there was evidence, albeit brief, that the team had reviewed his daily progress notes from school. His IEP indicated that his QIDP, behavioral health services staff member, and residential coordinator all attended the meeting. Finally, there was evidence that inclusion and an extended school year had been considered for Individual #408.

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.

Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/2	N/A	0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/2		0/1				0/1			
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/2		0/1				0/1			
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/2		0/1				0/1			
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/2		0/1				0/1			
Comments: a. through d. For the two individuals that had refused dental services, IDTs had not developed specific goals/objectives related to their refusals.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Since the last review, some good improvement occurred with the measurability of communication goals/objectives the Monitoring Team reviewed. Work is still needed to improve the clinical relevance of communication goals/objectives. It also will be important for SLPs to work with QIDPs to include data and analysis of data on communication goals/objectives in the QIDP integrated reviews. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	22% 2/9	0/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	78% 7/9	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	33% 3/9	1/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. The goals/objectives that were clinically relevant, as well as measurable were Individual #197's goal to learn to use a pen reader; and Individual #269's goal/objective to alert to sound.

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 #237 (i.e., reading words on flash cards), Individual #227 (i.e., answering multiple choice questions), Individual #321 (i.e., turning on the radio), Individual #176 (i.e., activating the pillow to make music), and Individual #23 (i.e., signing "bed").

c. through e. QIDP reviews included analysis of data for Individual #197's goal/objective to learn to use a pen reader. However, based on progress notes, the individual decided she did not want to learn to use it, and, therefore, on 2/22/18, treatment ended. Based on documents provided, no other methods to address her desire to read were trialed or implemented.

For Individual #269's goal/objective to alert to sound, although data were submitted to show it was implemented, no evidence was found to show the QIDP had analyzed the data.

For all nine individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: It was good to see substantial improvement in the inclusion of data in monthly ISP integrated reviews to document implementation of communication strategies and action plans. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	237	319	227	321	12	197	269	176	23
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	100% 7/7	1/1	N/A	1/1	1/1	N/A	1/1	1/1	1/1	1/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	100% 1/1	N/A					1/1			

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. In reviewing these reports, it was good to see substantial improvement in the inclusion of data to support implementation of communication strategies and action plans.

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 continue to focus on ensuring individuals have their AAC devices with them. Most importantly, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	250	99	58	280	172	21	All-served in Tulip		
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	71% 5/7	1/1	0/1	0/1	1/1	1/1	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.	0% 0/7	0/1	1/1	0/1	0/1	0/1	0/1	0/1		
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	0% 0/4									

Comments: a. and b. At times, individuals' AAC devices were present and readily accessible, but this is an area that requires continual focus. Of concern, when opportunities for using the devices presented themselves, staff did not prompt individuals to use them.

During the onsite review week, SLPs provided the Monitoring Team with a summary of the pilot project they began using in Tulip that incorporated the core vocabulary concept. The intent was to assist staff and individuals to become more engaged in AAC use. Based on the Monitoring Team's observations during the review week, none of the individuals used the boards. The board in the dining room was smaller than a sheet of paper and had icons that were only slightly larger than a key on a computer keyboard, which likely is not functional for the individuals living in Tulip. Based on staff interviews in the home, there was little consistency with how boards were implemented. Moving forward, it will be important to collect data (e.g., through formal goals/objectives) to determine the effectiveness of all-served devices, as well as personal communication devices.

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, one will move to the category requiring less oversight.

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

On a particularly positive note, transition staff described an initiative to train IDTs on the basics of the CLDP process as referrals were received and created a flow chart for this training to demonstrate how the ISP should form the basis for identification of needed supports. Once an individual had made their final selection, transition staff also held similar meetings to orient providers to the CLDP process and provided them with a guide to help them prepare for post-move monitoring (PMM). That being said, more work was needed to make supports in the CLDPs measurable. In addition, although improvement was noted, a number of essential supports were missing from the CLDPs reviewed, and Center staff should continue their focus in this area. These indicators will remain in active oversight.

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 the PMM and IDTs following up in a thorough manner when the PMM notes problems with the provision of supports. These indicators will remain in active oversight.

Both individuals experienced PDCT events, including police contact and incarceration, and at the time of the onsite review, both individuals were scheduled to return to the Center. 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.

For this and the previous two reviews, APC and transition department staff collaborated with the LIDDA staff when necessary to meet the individuals' needs during the transition and following the transition. The related indicator will move to the category requiring less oversight. The APC Department's practice of carefully reviewing transition assessments and providing feedback to the disciplines was a good one. However, although some improvement was noted, the content and recommendations generated from transition assessments still required improvement. Although Center staff provided training to community provider staff and some improvement was noted, the CLDPs did not define the competency measures, important topics of training were not

included, and prior to transitions, Center staff did not confirm provider staff had the necessary competencies to address individuals' health and safety 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: On a particularly positive note, transition staff described an initiative to train IDTs on the basics of the CLDP process as referrals were received and created a flow chart for this training to demonstrate how the ISP should form the basis for identification of needed supports. Once an individual had made their final selection, transition staff also held similar meetings to orient providers to the CLDP process and provided them with a guide to help them prepare for post-move monitoring (PMM). That being said, more work was needed to make supports in the CLDPs measurable. In addition, although improvement was noted, a number of essential supports were missing from the CLDPs reviewed, and Center staff should continue their focus in this area. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	221	121								
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1								
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1								

Comments: Since the last review, five individuals transitioned from the Center to the community. Two were included in this review (i.e., Individual #221, and Individual #121). Both individuals transitioned to a community group home. The Monitoring Team reviewed these two transitions and discussed them in detail with the Lubbock SSLC Admissions and Placement staff. In interview, transition staff described improvements to their planning processes, including meeting with the IDTs at the 14-Day referral ISPA meetings and, later in the process, for a pre-CLDP. They described another positive initiative to train IDTs on the basics of the CLDP process as referrals were received and created a flow chart for this training to demonstrate how the ISP should form the basis for identification of needed supports. Once an individual had made their final selection, transition staff also held similar meetings to orient providers to the CLDP process and provided them with a guide to help them prepare for PMM. The Monitoring Team commends the Center for these efforts.

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how individuals' needs and preferences will be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. To move toward compliance, the IDTs needed to continue to focus on identifying the measurable criteria upon which the Post-Move Monitor (PMM) can accurately judge implementation of each support. Examples of supports that did not meet criterion are described below:

- Pre-move supports: The respective IDTs developed ten pre-move supports for Individual #221, and 21 pre-move supports for

Individual #121. Some were measurable, but important pre-move training supports were not:

- For Individual #221, the CLDP included four pre-move supports for one-to-one consultations with the following disciplines: primary care provider (PCP), board-certified behavior analyst (BCBA), registered nurse case manager (RNCM), and residential coordinator. This was positive, but the supports did not provide any measurable criteria or expectations for the documentation to be completed as evidence. For example, the one-to-one between the two physicians should have included his concerns about not changing specific medications and why that was important, but it did not. Individual #121's pre-move supports for one-to-one consultations also reflected these concerns.
- Individual #221's CLDP evidenced some progress in developing pre-move supports for competency training in that they described who would be trained, who would do the training, and, at least broadly, what the topics of training would be. Still, none of the five pre-move training supports provided specific competencies.
- Individual #121's CLDP included four pre-move training supports. All described who would be trained and who would do the training, but only broadly stated what the topics of training would be. None, however, provided the specific competencies that should be achieved and tested.

- Post-Move: The respective IDTs developed 44 post-move supports for Individual #221, and 35 post-move supports for Individual #121. Some post-move supports were measurable, but this continued to be an area that needed improvement. Examples included, but were not limited to:
  - For both individuals, post-move supports for training any new staff did not meet criterion. Like the pre-move training supports, these did not consistently describe competency criteria or describe adequate competency testing.
  - IDTs needed to describe required evidence that would provide the PMM with clear measurable indicators. Examples of post-move supports that did not meet this criterion included:
    - For Individual #221, the CLDP recommended that he maintain head-of-bed elevation at 25°. The final related post-move support called for any new staff to be in-serviced on this topic, but did not include interviews to evaluate staff knowledge or for the PMM to check the bed for the proper elevation.
    - For Individual #221, a post-move support indicated the provider would follow the positive behavior support plan (PBSP) for 90 days or until the provider BCBA changed or developed a new plan. For evidence, the CLDP only required incident reports by the provider staff at each monitoring visit. By itself, this form of evidence would not allow the PMM to substantiate whether the staff were following the plan as written; rather, it would only demonstrate whether incidents had occurred and perhaps how the provider responded at the time. To be fully measurable, the support should also probe whether provider staff had knowledge of the ongoing preventative strategies included in the PBSP, through staff interview and perhaps observation.
  - For Individual #121, the pre-move training supports did not always have corresponding post-move supports for staff knowledge. This was problematic because once those pre-move supports had been initially considered met, the PMM did not probe them again to test whether staff had retained the needed knowledge. As a result, the CLDP did not provide a mechanism for measuring staff knowledge of important needs. Examples of such needs for staff knowledge that were not addressed in post-move supports included: metabolic syndrome, communication strategies, side effects to be reported, behavioral history and triggers, psychiatric symptoms, PSP strategies, and, bowel management needs.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for this indicator to be scored as meeting criterion. The Center had identified many supports for these two individuals and it was positive they had made a diligent effort to address their needs. Still, neither of these CLDPs fully and comprehensively addressed

support needs and did not meet criterion, as described below.

- Past history, and recent and current behavioral and psychiatric problems: The CLDPs did not include supports that comprehensively addressed past history, and recent and current behavioral and psychiatric problems. To meet criterion, the IDTs should continue to make improvement toward developing comprehensive supports that address behavioral and psychiatric history and needs. Findings included:
    - For both individuals, the IDTs did develop some post-move supports related to current behavioral needs. This was positive, but these supports were not consistently clear and/or comprehensive.
    - Neither had a clear support about the protocol the provider would need to adhere to for the individual to continue receiving their prescribed Clozapine when they transitioned to the community. This protocol required the prescribing PCP and the dispensing pharmacy to be registered in the Risk Evaluation and Mitigation Strategy (REMS) system and for monthly blood testing to be completed to monitor significant side effect risks.
    - For Individual #221, supports did not address many of his behavioral needs. As described above, pre- and post-move training supports did not provide any staff competency criteria. Additional examples included:
        - It was positive transition staff prompted behavioral staff to include supports for past behaviors, including suicidal gestures and elopement even though they had been removed from the PBSP. Still, the final training supports did not focus on what provider staff needed to know about that behavioral and psychiatric history.
            - He had a history of inappropriate social/sexual behavior, but the CLDP provided no description of what this behavior might look like or signs for which to watch.
            - Similarly, documentation noted he had been arrested for terroristic threats and had self-injurious behavior, but supports did not indicate what provider staff should monitor.
            - Individual #221 required a crisis intervention plan (CIP) at the Center, but this was not described in CLDP supports, and the IDT did not include expectations for how community staff should address behaviors that posed a threat of harm to Individual #221 or others.

              In its comments on the draft report, the State disputed this finding, and stated: "14 Day ISPA states CIP is no longer needed by BCBA." The Lead Monitor reviewed the referenced document, which stated: "[Individual #221] had a crisis intervention plan implemented on 6/20/17 due to having an increased amount of restraints. [Individual #221] only had 1 restraint since the implementation and a crisis intervention plan is not needed for the community." This narrative indicates that the individual had a recent history of the use of crisis intervention restraint and still had a CIP in place at the Center. It supports the Monitoring Team's finding that the IDT should have planned for how the community provider would address potential behaviors that posed a threat of harm. Moreover, the Behavioral Health discharge assessment, dated 5/6/18, stated: "*Restraints Debrief:* He can be restrained using the Standing Baskethold and horizontal side-lying restraint as necessary. [Individual #221] has been restrained 7 times over the past year (5/6/17 through 5/6/18). His last restraint was on 11/11/17, which was over 5 months ago. He currently has a CIP." Again, this recent history of restraints indicated a need for the IDT to plan for its possibility in the community.
            - Per the documentation, suicidal threats and gestures had not occurred for over a year and the IDT only re-added them as a target behavior to meet the requirements specified for his community

transition, but indicated that no further analysis was possible or necessary. This missed the point that the purpose of providing the history is to explain what the behavior looked like, how to monitor for its re-emergence, and to describe what strategies had been successful in reducing it or intervening with it in the past.

- For Individual #121:
  - The CLDP narrative documented the importance of continuity of her weekly counseling sessions. The IDT recommended the Center BCBA contact the counselor prior to the move to ensure the transition was seamless, but this was not included in any supports
  - The psychiatry assessment indicated she should see the community psychiatrist within 30 days. The IDT changed this to 60 days because the provider indicated it would be difficult to meet this time-frame, but did not provide any evidence the Center clinician was consulted to ensure this would meet Individual #121's needs. The CLDP did not include a support for ongoing psychiatric care.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The respective IDTs developed supports in some areas related to safety, medical, healthcare, therapeutic and risk needs, such as for scheduling of health care appointments. To meet criteria, the IDTs still needed to develop clear and comprehensive supports in these areas. Findings included:
  - Neither CLDP provided an individualized support regarding specific needs for supervision.
  - Other examples for Individual #221 included, but were not limited to:
    - The CLDP did not provide clear supports for the use of his nebulizer and glucometer. The support for the nebulizer indicated the Center would loan the equipment until the provider could obtain a replacement and that treatments would be monitored on the Medication Administration Record (MAR). The support did not address staff knowledge for the use of the nebulizer. The support related to his glucometer indicated results would be monitored at each visit, with required evidence for readings twice per day. The CLDP did not describe any glucose level parameters for staff to monitor or when to report variances to nursing staff.
    - During the CLDP discussion of nutrition, the provider stated it could use a sample diabetic diet meal chart until the community dietitian saw Individual #221 and that staff would track the meals. Based on this discussion, the IDT decided to discontinue the recommendation for sample meal plans, since the provider would have the support in place before Individual #221 moved. While it was certainly positive the provider described a plan to address the need, this did not constitute a good reason to discontinue an important support. In general, transition planning should ensure that the provider has both the capacity as well as plans in place for meeting individuals' needs before transition takes place, but this would not obviate the requirement to specify the required supports.
    - The IDT did not develop a support that required knowledge of his allergies to Abilify and Haldol.
  - Other examples for Individual #121 included, but were not limited to:
    - Individual #121 received Depo Provera for management of her menses. On 5/7/18, she told the Center registered nurse (RN) that she had not had her menses for some time. The RN reported a gynecology consult appointment was to be made for follow-up, but the CLDP did not provide any documentation this had been completed or include a support for follow-up after transition.
    - The psychiatry assessment stated the provider should monitor Individual #121's weight, height, and body mass index (BMI) quarterly. The IDT deferred this recommendation to nutrition, but that related support only

addressed weight, not height and BMI.

- In reviewing the nutrition assessment, the IDT documented a good discussion about weight management. Supports then included having provider staff write down what food they prepared at home, and for Individual #121 to write down what she had for lunch at the day habilitation program. The Center dietitian would then review this documentation for the PMM and red-flag any concerns. This was positive. On the other hand, the IDT also discussed weight management strategies such as playing basketball or volleyball and going to a local YMCA where the provider had a membership. The only support for playing volleyball or basketball was for quarterly participation, which would have a negligible impact on weight management. The IDT did not develop a support for participating at the YMCA. The IDT also discussed meal replacement training and how she might be able to shop for meals suitable for diet. In discussion, the provider stated this could be a training program, but the IDT indicated this would not be included as a support because the training program would have to be developed. This again missed the point: the CLDP needed to formalize supports that described the agreed-upon expectations.
- The CLDP did not include supports that addressed many important needs identified in the nursing in-service. These included: blood pressure and heart rate checks twice a day in the morning and at bedtime to monitor for tachycardia; foot cream application every day to dry feet and cracked heels; symptoms of constipation for which to watch; encouragement not to drink after 7 p.m.; side effects related to her medication for enuresis; and, side effects related to her antipsychotic medications for which to watch and report to nursing.

- What was important to the individual: The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. While both CLDPs did address some outcomes important to each individual, neither CLDP did so assertively. Examples included:
  - For Individual #221, the CLDP documented he wanted to stay calm and have no behaviors so he could go back to work at a sheltered workshop and make a lot of money. The IDT did not create assertive supports in either the behavioral or vocational domains.
  - Per the ISP, Individual #221's independence goal was to cook a meal on campus once a month. He already could prepare foods such as sandwiches and hamburgers and could operate appliances, but still needed to know what kinds of things he could eat given his diabetic diet restrictions. He said he would like additional training on how to cook or prepare meals and would like to learn how to use the stove. ISP Action Plans included skill acquisition programs (SAPs) for learning about his diabetic diet, use of kitchen utensils and safety with the stovetop, and grilling and use of the oven. The CLDP did not identify any related supports for these SAPs.
  - Individual #221 had important relationships with certain Center staff. The Admissions/Placement Coordinator (APC) asked how often the residential coordinator thought Individual #221 should contact these staff, who stated at least once a week or at his leisure, but that only once per month would be required for the support. The final support indicated he would call a member of his IDT team once per month. This was insufficient in terms of its wording to satisfy the intent to help him make the transition. The QIDP also stated he might need assistance with making a phone call, which would have been an important component for facilitating the achievement of this support, but the CLDP did not include it.
  - For Individual #121:

- Transition-related documentation indicated she had a boyfriend and other friendships she wanted to maintain, as well as a foster mother who she called several times per month. The IDT did not develop any supports to foster relationships other than to call a friend once a month.
- Per the ISP, she wanted to play volleyball in the community. The IDT identified an ISP action to explore a community athletic association where she might have been able to get a scholarship or have the fees waived. Additional action plans addressed starting to play volleyball in the Special Olympics and a SAP to learn the rules. Further, the IDT identified that she might enjoy other sporting events in the community. These activities could have supported not only those things that were important to her, but might also have promoted community integration, but the team did not include them in the CLDP.

- Need/desire for employment, and/or other meaningful day activities: One of the two CLDPs met criterion:
  - Per Individual #221's ISP, his employment goal was to work in the community part time. He indicated he preferred physical labor and stated preferences including fast food restaurants, gyms and car-washes. He had filled out applications at several community work sites. Per the ISP, he stated he wanted to improve his behaviors so he could work in the community and earn a lot of money. ISP action plans included completing applications for community employment. Given his emphasis on working and making money, the IDT did not develop assertive supports to facilitate community work opportunities. These were limited to enrollment at a day habilitation program, a referral to the Texas Workforce Commission for assistance in finding community employment, and to work with an employer of his preference or sheltered workshop within the next year. While it was positive the IDT included an outcome expectation in this regard, it was far into the future and without a specific assertive plan to achieve it. For example, during the CLDP discussion, the Legally Authorized Representative (LAR) talked about how Individual #221 might have the opportunity to work at the day habilitation program as a custodian, but the IDT did not develop any supports for this as a means to make money or even any supports to develop vocational skills. The IDT also had discussion about an available sheltered workshop that he was not allowed to attend at the time of transition, due to past history, but that he might be able to attend if he did well in the community for six months. The CLDP did not include a support to re-visit this as a work opportunity after that period.
  - Individual #221's CLDP also spelled out only minimal expectations about community participation and integration. These were limited to going out to eat quarterly with housemates or a friend at restaurant of his choice, and to participate in Special Olympics within the next year in the sports of his choice.
  - For Individual #121, the LIDDA's outcome focus on ensuring employment was available at the time of transition was a very positive development. As a result, she had a job before transition and her supports focused on attending work regularly. This met criterion.
- Positive reinforcement, incentives, and/or other motivating components to an individual's success. Neither CLDP addressed this assertively.
  - For Individual #221, documentation indicated he responded well to a token program and the IDT needed to assess for how it could work in the community placement. The CLDP did not include these supports.
  - It was positive the IDT provided an in-service that included Individual #121's communication strategies, but her CLDP included no specific supports for staff use of these strategies or for any other reinforcement or motivating components.
- Teaching, maintenance, participation, and acquisition of specific skills: The IDT did not provide supports for this area. Examples included, but were not limited to:

- As described above, Individual #221's IDT did not address learning for the cooking skills that figured prominently in his ISP. In the ISP living options discussion, the IDT also indicated that he should have a community training SAP to learn how to take the bus, starting with identifying street signs and followed by using public transportation. Each of these would have been useful and practical community living skills for Individual #221, but the CLDP did not include any related supports.
- For Individual #121, the functional skills assessment (FSA) identified needs related to reading, money management help in planning events, and verbal prompting when completing chores. The FSA also recommended she continue to learn her ironing skills and to work on writing skills. The CLDP did not include any related supports.

- All recommendations from assessments are included, or if not, there is a rationale provided: Lubbock SSLC had a process in place for documenting in the CLDP the team's discussion of assessments and recommendations, including the IDT's rationale for any changes to, or additional recommendations. The Monitoring Team noted this process was often used very effectively to identify and rectify issues related to clarity, measurability, and comprehensiveness, which was further supported by the transition staff's ongoing activity to query disciplines about their assessments as needed. Still, for both individuals included in this review, the IDTs did not yet address all recommendations with supports or otherwise provide a justification. Issues the Center should address included:
  - As described above, IDTs needed to be cautious about not including formal supports in the CLDP because the provider indicated they either had a plan for addressing certain needs or needed time to develop such a plan.
  - The IDTs should also include supports to address important needs about which they have knowledge, even when those might fall outside the monitoring period. For example, the audiological assessment for Individual #221 recommended evaluations every three years, or sooner if needed. The IDT determined this was outside of the monitoring time frame and therefore agreed to discontinue the support. It is still incumbent upon the IDT to develop a support for provider knowledge. It is true the Center would not be confirming an evaluation taking place three years hence, but the Center would be able to track a provider's awareness that it needed completion.
  - Assessments still sometimes included important information about needed supports in the narrative that were not reflected in the recommendations section. As transition staff and the IDT review assessments prior to the CLDP meeting, they should ensure both the narrative and recommendation sections are reviewed and reconciled.

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 the PMM and IDTs following up in a thorough manner when the PMM notes problems with the provision of supports. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 221	121							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	100% 2/2	1/1	1/1							

4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1							
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1							
6	The PMM's scoring is correct based on the evidence.	0% 0/2	0/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, the IDT/Facility implemented corrective actions in a timely manner.	0% 0/2	0/1	0/1							
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A	N/A	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A	N/A	N/A							

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

4. The PMM Checklists provided some good examples of documenting valid and reliable data, but this was not yet consistent. To continue to move toward compliance, the Center should continue to focus on improving overall clarity and measurability of supports that provide guidance to the PMM as to what criteria would constitute the presence of various supports. Findings included:

- As described above in relation to Indicator #1, the provider staff training supports for both individuals did not specify the competency criteria the PMM needed to be able to accurately collect valid data.
- The evidence the PMM provided did not always address all evidence requirements. Examples included, but were not limited to:
  - At the time of Individual #221's seven-day PMM visit, the PMM documented interviewing staff who said he was doing very well with no targeted behaviors displayed. The PMM indicated the support for implementation of his PBSP was met, but the evidence provided did not substantiate this. She did not document probing staff knowledge of the PBSP, which included prevention strategies and de-escalation strategies of which all staff needed to be aware in addition to interventions for problem behaviors.
- For Individual #121, the IDT developed a post-move support for a monthly complete blood count (CBC) with differential and for entry of the results in the REMS program. At the time of the 45-day PMM visit, the PMM documented that the lab had been drawn and the next one was due in July. It did not reference entering the results in the REMS program database.

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

- For Individual #221:
    - At the time of the seven-day PMM visit, the provider did not provide documentation his weight had been checked within two days of transition as required. On 6/12/18, the Center followed up to request information again, but the documentation was still not available.
    - The PMM documented interviewing staff about the implementation of the PBSP, who said he was doing very well and they had not seen any of the targeted behavior displayed. The PMM indicated the support was met, but the evidence provided did not substantiate this. The PMM did not document probing staff knowledge of the behavior support plan, which did not just include interventions in the case a behavior occurred, but also included prevention strategies and de-escalation strategies that all staff needed to know.
- For Individual #121, in addition to the examples in the previous indicator:
    - At the time of the seven-day PMM visit, she had not been weighed as required. It was positive the PMM took good follow-up action to resolution in this instance.
    - At the time of the seven-day PMM visit, the documentation stated she had not been keeping a food diary. Despite this comment, the PMM scored the support as not applicable because she did not have evidence to confirm or deny any food diary. This was contrary to the documentation. This support had also not been met at the time of the 45-day PMM visit and the provider staff interviewed were not familiar with its requirements.
    - At the time of the seven-day PMM visit, Individual #121 reported that the grab bar in the shower was not fastened on the wall, but affixed to the tile with suction cups. She further said she tried to pull herself up on the bar and slipped. The PMM also noted the grab bar did not appear to be positioned in the correct place. The PMM indicated she would follow up with the occupational therapist (OT), which was positive, but incorrectly marked the support as in place. This also called into question whether the pre-move for the OT to complete an assessment had been met as required. Per documentation the Monitoring Team requested, the OT acknowledged she thought the grab bar in place at the time she made the assessment was temporary and that she planned to revise her site assessment process in the future to ensure such supports were adequate in nature. Documentation for this support continued to be unclear at the time of the 45-day PMM visit. The PMM documented the grab bar was in the shower and that the support was met, but did not specify whether needed modifications had been made.
    - Per the CLDP, Individual #121 was to see the counselor once a week. By the time of the 45-day PMM visit, she had not attended any counseling visits.

6. Based on the supports defined in the CLDP, the Post-Move Monitor's scoring was frequently correct, but there were still exceptions in which the evidence provided did not clearly substantiate the finding with valid and reliable data as described with regard to the previous indicator.

7. through 8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed through to resolution. Whether follow-up is completed as needed relies heavily on the accuracy of the PMM's assessment of whether supports were, or were not, in place. This, in turn, relies on accuracy, completeness, and measurability of the supports. Overall, the PMM accurately identified when supports were not in place and took action toward resolution. This was positive; however, the Monitoring Team did not always find the PMM's determination that concerns had been resolved to be supported by the evidence. In addition to examples included above, findings included:

- For Individual #221:
    - The PMM appropriately scored a post-move dental support as not in place because he was not flossing and did not have any floss or floss picks. The provider staff indicated he would have to purchase these with his own money, so the transition specialist conducted good follow-up in going to the home and leaving some floss with him.
    - On 5/31/18, the Center RNCM entered a nursing progress note documenting a head-to-toe assessment completed immediately prior to his transition. The note indicated there was some breast tissue swelling to bilateral breasts, with the right slightly more than the left. The Center did not provide any evidence this information was communicated to the provider for follow-up.
- For Individual #121:
    - At the time of the seven-day PMM visit she had not been weighed. The PMM documented good follow-up to resolution.
    - At the time of the 45-day, staff at the home were not aware of the medication administration plan to ensure she received her psychiatric medications as needed and to notify the Center if she did not. The PMM appropriately recommended training for provider staff, but had not documented whether the training occurred. Instead, the documentation only referenced receiving an email that the plan was in her book at the residence.

9. through 10. These indicators were not scored because post-move monitoring did not occur for these two individuals during the Monitoring Team's visit.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of preventable negative events following transition into the community.												
Summary: Both individuals experienced PDCT events, including police contact and incarceration, and at the time of the onsite review, both individuals were scheduled to return to the Center. 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. This indicator will continue in active oversight.			Individuals:									
#	Indicator	Overall Score	221	121								
11	Individuals transition to the community without experiencing one or	0%	0/1	0/1								

	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.	0/2									

Comments: 11. Both individuals experienced multiple PDCT events. At the time of the Monitoring Team's onsite visit, both individuals were scheduled to return to the Center.

- Individual #221 had experienced five events within 17 days of transition, over a two-week period beginning the day after the seven-day PMM visit. All five events involved law enforcement contact for aggression and/or property destruction, with the final event resulting in his arrest and incarceration. At the time of the document request for this review, he remained in jail. Once on site, the Monitoring Team was informed that he had experienced three more such events and was again being held in jail.
    - The first event occurred on 6/7/18, when Individual #221 threw a vase at provider staff and charged at the person. After being unable to de-escalate the behaviors, staff called law enforcement. On 6/10/18, he became upset with provider staff, called 911, and then hung up. Police were dispatched anyway. On 6/14/18, and 6/16/18, provider staff again called police for aggressive behaviors. Once the police arrived, Individual #221 calmed quickly, stating he did not want to go to jail. On 6/24/18, he next set of events occurred. He got up during the night and went to the restroom, where he broke the bathroom mirror and threw a vase. The next morning, he got out of bed and immediately started talking about wanting to fight housemates. He hit a peer, who then called 911. Provider staff reported the peer wanted to press charges, so Individual #221 was subsequently arrested on a charge of domestic violence. After release from jail on 7/20/18, he returned to the provider's care, but in a different home. This was unsuccessful, with additional law enforcement contact. On 7/26/18, the IDT met and determined another home would be tried. This was also unsuccessful. On 7/26/18, he threatened his peers with a butter knife and was arrested on a charge of assault with a deadly weapon. On 8/1/18, the IDT met with all involved parties and agreed he should return to the Center.
    - The IDT should use the PDCT process to critically analyze the transition planning and monitoring process for the purposes of both remediation and performance improvement for future transitions. At the related PDCT ISPA meetings, the IDT discussed several factors that might be contributing and planned related remedial actions, but did not identify many of the concerns about the adequacy of the CLDP supports at the time of transition. Examples included, but were not limited to:
        - The IDT identified Individual #221's insecurity in a new setting and the need for time to adjust to it and new staff, further stating that it might take some time to develop relationships with new staff. The BCBA indicated this was typical of his behavior. Per pre-transition documentation, the IDT was aware of this, but had not developed a specific support, such as considering a pre-move transition plan that gave him time to develop the relationships with provider staff.
        - In the second PDCT, a Center behavioral health services assistant attended who had worked with Individual #221 for many years. She shared specific strategies she used with Individual #221 that she found to be successful. This should have prompted the IDT to consider how it identifies which staff need to participate in a CLDP meeting and whether the supports it developed gave provider staff important strategies that would

promote a successful transition, but the IDT did not identify these needed changes to the process.

- The IDT noted they had identified he might have some trouble adjusting and had put a support in place to call Center staff. Given the IDT's acknowledgement that they knew he would have trouble adjusting, they should have considered whether a support for calling once a month was adequate for the purpose of easing his transition.
- The IDT also discussed whether the situations might be related to his blood sugar levels because these four events all occurred late in the day just prior to the evening meal or shortly after. The provider could not provide any data on his glucose levels. As described above in regard to Indicator 2, the CLDP did not have clear and assertive supports for monitoring his glucose levels. The IDT should have identified this as an area for improvement. In terms of remediation, the IDT did discuss checking in with the home prior to the 45-day PMM visit to ensure his glucose levels remained within range, but should have considered an immediate examination of the supports in this area.
- As noted above with regard to Indicator 2, Individual #221 required a CIP at the Center, but this was not described in CLDP supports, and the IDT did not include expectations for how community staff should address behaviors that posed a threat of harm to Individual #221 or others. The IDT did not discuss how the absence of a clear plan for provider staff to follow during behavioral crises might have been a factor in frequent law enforcement contact as a default strategy.

- For Individual #121:
  - On 6/26/18, the IDT held a PDCT meeting to review an incident that occurred on the morning of 6/26/18. On that date, she refused to go to work and was given the opportunity to spend the day at the day habilitation program. She took the cup with her medication and threw it into the trash and walked out of the house. They found her at a nearby convenience store, knocking over displays. She did some damage to a vehicle in the parking lot and an employee at the store called the police. She was taken to the hospital for an evaluation and was going to be sent for psychiatric evaluation. The social worker told her they were going to release her instead, but when she turned around, Individual #121 hit her in the back of the head. Police witnessed the event and took Individual #121 to the detention center. The documentation indicated that she had disrupted a team meeting the previous afternoon, but no other behaviors or negative attitudes had been noted. Her LAR spoke to Individual #121 while she was in jail, and Individual #121 was adamant that she did not want to return to the provider and wanted to live with her family or in her own apartment. The LAR said these were not options for her at this time.
  - When discussing what could had been done differently, the IDT concluded several supports could have been stronger, but did not provide any specific details about what supports these were or how they could have been strengthened.
  - After reviewing the documentation provided in response to the document request, the Monitoring Team noted it raised some question about whether Individual #121 received her Clozapine as required. At the time of the 45-day PMM visit, the PMM documented Clozapine dosages were missing from the MAR she reviewed, and indicated the provider stated that the prescription was filled after 7/1/18. This should have been a red flag. Individual #121 had moved with a 30-day supply, which would have would have run out by 6/24/18. According to the documentation, provider staff noted the beginning of behavioral changes on 6/25/18. The IDT did not acknowledge this or examine it further. During the on-site interview with transition staff, the Monitoring Team requested any MAR documentation that would demonstrate whether the doses in question had been given. Upon review, the documentation showed Individual #121

did not receive Clozapine starting with the evening dose on 6/23/18 and continuing through the time she went to jail on 6/26/18. Per the staff notes for 6/24/18 and 6/25/18, the medication was not available and the PCP was in the process of registering in the REMS system. This indicated the PCP had not registered in a timely manner to ensure Individual #121's critical need for continuity of medication administration would be met. It was concerning the IDT did not identify this and then further assess whether the CLDP supports had been sufficient to achieve the required outcome. For example:

- The IDT had not developed any supports for ensuring the REMS registration was completed in a timely manner and that the Clozapine could be ordered prior to the end of the 30-day supply the Center provided. This would have been an important "lesson learned" for future transitions that involved individuals with similar needs.
- On the other hand, it was positive the IDT developed a support for a medication refusal plan that required the provider to contact the IDT if Individual #121 missed three dosages within a 24-hour period. Unfortunately, the provider did not follow this plan as required.
- At the time of the 7-day PMM visit on 5/31/18, it was positive the PMM identified that provider staff did not know about this medication administration plan support. This should have led the IDT to consider whether its training in this area was sufficient to result in provider staff competency.
- It was also positive the PMM recommended re-training on the medication refusal plan, but the follow-up that occurred did not ensure staff knowledge. On 6/5/18, the PMM followed up with the provider by email regarding this support and was informed the information had been placed in her book at the residence. The PMM documented this was resolved, but the documentation did not provide assurance that staff training had taken place. Placing the information in her book would not have been sufficient to achieve the needed result, and the fact that the provider staff did not follow the plan later in June further called that into question.

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: Given that over the last two review periods and during this review, APC and transition department staff collaborated with the LIDDA staff when necessary to meet the individuals' needs during the transition and following the transition (Round 11 – 100%, Round 12 – 100%, and Round 13 - 100%), Indicator 18 will move to the category requiring less oversight. The APC Department's practice of carefully reviewing assessments and providing feedback to the disciplines was a good one. However, although some improvement was noted, the content and recommendations generated from transition assessments still required improvement. Although Center staff provided training to community provider staff and some improvement was noted, the CLDPs did not define the competency measures, important topics of training were not included, and prior to transitions, Center staff did not confirm provider staff had the necessary competencies to	Individuals:

address individuals' health and safety needs. On a positive note, for both individuals reviewed, the Center and LIDDA collaborated throughout the transition process. The remaining indicators will continue in active oversight.											
#	Indicator	Overall Score	221	121							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	100% 2/2	1/1	1/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	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% 0/0	0/1	0/1							
18	The APC and transition department staff collaborates with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition.	100% 2/2	1/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							
Comments: 12. Assessments did not consistently meet criterion for this indicator. The Center had implemented some improved processes in this area. For example, transition staff had developed training materials such as a "cheat sheet" to guide the disciplines about requirements for assessment recommendations. The Center also provided good documentation of persistent follow-up by transition staff for clarifications and additional information. Transition staff should continue to pursue these strategies, with the											

expectation that discipline assessment practices will improve over time. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated with 45 Days of transition: Most assessments provided for review met criterion for timeliness. Assessments that did not meet criterion included:
    - The Monitoring Team could not confirm Individual #121's FSA had been updated by the responsible staff member from the time of the first CLDP. The available document was dated 3/8/18, which was more than 45 days prior to the final CLDP and did not have any notation that indicated it remained current.
    - The responsible disciplines did not consistently ensure all information in their assessments was current, as described below.
- Assessments provided a summary of relevant facts of the individual's stay at the Center: Many discipline assessments provided a summary of relevant facts in the available assessments. Concerns included:
    - As described with regard to Indicator 2 above, Individual #221's behavioral health assessment (BHA) did not provide a clear and comprehensive summary of his behavioral history. In addition, that assessment reported Inventory for Client and Agency Planning (ICAP) results from 8/9/16, but the 14-day ISPA indicated the ICAP needed to be updated prior to transition.
    - The AMA did not provide updated information regarding Individual #221's hemoglobin A1C status, instead indicating it relied upon data from 12/2016.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments that did not yet thoroughly provide recommendations to support transition included:
    - For Individual #121, it was concerning that the BHA did not make a specific recommendation for a support to contact her counselor prior to transition to ensure those services were delivered in a consistent and seamless manner.
    - Individual #121's residential assessment provided only very broad and generic recommendations, such as to continue to be on a structured routine and to work at a job she liked in the community. This was also true for the outdated FSA.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not fully address/focus on the new community home and day/work settings. Currently, assessments did not consistently meet criterion in this area.

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

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

Indicator 1 above and further below, but some improvements were noted. Findings included:

- The IDTs did not clearly identify the expected provider staff knowledge or competencies that needed to be demonstrated.
- The Center did not provide sufficient evidence it had confirmed provider staff had the knowledge and competencies to address the individuals' health and safety needs or otherwise ensure supports were implemented as required.
- Some training materials, such as the behavioral training materials for Individual #221, still referenced Center-specific expectations that would not be applicable in the community.
- Competency testing did not consistently cover important support needs. For example, for Individual #221, the nursing competency testing did not address the use of glucometer; while Individual #221 knew how to check his blood sugar, provider staff should also have been trained. The training also did not address parameters for high or low blood sugar that might need to be reported.
- The Monitoring Team did observe some improvements in training content and testing for some disciplines. For example, Individual #121's nursing training had a clear description of what provider staff needed to know as well as a competency test that addressed those requirements. The occupational therapy training and testing for Individual #221 also evidenced improvement in this area.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The IDT should include in the CLDP a specific statement as whether any collaboration was needed, and if any was completed, summarize findings and outcomes. It was very positive the IDTs undertook a robust consideration of the need for such collaboration and identified four such supports for each individual. Still, the IDTs did not specify an expectation for documenting content covered and other outcomes. The disciplines' documentation regarding contacts with their community counterparts did not consistently provide evidence of a complete or successful collaboration.

- For Individual #221:
    - The pre-move support for PCP collaboration had not been completed at the time of the pre-move site review (PMSR) as required. On 6/5/18, the Center PCP completed a progress note indicating he had talked to the designated community PCP, but that new PCP was not aware that Individual #221 was going to be under his care and he did not see the point in receiving medical information from him. This should have prompted needed follow-up, but did not.
    - Transition staff provided an email, dated 5/21/18, from the BCBA indicating he had spoken with the community clinician and provided the information she needed. This was insufficient documentation.
- For Individual #121, the documentation of the nursing collaboration stated only that it had been completed on 5/17/18, and that in-service and medical information had been emailed. It did not provide any description of the information imparted.

16. SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs: The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. Neither CLDP met criterion. For Individual #221, the IDT did not provide documentation of this consideration. For Individual #121, as described above with regard to Indicator 5, the settings assessment related to the grab bar was not completed in an effective manner and the IDT did not review the findings in a timely manner.

17. Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual: The CLDP should include a specific statement of IDT considerations of activities SSLC and community provider staff should

engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results. Examples include provider direct support staff spending time at the Center, Center direct support staff spending time with the individual in the community, and Center and provider direct support staff meeting to discuss the individual's needs. Neither CLDP provided a specific description of any considerations for the involvement of direct support staff in such activities.

18. The APC and transition department staff collaborate with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition: Both CLDPs met criterion. It was very positive in particular, to note the LIDDA's active focus on individuals' employment needs.

19. The PMSRs for both individuals were completed in a timely manner. It is essential the Center can directly affirm provider staff competency to ensure an individual's health and safety prior to relinquishing day-to-day responsibility, but neither of these two PMSRs accomplished this. Examples of concerns from this review included:

- For both individuals, the PMM documented receiving the signed training rosters after the completion of the training, but even with the progress made in provider training as described with regard to Indicator 14 above, these were insufficient as evidence that provider staff were competent.
- For both individuals, the Center did not have documentation that ensured the pre-move supports for discipline collaborations had been completed in an effective manner.
- The Center assisted Individual #121 to obtain an identification card, but she lost it a week prior to transition. Center staff then assisted her to complete the forms for a new one, which was expected to be mailed to her at her new residence in four to six weeks. The PMM scored this support as being met. While it was positive the Center acted to help Individual #121 obtain the card, it was not yet in place and should have been marked for follow-up until it was complete.

Outcome 5 – Individuals have timely transition planning and implementation.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	221	121							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	50% 1/2	1/1	0/1							

Comments: 20. One of the CLDPs met criterion for this indicator.

- Individual #221 was referred on 1/11/18, and transitioned on 6/1/18. This was within 180 days.
- Individual #121 was referred on 10/31/17, and transitioned on 5/24/18. This exceeded 180 days. The transition was delayed for approximately two months because she had not yet obtained employment, a pre-move condition set by the LIDDA. Per the documentation reviewed and interviews with transition staff, the IDT had not acted assertively to address this requirement in a timely manner.

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