United States v. State of Texas

Monitoring Team Report

Lubbock State Supported Living Center

Dates of Remote Review: November 1st through 4th, 2021

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Submitted By:	Maria Laurence, MPA Alan Harchik, Ph.D., BCBA-D Independent Monitors
Monitoring Team:	James M. Bailey, MCD-CCC-SLP Paula Casey, MSN, RN, CCM Susan Thibadeau, Ph.D., BCBA-D Teri Towe, BS Rebecca Wright, MSW Wayne Zwick, MD

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Background

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

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

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

For this review, this report summarizes the findings of the two Independent Monitors, each of whom have responsibility for monitoring approximately half of the provisions of the Settlement Agreement using expert consultants. One Monitoring Team focuses on physical health and the other on behavioral health. A number of provisions, however, require monitoring by both Monitoring Teams, such as ISPs, management of risk, and quality assurance.

Methodology

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

a. **Selection of individuals** – During the weeks prior to the review, the Monitoring Teams requested various types of information about the individuals who lived at the Center and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a Center's compliance with all provisions of the Settlement Agreement.

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

Organization of Report

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

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

Executive Summary

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

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

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

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

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

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

Restraint – At the time of the last review, the Center showed sustained substantial compliance with many of the requirements of Section C of the Settlement Agreement. The exceptions are Section C.5 related to licensed health care staff's (nurses' and/or physicians') roles in the monitoring of all types of restraints, and physicians' roles in defining monitoring schedules, as needed; and Section C.6 related to assessments for restraint-related injuries, as well as monitoring of individuals subjected to medical restraint. The Monitoring Teams will continue to monitor these remaining areas for which Center staff have not obtained substantial compliance using the outcomes and indicators related to these subjects. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Lubbock SSLC exited from the other requirements of Section C of the Settlement Agreement. This resulted in the exit of 20 indicators and seven outcomes.

Abuse, Neglect, and Incident Management - In September 2019, the parties indicated that they reached agreement that Lubbock SSLC met the substantial compliance requirements of section D of the Settlement Agreement. Thus, the Monitors did not conduct monitoring of this area.

Aspects of incident management, occurrences of abuse/neglect, and investigations have remained or become part of the Center's quality improvement system and will be reviewed by the Monitoring Team as part of its monitoring of Quality Assurance/Improvement (i.e., section E of the Settlement Agreement). This includes what were indicators 20-23 in previous monitoring reports as well as information on non-serious injury investigations, which was indicator 15 in previous monitoring reports.

Pharmacy - After Round 14, DOJ and the State agreed that the Center achieved substantial compliance with most of the requirements of Section N of the Settlement Agreement. The exceptions are Section N.6 related to adverse drug reactions, and Section N.8 related to medication variances that the Monitoring Team will review as part of Section E, and Section N.5 related to quarterly monitoring for tardive dyskinesia that will be measured through Section J.12.

As a result, for this review, this Domain now contains six outcomes, and 25 underlying indicators. Two of these indicators were moved to, or were already in, the category of less oversight after the last review. Presently, no additional indicators 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.

Restraint
For one of the six restraints reviewed, nurses performed physical assessments, and documented whether individuals sustained any restraint-related injuries or other negative health effects. Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: conducting follow-up assessments for individuals who initially refuse, and conducting assessments for individuals with chemical restraints that are in accordance with the nursing guidelines.

Other
Interdisciplinary Teams (IDTs) were reviewing pre-treatment sedation (PTS) and making a determination of whether intervention was needed.

Restraint

At a previous review, the Monitor found that that the Center achieved substantial compliance with many of the requirements of Section C of the Settlement Agreement.

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

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

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.	
Summary: For one of the six restraints reviewed, nurses performed physical assessments, and documented whether individuals sustained any restraint-related injuries or other negative health effects. Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: conducting follow-up assessments for individuals who initially refuse, and conducting assessments for individuals with chemical restraints that are in accordance with the nursing guidelines. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	416	134	325	440					
a.	If the individual is restrained using physical or chemical restraint, nursing assessments (physical assessments) are performed in alignment with applicable nursing guidelines and in accordance with the individual's needs.	17% 1/6	0/2	1/2	0/1	0/1					
b.	If the individual is restrained using PMR-SIB:										
	i. A PCP Order, updated within the last 30 days, requires the use of PMR due to imminent danger related to the individual's SIB.	N/A									
	ii. An IHCP addressing the PMR-SIB identifies specific nursing interventions in alignment with the applicable nursing guideline, and the individual's needs.	N/A									
	iii. Once per shift, a nursing staff completes a check of the device, and documents the information in IRIS, including: a. Condition of device; and b. Proper use of the device.	N/A									
	iv. Once per shift, a nursing staff documents the individual's medical status in alignment with applicable nursing guidelines and the individual's needs, and documents the information in IRIS, including: a. A full set of vital signs, including SPO2; b. Assessment of pain; c. Assessment of behavior/mental status; d. Assessment for injury; e. Assessment of circulation; and f. Assessment of skin condition.	N/A									
c.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	67% 4/6	2/2	2/2	0/1	0/1					
d.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	33% 1/3	1/2	N/A	N/A	0/1					

Comments: The restraints reviewed included those for: Individual #416 on 5/4/21 at 9:16 p.m., and 6/2/21 at 6:25 p.m. (chemical); Individual #143 on 4/20/21 at 8:01 p.m. (chemical), and 8/22/21 at 11:22 p.m.; Individual #325 on 7/22/21 at 1:05 p.m.; and Individual #440 on 8/19/21 at 10:27 a.m.

a., and c. and d. For Individual #143's restraint on 4 8/22/21 at 11:22 p.m., the nurse performed physical assessments to the extent possible, because the individual was continually running. Although the nurse was not able to fully assess the individual for any

restraint-related injuries or other negative health effects, they did note their observations when the individual was placed in the ambulance for transport to the ED for treatment of an acute psychotic event.

The following provide examples of other findings:

- For Individual #416's restraint on 5/4/21, a nurse completed timely assessments of the individual's vital signs, and assessed the individual for restraint-related injuries. The description of the individual's mental status was incomplete (i.e., alert and appropriate). The individual sustained scratches to her wrist due to self-injurious behavior (SIB), which nursing staff treated and followed post-restraint.
- On 6/2/21, at 6:25 p.m., Individual #416 received a chemical restraint of 2 milligrams (mg) Ativan intramuscular (IM). Nursing staff noted attempts to take the individual's vital signs and her refusals. However, they did not document assessments according to the nursing guidelines for chemical restraint. For example, based on documentation submitted, they did not assess the individual's pain, or gait/balance/coordination. In addition, the individual received a scratch following needle removal. No documentation was submitted to show that nursing staff conducted a follow-up assessment of the scratch and/or monitored healing.
- For Individual #134's chemical restraint on 4/20/21, nursing staff did not follow the timelines for conducting assessments per the guidelines. For example, they did not conduct the 30-minute assessments. While a nurse conducted an assessment at 8:01 p.m., the next documented attempt was not until 12:00 a.m., and then 2:10 a.m., and 4:08 a.m.
- For Individual #325's restraint on 7/22/21, at 1:05 p.m., a nurse attempted to complete an assessment at 1:15 p.m. The individual refused a vital sign assessment, but the nurse documented her respirations were 18, which was positive. No evidence was found that nursing staff made any additional attempts to conduct an assessment, including vital sign assessments and/or an assessment for injuries.
- Similarly, for Individual #440's restraint on 8/19/21, at 10:27 a.m. , in an IPN, at 10:35 a.m., a nurse documented that they had attempted to assess the individual multiple times and she was refusing an assessment. The nurse did not document when those attempts were made. Staff stated that the individual might have a scratch on her right forearm, but she would not allow the nurse to assess it. No evidence was found that nursing staff made any additional attempts to conduct an assessment.

Abuse, Neglect, and Incident Management

In September 2019, the parties indicated that they reached agreement that Lubbock SSLC met the substantial compliance requirements of section D of the Settlement Agreement. Thus, the Monitors did not conduct monitoring of this area.

Aspects of incident management, occurrences of abuse/neglect, and investigations will remain and/or become part of the Center's quality improvement system and will be reviewed by the Monitoring Team as part of its monitoring of Quality Assurance/Improvement (i.e., section E of the Settlement Agreement).

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/4	N/A	0/1	N/A	0/1	0/1	N/A	N/A	N/A	0/1
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. Since the last review, the Center held a number of total intravenous anesthesia (TIVA) clinics. For the four individuals in the review group who received TIVA for dental treatment, informed consent, confirmation of nothing-by-mouth status, nursing staff's monitoring of vital signs, and dental progress notes with descriptions of treatment provided were generally found.

However, as discussed in previous reports, the Center's policy related to perioperative assessment and management needed to be expanded and improved. Dental surgery is considered a low-risk procedure; however, an individual might have co-morbid conditions that potentially put the individual at higher risk. Risks are specific to the individual, the specific procedure, and the type of anesthesia. The outcome of a preoperative assessment should be a statement of the risk level. The evaluation should also address perioperative management, which includes, for example, information on perioperative management of the individual's routine medications. A number of well-known organizations provide guidance on the completion of perioperative evaluations for non-cardiac surgery. Given the risks involved with TIVA, it is essential that such guidelines be revised/developed and implemented. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures.

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 were administered oral pre-treatment sedation for dental treatment.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/4	N/A	0/2	0/1	N/A	0/1	N/A	N/A	N/A	N/A

Comments: a. In the six months prior to the review, the following individuals in the physical health review group required the use of pre-treatment sedation: Individual #134 for an orthopedist appointment on 5/3/21, and for an orthopedist appointment on 9/16/21; Individual #354 for a positron emission tomography (PET) scan on 4/29/21; and Individual #203 for audiology on 8/12/21.

For the following uses of medical pre-treatment sedation, evidence was not submitted to show that the PCP determined the medication and dosage with input from an interdisciplinary team: Individual #134's orthopedist appointment on 9/16/21, and Individual #354's PET scan on 4/29/21.

It was positive that for each of these uses of medical pre-treatment sedations, Center staff obtained informed consent, and that nurses completed pre-procedure vital signs.

For the following uses of medical pre-treatment sedation, nurses did not follow the nursing guidelines when conducting post-procedure vital sign assessments: Individual #134's orthopedist appointment on 5/3/21, Individual #354's PET scan on 4/29/21, and Individual #203's audiology appointment on 8/12/21.

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: IDTs were reviewing PTS and making a determination of whether intervention was needed (i.e., indicators 1 and 2). Indicators 3-6 will remain in active monitoring for review at the monitoring review.

#	Indicator	Overall Score	Individuals: 328	386	325	99	399	298	174	134	236
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
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.	N/A									
4	Action plans were implemented.	N/A									
5	If implemented, progress was monitored.	N/A									
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A									

Comments:
1-6. Based upon the documentation provided, it was determined that four of the nine individuals received pretreatment sedation over the previous 12-month period. These were Individual #399, Individual #174, Individual #134, and Individual #236.

Individual #399 required general anesthesia for a colonoscopy. Individual #174 required PTS for laceration repair and his comprehensive annual dental exam. Individual #134 required PTS for transfer to the emergency room, orthopedic care, wound care, an infusion, and his comprehensive annual dental exam. Individual #236 required PTS for an in-depth ear exam and his comprehensive annual dental exam.

Information was either included in their ISPs or identified in an ISPA. PTS usage was reviewed, behaviors observed without the use of PTS were described, and the risk/benefit of the procedure was noted. Informed consent was obtained for all these procedures.

The IDTs had determined that no action plans were necessary to address the use of PTS.

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	160	116	226	211					
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 4/4	1/1	1/1	1/1	1/1					
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1					

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

- On 2/2/21, Individual #308 died at the age of 46 with cause of death listed as sepsis secondary to recurring small bowel obstruction.
- On 2/25/21, Individual #160 died at the age of 73 with cause of death listed as large B cell lymphoma.
- On 3/11/21, Individual #116 died at the age of 66 with causes of death listed as metabolic acidosis, acute hypoxic respiratory failure, and sepsis.
- On 7/11/21, Individual #226 died at the age of 67 with causes of death listed as acute hypoxemic respiratory failure, and Allan-Herndon-Dudley syndrome.
- On 7/17/21, Individual #211 died at the age of 43 with causes of death listed as malignant bowel obstruction, and colon cancer.

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

- As is illustrated throughout this report, the Monitoring Team's review of medical, nursing, and habilitation therapy supports for the nine individuals in the physical health review group showed ongoing problems with regard to the supports the Center provided. The mortality reviews completed for the four individuals who died did not identify many of the systemic issues that the Monitoring Team identified (e.g., insufficient assessments, incomplete planning, incomplete follow-up for acute issues, and an overall lack of interdisciplinary coordination).
- For Individual #160:
    - The nursing death review was not thorough. For example, the Center's nurse reviewer did not fully review the Integrated Risk Rating Form (IRRF) other than to note the risks and levels assigned. Despite the individual's weight loss of over 15 pounds in six months, the IDT had not rated the individual at medium or high risk for weight. The Center's nurse reviewer did not review the individual's Integrated Health Care Plan (IHCP) goals and/or interventions to determine if they met the individual needs, but rather only reviewed whether or not they existed for each risk identified. The Center's nurse reviewer did not review medications given within the last 24 hours. They also did not conduct a review of acute care plans other than to note that they individual had some. There was no review of the quality of the content or nurses' implementation of them.
    - The clinical death review did not result in an opportunity to review lymphomas with the medical staff.
- For Individual #116:
    - The Center's death review committees identified some important deficits that required correction, and recommendations to address them. For example, recommendations were made to address the need for in-service training on inflammatory breast cancer, screening for breast cancer, the frequency of breast exam completion, development of IRRFs and IHCPs for new chronic conditions, the need for nurses to execute new orders timely, the need for nurses to promptly notify primary care providers (PCPs) when individuals experience changes of status, the need for competency and integrity checks for positive behavior support plans (PBSPs), and the need for direct support professionals (DSPs) to complete timely documentation in CareTracker.

- The nursing review was incomplete. For example, the Center's reviewer did not review the quality of the content of interventions and goals included in the individual's IHCPs. They did not provide a listing of medications. Although the reviewer listed the acute care plans, and concluded they were appropriate, a thorough review of their quality was not evident. In addition, nursing staff had not developed and implemented an acute care plan for pain management two days following the individual undergoing femoral nailing. The Center's reviewer did not complete and/or document a review of nursing care for the previous six months, or review of the events leading up to the individual's death.

- For Individual #226:
  - The nursing review was minimal and largely consisted of copying Integrated Progress Notes (IPNs) into the review format. Neither the nursing nor habilitation therapy recommendations addressed that the individual was not positioned properly in the bathing sling and re-education of staff was needed. The Center's nurse reviewer did not conduct a review of the IHCP interventions to determine whether or not nursing staff implemented them. Additionally, the Center's nurse reviewer did not identify that nurses did not conduct a lung assessment (according to documentation) following the individual's initial apneic episodes.
  - The clinical death review did not result in an opportunity to review restrictive lung disease, and/or hypotonic diseases with the medical staff.
  - As noted above, Center staff did not identify and/or address a full set of issues that that the Monitoring Team identified in its review of this individual's care and treatment. For example, the Center's mortality reviews did not identify concerns related to the insufficiency of IHCPs, and/or lapses in nursing assessments for exacerbations in chronic conditions.
- For Individual #211:
  - The Center's death review committees identified some important deficits that required correction, and recommendations to address them. For example, for this individual who died of a malignant bowel obstruction, and colon cancer, the death review committees made recommendations to address the need to educate PCPs and nursing staff on positive fecal immunochemical tests (FITs) to ensure follow-up with gastroenterology, and develop a protocol for positive FIT findings. The committee also agreed to recommendations related to documentation of gastric residuals and a related monitoring process, the quality of documentation for IHCP implementation, and a process for updating family medical history annually.
  - The nursing review was incomplete. For example, the Center's nurse auditor did not review the IRRF, and did not identify a lack of change of status (CoS) IRRF following three hospitalizations within three months. They identified problems with documentation related to IView and acute care plans, but did not identify a corresponding recommendation. The Center's nurse reviewer did not identify the lack of an acute care plan for the individual's hospital admission in March for ileus. They also did not assess nursing care over the previous six months, but rather provided only a line listing of events. The Center's nurse auditor did not review the quality of the content or completeness of assessments, or IHCP interventions and their implementation.

e. At times, evidence was not presented to show that Center staff implemented the death review recommendations. For example, for Individual #116, evidence was not found for a recommendation to address a lack of consistent notes from DSPs.

Some improvement was noted with regard to the mortality committee writing recommendations in a way that ensured that Center practice improved. For example, a recommendation that read: "Inservice staff regarding appropriate documentation of gastric residuals" resulted in an in-service training, but the death review committee also appropriately required development of an audit process to include monthly monitoring of residual documentation.

However, several other recommendations did not follow this format. Frequently, the "monitoring plan" was "completion of inservices." For example, another recommendation was: "IDTs will be inserviced that any new chronic or acute disease processes need to be added to the IRRF and IHCP. If there is no risk category that encompasses the issue, it should be added to the 'Other' category." The monitoring plan was "Completion of inservices." This did not ensure that the practices that caused the need for a recommendation changed. The recommendation and/or its implementation plan should have been written in a manner that required checks to determine whether or not IDTs were addressing new chronic conditions through the development of IRRFs and IHCPs.

The documentation the Center provided made it difficult to determine whether or not, and when a Clinical death review recommendation was considered closed. Specifically, the charts that listed the recommendations did not include a column to indicate the date on which the recommendation was initiated and a date on which it was closed, or to provide a "pending" status update.

In addition, as indicated in previous reports, in response to the Monitoring Team's Tier II request, Center staff often provided raw data as evidence of implementation. For example, staff training rosters were included, but Center staff did not include information about how many staff required training. As a result, this documentation could not be used to determine whether or not staff fully implemented the recommendation. The Monitoring Team previously recommended that Center staff identify the number of staff trained (n), and the number of staff who required training (N).

During the remote review, a member of the Monitoring Team requested information in this format, including the percentage of staff trained. Center staff created a document to respond to this request. It showed that for most in-service training recommended, respective staff completed the training. It identified that training due on 9/30/21, that was recommended in response to Individual #211's death related to nursing staff was still pending. Such a format of summarizing training needed/completed is necessary not just to provide evidence to the Monitoring Team, but also for internal tracking purposes.

Quality Assurance

After Round 14, based on the Center's scores over the past three monitoring cycles, DOJ and the State agreed that the Center achieved substantial compliance with most of the requirements of Section N of the Settlement Agreement. The exceptions are Section N.6 related to adverse drug reactions (i.e., see below), and Section N.8 related to medication variances that the Monitoring Team will review as part of Section E, and Section N.5 related to quarterly monitoring for tardive dyskinesia that the Monitoring Team will measure through Section J.12. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Lubbock SSLC exited from the other requirements of Section N of the Settlement Agreement. Therefore,

for this report, the Monitoring Team did not monitor the outcomes and indicators related to the exited provisions of the Settlement Agreement.

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: For the one ADR reviewed, Center staff followed the proper procedures. If the Center sustains its progress, after the next review, Indicators a through d might move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
a.	ADRs are reported immediately.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	Clinical follow-up action is completed, as necessary, with the individual.	100% 1/1		1/1							
c.	The Pharmacy and Therapeutics (P&T) Committee thoroughly discusses the ADR.	100% 1/1		1/1							
d.	Reportable ADRs are sent to MedWatch.	N/A		N/A							

Comments: a. through d. On 5/25/21, Individual #134 had a critical lab value returned, which nursing staff reported to the PCP and the psychiatrist. The neuroleptic malignant syndrome (NMS) was associated with Haldol and Olanzapine. While the individual was in the hospital, the medication was discontinued, and the individual's labs were monitored for improvement. On 6/30/21, the P&T Committee reviewed the ADR.

As discussed in the Monitoring Team's previous reports on the Center's QA/QI system, it is essential Center implement reliability probes/checks to determine whether or not data are reliable. These would include mechanisms to ensure that potential ADRs are reported (e.g., comparing lists of medications prescribed for allergic reactions to the list of ADRs reported, etc.). In addition, guidelines such as those that the American Society of Hospital Pharmacists (ASHP) publishes provide direction in terms of ensuring full reporting.

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.

Psychiatry – Since the last review, the Center met the requirements and exited from Section J of the Settlement Agreement. This resulted in the exit of 20 indicators, and five outcomes.

This Domain contains 27 outcomes and 112 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, 24 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, six additional indicators in the areas of ISPs, psychology, medical, nursing, communication, 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.

Assessments

For the ISPs, the IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting. The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting. Assessments were updated as needed in response to significant changes.

In behavioral health, almost all individuals had a current, and complete annual behavioral health update. The functional assessment content was complete for about half of the individuals.

Vocational assessments and/or Functional Skills Assessments (FSAs) did not include any recommendations for skill acquisition plans (SAPs).

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 and update the Integrated Risk Rating Forms (IRRFs) within no more than five days.

For the nine individuals in the review group, primary care providers (PCPs) completed timely annual medical reviews (AMAs), as well as interval medical reviews (IMRs).

Center staff should continue to improve the quality of annual medical assessments, particularly with regard to up-to-date family histories, and thorough plans of care for each active medical problem, when appropriate. It was positive that the interval medical reviews (IMRs) for the selected chronic conditions/at-risk areas for individuals in the review group generally followed the State Office template, and provided necessary updates.

Of the nine individuals in the review group, seven had recent dental exams. Although five of the seven recent exams did not also meet the criterion for having been completed within 365 days of the previous ones, the completion of annual dental exams within the last 12 months for many of the individuals was significant progress.

For the six individuals in the nursing review group, nurses completed timely quarterly nursing record reviews and physical assessments.

It was positive that for about a third of the risks reviewed, the quarterly record reviews included relevant clinical data. In three of 11 quarterly reviews, Registered Nurse Case Managers (RNCMs) analyzed this information. Work is still needed to make improvements in this regard with annual, as well as quarterly reviews, and RNCMs need to offer relevant recommendations. Work is also needed to improve the content and thoroughness of annual and quarterly physical assessments, and to ensure that nurses complete thorough record reviews on an annual and quarterly basis.

When individuals experience exacerbations of their chronic conditions, nurses need to complete assessments in accordance with current standards of practice.

In comparison with previous reviews, the scores during this review generally showed improvement with regard to the timely referral of individuals to the Physical and Nutritional Management Team (PNMT), timely completion of PNMT comprehensive assessments, and the completion of the correct type of assessment (i.e., review or comprehensive assessment). The Center should focus on continuing its progress in these areas.

It was positive that one of the five comprehensive PNMT assessments met all of the criteria for quality. The remaining assessments met many of them, but were deficient with regard to between two and four of the essential components.

For the nine individuals in the review group, Center staff completed timely Occupational Therapy/Physical Therapy (OT/PT) assessments that were of the types that were in accordance with their needs and/or based on changes in status. Overall, many of the assessments met many of the criteria for quality, but were missing thorough assessment in one or two areas. With minimal effort, by the time of the next review, Center therapists could make additional progress.

Some progress occurred with regard to the quality of communication assessments, but additional improvement continued to be needed in order to ensure that SLPs provide IDTs with clear understandings of individuals' functional communication status;

alternative and augmentative communication (AAC) options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated.

Individual Support Plans (ISPs)

In the ISPs, two individuals' goals met criteria for all five personal goal areas. Moreover, across the six individuals, personal goals met criteria in from one to five areas for a total of 16 goals that met criteria. Overall, this was about the same as at the last review. More work was needed regarding health and wellness goals regarding actions the individual might take to improve his or her own health and wellness and address any IRRF/risks.

About half of ISP goals were written in measurable terminology. About one-third of the goals that met criteria with indicator 1 had a good set of action plans to support achievement of the goal.

For ISP action plans, implementation and actions were not occurring and as a result progress was not occurring.

Staff were knowledgeable of the individuals they supported with one exception. ISP action plan implementation and revisions to actions when there was no progress remained in need of improvement.

In behavioral health, performance on inter-observer agreement (IOA) and data collection timeliness (DCT) was higher than ever before, that is, criteria were met for about half of the individuals. For the other half, some but not all of the criteria were met. That is, IOA and DCT assessments were not conducted as often as they needed to be and/or the scores on these assessments averaged below 80%.

The Positive Behavior Support Plans (PBSPs) contained many of the required components, but each was missing one or more.

For SAPs, reliable and valid data were available that reported the individual's status and progress for about 20% of the SAPs.

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

As noted in the last report, Center staff made and now sustained some good progress with regard to the inclusion of nursing interventions in individuals' IHCPs. Staff are encouraged to continue these efforts because most plans reviewed still were missing key supports, and/or did not identify measurable goals/objectives to allow IDTs to track individuals' progress.

Seven out of nine Physical and Nutritional Management Plans (PNMPs) reviewed met the requirements for quality, which was good to see. With minimal effort and attention to detail, the Habilitation Therapy staff could make the needed corrections to PNMPs.

ISPs

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

Summary: None of the individuals had goals that met criteria for indicator 1 in all six ISP areas, however, two individual's goals met criteria for all five personal goal areas. Moreover, across the six individuals, personal goals met criteria in from one to five areas for a total of 16 goals that met criteria. Overall, this was about the same as at the last review. More work is needed regarding health and wellness goals regarding actions the individual might take to improve his or her own health and wellness and address any IRRF/risks.

The Monitor has provided additional calculations to assist the Center in identifying progress as well as areas in need of improvement. For indicator 1, the data boxes below separate performance for the five personal goal areas from the health and wellness goals. The Monitoring Team looks at two health and wellness areas that rated as being at medium or high risk (in the IRRF) plus a dental goal if that area is rated as being at medium or high risk, plus suction toothbrushing if the individual receives suction toothbrushing.

Indicator 2 shows performance regarding the writing of goals in measurable terminology. For none of the individuals, all of their goals that met criteria with indicator 1 were written in measurable terminology. Overall, about half of goals were written in measurable terminology. Indicator 3 shows that about one-third of the goals that met criteria with indicator 1 had a good set of action plans to support achievement of the goal. These three indicators will remain in active monitoring.

#	Indicator		Overall Score	Individuals: 399	298	174	134	249	182			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and	Personal goals	33% 2/6 55% 16/29	5/5	1/5	1/5	3/5	4/4	2/5			

	strengths, and input from the individual on what is important to him or her.	Health goals	0% 0/6 0% 0/14	0/2	0/2	0/2	0/2	0/2	0/4			
2	The personal goals are measurable.	Personal goals	0% 0/6 56% 9/16 50% 11/22	4/5 4/5	0/1 1/3	0/1 1/3	1/3 1/4	3/4 3/4	1/2 1/3			
		Health goals	0% 0/6 --% -/- 0% 0/14	-/- 0/2	-/- 0/2	-/- 0/2	-/- 0/2	-/- 0/2	-/- 0/4			
3	ISP action plans support achieving the individual's personal goals.		0% 0/6 32% 5/16	2/5	0/1	1/1	0/3	1/4	1/2			

Comments: The Monitoring Team reviewed the ISP process for six individuals at the Lubbock State Supported Living Center: Individual #134, Individual #298, Individual #399, Individual #174, Individual #249, and Individual #182. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed staff, including DSPs and QIDPs, and directly remotely observed individuals at the Lubbock SSLC facility.

1. None of the individuals had a comprehensive score that met criterion for the indicator. During the last monitoring visit, the Monitoring Team found 16 goals that met criterion for being individualized, reflective of the individuals' preferences and strengths, and based on input from individuals on what was important to them. For this review, 16 goals met this criterion. The personal goals that met criterion were:

- the leisure goal for Individual #399 and Individual #249
- the relationship goal for Individual #134 and Individual #399.
- the work/day/school goal for Individual #399 and Individual #249.
- the independence goal for all six.
- the living options goal for Individual #134, Individual #399, Individual #249, and Individual #182.

- Individual #134 and Individual #298 had limited opportunities to explore new activities and identify new preferences. Individual #134's recreation goal to play his Nintendo Switch and Individual #298's goal to secure her important documents and cards at her home weekly were based on activities that they routinely engaged in and did not offer opportunities for

exposure to new recreational/leisure activities. Individual #134's recreation goal would have been a good short-term training objective to support his greater independence with a new device. Documentation indicated that he was able to turn on and off similar devices independently (TV, DVD, Gameboy). It did not reflect a long-term goal that would offer him opportunities to participate in new recreational activities in a less restrictive setting.

- Individual #298, Individual #174, Individual #249, and Individual #182 did not have a relationship goal. Per Individual #298, Individual #174, and Individual #182's ISPs, they had limited relationships and limited relationship building skills. The IDT should consider teaching skills that might expand their ability to communicate and build positive relationships with others. Individual #249 had several meaningful relationships both at the Lubbock SSLC and in the community. She was able to initiate communication with friends. Her IDT agreed that this was not a priority training area. The Monitoring Team agreed and as a result, the denominator for Individual #249 in the above scoring is 4 rather than 5.

- Individual #134, Individual #298, Individual #174, and Individual #182 did not have day programming goals. During observations, they were not meaningfully engaged throughout the day. Their ISPs offered few opportunities for functional training and few opportunities for exposure to new activities. For example,
    - Individual #298 had one skill acquisition plan that was scheduled two days per week to sort laundry. QIDP monthly reviews indicated that she infrequently attended structured day programming. In July 2021, she attended three music and memory classes. There were no data for attendance in August and September 2021. It was noted that she attended day programming on the home, however, the IDT was not tracking the frequency or any training that she participated in at her home.
    - Individual #134 had two skill acquisitions plans (SAPs) that were scheduled for implementation on the weekend and one SAP to open his lockbox scheduled two days per week during the week. QIDP monthly reviews noted that training data had not been submitted since February 2021 for his SAPs and his programs were on pause while he experiences his psychiatric issues. His ISP noted that he was scheduled to attend the work program on campus on Thursdays for one hour. It was noted that he rarely attended the work program. At the time of this review, he did not have a work schedule in place and the IDT did not have a plan to attempt to engage him in training or other activities.
    - Individual #174 had one SAP to make a shake. Training had been implemented one to four times per month over the past year. One other SAP to sign drink had been discontinued because he was not making progress. At his annual ISP meeting, his SLP suggested that he had not made progress due to the low number of trials that had been implemented. He was scheduled to attend day programming for 30 minutes two days per week.
    - Individual #182 had two broadly stated action plans to attend programs at the Education building and music classes. Both action plans were on hold. His ISP noted that he attended day program at his home and often slept through programming. He had two SAPs to use his switch when he wanted to play dominoes or transfer from his chair. Both SAPs had been implemented at a low frequency over the past seven months.

- Individual #298 and Individual #174's living option goals were to live at Lubbock SSLC. These goals were not aspirational.

- None of the individuals had goals to support their participation in improving or maintaining their own health and wellness. Fourteen health/wellness/risk areas were identified across the six individuals. There were goals related to clinical outcomes (e.g., medical, nursing, dental; see bulleted list below), but none related to actions in which the individual might engage.

- Individual #134: gastrointestinal issues and weight
- Individual #298: cardiac issues and osteoporosis/falls/fractures
- Individual #399: choking and gastrointestinal issues
- Individual #174: osteoporosis/falls/fractures and cardiac issues
- Individual #249: gastrointestinal issues and weight
- Individual #182: choking, gastrointestinal issues, dental, and suction toothbrushing

The QIDP department was focused on revising the PSI process to improve identification of individual's preferences. This should lead to the development of better goals. Individual #174's annual ISP meeting was observed. The QIDP made recommendations for additional goals that would offer greater exposure to new activities and expand his skills.

2. Of the 16 personal goals that met criterion for indicator 1, nine also met criterion for measurability. Two others that did not meet criteria for indicator 1 were measurable. Those that were measurable:

- Recreation/Leisure: Individual #399 and Individual #249
- Relationship: Individual #399
- Job/School/Day: Individual #249 and Individual #399
- Living Option: all six

For goals that were not measurable, the goal was not written in observable, measurable terms, did not indicate what the individual was expected to do, or how many times they were expected to complete tasks/activities. Those included:

- Recreation/leisure: Individual #134, Individual #298, Individual #174, and Individual #182
- Relationship: Individual #134, Individual #298, Individual #174, and Individual #182
- Job/School/Day: Individual #134, Individual #298, Individual #174, and Individual #182
- Greater Independence: Individual #134, Individual #298, Individual #399, Individual #174, Individual #249, and Individual #182. For example, for Individual #249 filling out a form for trust fund money, there was no indication of how often or how many times would show success and achievement.
- Health and Safety: Individual #134, Individual #298, Individual #399, Individual #174, Individual #249, and Individual #182

3. For the 16 goals that met criterion for being personal and individualized, five had corresponding action plans that were supportive of goal-achievement. Action plans to support goals should include all necessary steps; be individualized; integrate strategies to reduce risk, incorporate needs included in ancillary plans; offer opportunities to make choices and decisions, where relevant; and support opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals. Goals that had action plans that were likely to lead to achievement of the goals were:

- Individual #174's greater independence goal.
- Individual #399's recreation/leisure and relationship goals.
- Individual #249's greater independence goal.
- Individual #182's greater independence goal.

Examples of goals that did not meet criteria:

- Individual #134's relationship goal to independently plan gaming night for his peers was aspirational and based on his preferences. Action plans were not clearly written, so that staff could implement consistently. The IDT did not develop action plans that addressed barriers or described supports that he would need to accomplish his goal. Action plans did not address needs documented in his assessments (i.e., training to learn to use a calendar, encouraging him to wear his glass, ensure that his diet texture is followed when choosing snacks). Action plans included:
    - QIDP will follow-up with the RC for the home to determine what gaming system should be purchased for the home.
    - Will dress up for his game nights the days he has the parties.
    - Will remind his friends of what kind of snacks they would prefer.
    - Will be encouraged to follow his fluid restriction the team noted he can save his extra fluids for his party so save his drinks.
    - Will paint for his flyers using the paint by the numbers method.
    - Speech will assess to see if he knows his days of the week or months within 30 days.

- Individual #298's greater independence goal was to wash her clothes with minimal assistance at her home weekly. Action plans did not include all necessary steps and did not include enough detail regarding supports needed. Action plans included:
    - Will continue to make choices of clothing daily.
    - Will be encouraged to not put her soiled clothes in her wardrobe but to place them into the basket.
    - SAP to sort clothes.

- Action plans to support Individual #399's goal to work at the diner completing janitorial work duties weekly. Action plans were not individualized to include training or supports needed specific to the job. Action steps included:
    - Will be verbally redirected to remain on task while at work.
    - SAP to trace his name.
    - Will complete the janitorial duties catered to the diner's needs (wipe tables, mopping, sweeping)
    - Will use a calendar or schedule in his tablet to not the days that he works at the diner.
    - Will have a job exploration.

- Action plans to support Individual #249's recreation leisure goal were not individualized, did not include supports necessary, and did not address her risks related to her pica diagnosis. Action plans included:
    - Will take a scrapbooking class (on/off campus or online)
    - Will shop for materials including scrapbook
    - Will have storage containers to store her materials in for scrapbooking.
    - Will have a small trunk/keepsake chest to store completed scrapbook in, once completed.
    - Will have informal training to work on scrapbook weekly
    - Will request magazines from on campus or community relations.

- Individual #182's living option goal was to live at a group home in the community in Lubbock by 2022. Action plans were broad statements, not individualized, that did not include teaching strategies and supports needed for consistent

implementation and documentation. Action plans did not include identifying specific living options near Lubbock that might support his needs:

- Will have the opportunity to attend provider fairs on campus once annually.
- Will participate in community outings to parks, church, Dollar Store, and other locations based on his preferences.
- Will hand his ID card to the nurse during medication pass.
- With staff's assistance, will make preferred purchases off campus
- Will participate in CLOIP videos and virtual tours to gain exposure.
- LAR will attend provider fairs.

Outcome 2: The individual's ISP set forth a plan to achieve goals.

Summary: About two-thirds of action plans had sufficient detail for implementation and useful documentation. The number of goals and action plans to which these indicators were applied was relatively small given that some did not meet criteria with indicators 1, 2, and/or 3. These will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 399	298	174	134	249	182			
4	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	75% 3/4 60% 3/5	0/2	-/-	1/1	-/-	1/1	1/1			
5	There is documentation (e.g., data, reports, notes) that is valid and reliable to determine if the individual met, or is making progress towards achieving, each of the personal goals.	50% 2/4 78% 7/9	3/4	-/-	-/-	1/1	3/3	0/1			

Comments:

4. Three of the five action plans (that met criteria with indicator 3) provided sufficient detailed information for implementation, data collection, and review to occur. For the most part, action plans were simple statements, lacking specific implementation strategies, supports needed, and criteria for documenting and assessing progress. The three goals that included action plans that met criteria were action plans to support Individual #174, Individual #249, and Individual #182's greater independence goal.

The QIDP department had identified the need to improve the quality of action plans to support achievement of goals.

5. Of the nine goals that met criteria with indicators 1 and 2, seven had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals. QIDPs were doing a better job of summarizing progress/lack of progress towards goals.

- For Individual #134's living option goal, the QIDP monthly reviews indicated that related action plans had not been implemented and he was not making progress.

- For Individual #399's recreation, relationship, and living option goals, his QIDP monthly review indicated that action plans had not been consistently implemented and he had not made progress towards his goals.
- For Individual #399's work/day goal, data did not reflect what progress had been made towards his goal to work at the diner completing janitorial work. At his ISP Preparation meeting, staff were unable to determine what specific progress had been made towards his goal due to the lack of meaningful data available.
- For Individual #249's recreation/leisure goal, work goal, and living options goal, QIDP monthly reviews indicated that none of her related action plans had been implemented and she was not making progress towards any of her goals.
- For Individual #182's living option goal, data were not available and the QIDP did not summarize progress towards his goal to live at a group home in the community.

For many of the action plans, the QIDP had documented the number of times that the action plan had been implemented, but did not comment on what supports were needed or what specific progress the individual had made towards the related goal. Examples included:

- Individual #174 had an action plan to wash his hands prior to making his snack for his independence goal. It was unclear from the QIDP monthly reviews what was being tracked (i.e., implementation, compliance, independent completion of the task). The summary would not allow the team to determine what supports he needed to complete the task and what additional training might be needed. The QIDP monthly review included the following:
  - September: Data: No-1; Yes- 51; Summary/Analysis: slight regression noted
  - August: Data: No – 2; Yes – 52; Refused – 2; Summary/Analysis: Progress noted
  - July: Data: - 3; Yes – 50; Summary/Analysis Regressed during this review period with 4 less yes responses.
- Individual #134 had an action step to play his game boy related to his leisure goal to independently plan his Nintendo Switch to play his game boy. It was not clear if the IDT was collecting data on implementation, compliance, or a skill related to the task. The QIDP review included the following:
  - September: Data 2 no; Summary/Analysis: regression is noted
  - August: Data: 2 no, 1 yes; Summary/Analysis: regression is noted
  - July: Data: 2 no, 3 yes; Summary/Analysis: progress is noted

Individual #399's ISP Preparation meeting and Individual #174's ISP meeting were observed. At both meetings, IDTs were unable to determine what specific progress had been made towards goals over the past year. Decisions to continue or discontinue goals were not based on data available to the team but relied on anecdotal reports from various IDT members on whether the person had made progress, needed more training, or was no longer interested in the activity.

Outcome 3: All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Implementation and action were not occurring and as a result progress was not occurring. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	399	298	174	134	249	182			

6	The individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/3 0% 0/7	0/3	-/-	-/-	0/1	0/3	-/-			
7	If personal goals were met, the IDT updated or made new personal goals.	N/A									
8	If the individual was not making progress, activity and/or revisions were made.	0% 0/3 0% 0/7	0/3	-/-	-/-	0/1	0/3	-/-			

Comments:
6. For all individuals, QIDP monthly review documented that action plans had not been consistently implemented, and as a result, individuals had not made progress towards their goals.

7. None of the individuals had met an ISP goal.

8. QIDPs were reviewing action plans monthly, which was good to see, however, action was not routinely taken to revise action plans when progress was not made. A review of ISP preparation documents and recent data indicated that action plans were rarely implemented at the recommended frequency and barriers to implementation were not addressed. IDTs were often waiting until the next annual ISP meeting to revise plans.

Outcome 4: ISPs, assessments, and IDT participation support the development of a comprehensive and individualized annual ISP.											
Summary: Due to sustained high performance, indicator 11b will be moved to the category of requiring less oversight. Overall, good performance was seen for all parts of indicator 11 (regarding assessments). Implementation, however, was not occurring in a timely manner (indicator 9b). These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	399	298	174	134	249	182			
9	a. The ISP was revised at least annually (or was developed within 30 days of admission if the individual was admitted in the past year).	Due to the Center's sustained performance, this sub-indicator was moved to the category of requiring less oversight.									
	b. 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			
10	The individual and all relevant IDT members participated in the planning process and attended the annual meeting.	50% 3/6	1/1	0/1	0/1	1/1	1/1	0/1			

11	a. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting. b. The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting. c. Assessments were updated as needed in response to significant changes.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
		100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
		100% 3/3		1/1			1/1	1/1			

Comments:

9b. The ISP was not implemented within 30 days of the meeting for any of the individuals. For all individuals, multiple action plans had not been implemented. Examples included:

- Action plans to support Individual #134's work/day goal had not been implemented. His action plan to add one-dollar bills was not implemented within 30 days. Skill acquisition plans related to his recreation goal had not been implemented.
- For Individual #298, there was no implementation documentation for her action plans to make a choice of clothing daily, sort her clothes, and hand her ID card to the nurse during medication passes.
- For Individual #399, the following action plans were not implemented within 30 days of ISP development: practice songs with his peers, research small churches in the community, have singing lessons on campus weekly, purchase clothing for church, use a calendar or schedule in his tablet to note days that he works, use a microwave, choose foods that he wants to make, and clean up after preparing his meals.
- For Individual #174, action plans not implemented within 30 days of ISP development included: using a VOCA with his mother's voice and making purchases on campus.
- For Individual #249, action plans to support her recreation/leisure, work/day and relationship goals had not been implemented within 30 days of ISP development.
- For Individual #182, his service objectives to hand his ID card to the nurse during medication passes and engage in playing dominoes during active treatment had not been implemented.

10. Three of the six individuals had appropriately constituted IDTs, based on their strengths, needs and preferences, who participated in the planning process. Findings included:

- Individual #298's OT, PT, and PCP did not attend his annual meeting. She had complex medical, and therapy needs and supports.
- Individual #174's SLP did not attend his annual meeting. He had support needs in this area.
- Individual #182 and his SLP were not present at his annual ISP meeting. He had one goal to use an adaptive switch for communicating his needs. According to team members, training supports had not been effective, and he had not made progress towards his goal. His ISP noted that communication was a barrier in most areas of his life.

11a. For all individuals, the IDT considered what assessments the individual needed and would be relevant to the developments of the ISP prior to the annual meeting.

11b. All of the IDTs arranged for and obtained the needed, relevant assessments prior to the IDT meeting.

11c. For all individuals assessments were updated as needed in response to significant changes.

Outcome 5: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.

Summary: For two-thirds of the individuals, there was a thorough examination of living options. More work was then needed on plans. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 399	298	174	134	249	182			
12	There was a thorough examination of living options.	67% 4/6	1/1	0/1	0/1	1/1	1/1	1/1			
13	a. ISP action plans integrated encouragement of community participation and integration.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
	b. The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
14	ISP action plans included individualized, measurable plans to educate the individual/ LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

12. For four individuals, there was a thorough examination of living options.
    - Individual #298's ISP did not document discussion regarding other living options that might support her needs and preferences. She had lived at an SSLC since 1958 and had minimal exposure to other living options.
    - Individual #174's ISP did not document discussion of how other living options may support his needs. His LAR expressed some concerns regarding care provided in the community. It was not evident that his IDT addressed those concerns. His annual ISP meeting for the upcoming year was observed. His LAR expressed a desire to learn more about community options by visiting homes in the community. She noted that transportation for visits would be a barrier for her. The IDT agreed to write an action plan for her to visit community options with Individual #174. They did not address barriers to her participating in visit. The IDT did not identify specific options that might support Individual #174's needs and preferences.

13a. One ISP (Individual #399) had action plans that were likely to lead towards community integration in a meaningful way. Other ISPs had broadly stated goals to visit in the community, however, there were no action plans to support integration. All supports, services, and training were being provided at the SSLC.

- Individual #399 had action plans to support his goal to sing in a church choir in the community. This goal offered opportunities for community participation and integration.

13b. One ISP (Individual #249) considered opportunities for day programming in the most integrated setting consistent with preferences and support needs. Day and work opportunities were limited for most individuals. Vocational training was not focused on building skills that might lead towards employment in a more integrated setting. Individual #134, Individual #298, Individual #174, and Individual #182 did not have day/work goals.

14. None of the ISP action plans included individualized measurable plans to educate the individual and LAR about community living options. Individuals had broadly stated action plans to provide information to the individual and LAR annually, attend provider fairs, and/or attend a community tour. Action plans were implemented year after year with little revision and little impact on the individual's understanding of living options. For example,

- Individual #134's action plans to support his goal to live near his father were:
  - Will attend community exposure tours and provider fairs virtual if possible.
  - Will attend community outings
- Individual #399's action plans to support his goal to live in a group home in Lubbock were:
  - Will compile a list of questions to ask the providers when attending exposure tours
  - Will attend exposure tours for group homes in person or virtual.
  - Will attend provider fairs on campus.
- Individual #249's action plans to support her goal to live in a group home in Abilene near her family were:
  - Will be provided the opportunity to attend exposure tours.
  - Will be provided the opportunity to attend provider fairs.

15. IDTs had not created individualized, measurable action plans to address identified obstacles to referral. Action plans were broadly stated and carried over year after year. Few addressed actual barriers to living in a less restrictive setting.

Outcome 6: Individuals' ISPs are implemented, progress is reviewed, and supports and services are revised as needed.

Summary: Staff were knowledgeable of the individuals they supported with one exception, noted in the comments below. ISP action plan implementation and revisions to actions when there was no progress remained in need of improvement. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	399	298	174	134	249	182			
16	Staff were knowledgeable of the individual's support needs, risk areas, ISP goals, and action plans.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
17	Action plans in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

18	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:

16. For five individuals, staff were knowledgeable of the individual's support needs, risk areas, ISP goals, and action plans. Staff were attentive and respectful to individuals during observations.

- Individual #298 had been diagnosed with breast cancer. Her QIDP was not aware of her current health status related to her diagnosis. She was aware of the LAR's decision not to seek further diagnostic testing or treatment and decision to implement a DNR order. The IDT had not discussed additional supports that may be needed related to her diagnosis (i.e., pain management) or how her diagnosis may impact her functioning on a daily basis.

17. For all individuals, action plans had not been implemented and individuals had not made progress towards most goals. There was a total of 128 action steps evaluated. Twenty-two (17%) were on hold either due to COVID-19 community gathering restrictions or behavioral/health concerns that impacted individual's ability to participate in implementation. There was no evidence that IDTs considered alternate training opportunities while action plans were on hold. For the 106 action plans that could be implemented, 24 (23%) had been consistently implemented.

Individual	# of Action Steps in ISP	Action Steps Implemented	Action Steps On Hold	Action Steps Not Fully Implemented
Individual #134	18	5	1	12
Individual #298	19	1	3	15
Individual #399	23	5	2	16
Individual #174	21	6	5	10
Individual #249	28	7	2	19
Individual #182	19	0	10	9

18. QIDPs did not ensure the individual received required monitoring/review and revision of treatments, services, and supports. QIDPs were reviewing all services and supports monthly, however, they were rarely summarizing specific progress towards goals. In most cases, they were documenting when an action plan was implemented, but not commenting on the individuals' response to training or noting specific supports needed. Plans were not revised, and barriers had not been addressed when services and supports were either not implemented or not effective or when the individual failed to make progress towards goals.

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 and update the IRRFs within no more than five days. These indicators will remain in active oversight.	Individuals:

#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
a.	The individual's risk rating is accurate.	33% 4/12	1/2	1/2	0/2	0/2	N/R	N/R	1/2	1/2	N/R
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	17% 2/12	0/2	0/2	0/2	0/2			2/2	0/2	

Comments: For six individuals, the Monitoring Team reviewed a total of 12 IRRFs addressing specific risk areas [i.e., Individual #298 – cardiac disease, and falls; Individual #143 – falls, and medication side effects/polypharmacy; Individual #354 – aspiration, and medication side effects/polypharmacy; Individual #209 – aspiration, and infections; Individual #226 – aspiration, and gastrointestinal (GI) problems; and Individual #182 – aspiration, and infections].

a. The IDTs that effectively used supporting clinical data, used the risk guidelines when determining a risk level, and as appropriate, provided clinical justification for exceptions to the guidelines were those for: Individual #298 – falls, Individual #143 – falls, Individual #226 – aspiration, and Individual #182 – infections.

b. For four of the six individuals in the review group, it was positive that the IDTs updated the IRRFs at least annually. The exceptions were for Individual #209, and Individual #182.

Often, when changes of status occurred that necessitated at least review of the risk ratings, IDTs did not review the IRRFs, and make changes, as appropriate. The following individual did not have changes of status in the specified risk areas: Individual #226 – aspiration, and GI problems.

Psychiatry

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

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.	
Summary: Indicator 5 scored higher than ever before, that is, criteria were met for about half of the individuals. For the other half, some but not all of the criteria were met. That is, IOA and DCT assessments were not conducted as often as they needed to be and/or the scores on these assessments averaged below 80%. This indicator	Individuals:

will remain in active monitoring. Indicator 2 will remain in the category of requiring less oversight, however, criteria were not met for three individuals as described in the comments below.											
#	Indicator	Overall Score	328	386	325	99	399	298	174	134	236
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.										
3	The psychological/behavioral goals/objectives are measurable.										
4	The goals/objectives were based upon the individual's assessments.										
5	Reliable and valid data are available that report/summarize the individual's status and progress.	44% 4/9	0/1	0/1	1/1	1/1	1/1	0/1	0/1	1/1	0/1

Comments:

2. Six of the nine individuals had measurable goals related to their psychological/behavioral health needs. The exceptions were Individual #328 whose goals did not identify an end date, and Individual #99 and Individual #134, neither of whom had an established goal for their identified replacement behaviors.

5. Based upon the information provided by the facility, it was determined that reliable data were available for four of the nine individuals. These were Individual #325, Individual #99, Individual #399, and Individual #134.

For the other five individuals, monitoring of inter-observer agreement and data collection timeliness either did not occur as frequently as indicated in their PBSPs or satisfactory levels were not achieved.

- Individual #328: across the review period, DCT score average was acceptable at 83%, but IOA average was slightly below acceptable at 71%.
- Individual #386: admitted April 2021; IOA and DCT assessed once between admission and monitoring review (it was in July 2021).
- Individual #298: the June 2021 BHS progress note reported that IOA and DCT assessments would occur quarterly, but then there were no reports for three months (June, July, August 2021) and then, when reported for September 2021, IOA was 50% and DCT was 0%.
- Individual #174: IOA and DCT were below acceptable levels in five of six months and three of six months, respectively.
- Individual #236: IOA and DCT were below acceptable levels in four of six months and three of six months, respectively.

During the Internal Peer Review meeting, a behavioral health services staff member questioned the reliability of Individual #325's data because her problem behaviors could occur throughout campus when familiar staff were not present. This may result in an underreporting of her target behaviors.

Further, on Monday of the review, when the Monitoring Team began remote observations at one home, staff reported that both Individual #99 and Individual #134 were in their rooms because they had exhibited behaviors earlier that morning. When their PBSP data sheets were reviewed for that day (11/1/21), no target behaviors were documented for either of these individuals. Similarly, it was reported at a home meeting that Individual #134 was aggressive towards a peer on 11/2/21. This also was not documented on the data sheet.

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

Summary: With sustained high performance, indicator 10 might be moved to the category of requiring less oversight. If the functional assessment handled what to do when no target behaviors occurred, performance would improve for indicator 12. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 328	386	325	99	399	298	174	134	236
10	The individual has a current, and complete annual behavioral health update.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
11	The functional assessment is current (within the past 12 months).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
12	The functional assessment is complete.	56% 5/9	1/1	1/1	1/1	0/1	1/1	0/1	0/1	0/1	1/1

Comments:
10. All nine individuals had a current Behavioral Health Assessment (BHA). This was complete for everyone, but Individual #236. Although an assessment of his cognitive abilities had been attempted, the results were inconclusive. The director of behavioral health services reported that he now had a qualified examiner on staff.

12. The functional assessment was considered complete for four of the nine individuals. These were Individual #386, Individual #328, Individual #325, and Individual #399. For the remaining five individuals, no target behaviors were exhibited during the one to two brief observations. There was no rationale for not conducting additional observations.

In comments on the draft version of this report, the State wrote "For individual #236 the document (TX-LB-2111.I.19) shows two formal observations, an informal observation, and a video review of a critical incident. He had no target behavior of UAD or attempts in the past 12 months." As a result, the Monitor has changed the score for this individual to a 1. The FA should include this information for the reader, IDT, and other clinicians.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
Summary: Due to sustained high performance, indicator 13 will be moved to the category of requiring less oversight. The PBSPs contained many of the required components, but each was missing one or more. Details are provided in the comments below. Indicator 15 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	328	386	325	99	399	298	174	134	236
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	The PBSP was current (within the past 12 months).	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 documentation provided, there was evidence that the PBSP had been implemented with 14 days of all consents for each of the nine individuals.

15. While none of the PBSPs were considered complete, 75% or more of the plans included
- operational definitions of both targeted problem behaviors and replacement behaviors,
- antecedent and consequent strategies, and
- sufficient opportunities for teaching/reinforcing functional replacement behaviors.

Individual specific feedback is provided below.
- Individual #386's plan indicated that staff should ask him if he was using appropriate language when he engaged in verbal aggression, followed by staff encouraging him to engage in problem solving. As one hypothesized function was to obtain attention, these responses may prove reinforcing to him.
- One of Individual #328's target behaviors was verbal aggression. Included in the definition was his "baiting and provoking" others. This definition needed improvement to ensure that all staff understand the meaning of these responses. Also, staff were advised to "pivot" in response to self-injurious behavior. The plan needs to provide specific guidance for what to do if his SIB becomes dangerous.
- The definition of Individual #325's disruptive behavior included cursing at others, which was also identified as a precursor to other behaviors. The guidelines for responding to this behavior were different in different sections of the plan. There were some restrictions included in her plan. For example, if she lent her phone to another individual, she would lose access to her phone for 14 days. Alternative strategies, including education and reinforcement for appropriate behavior, should be stressed.
- Individual #99's replacement behavior was to use his sign language book, however, it was not clear what observable action he was to make (e.g., point to the sign, imitate the sign). When observing him in his home, the staff member was unaware of an individualized book for Individual #99 and instead referenced a chart on the wall. During another observation, the staff member indicated that several pages included in his I-Book served as his sign language book. His PBSP noted that staff should

encourage him to use his sign language book, but there were no instructions if he refused. Lastly, staff were advised to remain at a distance from him once he stopped displaying aggression, but a time frame was not identified.

- Individual #399's PBSP included all required components with the exception of current treatment objectives. The plan was implemented in April 2021, but the goals were to be met by March 2021.
- Individual #298's plan indicated that collectively, professional staff were to spend a minimum of 15 minutes per week providing dense attention to her. Further, professional staff were not to provide attention when she was in their offices, in the front hallway, or when she knocked on their doors. Staff should develop an alternative plan for reinforcing an acceptable frequency of such behaviors (e.g., scheduled office visits, a specified number of office visit tokens each day). In addition, reference was made to rectal digging in the prevention section and there were consequences identified for observed aggression. Neither of these behaviors were identified and defined as target behaviors. Her PBSP advised staff to avoid reacting to her attempts to touch others after she engaged in rectal digging. This behavior was first mentioned in the prevention section, but was not otherwise addressed. Even if addressed in the plan as a monitored behavior, it is important to provide staff with an operational definition of this behavior, so they can respond and record data accordingly.
- Individual #174's PBSP indicated that escape was the primary hypothesized function of his identified target behaviors. While his replacement behavior addressed communicating his desire to eat, drink, or obtain his blanket, it did not specifically address escape.
- Individual #134's PBSP summary noted multiple revision dates, including the addition of two target behaviors. None of these revisions were evident in his full PBSP. An ISPA meeting on 10/7/21 noted that a revision to his PBSP was necessary. When an updated PBSP was requested, the facility provided his PBSP summary which was last updated on 9/29/21. Behavioral health services staff need to ensure that recommended changes are implemented in a timely manner.
- As discussed with the director of behavioral health services, Individual #236's PBSP should be revised so that clear guidelines are presented with regard to protecting his safety should he engage in unauthorized departure. The plan currently reads that staff should block him from getting into the street by "any means necessary" to ensure his safety.
- Facility staff are commended for creating contracts and token programs to assist with positive behavior change. The contracts and token programs are in a separate document from the PBSP and are not part of the criteria for indicator 15. That being said, these should be of sufficient detail so that all parties agree on the contingencies. For example, Individual #399 had a contract that addressed his pulling the fire alarm or turning on the stove. If he refrained from engaging in both of these behaviors for a week, he could earn some ice cream. It was not clear when and where the exchange was to occur, nor was it clear how much ice cream he was to obtain. He had another contract in which he could earn a meal of his choice, but again the time and place of token exchange was not specified. Nor was it clear that he could choose a meal from any restaurant available. Individual #399 was to earn a card for every meal he ate, but it was not specified whether cards were earned after each meal or at a specified time.
    - Although also not part of the criteria for indicator 15, some of these were inconsistently applied. Reinforcement contingencies are an integral part of any PBSP, these should be implemented with the same degree of fidelity or integrity that is expected regarding all other plan components. Additionally, it is important for behavioral health services staff to provide appropriate models when implementing any strategies that are designed to result in positive behavior change.

Comments regarding two individuals reviewed by the physical health monitoring team are provided below.

- Individual #249 had a restriction put in place in May 2021 following her last ingestion of a non-edible item that required surgical removal. The need for the restriction was clear and the Center provided rationale for it. She was to be restricted to her home, except for five, 15-minute breaks daily to have a cigarette. Her access to her personal possessions, including clothing and her cell phone, was also restricted. After three months of no self-injurious or pica behavior, time outside of her home was to increase in one hour increments. The Center reported that restrictions were added only after a range of less restrictive interventions were approved through due process, that restrictive interventions were systematically removed, and that the interventions resulted in decreased incidence of dangerous ingestion. Although not part of the criteria for this monitoring indicator, the Monitoring Team also recommends that such a highly restrictive intervention should be reported on in her monthly PBSP progress notes, too.
- Individual #182 had an interim PBSP that was implemented in June 2021. This was initiated in response to an observed increase in his pica behavior. The plan was to complete a behavioral health assessment, part of which is a functional behavior assessment, within 60 days. At about the same time, he moved homes. The behavior health specialist assigned to his new home was on extended leave. The director of behavioral health services reported that this lapse in completion of the new assessment and updated PBSP was not discovered until the document request was received on the 10/1/21. At the time of the review, this matter had still not been resolved.

Although not found in his PBSP, at Individual #99's ISP meeting, staff discussed the use of a soft helmet to protect him due to his self-injurious behavior. When the director of behavioral services was asked about this, he provided a timeline of events that led the IDT to add this to his PNMP. It was reported that feedback had been provided immediately and a campus wide inservice was to occur to ensure all staff understand the restrictiveness of a PMR-SIB plan and the protocols that must be followed if this is determined to be necessary. The facility director also reported that this would be added to quarterly training provided to QIDP staff.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.												
Summary: Performance had not maintained, however, given these indicators were in the category of less oversight, they will remain in this category. Comments, however, are provided below.			Individuals:									
#	Indicator	Overall Score										
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	Due to the Center's sustained performance, these indicators were 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.											

Comments:

24. Four individuals had been referred for counseling. Individual #134 had been discontinued from counseling in May 2021 with no clear plans for how or when this would be re-introduced.

25. A counseling treatment plan was not provided for any of the four individuals. Three months of progress notes were provided for Individual #328, Individual #325, and Individual #399. The progress notes did not indicate that evidence-based practices were being

employed, did not identify a data-based criterion that would trigger review of the counseling services and/or goals, and did not include plans for generalization of skills learned in counseling. The goals for Individual #325 were considered measurable. In addition to a narrative report, the counselor included data for each individual's objectives.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: For the nine individuals in the review group, PCPs completed timely AMAs, as well as IMRs. Given the Center's sustained progress with the timely completion of AMAs (i.e., Round 15 – 89%, Round 16 – 100%, and Round 17 – 100%), Indicator b will move to the category requiring less oversight. If Center staff sustain their progress with the timely completion of IMRs, then after the next review, Indicator c might move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: b. It was positive that all nine individuals in the review group had timely AMAs. c. Per the instruction of State Office, and as memorialized in the State Office Medical Care policy #009.3, with an effective date of 2/29/20, PCPs are expected to complete IMRs quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable"). It appeared that PCPs at Lubbock SSLC were following this guidance.											

Outcome 3 – Individuals receive quality routine medical assessments and care.	
Summary: Center staff should continue to improve the quality of annual medical assessments, particularly with regard to up-to-date family histories, and thorough plans of care for each active medical problem, when appropriate. It was positive that the IMRs for the selected chronic conditions/at-risk areas for individuals in the review group followed the State Office template, and provided necessary updates.	Individuals:

Indicators a and c will remain in active oversight. If Center staff sustain their progress with regard to the quality of the IMRs, after the next review, Indicator c might move to the category requiring less oversight.											
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
a.	Individual receives quality AMA.	22% 2/9	0/1	0/1	1/1	0/1	1/1	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 individualized needs, but no less than every six months.	94% 17/18	2/2	2/2	2/2	2/2	2/2	1/2	2/2	2/2	2/2

Comments: a. It was positive that two individuals' AMAs (i.e., Individual #354, and Individual #203) included all of the necessary components, and addressed the selected chronic diagnoses or at-risk conditions with thorough plans of care. Problems varied across the remaining AMAs the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all AMAs addressed pre-natal histories, social/smoking histories, childhood illnesses, past medical histories, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Most, but not all included updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, up-to-date family histories, and thorough plans of care for each active medical problem, when appropriate.

Most of the annual medical assessments met most of the criteria for quality. With concentrated efforts on the remaining areas of focus, PCPs could make good progress on this indicator.

c. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions [i.e., Individual #298 – breast cancer, and weight; Individual #134 – polypharmacy, and urinary tract infections (UTIs); Individual #354 – esophageal cancer, and fluid imbalance; Individual #209 – seizures, and UTIs; Individual #203 – weight, and falls; Individual #249 – skin integrity, and weight; Individual #226 – constipation/bowel obstruction, and respiratory compromise; Individual #182 – cardiac disease, and behavioral health/pica; and Individual #241 – cardiac disease, and weight].

It was positive that most of the IMRs for these selected chronic conditions/at-risk areas followed the State Office template, and provided necessary updates. The exception was for Individual #249 for weight for whom the PCP did not mention weight in the IMR.

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.	
Summary: As indicated in the last several reports, overall, much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs. These indicators will continue in active oversight.	Individuals:

#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

Comments: a. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions (i.e., Individual #298 – breast cancer, and weight; Individual #134 – polypharmacy, and UTIs; Individual #354 – esophageal cancer, and fluid imbalance; Individual #209 – seizures, and UTIs; Individual #203 – weight, and falls; Individual #249 – skin integrity, and weight; Individual #226 – constipation/bowel obstruction, and respiratory compromise; Individual #182 – cardiac disease, and behavioral health/pica; and Individual #241 – cardiac disease, and weight).

No IHCPs were submitted for the following active problems/chronic conditions: Individual #298 – breast cancer (and/or palliative/comfort care), and weight loss; Individual #354 – esophageal cancer; Individual #182 – pica; and/or Individual #241 – weight loss. None of the remaining IHCPs included action steps to sufficiently address the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.

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

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: Progress was noted with regard to ensuring that individuals had current dental examinations. The Center should continue to focus on completing timely dental exams and summaries, at least annually, as well as improving the quality of dental exams and summaries. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
a.	Individual receives timely dental examination and summary:										

	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A									
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.	22% 2/9	1/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	56% 5/9	1/1	0/1	1/1	0/1	1/1	1/1	0/1	0/1	1/1
b.	Individual receives a comprehensive dental examination.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1
c.	Individual receives a comprehensive dental summary.	56% 5/9	1/1	0/1	1/1	0/1	1/1	1/1	0/1	0/1	1/1

Comments: a. For the previous three reviews, due to staffing issues in the Dental Department, as well as COVID-19 restrictions, individuals often did not have timely dental exams. The following describes both progress and ongoing concerns noted:

- Of the nine individuals in the review group, seven had recent dental exams. Although five of the seven recent exams did not also meet the criterion for having been completed within 365 days of the previous ones, the completion of annual dental exams within the last 12 months for many of the individuals was significant progress.
- The Center did not submit current dental exams for Individual #226 or Individual #182, whose last dental exams occurred, respectively, on 9/9/17, and 4/17/17. Individual #226 was not cleared by the pulmonologist for TIVA/GA. Individual #182, required general anesthesia in a hospital setting.
    - For individuals needing hospital dentistry, there is a need for staff to clearly document this need and the reason(s) for it in the individuals' records.
    - In addition, at the time of the Monitoring Team's review, Lubbock SSLC was negotiating a hospital dentistry contract, but it had not yet been finalized. Center staff need to identify and address the barriers to finalizing a contract.
- For Individual #134 and Individual #209, the annual dental summaries were based on outdated annual dental exams, so the information available to the IDTs was not useful for planning. The IDT for Individual #134 held his annual ISP planning meeting on 1/7/21, and Dental Department staff completed his annual dental summary on 12/20/20. However, it was based on a dental exam dated 11/15/19. The IDT for Individual #209 held his annual ISP planning meeting on 8/9/21, and Dental Department staff completed his annual dental summary on 7/22/21. However, it was based on a dental exam dated 12/13/19.

b. As described above, for Individual #226 and Individual #182, Center staff did not submit a dental examination completed in the last 12 months. It was very positive, though, that all seven recent exams thoroughly addressed all of the required components of the annual dental exams were thoroughly addressed.

c. The dental summaries for Individual #134, Individual #209, Individual #226, and Individual #182 were based on outdated exams and, therefore, were not useful to the IDTs for planning. For the remaining five individuals, it was positive that the annual dental summaries reviewed included all of the required components.

In its comments on the draft report, the State asked for clarification related to the findings for Indicator c, and stated: "This indicator for the previous 2 rounds scored 100% even though the summaries were also based upon outdated exams. Please clarify why the standard has changed or correct the score." The standard did not change, and the previous two reports provided scores that reflected this standard, as well as narrative to explain the reason for summaries that did not meet criterion. More specifically, for Round 15, the score for Indicator c was 67%, and. for Round 16, it was 0%. The narratives in these reports read:

Round 15 with score of 67% (6/9): "At the time of the last review [Round 14], most of the individuals reviewed did not have updated dental exams, so the dental summaries were based off of old information and were of little use to the IDTs. During this review, this was only a problem for three of the nine individuals."

Round 16 with score of 0% (0/9): "Even when examinations could not be completed due to COVID-19 precautions, Dental Department staff completed timely annual dental summaries to provide the IDTs with information for ISP meetings. This was positive.

As described above, though, the dental summaries were often based on older exams. However, the Monitoring Team has provided scores and information about the inclusion in the summaries of the necessary information. For the nine individuals reviewed, none of the annual dental summaries reviewed included all of the required components, but most were missing only one or two of the required components…"

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.											
Summary: For the six individuals in the nursing review group, nurses completed timely quarterly nursing record reviews and physical assessments. As a result of the Center's sustained performance (i.e., Round 15 – not rated, Round 16 – 100%, and Round 17 – 100%), Indicator a.iii will move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.										

	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	100% 6/6	1/1	1/1	1/1	1/1	N/R	N/R	1/1	1/1	N/R
	Comments: a.iii. It was positive that for the six individuals in the nursing review group, RNCMs completed timely quarterly nursing record reviews and physical assessments.										

Outcome 4 – Individuals have quality nursing assessments to inform care planning.											
Summary: It was positive that for about a third of the risks reviewed, the quarterly record reviews included relevant clinical data. In three of 11 quarterly reviews, RNCMs analyzed this information. Work is still needed to make improvements in this regard with annual, as well as quarterly reviews, and RNCMs need to offer relevant recommendations. Work is also needed to improve the content and thoroughness of annual and quarterly physical assessments, and to ensure that nurses complete thorough record reviews on an annual and quarterly basis. When individuals experience exacerbations of their chronic conditions, nurses need to complete assessments in accordance with current standards of practice. All of these indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
a.	Individual receives a quality annual nursing record review.	0% 0/6	0/1	0/1	0/1	0/1	N/R	N/R	0/1	0/1	N/R
b.	Individual receives quality annual nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	0% 0/6	0/1	0/1	0/1	0/1			0/1	0/1	
c.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/12	0/2	0/2	0/2	0/2			0/2	0/2	

d.	Individual receives a quality quarterly nursing record review.	0% 0/6	0/1	0/1	0/1	0/1			0/1	0/1	
e.	Individual receives quality quarterly nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	0% 0/6	0/1	0/1	0/1	0/1			0/1	0/1	
f.	On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk.	0% 0/11	0/2	0/2	0/1	0/2			0/2	0/2	
g.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	17% 2/12	0/2	0/2	0/2	0/2			0/2	2/2	

Comments: a. It was positive that all of the annual or new-admission nursing record reviews for individuals in the review group included, as applicable, the following:

- Immunizations;
- Tertiary care; and
- Allergies or severe side effects to medication.

The components on which Center staff should focus include:

- Active problem and diagnoses list updated at the time of annual nursing assessment (ANA);
- Family history;
- Procedure history;
- Social/smoking/drug/alcohol history;
- List of medications with dosages at the time of the ANA;
- Consultation summary; and
- Lab and diagnostic testing requiring review and/or intervention.

b. and e. Problems with the physical assessments included incomplete vital signs, a lack of pain assessments or no reference to the pain scale used, missing or incomplete system assessments, and/or a lack of follow-up on abnormal findings.

c. and f. For six individuals, the Monitoring Team reviewed a total of 12 specific risk areas (i.e., Individual #298 – cardiac disease, and falls; Individual #143 – falls, and medication side effects/polypharmacy; Individual #354 – aspiration, and medication side

effects/polypharmacy; Individual #209 – aspiration, and infections; Individual #226 – aspiration, and GI problems; and Individual #182 – aspiration, and infections).

Overall, none of the annual comprehensive nursing or quarterly assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. However, on a positive note, nurses included status updates, including relevant clinical data, for about a third of the risk areas reviewed in the quarterly assessments (i.e., Individual #298 – falls; Individual #354 – aspiration; and Individual #226 – aspiration, and GI problems).

Unfortunately, nurses had only analyzed this information, including comparisons with the previous quarter or year for the following: Individual #298 – cardiac disease; and Individual #226 – aspiration, and GI problems. Overall, nurses had not made necessary 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. The exception to this was the quarterly assessment for Individual #354 – aspiration.

d. It was positive that all of the most recent quarterly nursing record reviews for individuals in the review group included the following, as applicable:

- Allergies or severe side effects to medication.

Most, but not all of the most recent quarterly nursing record reviews for individuals in the review group included, as applicable:

- List of medications with dosages at the time of the quarterly nursing assessment; and
- Immunizations.

The components on which Center staff should focus include:

- Active problem and diagnoses list updated at the time of the quarterly assessment;
- Family history;
- Procedure history;
- Social/smoking/drug/alcohol history;
- Consultation summary;
- Lab and diagnostic testing requiring review and/or intervention; and
- Tertiary care.

g. The following are examples of when assessing exacerbations in individuals' chronic conditions (i.e., changes of status), nurses adhered to nursing assessment guidelines in alignment with individuals' signs and symptoms:

- On 7/27/21, at 7:40 p.m., during medication pass, Individual #182 was coughing. The nurse followed the nursing assessment guidelines for respiratory distress/aspiration.
- On 7/27/21, during medication pass, Individual #182 had a fever and cough. The nurse conducted an assessment in accordance with the nursing guidelines for a temperature elevation.

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

- On 8/20/21, at 12:45, Individual #298's blood pressure was 97/58. At 11:37 a.m., nursing staff had administered Verapamil, but they did not take her blood pressure prior to administration. During this time period, she also had received monoclonal antibodies via intravenous (IV), so nursing staff were monitored her for that. A nurse documented that "VS's [vital signs] consistently stable throughout the monitoring." Although the individual had orders to contact her PCP for blood pressure readings less than 100/60, the nurse did not document contact with the provider. The nurse did assess the individual's blood pressure every 15 minutes, but this was related to the IV treatment. Based on documentation submitted, nursing staff did not conduct assessments in accordance with nursing standards which would have included assessing the individual for blurred vision, nausea, confusion, and dizziness.
- According to an IPN, dated 9/24/21, at 9:36 a.m. (i.e., page 41 of TX-LB-2111-II.37…V.3), on 9/22/21, Individual #298 fell. From the note, it was not clear when staff notified the nurse. On 9/24/21, a nurse conducted and/or documented an assessment. The fall was described as a "true fall" that was "witnessed." The individual "fell forward out of wheel chair [sic]." The assessment that the nurse conducted on 9/24/21, was in alignment with the fall guidelines, but was not in alignment with the head injury guidelines.
- On 9/11/21, Individual #134 fell twice, including at 2:30 p.m., and 4:12 p.m. Based on IView documentation, nursing staff did not assess the individual until 5:07 p.m. At that time, the nurse noted that the individual did not have issues with range-of-motion (ROM). During a follow-up assessment at 10:30 p.m., a nurse noted that the individual's right hand was very edematous, with a large amount of ecchymoses, and the individual's 5th digit was disfigured and sticking out and away from his hand. There was no active ROM, and the individual's pulse was now 140 with a pain rating of 7. Nursing staff did not conduct the assessment according to the nursing guidelines for falls; they did not review the individual's finger ROM.
- On 5/24/21, Individual #134 presented with diaphoresis and a rapid heart rate. On 5/17/21, staff had completed the AIMS and MOSES screenings. The scores were 0 and 25, respectively. On 5/24/21, nursing staff did not reassess the individual. The nurse did note the individual's gait was characterized by leaning forward. The nurse also noted the individual's vital signs, and blood sugar, as well as pain, although the nurse did not document the pain scale used. The nurse noted that they called the PCP with no new orders. The nurse also called the psychiatrist, who did not answer. The nurse noted they would call again, but documentation was not submitted to show that a repeat call occurred. On the next day, the psychiatrist saw the individual.
- On 6/28/21, at 12:01 p.m., Individual #354 vomited three times. A nurse noted that his lungs were clear and bowel sounds times three. The nurse also provided a description of the emesis and noted the amount in IView. The nurse also noted the individual's vital signs, and oxygen (O2) saturation. However, the nurse did not assess the individual's level of consciousness (LOC), hydration, and/or skin, as indicated by the nursing guidelines for vomiting and respiratory distress/aspiration.
- On 6/8/21, at 6:37 p.m., Individual #354 returned to the Center after receiving his first round of chemotherapy and radiation therapy. A nurse assessed his vital signs, but did not assess him for nausea and vomiting. It was not until 11:50 p.m., that a nurse reassessed him.
- On 5/17/21, at 3:20 a.m., Individual #209 had emesis of formula. A nurse took his vital signs, and described a moderate amount of formula mixed with sticky mucus. The nurse documented that the individual's lungs were clear, bowel sounds active, and his breathing was even and unlabored. The nurse stated: "pain not noted," and LOC "normal to resident." This assessment did not coincide with nursing guidelines for vomiting in that the nurse did not assess the individual's hydration, positioning at time of emesis, presence/absence of nausea, and did not identify the pain scale used to assess pain.
- On 6/2/21, at 9:45 a.m., Individual #209 was crying and agitated, shaking his head back and forth, moaning, and drawing his legs up to abdomen. The nurse took the individual's vital signs. His blood pressure was 177/93, temperature was 36.6, his

heart rate was 98, and his respirations were 18. The nurse called the provider, and obtained an order for a urinalysis (UA) via straight catherization. The assessment was not in alignment with the nursing guidelines, because the nurse did not include the frequency/voiding patterns, an intake and output (I&O) analysis, urgency, characteristics of the individual's urine, or his orientation. The nurse also did not assess the individual's bowel sounds/abdomen.

- On 7/9/21, Individual #226 experienced apneic episodes, including one at 8:37 a.m. A nurse listened to his bowel sounds, and documented an infrequent cough. The individual was able to clear secretions. The nurse assessed the individual's gastrostomy tube (G-tube), urinary system, and skin. The nurse did not listen to the individual's lung sounds, which was inconsistent with the respiratory distress/aspiration nursing guidelines. It was not until 10:09 a.m. that a nurse assessed his lung sounds.
- On 6/16/21, at 8:20 p.m., staff noted that Individual #226 had not had a bowel movement since 6/13/21, at 3:04 p.m. A nurse administered a Bisacodyl suppository for constipation with positive results. However, the nurse did not complete an assessment according to the nursing guideline for constipation. The nurse did not assess the individual's vital signs, LOC, lung sounds, hydration, or change in appetite, or to determine if he had nausea or vomiting. The nurse did assess the individual's bowel sounds. While the nurse noted the administration of Bisacodyl in an IPN, they did not document in IView that it was given.

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

Summary: As noted in the last report, Center staff made and now sustained some good progress with regard to the inclusion of nursing interventions in individuals' IHCPs. Staff are encouraged to continue these efforts because most plans reviewed still were missing key supports, and/or did not identify measurable goals/ objectives to allow IDTs to track individuals' progress. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
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.	42% 5/12	2/2	0/2	1/2	1/2	N/R	N/R	0/2	1/2	N/R
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	42% 5/12	1/2	1/2	0/2	1/2			1/2	1/2	
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).	8% 1/12	2/2	0/2	0/1	1/2			0/2	0/2	
d.	The IHCP action steps support the goal/objective.	50% 6/12	2/2	0/2	1/2	1/2			1/2	1/2	

e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	75% 9/12	2/2	0/2	2/2	2/2			2/2	1/2	
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	75% 9/12	2/2	0/2	2/2	2/2			2/2	1/2	

Comments: a. through f. As noted in the last report, Center staff made and now sustained some good progress with regard to the inclusion of nursing interventions in individuals' IHCPs. Individual #298's IHCP for cardiac disease met criteria for all of these indicators. The remaining IHCPs were missing some key nursing supports. It was positive that some of the IHCPs reviewed included action steps for nursing assessments/interventions to address the underlying cause(s) or etiology(ies) of the at-risk or chronic condition (e.g., for individuals with high risk for falls, weekly observation of the individual's ability to self-propel via wheelchair to dining chair, or twice monthly monitoring of the individual's gait; or monthly monitoring of medication passes for an individual with high risk for aspiration). Additional work is needed to make sure that interventions are measurable, and that the IHCPs include interventions that comprehensively address the individuals' chronic conditions and areas of risk. For example, at times, IDTs included a partial list of regular nursing assessments needed to address the individuals' needs, but left out important assessment steps or criteria. Similarly, at times, preventative interventions were only partially included, and essential ones were missing.

a. The IHCPs that included interventions for ongoing nursing assessments that were in alignment with applicable nursing guidelines/standards of care were those for: Individual #298 – cardiac disease, and falls; Individual #354 – medication side effects/polypharmacy; Individual #209 – aspiration; and Individual #182 – aspiration.

b. Half of the IHCPs reviewed included preventative interventions. Continued work is needed to ensure that IHCPs include interventions for staff and individuals to proactively address the chronic/at-risk condition. Examples might include drinking a specific amount of fluid per day to prevent constipation, washing hands before and/or after completing certain tasks to prevent infection, etc. The IHCPs that included sufficient preventative interventions were for: Individual #298 – cardiac disease; Individual #143 – falls; Individual #209 – aspiration; Individual #226 – aspiration; and Individual #182 – aspiration.

c. The IHCP with a measurable objectives for tracking progress was for: Individual #298 – cardiac disease.

d. The IHCPs that included action steps to support the goal/objective were for: Individual #298 – cardiac disease, and falls; Individual #354 – medication side effects/polypharmacy; Individual #209 – aspiration; Individual #226 – GI problems; and Individual #182 – aspiration.

e. The IHCPs that included specific clinical indicators for measurement were for: Individual #298 – cardiac disease, and falls; Individual #354 – aspiration, and medication side effects/polypharmacy; Individual #209 – aspiration, and infections; Individual #226 – aspiration, and GI problems; and Individual #182 – aspiration.

f. The IHCPs that identified the frequency of monitoring/review of progress were for: Individual #298 – cardiac disease, and falls; Individual #354 – aspiration, and medication side effects/polypharmacy; Individual #209 – aspiration, and infections; Individual #226 – aspiration, and GI problems; and Individual #182 – aspiration.

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: In comparison with previous reviews, the scores during this review generally showed improvement with regard to the timely referral of individuals to the PNMT, timely completion of PNMT comprehensive assessments, and the completion of the correct type of assessment (i.e., review or comprehensive assessment). The Center should focus on continuing its progress in these areas. If the Center sustains its progress with regard to the timely completion of comprehensive PNMT assessments, after the next review, Indicator c might move to the category requiring less oversight. It was positive that one of the five comprehensive assessments met all of the criteria for quality. The remaining assessments met many of them, but were deficient with regard to between two and four of the essential components. Currently, the remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	100% 8/8	1/1	2/2	1/1	2/2	1/1	N/A	1/1	N/A	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	67% 2/3	1/1	1/1	N/A	N/A	0/1		N/A		
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	100% 5/5	N/A	1/1	1/1	2/2	N/A		1/1		
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	88% 7/8	1/1	2/2	1/1	2/2	0/1		1/1		
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	25% 2/8	0/1	0/2	0/1	1/2	0/1		1/1		
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem;	0% 0/3	0/1	0/1	N/A	N/A	0/1		N/A		

	• 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.										
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	20% 1/5	N/A	0/1	0/1	1/2	N/A		0/1		

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

- Individual #298 fell from her wheelchair three times in 30 days (i.e., on 8/28/21, 9/6/21, and 9/22/21). In the previous year, she had fallen 11 times with two serious injuries. On 9/27/21, she was referred to the PNMT. On 9/30/21, the PNMT completed a review with the presenting problem listed as more than three falls in 30 days.

  The PNMT considered the falls to be related to problem behaviors, because the individual had a history of sliding herself off of her wheelchair. However, no Behavioral Health Services staff participated in the PNMT review. In addition, the review did not provide any detail or summary of the behavioral interventions in place to address these concerns, and/or their effectiveness in reducing the behavior. In the review, the PNMT stated that "it has been observed that staff are following [Individual #298's] PNMP correctly for transfers and positioning," but they did not indicate how many observations they conducted and/or during which activities they made observations to come to this conclusion.
- For Individual #134:
  - On 4/14/21, the PNMT made a self-referral related to falls. On 4/15/21, they initiated an assessment, and on 5/13/21, they completed it. Given that the individual's behaviors were identified as a primary factor in the falls and injuries, BHS staff should have participated in the assessment. No evidence was found to show their participation. The quality of the assessment is discussed below.
  - On 9/21/21, the PNMT conducted a review for falls for Individual #134. As the State indicated in the comments on the draft report, the referral form showed the date of request was 9/16/21, and that PNMT responded on 9/21/21. PNMT review was signed on 9/21/21. Similar to the assessment in April, no BHS staff participated in this review.

    With regard to the quality of the review, the PNMT identified the presenting problem as eight falls within 30 days. They reviewed risk ratings for osteoporosis, falls, and fractures. They stated that their data review did not show falls were related to changes in his baseline gait or mobility.

    The PNMT mentioned an ISPA meeting on 8/31/21, at which the IDT discussed supports, and concluded that current supports remained appropriate. The review should have included more than a statement that these topics were discussed. Rather, it should have included a description of what was discussed to justify the conclusion that current supports remained sufficient to meet the individual's needs despite ongoing falls. As with the previous assessment, the PNMT set forth no clear path to mitigate his sensitivity to the supportive equipment, which remained an issue.

- On 5/18/21, the PNMT made a self-referral of Individual #354 due to a scheduled J-tube placement (i.e., for 5/24/21) secondary to an esophageal cancer diagnosis. On 5/20/21, the PNMT initiated an assessment, and on 6/4/21, they completed it. Although the assessment included a note from the Registered Dietician, their signature was not included (i.e., similar to the concern noted below for Individual #209, the only electronic signature on the document was from the RN). The quality of the assessment is discussed below.
- For Individual #209:
    - During a hospitalization, on 9/6/20, the individual had a G-tube placed due to a failed MBSS. On 9/14/20, he was referred to the PNMT, who initiated an assessment on 9/15/20. On 10/12/20, they completed the assessment. The quality of the assessment is discussed below.
    - On 8/23/21, Individual #209 fell out of the ARJO lift, and fractured his tibia. On 8/31/21, he returned to the Center from the hospital. On 9/1/21, he was referred to the PNMT. On 9/2/21, they initiated an assessment, which they completed on 9/23/21. The only signature on the assessment was from the RN. The quality of the assessment is discussed below.

      In its comments on the draft report with regard to Indicator f, the State indicated: "For individual #209, HT puts PNMT assessment in the computer in the adhoc form and also in Word format per SO request with all the therapists [sic] names listed (RN; PT, DPT; MS, RDN, LD; CCC/SLP, OTR, MOT); TX-LB-211-II.10.209 pg. 23." As the Monitoring Team has discussed with State Office and stated in previous reports, without signature pages that include dates, it is not possible to determine which members of the PNMT participated in the PNMT assessments. This is an example of a PNMT document that included a list of "participants" within the document. Given that PNMT members are licensed clinicians, the Center needs to have a mechanism to verify the participation of each clinician in the PNMT assessment process.
- On the following dates, Individual #203 fell: 4/9/21, 4/12/21, 4/17/21, 4/30/21, 5/12/21, 6/1/21, 6/3/21, 6/4/21, 6/13/21, and 6/17/21. According to Habilitation Therapy notes, on 5/20/21, 6/17/21, and 9/2/21, he met criteria for referral to the PNMT, but his IDT did not refer him, and the PNMT did not make a self-referral. The Habilitation Therapy note, dated 9/2/21, referenced a past PNMT assessment and that falls were due to his startle reflex. However, in the documents available, the only past assessment was referenced as having been completed in 2016.

  On 6/9/21, the PNMT stated that the RN would complete a chart review to determine the need for PNMT involvement. On 6/17/21, the PNMT note stated that the RN completed a chart review and no PNMT involvement was warranted. The note included no summary of the findings to justify this conclusion. No review was provided.
- Between 10/17/20 and 5/16/21, Individual #249 engaged in multiple episodes of pica. Based on PNMT notes, the ingestion episodes were thought to be related to suicidal thoughts. The individual had no impairments with her swallow function. On 5/19/21, the PNMT attended an ISPA meeting, and discussed the PNM-related plans of care with the IDT. A formal PNMT review was not indicated.
- Within two days of a weight report, dated 10/28/20, the PNMT made a self-referral of Individual #226 due to weight loss reports of 8.8% (i.e., 15 pounds) in one month and 8.5% (i.e., 14.6 pounds) over three months. They initiated an assessment two days later, and on 11/19/20, the PNMT completed its assessment. The quality of the assessment is discussed below.

h. For the five PNMT assessments completed for individuals in the review group:

- It was positive that Individual #209's assessment, dated 8/3/21, related to his tibia fracture met all of the criteria for quality. The remaining assessments met many of them, but were deficient with regard to between two and four of the essential components.
- It was positive that all of them thoroughly addressed the following:
  - Presenting problem;
  - Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs;
  - Discussion of medications that might be pertinent to the problem, and discussion of relevance to PNM supports and services;
  - Evidence of observation of the individual's supports at his/her program areas; and
  - Identification of the potential causes of the individual's physical and nutritional management problems.
- For Individual #134, the following summarizes some of the concerns with the assessment:
  - The PNMT noted that the individual had an aversion to many of the supports designed to help protect him from injury and/or falls. More specifically, on page 2 of the assessment, dated 5/13/21, the PNMT noted that Individual #134 refused to wear his walking boots. On page 7, they noted that he refused to have the proper pillows in his chair for positioning, but this was not addressed in the recommendations. On page 7, the PNMT RN and OT requested he wear a gait belt as tolerated like the rest of his adaptive equipment. However, the PNMT assessment offered no clear plan/recommendation to address this sensitivity, and increase his acceptance of the needed equipment.
- For Individual #354:
  - The PNMT identified Intermittent Explosive Disorder as a barrier to the individual making decisions, but did not state how or if this impacted the plan of care.
  - The PNMT did a nice job reviewing mobility, transfers, and activities of daily living skills (ADLs). The registered dietician also discussed weight, intake, and enteral nutrition.
  - In 2018, the individual completed his last modified barium swallow study (MBSS), which was prior to the mass being identified. On 3/1/21, clinical staff downgraded his diet texture from regular to chopped, and again, on 3/10/21, from chopped to ground. Since the mass was identified and he experienced increased difficulty in swallowing in March 2021, no MBSS had been scheduled.

    In its comment on the draft report, the State made the following request for clarification: "For individual # 354 (TX-LB-2111-II.75.354 Pg. 26) The [sic] OT note under dysphagia section discusses first request for an MBS. On pg. 25 again it states OTR and SLP continue to recommend MBS. On pg. 23 it states 'OTR continues to recommend an MBS for individual #354.' On pgs. 21 and 22 the SLP consult recommended MBS. On pg. 19 it states 'Individual #354 is being referred to GI and ENT, PCP has ordered MBS and CT of the head and neck.' On pg. 17 it states, 'awaiting MBS and EGD.' On pg. 16 it states 'awaiting MBS and EGD.'

    There were multiple requests from HT for an MBS. Change in his texture was done clinically with discussion with client and assessment. It is felt that therapists did due diligence for the needs of the client for comfort with oral

consumption. Is there another recommendation that the monitoring team can provide if MBS has been requested and does not get completed per PCP discretion?"

For individuals at the Center, decisions about medical evaluation and treatment are/should not made by one clinician, but require input from the legally authorized representative and/or the Center Director, as well as the entire IDT. When IDTs have differences of opinion that they cannot resolve, the current ISP process includes a process for resolution. The process to address a lack of consensus is described in the State Office ISP policy (#004.4).

- With regard to the individual's current supports, the PNMT stated that the plan appeared to be effective, but they did not provide supporting statements to justify this conclusion. Particularly because there was not a recent swallow function assessment, it was not clear how the PNMT was able to fully assess the appropriateness of the current supports.
- The PNMT identified that the individual's skin integrity risk was increased due to the new diagnosis of cancer, but they did not offer any proactive recommendations to mitigate the increased risk to the extent possible.

In its comments on the draft report, the State disputed this finding, and stated: "For individual # 354, (TX-LB-2111-II.10.354 pgs. 6) under current services it states 'Nursing assessed skin, chest area and IV port site for s/s redness, swelling, blisters, drainage, odor, warmth. Assess oral mucosa for blisters, drainage, odor, pain, and notify PCP and/or RNCM of abnormal findings.' (TX-LB-2111-II.10.354 pgs. 10) Under positioning it states the following, 'PNMT and home PT brought a wedge for individual # 354 to trial and he stated he was very comfortable. He had a wedge in the past which was discontinued due to medicine controlling his GERD, but now with the tube a wedge is appropriate. Individual #354 can position himself. A supporting document was implemented 5/27/21 to reflect the use of a wedge for head of bed elevation under his mattress and a gel cushion mattress overlay for comfort.' This information in the assessment shows that these are skin integrity supports implemented by PNMT during the time of assessment." At the time of the PMT assessment, skin integrity and supports were assessed, but did not reflect a proactive plan to mitigate the increased risk due to the diagnosis of cancer. Proactive individualized monitoring and review should have been integrated into the assessment.

- For Individual #209's assessment, completed on 10/12/20:
  - The PNMT discussed his skin integrity risk as it related to a Stage 2 pressure injury that he developed while in the hospital. However, the PNMT did not discuss the impact of the changing form of nutrition on his risk for skin issues/ impairment.

    In its comments on the draft report, the State disputed this finding, and stated: "For individual # 209 (TX-LB-2111-II.10.209 pg. 35) the RDN note states under interventions/recommendations that they are increasing his Juven and 'RDN continues to monitor due to wound 2 times per month.' This is addressing the skin integrity related to change in nutrition and new pressure injury." As part of the review of risk ratings, information should be included that may have an impact on the risk level. In this case, the PNMT listed skin integrity as a high risk, but did not clearly discuss how the change to tube feeding might impact the overall risk. The assessment provided only an assessment and plan for monitoring, which is not the same as discussing the risk of skin issues related to the tube leaking or a potential change in bowel patterns.

- The PNMT offered no clear plan or recommendations related to his potential ability to return to oral intake.

  In its comments on the draft report, the State asked for clarification about this finding, and stated: "For individual # 209, (TX-LB-2111-II.10.209 pg. 36) where it states 'f/u SLP/PCP with f/u MBS if individual # 209 status improves. This was the plan to have another MBS when he was stable. TX-LB-2111-II.72.209, pgs. 6 & 12. Following the PNMT assessment, PNMT continued to follow up on the plan for an MBS pg. 6 states the following: 'An MBS is currently pending for 12/1/20 to re-evaluate swallow function since individual #209 G tube placement. On pg. 12 it states 'An MBS previously pending for 12/01/20 to re-evaluate swallow function since individual #209 G-tube placement was canceled per PCP d/t weight concerns. IDT stated they will follow up on discussion of MBS in the future if PCP deems appropriate.' It was a recommendation from PNMT to have an MBS, but this order was cancelled."

  A scheduled MBSS or a plan to complete an MBSS does not reflect a comprehensive plan to return to oral intake. A plan should be developed that clearly identifies barriers to the individual returning to oral intake, as well as the steps, as appropriate. to address and mitigate the individual's risk, and strengthen any deficits that might impact or impede the individual's ability to return to oral intake.
- The only goal that the PNMT recommended was related to nutrition and hydration via the G-tube to promote wound healing and improve strength, as evidence by healed wounds and level of activity at baseline.

- For Individual #226's assessment:
  - In discussing the effectiveness of his current supports, the PNMT stated that the calorie increases were appropriate to achieve weight gain. However, they had not been effective in achieving weight maintenance or weight gain. If the calorie increases were not effective, then the justification for them was unclear.
  - Recommended goals included language that was not measurable (e.g., "given the appropriate nutrition").

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

Summary: It was positive that many of the IHCPs reviewed identified clinical indicators, as well as individualized triggers and action staff should take if they occurred. Overall, though, ISPs/IHCPs were still missing key PNM supports, and the IDTs had not addressed the underlying cause(s) or etiology(ies) of the PNM issues in the action steps. In addition, many action steps were not measurable.

Seven out of nine PNMPs reviewed met the requirements for quality, which was good to see. With minimal effort and attention to detail, the Habilitation Therapy staff could make the needed corrections to PNMPs.

#	Indicator	Overall Score	Individuals: 298	134	354	209	203	249	226	182	241
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	1/2

	assessment/review or Physical and Nutritional Management Plan (PNMP).										
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	72% 13/18	1/2	1/2	2/2	2/2	2/2	1/2	0/2	2/2	2/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	81% 14/17	2/2	0/2	2/2	2/2	2/2	2/2	1/1	2/2	1/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	39% 7/18	0/2	0/2	2/2	2/2	2/2	1/2	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: Individual #298 – falls, and choking; Individual #134 – falls, and choking; Individual #354 – aspiration, and choking; Individual #209 – aspiration, and fractures; Individual #203 – falls, and choking; Individual #249 – GI problems, and choking; Individual #226 – weight, and aspiration; Individual #182 – aspiration, and falls; and Individual #241 – aspiration, and falls.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP. The exceptions were for: Individual #226 – weight, and Individual #241 – falls.

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

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

- Although Individual #354's PNMP identified the need for staff to ensure that he did not overfill his mouth, it did not specify the strategy(ies) staff should use to accomplish this.
- Based on observation and the PNMP available to staff at the time of the observation, Individual #241's PNMP/Dining Plan did not appear to match his current level of functioning. His lethargy required a heightened level of awareness when feeding him to ensure his safety. In addition, the communication strategies did not reflect that it was best for staff to speak in an elevated volume.

With minimal effort and attention to detail, the Habilitation Therapy staff could continue to make the needed corrections to PNMPs.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for: Individual #298 – falls; Individual #134 – falls; Individual #354 – aspiration, and choking; Individual #209 – aspiration, and fractures; Individual #203 – falls, and choking; Individual #249 – GI problems; Individual #182 – aspiration, and falls; and Individual #241 – aspiration, and falls.

f. The IHCPs that identified triggers and actions to take should they occur were those for: Individual #298 – falls, and choking; Individual #354 – aspiration, and choking; Individual #209 – aspiration, and fractures; Individual #203 – falls, and choking; Individual #249 – GI problems, and choking; Individual #226 – aspiration; Individual #182 – aspiration, and falls; and Individual #241 – falls.

g. The IHCPs that included the frequency monitoring/review of progress were for: Individual #354 – aspiration, and choking; Individual #209 – aspiration, and fractures; Individual #203 – falls, and choking; and Individual #249 – choking.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
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% 4/4	N/A	N/A	1/1	1/1	N/A	N/A	1/1	1/1	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/2			0/1	0/1			N/A	N/A	

Comments: a. It was positive that for the four applicable individuals, IDTs documented clinical justification for the continued medical necessity of enteral nutrition, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.

b. Individual #354 received pleasure foods at his request. He was in the process of receiving cancer treatment, and it was unclear when/if he might return fully to by-mouth intake or tolerate an upgrade in texture. Habilitation Therapy staff completed multiple monitoring sessions focused on intake and tolerance of oral intake. Documentation for each monitoring session included a plan to continue to monitor "as needed." There was no clear cohesive plan in place.

Similarly, for Individual #209, the IDT had not documented a clear cohesive plan that outlined the steps that would take place and/or interventions that staff would implement to potentially return him to oral status.

As indicated in the PNM audit tool, such a plan should include the following components, as appropriate:

- Staff training required prior to implementation;
- Staff roles and responsibilities (e.g., implementation and monitoring);
- Time and schedule of interventions;
- Specific triggers for when the plan should be stopped in the short-term;
- Milestones for proceeding with or indicators for discontinuing the plan in the longer-term;
- Documentation requirements (i.e., method for tracking progress); and
- Frequency of assessments and staff responsible.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: For the nine individuals reviewed, Center staff completed timely assessments that were of the types that were in accordance with their needs and/or based on changes in status. If the Center sustains its progress in these areas, then after the next review, Indicators a.ii and a.iii might move to the category requiring less oversight. Center staff should continue to focus on improving the quality of the assessments. Overall, many of the assessments met many of the criteria for quality, but were missing thorough assessment in one or two areas. With minimal effort, by the time of the next review, Center therapists could move further towards substantial compliance with this indicator. These remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	100% 9/9	1/1	1/1	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; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	22% 2/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	N/A									

Comments: a. and b. All nine individuals reviewed received timely OT/PT reassessments that were of the correct type based on their needs and/or any changes of status.

d. It was positive that the comprehensive assessments for Individual #354 and Individual #241 met all criteria for a quality assessment. Overall, many of the assessments met many of the criteria for quality, but were missing thorough assessment in one or two areas. With minimal effort, by the time of the next review, Center therapists could move further towards substantial compliance with this indicator.

It was also positive that all comprehensive assessments reviewed met criteria, as applicable, with regard to:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths were used in the development of OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living; and,
- 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).

Most of the remaining assessments also met criteria, as applicable, with regard to:

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments; and,
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services.

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

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings; and,
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

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

Summary: Given that over at least three reviews, individuals' ISPs included a description of how the individual functions from an OT/PT perspective (Round 15 – 89%, Round 16 – 100%, and Round 17 - 100%), Indicator a will move to the category requiring less oversight. However, due to a decline in performance (i.e., Round 15 – 67%, Round 16 -89%, and Round 17 -67%), Indicator b is in jeopardy of returning to active oversight. Improvement is needed with regard to the remaining indicators, which will continue in active oversight. To move forward, QIDPs and OTs/PTs should work together to make sure IDTs discuss and include information related to individuals' OT/PT supports in ISPs and ISPAs.

#	Indicator	Overall Score	Individuals: 298	134	354	209	203	249	226	182	241
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.	0% 0/5	N/A	0/1	0/2	N/A	N/A	N/A	N/A	0/2	N/A

d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	0% 0/3	N/A	0/1	0/2	N/A	N/A	N/A	N/A	N/A	N/A

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

b. Indicator b has been in less oversight since after Round 13 monitoring, but performance has varied since that time (i.e., Round 15 – 67%, and Round 16 - 89%). During this review, in the review of individuals' ISPs, for three of nine individuals, problems were again noted with regard to IDT review and updating of the PNMP/Positioning Schedule (i.e., adherence to the indicator was only 67%). If Center staff do not take steps to correct this concern, then after the next review, Indicator b will return to active oversight.

c. and d. As applicable, OT/PT assessments did not consistently include recommendations for OT/PT-related strategies, interventions and programs, and when they did, individuals' ISPs/ISPAs did not include the strategies, interventions, and programs as recommended in the assessment. In addition, for two applicable individuals, when a new OT/PT service or support was initiated outside of an annual ISP meeting, or a modification or revision to a service was indicated, the respective IDTs did not meet to discuss and approve implementation. OTs/PTs should work with QIDPs to ensure assessments provide the needed recommendations for IDTs to consider.

In its comments on the draft report, the State disputed the findings for Individual #134 and Individual #354, and listed a number of ISPA dates and the topics discussed. For Individual #134, the problem was that the IDT did not clearly discuss the following goal/objective, including defining the criteria for achievement (i.e., to ensure the individual mastered the skill): "will grasp an item using his left hand during preferred tabletop activities 3/5 trials in the next week." For Individual #354, the problem was similar in that no ISPA was found to show the team reviewed and approved two goals/objectives related to transfers and ambulation with a rolling walker.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.	
Summary: Some progress occurred with regard to the quality of communication assessments, but additional improvement continued to be needed 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	298	134	354	209	203	249	226	182	241
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.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.										
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.										
b.	Individual receives assessment in accordance with their individualized needs related to communication.										
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	33% 3/9	0/1	0/1	0/1	1/1	1/1	1/1	0/1	0/1	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	N/A									

Comments: d. It was positive that the comprehensive assessments for Individual #209, Individual #203, and Individual 249 met all criteria for a quality assessment. It was also positive that all of the comprehensive assessments reviewed met criteria, as applicable, with regard to the following sub-indicator:

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

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

- The individual's preferences and strengths are used in the development of communication supports and services. On 1/7/21, 1/14/21, 1/21/21, and 1/28/21, Individual #134 participated in an informal communication group. There was no clear plan or goal in place that clearly identified the rationale or purpose to his participation or removal from the communication group;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services. Individual #182's assessment did not meet criterion, because his assessment did not address the lethargy that was a potential side effect of medication(s), including its relevance to his communication;
- 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. Individual #354's assessment stated he was able to problem solve, reason, and make decisions, but did not specify to what level. It remained unclear whether or not he had the ability to complete complex community-based problem-solving or only simple problem-solving, and/or how his skills might be expanded and improved upon;
- A comparative analysis of current communication function with previous assessments; and,
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services. Individual #298's assessment discussed her current supports, such as the wheelchair attached VOCA. The VOCA was designed to get others' attention, to possibly prevent her from sliding out of the wheelchair and to avoid the running into others with the wheelchair. In the assessment the SLP stated that staff reported that individual did not utilize the supports, and, therefore, they were discontinued. The assessment included no evidence of discussion regarding what could be done to improve the individual's utilization or what might be otherwise done to address the unmet need(s); and
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated. For Individual #298, the communication assessment only stated that staff hypothesized that her behavior was to obtain someone's attention. The communication assessment provided no information about how this determination was made. For Individual #182, the assessment indicated that the SLP attended a Behavior Services Committee (BSC) meeting, and that the SLP worked with BHS to develop a VOCA as a replacement behavior, but it offered no additional information on the supports' effectiveness or status.

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

- The effectiveness of current supports, including monitoring findings; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

Summary: The Center made substantial progress with regard to ensuring that individuals' ISPs/ISPAs included recommended communication strategies, interventions and programs. However, the Center still needed to ensure that Speech-Language Pathologists (SLPs) and QIDPs worked together to ensure that assessments included applicable recommendations to meet individuals' communication needs for IDTs to consider. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	100% 6/6	1/1	N/A	N/A	1/1	1/1	N/A	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.	100% 5/5	1/1	N/A	N/A	N/A	2/2	N/A	N/A	1/1	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
Comments: b. through d. For the individuals reviewed, it was positive that, as applicable IDTs documented a thorough review of individuals' Communication dictionaries and included in individuals' ISPs/ISPAs the communication strategies, interventions and programs recommended in assessments or initiated outside of an annual ISPA. However, as described with regard to Indicator 2d above, the Center still needed to ensure that SLPs and QIDPs worked together to ensure that assessments included applicable recommendations to meet individuals' communication needs for IDTs to consider.											

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: High performance maintained for indicator 3, which will be moved to the category of requiring less oversight. Performance for the other two indicators	Individuals:

remained about the same as at the last review and both indicators will remain in active monitoring.											
#	Indicator	Overall Score	328	386	325	99	399	298	174	134	236
1	The individual has skill acquisition plans.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The SAPs are measurable.										
3	The individual's SAPs were based on assessment results.	95% 19/20	0/1	1/1	2/2	3/3	3/3	2/2	2/2	3/3	3/3
4	SAPs are practical, functional, and meaningful.	60% 12/20	0/1	0/1	1/2	3/3	1/3	1/2	2/2	1/3	3/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	18% 3/17		0/1	0/2	2/3	0/3	0/2	0/2	1/3	0/1

Comments:
All nine individuals had skill acquisition plans (SAPs). Three SAPs were reviewed for Individual #99, Individual #399, Individual #134, and Individual #236. Individual #325, Individual #298, and Individual #174 had two SAPs, and Individual #386 and Individual #328 each had one SAP. although Individual #328 had been in residence since February of 2021, his one SAP was not introduced until eight months later in October.

3. Nineteen of the 20 SAPs were based on assessment results. The exception was Individual #328's mug cake SAP. His Functional Skills Assessment (FSA) indicated he had good cooking skills, and in baseline, it was noted that he could perform four of the five steps independently. The recommendation was to evaluate his performance in three months. With simple exposure, he may learn to mix all the cake powder with the water. In fact, when observed, he completed the SAP independently, even though this had been introduced only three weeks earlier.

4. Twelve of the 20 SAPs were considered practical, functional, and/or meaningful. The exceptions were SAPs that were not related to the identified goal. These were the following: Individual #386 using the Internet, Individual #328 making a mug cake, Individual #325 learning side effects of her medication, Individual #399 counting pennies and identifying letters, Individual #298 applying stickers, and Individual #134 writing his last name and opening his lock box.

5. Documents provided by the facility reflected two different forms used to monitor SAPs for data reliability and treatment integrity. One form, used to monitor three SAPs (Individual #99 sign "movie" and use a choice board, and Individual #134 write his last name) included a section in which the data recorded by two independent observers could be compared for inter-observer agreement.

On the other hand, the other form, with a revision date of 8/22/19, did not allow for a comparison of the data recorded by two independent observers (i.e., the person who completed the teaching session and the behavioral health services staff member who observed the teaching session). Fourteen SAPs either were not monitored in accordance with the facility's policy, or they were monitored using this second form. Three SAPs were excluded from this analysis because these had been implemented for one month or less at the time of the document request.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.											
Summary: Indicator 12 continued to score low because, as in past review, vocational assessments and/or FSAs did not include any recommendations for SAPs. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	328	386	325	99	399	298	174	134	236
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	0/1	0/1	0/1	0/1	1/1	1/1	0/1	1/1	0/1

Comments:
12. Recommendations for skill acquisition plans (SAPs) were found in the FSA and vocational or day program assessments for three of the nine individuals. These were Individual #399, Individual #298, and Individual #134.

For five of the other six individuals (Individual #328, Individual #325, Individual #99, Individual #174, Individual #236), there were no SAP recommendations found in their vocational assessments. In Individual #386's case, his FSA did not include any SAP recommendations. Completion of an assessment without the identification of recommended skills to address in the coming year is of little to no assistance to the IDT.

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.

Restraint – At the time of the last review, the Center showed sustained substantial compliance with many of the requirements of Section C of the Settlement Agreement. The exceptions are Section C.5 related to licensed health care staff's (nurses' and/or physicians') roles in the monitoring of all types of restraints, and physicians' roles in defining monitoring schedules, as needed; and Section C.6 related to assessments for restraint-related injuries, as well as monitoring of individuals subjected to medical restraint. The Monitoring Teams will continue to monitor these remaining areas for which Center staff have not obtained substantial compliance using the outcomes and indicators related to these subjects. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Lubbock SSLC exited from the other requirements of Section C of the Settlement Agreement. This resulted in the exit of 11 indicators and one outcome.

Psychiatry – Since the last review, the Center met the requirements and exited from Section J of the Settlement Agreement. This resulted in the exit of 26 indicators, and nine outcomes.

Pharmacy - After Round 14, DOJ and the State agreed that the Center achieved substantial compliance with most of the requirements of Section N of the Settlement Agreement. The exceptions are Section N.6 related to adverse drug reactions, and Section N.8 related to medication variances that the Monitoring Team will review as part of Section E, and Section N.5 related to quarterly monitoring for tardive dyskinesia that the Monitoring Team will measure through Section J.12. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Lubbock SSLC exited from the other requirements of Section N of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the Pharmacy outcomes and indicators.

At the time of this review, this Domain now contains 23 outcomes, and 92 underlying indicators. Thirteen of these indicators were moved to, or were already in, the category of less oversight after the last review. Presently, four additional indicators will move to the category of less oversight in the areas of medical, dental, and nursing.

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

Goals/Objectives and Review of Progress
In behavioral health, if the individual was not making progress, worsening, and/or not stable, corrective actions were identified/ suggested for one-quarter of individuals, a decrease since the last review.

Acute Illnesses/Occurrences

Nursing assessments at the onset of signs and symptoms of acute illnesses/occurrences that are in alignment with applicable guidelines, as well as on an ongoing basis for acute illnesses/occurrences remained areas on which the Center needs to focus. It was positive that in most instances reviewed, nursing staff timely notified the practitioner/physician, but work was needed to ensure they completed and documented this in accordance with the nursing guidelines for notification. For the five acute illnesses/occurrences reviewed, nursing staff developed acute care plans. All of them included some of the necessary interventions, but all were missing key interventions. Nurses thoroughly implemented one of the six acute care plans.

Overall, the Center showed continued improvement with the provision of timely acute medical care. For most of the acute issues/illnesses treated at the Center that the Monitoring Team reviewed, PCPs assessed the individuals according to accepted clinical practice, and conducted necessary follow-up. It was also positive that for the acute issues/illnesses reviewed that required ED visits or hospitalizations, individuals received timely acute medical care, and follow-up care.

For one of two dental emergencies reviewed, Dental Department staff needed to provide improved documentation about the nature of the emergency, when it occurred, as well as the timing of notifications.

Implementation of Plans

In behavioral health, due to improvements in data reliability, progress could be assessed for four of the individuals. Of these, two were progressing. The other two were not progressing and some of the other monitoring indicators in psychology/behavioral health did not meet criteria.

In behavioral staff, regarding PBSPs, for about half of the individuals, criterion for staff training was met. For the other half, criterion was partially met.

Behavioral health PBSP data collection and checks of reliability (IOA and DCT) and integrity (TI) were occurring. Some changes in protocols and systems remained needed.

Although improvements continued, for individuals with medium and high mental health and physical health risks, most IHCPs did not fully meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not nurses implemented them. 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 nurses implemented the interventions thoroughly.

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.

Although additional work was necessary, it was positive that for a number of individuals' chronic or at-risk conditions, medical assessments, tests, and evaluations consistent with current standards of care were completed, and the PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate.

Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. For 17 of the 18 chronic conditions/risk areas reviewed, either no IHCP existed or the IDT assigned no interventions to the PCP. For the one remaining IHCP, documentation was not found to show implementation of the one action step that the IDT assigned to the PCP and included in the IHCP. Due to ongoing problems with the quality of the medical plans included in IHCPs, the related indicator did not provide an accurate picture of whether or not PCPs implemented necessary interventions.

It was good to see continued progress with regard to PCPs writing orders for agreed-upon recommendations from non-facility consultants. It was also positive that the PCP referred the one applicable consultation to the IDT, and the IDT held an ISPA meeting to discuss it.

Overall, since the last review, it was clear that Center staff focused on making improvements to dental care and treatment. This had been an interdisciplinary effort with support from leadership. These efforts had begun to show positive results for the individuals the Center supports. It was particularly good to hear that the group approached dental care across disciplines, and included residential services with a goal of improving the dental supports provided to individuals on a day-to-day basis, as well as in the dental clinic. For example, one of the group's focuses was on the supports provided to individuals with poor oral hygiene. Efforts were underway to assist such individuals to participate in reducing their own risk.

Since the last review, it was positive that the Center held a number of TIVA clinics. As a result, a number of the nine individuals received some of their needed dental treatment. However, six of the seven applicable individuals reviewed still did not receive all of their needed dental care.

For individuals needing hospital dentistry, there is a need for staff to clearly document this need and the reason(s) for it in the individuals' records. In addition, the Center does not currently have a contract to provide it. Center staff need to identify and address the barriers to finalizing a contract.

During observations, medication nurses generally followed individuals' PNMPs. Due to the Center's sustained performance, the related indicator will move to less oversight. Of note, during the last review, the problems noted with regard to nurses following the nine rights were related to not using the correct amount of fluid with MiraLAX and Psyllium. During the last review, the Center's nurse auditor did not identify those issues. A similar problem was noted during this review, and the Center's nurse auditor also did not identify it.

It was positive to see improvement in the inclusion in IHCPs of respiratory assessments for individuals at high risk for respiratory compromise that were consistent with the individuals' level of need. However, nurses need to implement these interventions thoroughly and consistently. More work is needed as well to ensure that nurses adhere to infection control standards during medication administration.

Proper fit was an issue for about 15% of the adaptive equipment observed.

It was positive that based on two observations, staff completed transfers correctly. However, there were still numerous instances (34% of 35 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. Often, the errors that occurred (e.g., staff not intervening when individuals took large bites, overfilled their mouths, and/or ate at an unsafe rate) placed individuals at significant risk of harm. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Center staff should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Restraints

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

Psychiatry

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

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.	
Summary: Due to improvements in data reliability, progress could be assessed for four of the individuals (as per indicator 5). Of these, two were progressing. The other two were not progressing and some of the other monitoring indicators in	Individuals:

psychology/behavioral health did not meet criteria. Indicator 8 did not score as high as at the last review. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	328	386	325	99	399	298	174	134	236
6	The individual is making expected progress	22% 2/9	0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	100% 1/1						1/1			
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	25% 1/4	1/1			0/1		0/1		0/1	
9	Activity and/or revisions to treatment were implemented.	100% 1/1	1/1								

Comments:
6. A review of the most recent PBSP progress note with data through September 2021 was completed for each of the nine individuals. Data depicted in the graphs for Individual #325 and Individual #399 suggested progress, and facility reports indicated that the data were reliable.

Progress was also suggested for Individual #386, Individual #174, and Individual #236, however, their data were not reliable.

Lastly, progress was not evident for Individual #328, Individual #99, Individual #298, and Individual #134.

7. Data indicated that Individual #298 had met the goals for her target behaviors and replacement behavior in May of 2021. These were revised by July of 2021.

8-9. Of the four individuals who were not making progress, corrective actions were taken for Individual #328. Self-injurious behavior had been added to his PBSP. No actions were identified for Individual #99 or Individual #298.

Lastly, while Individual #134's PBSP summary noted multiple revisions, his full PBSP remained as it had been developed in January 2021. But, his behavior had worsened and two new behaviors had emerged: inappropriate sexual behavior and newly defined disruptive behavior that included climbing on furniture and dropping to the ground. Additionally, at an ISPA meeting held on 10/7/21, the IDT agreed to a needed change to his PBSP. It was noted that adjusting his bedroom door, so that it remained open was in violation of the life safety code. This was to be removed from his PBSP, but when this was checked during the review week, it remained in his updated PBSP summary.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.	
Summary: For about half of the individuals, criterion for staff training was met. For the other half, criterion was partially met. Indicators 17 and 18 are, and will	Individuals:

remain, in the category of requiring less oversight. However, performance was lower than in past. Comments are below. Indicator 16 will remain in active monitoring.											
#	Indicator	Overall Score	328	386	325	99	399	298	174	134	236
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.	56% 5/9	0/1	0/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1
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 80% or more of assigned staff had been trained on the PBSP for Individual #325, Individual #298, Individual #134, and Individual #236. When updated rosters were requested during the visit, an additional training in October 2021 brought Individual #99's percentage of trained staff over the required criterion. For the remaining four individuals, evidence indicated that between 58% and 79% of assigned staff had received training on the individual's PBSP.

17. The facility provided PBSP summaries for all nine individuals. It was positive to find approval or implementation dates on each of these, along with the identified author of the plan. Three of these did not offer quick references to the identified plan as they were over two pages long. These were the summaries for Individual #325, Individual #399, and Individual #134.

18. The functional assessment and PBSP for six of the nine individuals was written by a BCBA, a staff member who was eligible to sit for the certification exam, or a staff member who had completed at least some coursework in Applied Behavior Analysis. The exceptions were Individual #386, Individual #399, and Individual #298. At the time of the review, two members of the behavioral health services department were BCBAs.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
Summary: Some adjustments to graphs would then meet criteria with indicator 20. Data and follow-up were needed in review meetings. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	328	386	325	99	399	298	174	134	236
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.	50% 1/2			1/1					0/1	
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	0% 0/3		0/1			0/1			0/1	
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months.	0%									

Comments:

20. The graphs included in the progress notes were easy to read and graphed at acceptable intervals.

None, however, included the consistent use of phase change lines to indicate potentially significant events. These included the introduction of a new or revised PBSP, introduction of additional reinforcement contingencies, such as contracts, medication changes, hospitalizations, transitions within the facility, etc.

While it was positive to find graphs in the progress notes for Individual #99, Individual #174, Individual #134, and Individual #236 appropriately labeled frequency, episodes, or frequency of episodes, others were mislabeled. This included graphs for Individual #386, Individual #325, Individual #399, and Individual #298 in which episodes of some identified target behaviors were measured, but the vertical axis was labeled as frequency. The graphs in Individual #328's progress notes were not labeled. Some graphs included call-out boxes or bubbles instead of phase change lines. Although not required to meet criteria with this monitoring indicator, the Center should avoid using these because they can be very intrusive and interrupt a clear and simple depiction of progress or the lack thereof. Finally, as noted previously, the department should also discontinue the use of trend lines as these can interfere with a visual analysis of the current data path.

21. During the review week, Individual #325 was presented at Internal Peer Review. Graphs were presented and her current performance was reviewed. There was good discussion among those present, with a succinct summary of recommendations made by the behavioral health services director at the end of the meeting. When Individual #134 was reviewed at a house meeting, data were not reviewed including an analysis of his current sleep patterns. The behavioral health specialist reported that his sleep was improving since the introduction of Seroquel, but a review by a member of the monitoring team of data through the end of October 2021 suggested a recent decrease in the number of hours slept. Staff should review objective data at all clinical meetings and ensure that phase change lines are appropriately placed to allow for determination of treatment efficacy.

22 . In the six month period prior to the remote review, three of the nine individuals had been presented to the Internal Peer Review Committee. A summary is provided below for each of these individuals.

- Individual #386 was presented on 8/3/21. His PBSP progress note for this same month indicated that the recommendations were reviewed with his team two days later. It was not clear how several recommendations were addressed because there were no further reports in subsequent progress notes. His schedule was to be revised as most of the peer to peer incidents occurred outside of work. It did not appear that this had occurred because the schedule provided at the time of the review was from May 2021. There was no evidence of a revision to his PBSP following this presentation.

- Individual #399 was presented on 5/10/21. There was no review of the recommendations found in his PBSP progress notes. Further, there was no evidence of revisions to his PBSP, including the addition of a social story or reference to special friends. A training on his PBSP had occurred after the committee reviewed his case.
- Individual #134 was presented on 4/13/21. Although there was a review of recommendations in his April 2021 PBSP progress note, there were no further notes to indicate whether the recommendations had been addressed. Consistent counseling had been one of the recommendations, but this service had been discontinued in early May 2021 with no further evidence of plans for its re-introduction.

23. Over a six month period (April 2021 through September 2021), the Internal Peer Review Committee met a total of 15 times. Two meetings were held in each of four months, with one meeting in June 2021 and four meetings in August 2021. This indicator was not met because internal peer review did not occur at a minimum of three times in each of the six months.

Outcome 8 – Data are collected correctly and reliably.

Summary: Data collection and checks of reliability (IOA and DCT) and integrity (TI) were occurring. The data collection system was scored positively for indicator 26, though the Center should develop a way of tracking whether a single episode lasted for an extended amount of time. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 328	386	325	99	399	298	174	134	236
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
30	If the individual has a PBSP, goal frequencies and levels are achieved.	44% 4/9	0/1	0/1	1/1	1/1	1/1	0/1	0/1	1/1	0/1

Comments:
26. With the exception of Individual #174 and Individual #236, every individual's PBSP included at least one targeted problem behavior defined as an episode. Episodes were separated by two to five minutes without the occurrence of the identified behavior. As has been noted previously, this allows for a great deal of variation in the length of reported episodes. In fact, an ISPA from September 2021 noted that Individual #134 displayed aggression towards staff for a few hours. It would be more accurate to use a duration measure, however, it would likely be challenging to do so reliably in this setting. That being said, given the Center's ability to define episodes and show that data were reliable (for the most part), the Monitor has scored this indicator positively for all of the individuals.

The Monitor recommended that the Center develop a method for the tracking/reporting of any single episode that lasted for an extended period of time. The Center was agreeable to coming up with a method and implementing it.

28. The behavioral health services staff were utilizing an assessment form that consisted of an observation of treatment integrity, data integrity or inter-observer agreement, data timeliness, and staff interview. Observed treatment integrity was determined by noting whether the staff member had responded to the replacement behavior(s) and/or targeted behavior(s) as indicated in the PBSP. As noted in the past, this form only assessed the appropriate use of consequent strategies. There was no review of reinforcement systems, antecedent management, or prevention strategies, all of which are critical components of the PBSP. For these reasons, it was determined that this was not an adequate measure of treatment integrity.

The method for assessing data integrity or inter-observer agreement had been revised and was introduced at the beginning of April 2021. Although the four questions described in previous reports remained in the form, staff were now instructed to calculate inter-observer agreement by dividing the smaller recorded number by the larger recorded number and then multiplying by 100. This was a very positive change. However, when the most recent completed monitoring form was reviewed for the nine individuals, the older form without this mathematical calculation of agreement was used for seven of the nine individuals. The new form was used to monitor the PBSPs for Individual #298 and Individual #236. The reported inter-observer score for Individual #298 was still based on the four questions, resulting in a score of 50%, even though mathematically, agreement was 100%. Individual #236's inter-observer agreement score was reported accurately in September 2021. The Monitoring Team suggests the Center consider dropping the four questions under data integrity because they may cause confusion for the person completing the monitoring.

Data collection timeliness was assessed by checking the computer generated report to determine whether staff entered the recorded data within two hours of the observation. Thus, the score could be either zero or 100. The director of behavioral health services may want to change the directions in this section to state that the <u>data</u> were recorded within two hours of the observation. The behavioral health services director had provided instructions for staff which appropriately included six items.

30. Based upon the documentation provided, there was evidence of regular (i.e., monthly) monitoring of data collection timeliness, inter-observer agreement, and treatment integrity for Individual #328, Individual #325, Individual #99, Individual #399, Individual #174, Individual #134, and Individual #236. This was a dramatic improvement from the last review.

Monitoring had not occurred for Individual #386 for three months following his admission and Individual #298's plan had been monitored three times in a six-month period.

Four individuals met this indicator due to regular monitoring and adequate reported levels of all three measures. These were Individual #325, Individual #99, Individual #399, and Individual #134.

Details about the other five individuals are above in indicator 5.

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.
The Monitoring Team no longer rates this outcome. The Center's responsibilities for these goals/objectives are now assessed as part of the Section F – ISP audit tool.

Outcome 4 – Individuals receive preventative care.

Summary: It was positive that five of the nine individuals reviewed received the preventative care they needed. The remaining three individuals received most of the preventative care they needed.

For the eight applicable individuals in the review group, medical practitioners 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. However, this is an area that still needs improvement.

#	Indicator	Overall Score	Individuals: 298	134	354	209	203	249	226	182	241
a.	Individual receives timely preventative care:										
	i. Immunizations	78% 7/9	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 6/6	1/1	N/A	1/1	1/1	N/A	N/A	1/1	1/1	1/1
	iii. Breast cancer screening	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
	vi. Osteoporosis	100% 5/5 Cannot fully rate due to	1/1	1/1	N/A	1/1	1/1	N/A	N/A	1/1	Not rated – C19 (N/R - C)

		COVID-19 impact									
	vii. Cervical cancer screening	100% 2/2	1/1	N/A	N/A	N/A	N/A	1/1	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.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1

Comments: a. For most of the individuals in the physical health review group, most preventative care was up-to-date.

The following provide information about problems noted:

- The immunization record showed that Individual #134 had received only two of the three vaccines in the Hepatitis B series.
- Based on documentation in the immunization record, Individual #354 had not had the tetanus, diphtheria, and pertussis (Tdap) vaccination.
- For Individual #249:
  - On 8/21/17, she completed her last audiological exam. The recommendation was for her to return in three years. Although the initial delay might have been related to COVID-19 restrictions, it was not clear why an update was not ordered until 10/18/21 (i.e., after the Monitoring Team identified the individual as part of the review group). For example, on 8/3/21, the PCP completed the individual's AMA. At a minimum, at this point, the PCP should have identified the need to order an updated audiological exam. Moreover, Center staff submitted no ISPA showing IDT discussion of the risk-benefit of delaying the preventative care appointment.
- On 8/28/18, Individual #241 had a DEXA scan, which showed a T-score of -2.1. COVID-19 precautions and the limited availability of appointments once they were lifted resulted in a delay in obtaining a repeat. However, he was scheduled for a DEXA scan on 7/5/22.

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

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	298	134	354	209	203	249	226	182	241

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	1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A
Comments: a. For both individuals in the review group with DNR orders in place, IDTs/PCPs documented clinical justification that was consistent with State Office guidelines.											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Overall, the Center showed continued improvement with the provision of timely acute medical care. For most of the acute issues/illnesses treated at the Center that the Monitoring Team reviewed, PCPs assessed the individuals according to accepted clinical practice, and conducted necessary follow-up. It was also positive that for the acute issues/illnesses reviewed that required ED visits or hospitalizations, individuals received timely acute medical care, and follow-up care. At this time, the remaining indicators will continue in active oversight. If the Center sustains its progress, after the next review, some of these indicators might move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
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.	86% 12/14	2/2	2/2	2/2	2/2	N/A	2/2	0/1	1/2	1/1
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	91% 10/11	1/2	1/1	2/2	1/1		1/1	1/1	2/2	1/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	100% 13/13	2/2	2/2	2/2	1/1	N/A	2/2	1/1	2/2	1/1
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	100% 4/4	N/A	2/2	N/A	N/A		N/A	N/A	1/1	1/1

e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	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.	100% 13/3	2/2	2/2	2/2	1/1		2/2	1/1	2/2	1/1
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	100% 7/7	N/A	2/2	1/1	1/1		1/1	N/A	2/2	N/A
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	100% 12/12	2/2	2/2	2/2	1/1		2/2	N/A	2/2	1/1

Comments: a. For eight of the nine individuals in the review group, the Monitoring Team reviewed 14 acute illnesses/occurrences addressed at the Center, including: Individual #298 (right hip and ankle pain on 6/17/21, and hit to forehead causing laceration on 8/28/21), Individual #134 (abdominal pain on 5/11/21, and headache on 5/19/21), Individual #354 (nausea/vomiting on 7/8/21, and low glucose on 7/23/21), Individual #209 (leg injury on 9/17/21, and leg warmth on 9/21/21), Individual #249 (allergies on 6/22/21, and skin rash on 9/23/21), Individual #226 (apneic episodes on 7/9/21), Individual #182 (bradycardia on 8/2/21, and low grade fever on 3/5/21), and Individual #241 (increased behavior problems on 4/13/21).

a. and b. For most of the acute issues/illnesses treated at the Center that the Monitoring Team reviewed, PCPs assessed the individuals according to accepted clinical practice, and conducted necessary follow-up.

The following provides information about concerns noted:

- On 8/28/21, at 8:45 p.m., Individual #298 leaned forward from her wheelchair and hit her forehead, causing a laceration in an area that split open often. The PCP applied Dermabond and Steri-strips. The PCP documented no follow-up.
- On 7/9/21, at 12:00 p.m., a nurse called the PCP about two apneic episodes that Individual #226 experienced. Habilitation Therapy staff were also onsite and re-educated staff about his positioning. His neck was very lax and hyperextended easily. According to nursing staff, once his head was repositioned, his breathing returned to baseline. The PCP's assessment was "good heart rate and breath sounds." The PCP's plan was to follow the Habilitation Therapy positioning plan. The PCP did not document a definitive or differential diagnosis.
- For Individual #182's bradycardia on 8/2/21, the PCP did not document the source of the information.

c. For eight of the nine individuals reviewed, the Monitoring Team reviewed 13 acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #298 (ED visit for head injury on 4/16/21, and ED visit for fall on 5/18/21), Individual #134 [hospitalization for agitation on 4/9/21, and hospitalization for extrapyramidal symptoms (EPS), possible rhabdomyolysis, and abnormal labs on 5/25/21], Individual #354 [hospitalization for jejunostomy tube (J-tube) dislodgement on 8/7/21, and ED visit for hole in J-tube on 9/1/21], Individual #209 (hospitalization for fractured tibia on 8/23/21), Individual #249 (ED visit for chest pain on 4/28/21, and hospitalization for suicidal ideation, and removal of foreign body on 5/16/21), Individual #226

(hospitalization for respiratory failure on 7/9/21), Individual #182 [hospitalization for dislodged G-tube on 4/12/21, and hospitalization for aspiration pneumonia on 7/27/21], and Individual #241 (ED visit for fall on 5/4/21).

c. through d., f. through h. It was positive that for the acute issues/illnesses reviewed that required ED visits or hospitalizations, individuals received timely acute medical care, and follow-up care.

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

Summary: It was good to see continued progress with regard to PCPs writing orders for agreed-upon recommendations. If the Center sustains this improvement, after the next review, Indicator d might move to the category requiring less oversight. Given that over at least three reviews, for the consultations reviewed, IDTs reviewed relevant recommendations and developed ISPAs documenting decisions and plans (Round 13 – 100%, Round 14 – 100%, Rounds 15 and 16 – N/A, and Round 17 – 100%), Indicator e will move to the category requiring less oversight.

#	Indicator	Overall Score	Individuals: 298	134	354	209	203	249	226	182	241
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
b.	PCP completes review within five business days, or sooner if clinically indicated.										
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.										
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	82% 9/11	N/A	1/1	1/1	1/2	2/2	0/1	N/A	2/2	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A		N/A	N/A

Comments: For eight of the nine individuals in the review group, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed included those for Individual #298 for pulmonary on 4/14/21, and surgery on 5/10/21; Individual #134 for orthopedics on 9/16/21, and urology on 7/27/21; Individual #354 for surgery on 8/3/21, and surgery on 8/25/21; Individual #209 for urology on 7/29/21, and orthopedics on 9/15/21; Individual #203 for vision on 5/28/21, and neurology on 7/14/21; Individual #249 for gastroenterology (GI) on 4/5/21; Individual #182 for hematology on 5/24/21, and pulmonary on 6/10/21; and Individual #241 for cardiology on 6/1/21, and GI on 6/28/21.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, with the exceptions of the following: Individual #209 for orthopedics on 9/15/21 (i.e., avoid submerging wound for two more weeks, and PT/OT continue strict non-weight bearing of lower left extremity), and Individual #249 for GI on 4/5/21 (i.e., Benefiber or other over-the-counter fiber, drink seven to eight glasses of water daily, resume activities tomorrow, and sitz bath as needed).

e. It was positive that the PCP referred Individual #298's consultation for surgery on 5/10/21, to the IDT, and the IDT held an ISPA meeting on 5/14/21, during which they discussed it.

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

Summary: Although additional work was necessary, it was positive that for a number of individuals' chronic or at-risk conditions, medical assessments, tests, and evaluations consistent with current standards of care were completed, and the PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.

#	Indicator	Overall Score	Individuals: 298	134	354	209	203	249	226	182	241
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.	67% 12/18	1/2	2/2	2/2	1/2	2/2	1/2	2/2	0/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #298 – breast cancer, and weight; Individual #134 – polypharmacy, and UTIs; Individual #354 – esophageal cancer, and fluid imbalance; Individual #209 – seizures, and UTIs; Individual #203 – weight, and falls; Individual #249 – skin integrity, and weight; Individual #226 – constipation/bowel obstruction, and respiratory compromise; Individual #182 – cardiac disease, and behavioral health/pica; and Individual #241 – cardiac disease, and weight).

a. For the following individuals' chronic or at-risk conditions, PCPs conducted medical assessment, tests, and evaluations consistent with current standards of care, and the PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #298 – weight; Individual #134 – polypharmacy, and UTIs; Individual #354 – esophageal cancer, and fluid imbalance; Individual #209 – seizures; Individual #203 – weight, and falls; Individual #249 – skin integrity; Individual #226 – constipation/bowel obstruction, and respiratory compromise; and Individual #241 – weight.

The following provide examples of concerns noted:

- On 2/9/21, Individual #298 underwent an ultrasound of her breasts. For several years, she had been unable to complete mammograms due to her abnormal posture and skeletal abnormalities. Ultrasounds had been completed serially. The ultrasound was read as consistent with multicentric breast cancer with four separate areas increasing in size. She was referred to surgery for a recommendation. The legally authorized representative (LAR)/family decided against a needle biopsy, because regardless of the results, they did not want to put her through the treatment. A PCP IPN, dated 5/17/21, summarized a

discussion of options with the family, but a decision was not forthcoming at that time. In an IPN, dated 7/25/21, the PCP documented further discussion with the LAR. The surgeon had discussed the individual's condition with the LAR, and indicated that after talking with the radiologist, it was more than likely cancer. From the perspective of the LAR, focus was to be on comfort. On 7/30/21, the LAR signed an out-of-hospital (OOH) DNR, as three medical professionals agreed that the findings on the ultrasound indicated malignancy (i.e., surgeon, radiologist, and PCP). Serial ultrasounds were offered, but due to the need for sedation each time, the LAR did not want to consider that option. There was the risk of a decline in the individual's mentation each time anesthesia was administered. Despite her weight loss trend, the individual remained spry. The LAR chose a hospice service, but had not enacted that service due to the individual feeling well.

Center staff submitted no IHCP to address the individual's declining condition related to her breast cancer, or describing the plan for palliative care. Despite the vagaries of the diagnosis, a care plan reflecting her current palliative care needs and the LAR's wishes would be essential at this time. Such a plan should incorporate all related recommendations to facilitate consistent care across all of the involved disciplines/departments. The AMA and the PCP's IPNs reflected detailed discussion with the family, and provided an important foundation for an initial IHCP for her breast cancer. At the time of the Monitoring Team's review, it was problematic that the IDT had not created an IHCP focused on palliative care or cancer care. Reportedly, at an ISPA meeting on 9/28/21, the IDT discussed her suspected breast cancer, and the action steps that the IDT should include in an IHCP, although this was only referenced in a separate document (i.e., the last ISPA submitted was for a meeting that occurred on 9/7/21, even though the Monitoring Team's document request went through 10/1/21). In response to a supplemental request during the week of the remote review, staff referenced aspects of the 9/28/21 ISPA meeting, but they did not submit an updated IHCP. Given the delays in developing a cogent plan of care to address the individual's current needs, the PCP might need to take a lead role in ensuring the IDT completes this important task.

Separately, it would be helpful for the IDT to determine measurable thresholds that would indicate the need to commence hospice involvement for end-of-life care (e.g., a certain amount of weight loss, pain not controlled by routine pain medication, skin breakdown, etc.). Development of these decision points will allow for an efficient transition to terminal care as the individual's health deteriorates.

- Individual #209 had a history of kidney stones. On 10/19/20, a computed tomography (CT) of the abdomen/pelvis indicated possible nonobstructive calculi in both kidneys. There was no hydronephrosis. There were no ureteral or bladder calculi. On 1/21/21, after extracorporeal shockwave lithotripsy, he had cystoscopy with right stent placement; there was notation of excellent fragmentation of the right-sided nephrolithiasis. Bladder mucosa was considered normal with a small patch of cystitis. On 1/25/21, a urinalysis (UA) was done, post cystoscopy, and the urologist subsequently treated him with an antibiotic. A 1/29/21 post-UTI follow-up indicated that he was voiding without problems.

  However, from 2/3/21 to 2/10/21, he was hospitalized for an infection associated with an indwelling ureteral stent and urinary stones. At the time of admission, a CT of the abdomen/pelvis indicated a distended urinary bladder with circumferential urinary bladder wall thickening, potentially reflecting cystitis. There was bilateral nephrolithiasis, but no hydronephrosis. The right ureteral stent was in good position. He was subsequently hospitalized from 2/18/21 to 2/22/21, 3/2/21 to 3/19/21, and 3/26/21 to 4/5/21, for urosepsis and kidney stones. He developed a resistant UTI, and his stent was

removed. It was anticipated the remaining stones would pass spontaneously. After stent removal, he received an additional five days of intravenous (IV) antibiotic. At an ISPA meeting on 4/6/21, the IDT reviewed steps to prevent UTI recurrence (i.e., peri-care instructions, tracking voids, assessing for pain, supervision of direct support professionals by the RNCM, and adequate hydration). Post hospitalization, his medication regimen for constipation was augmented with daily MiraLAX. He was started on medication for UTI prevention (i.e., cipro, and phenazopyridine).

On 6/8/21, he developed a UTI, and was treated with an antibiotic. On 7/29/21, he underwent urology follow-up. A kidney, ureter, and bladder (KUB) x-ray was ordered and showed no renal calcifications. Urologically, he had been stable since that time. However, the PCP did not include his repeated UTIs and renal calculi, urological consultation, and urological procedures with use of medication to prevent UTI in the assessment/plan of care section or risk section of the AMA, dated 7/26/21. In addition, the recurrent UTIs and renal calculi were not listed on the active problem list, which was problematic, given that his several hospitalizations in 2021 were related to recurrent UTIs and kidney stones. Evaluation had been appropriate, but successful ongoing treatment requires communicating the ongoing risk and medical/surgical treatments to date, as well as the plan for ongoing medical treatment and monitoring to minimize future UTIs.

- Individual #249 had a diagnosis of severe obesity [i.e., Class 3 with a body mass index (BMI) of 40 or higher]. In the IMRs, dated 2/18/21, and 5/24/21, the PCP did not mention the individual's weight. A nutrition note, dated 7/16/21, indicated she was not compliant with GI recommendations. On 6/8/21, she was started on Topiramate, and had been on home restriction with limited access to purchase food away from the home. Staff believed that Topiramate assisted in some weight reduction, but then she plateaued at 245 to 249 pounds. The psychiatrist also tapered Abilify, and started her on Invega. On 9/23/21, Abilify was discontinued completely. An AMA plan of care, dated 8/4/21, included encouraging the individual to adhere to her current diet and staying physically active. However, she had access to the diner to purchase her own food and sodas. At the time of the Monitoring Team's review, she was in isolation in her own room. In submitted documentation, there was no discussion concerning any exercise program details, such as a treadmill or stationary bicycle in her room. No clear plan for exercise was set forth, taking into consideration the individual's preferences, and including the frequency, length of time of exercise sessions, and the level of strenuous activity (which might require PT evaluation), with attention of the need for one-to-one staffing supports to ensure she did not take the equipment apart and/or attempt to swallow items. The submitted documentation did not indicate how staff were to teach her healthy food choices, or if/when the teaching started.

- Individual #182 had a history of coronary artery disease, cardiomegaly, congestive heart failure, pulmonary hypertension, essential hypertension, mixed hyperlipidemia, metabolic syndrome, obesity, and obstructive sleep apnea. On 2/22/04, he was started on a diuretic. A transthoracic echocardiogram, dated 4/13/20, demonstrated moderate to severe pulmonary hypertension. At that time, the individual's left ventricular systolic function had an ejection fraction of >75%, and there were no regional wall motion abnormalities noted. A 6/3/20 pulmonology consult documented the individual's noncompliance with continuous positive airway pressure (CPAP) treatment for his sleep apnea, also indicating that a tracheostomy was not an option and a dental appliance also would not be effective. No further sleep studies were indicated. More recently, on 6/8/20, the cardiologist saw him, and started him on sildenafil for pulmonary hypertension and also changed his lipid medication. From 6/30/20 to 8/10/20, he was hospitalized. During that time, he was diagnosed with several conditions, including acute diastolic heart failure, pulmonary hypertension, and sinus bradycardia. On 9/8/20, he experienced bilateral lower extremity

edema, and he was restarted on Lasix. Staff also ordered him elastic socks. On 9/10/20, he had a follow-up visit with pulmonology, and was considered stable with underlying chronic obstructive pulmonary disease (COPD). He was to continue his bronchodilator treatment, as needed.

From 1/10/21 to 1/25/21, he was hospitalized for sepsis, at which time he also was diagnosed with congestive heart failure and pulmonary hypertension. A chest x-ray showed moderate to severe cardiomegaly and moderate pulmonary edema with small bilateral pleural effusions. From 2/11/21 to 2/18/21, he was hospitalized for sepsis, at which time he was noted to have continued pleural effusion, and the Lasix was increased to twice daily. A cardiology consult, from 3/4/21, confirmed cardiomegaly and right heart enlargement. There had not been a right heart catheterization or prior classification of his pulmonary hypertension. The use/benefit of sildenafil was unclear, because the classification had not been determined. The recommendation was to continue the current regimen and return in six months with an echocardiogram. An electrocardiogram (EKG) documented sinus rhythm. A 6/10/21 pulmonary consult indicated he did not need supplemental oxygen (O2), and he was to continue Duoneb nebulizer treatments pro re nata (PRN, or "as needed"). On 7/6/21, at an ISPA meeting, the IDT documented that Habilitation Therapy Services recommended discontinuation of skilled therapy and initiation of weekly monitoring, because he had improved in his strength and coordination/balance.

On 7/27/21, he developed respiratory distress and hypoxia with rapid decline. Radiologic studies indicated cardiomegaly with bilateral pleural effusion and airspace opacities compatible with congestive heart failure and pulmonary edema, with possible superimposed aspiration pneumonitis initiating the cascade. On 8/20/21, he completed a cardiology consultation that resulted in a recommendation for a right heart catheterization to classify his pulmonary hypertension to determine the benefit of sildenafil. He also was prescribed Lasix, a potassium supplement, aspirin, and was maintained with a 2000-milliliter (ml)-per-day fluid restriction. A transthoracic echocardiogram had been completed, noting an ejection fraction of 50 to 54% with right ventricle systolic function reduced and Grade 1 diastolic dysfunction of the left ventricle. In an IPN, dated 9/23/21, the PNMT documented that during an ISPA meeting, the PCP contacted the LAR concerning consent for right heart catheterization, but the LAR made no decision at that time. In follow-up, on 9/23/21, the QIDP and RNCM discussed the recommendation for a right heart catheterization with the LAR, but the LAR declined at that time, with the explanation "she does not feel comfortable putting him through the procedure." It was not clear whether the cardiologist had discussed the procedure and benefits/risks of the procedure with the LAR. Given the decline in cardiac function, lack of consent was problematic. Administrative support might be needed to ensure that the LAR has been provided with the information necessary to make an informed decision that is consistent with the best interest of the individual. Currently, the LAR's decision limited the PCP's ability to complete the evaluation and treatment processes.

- Individual #182 had a long history of pica, dating from 1987. More recently, in an ISPA, dated 4/1/21, the IDT documented that staff reported he chewed on a tag from a padded bed rail. The ISPA reviewed that he had never officially carried a pica diagnosis, as he only chewed items and never swallowed them. On 5/21/21, staff found him chewing on paper towels from an overflowing trashcan. On 5/24/21, staff found him with a small plastic trash bag in his mouth. On 5/28/21, staff found him with gauze in his mouth, and on 6/2/21, staff found him trying to put dominoes in his mouth. In an IPN, dated 6/4/21, a nurse reviewed interventions in place, including the nurse not using drain sponges or gauze for his tube dressings, and an increased level of supervision (LOS) during waking hours. He recently moved homes, and staff believed he had difficulty adjusting to the

move, with increased pica activity, and also wanting to eat orally, although he was supposed to receive nothing by mouth (NPO) due to two failed modified barium swallow studies (MBSS).

On 6/7/21, staff found him chewing on plastic from an abdominal brief. In an ISPA, dated 6/8/21, the IDT documented additional interventions for his pica behavior. Large dominoes were to be purchased that he could not fit into his mouth. Home staff were to undergo training on pica, including active treatment activities that were considered safe for him. A chew device was to be trialed. Staff were to be present during the entire medication pass. Staff were to complete pica sweeps, and remove any trash/trash can from his room. On 6/11/21, the chewing device trial was completed, but he did not have interest in it, and did not like the string hanging out of his mouth. On 6/17/21, he placed a clothing sticker in his mouth and swallowed it. At that time, he was placed on enhanced supervision at all times. At an ISPA meeting on 6/18/21, the IDT documented obtaining pica blankets, purchasing large active treatment items, and contacting the tele-psychiatrist. Staff reviewed the old PBSP, which had been discontinued due to the individual's decline in health. At the time it was created, the replacement behavior was to offer a beverage. An updated/new PBSP was to considered after the psychiatrist made a diagnosis of pica.

On 6/21/21, he had an episode of coprophagia. In an assessment, dated 6/29/21, the psychiatrist confirmed a diagnosis of pica disorder. The psychiatrist did not recommend medication. The individual was considered stable psychiatrically. The individual's zinc and iron levels were to be considered. However, he was already prescribed an iron supplement and zinc supplement, as well as formula feeding including additional amounts of zinc.

On 7/13/21, he grabbed gauze off of the nurses' cart, but staff were able to retrieve it before he swallowed it. At an ISPA meeting on 7/30/21, Habilitation Therapy staff expressed the opinion that he was not interested in eating. The only evidence for this was that he did not reach or pick at any of his peer's meals when in the kitchen area. The LAR had earlier indicated he enjoyed eating and might miss that opportunity. On 9/14/21, staff found him with a sock in his mouth, and on 9/20/21, he had feces in his mouth. At an ISPA meeting on 9/21/21, the IDT reviewed three months of his enhanced level of supervision (i.e., from 6 a.m. until 30 minutes after sleeping), with a planned titration down when pica incidents stopped. On 9/24/21, he placed plastic from a cushion in his mouth.

During the time period of submitted documentation, the individual was still having episodes of pica, indicating the need for further steps and/or supervision, review of environmental checks, etc. Psychiatric and other medical causes had been ruled out. The IDT was already discussing a plan to wean him from enhanced LOS, although he had not demonstrated successful elimination of the behavior. Evaluation and treatment needed further review and aggressive management. Although Habilitation Therapy staff indicated that he did not have interest in eating, more evidence of this was needed. In addition, there was a delay in creating and implementing an updated PBSP to address his pica behavior.

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. For 17 of the 18 chronic conditions/risk areas reviewed, either no IHCP existed or the IDT assigned no interventions to the PCP. For the one remaining IHCP, documentation was not found to show implementation	Individuals:

of the one action step that the IDT assigned to the PCP and included in the IHCP. Due to ongoing problems with the quality of the medical plans included in IHCPs, this indicator did not provide an accurate picture of whether or not PCPs implemented necessary interventions. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.											
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A
Comments: a. As noted above, no IHCPs were submitted for the following active problems/chronic conditions: Individual #298 – breast cancer (and/or palliative/comfort care), and weight loss; Individual #354 – esophageal cancer; Individual #182 – pica; and/or Individual #241 – weight loss. The remaining 13 IHCPs did not include a full set of medical interventions as necessary to meet the individuals' needs. In sum, for 17 of the chronic conditions/risk areas reviewed, either no IHCP existed or the IDT assigned no interventions to the PCP. For the one IHCP for Individual #182 that assigned one intervention to the PCP, documentation was not found to show the PCP completed it. The intervention included in the IHCP required the PCP to complete lipid monitoring every six months. Only one lipid panel was submitted from February 2021. Due to ongoing problems with the quality of the medical plans included in IHCPs, this indicator did not provide an accurate picture of whether or not PCPs implemented necessary interventions.											

Pharmacy

After Round 14, based on the Center's scores over the past three monitoring cycles, DOJ and the State agreed that the Center achieved substantial compliance with most of the requirements of Section N of the Settlement Agreement. The exceptions are Section N.6 related to adverse drug reactions (i.e., see below), and Section N.8 related to medication variances that the Monitoring Team will review as part of Section E, and Section N.5 related to quarterly monitoring for tardive dyskinesia that the Monitoring Team will measure through Section J.12. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Lubbock SSLC exited from the other requirements of Section N of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the outcomes and indicators related to the exited provisions of the Settlement Agreement.

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: N/A	Individuals:
The Monitoring Team no longer rates this outcome. The Center's responsibilities for these goals/objectives are now assessed as part of the Section F – ISP audit tool.	

Outcome 4 – Individuals maintain optimal oral hygiene.
This outcome is no longer rated.

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: Since the last review, it was positive that the Center held a number of TIVA clinics. As a result, a number of the individuals received some of their needed dental treatment. However, six of the seven applicable individuals reviewed still did not receive all of their needed dental care. As a result of the Center's sustained performance in provided needed dental x-rays (i.e., Round 15 – 100%, Round 16 – 89%, and Round 17 – 100%), Indicator c will move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
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.	80% 4/5	N/A	1/1	N/A	1/1	1/1	N/A	N/A	0/1	1/1
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	14% 1/7	N/A	0/1	0/1	0/1	0/1	N/A	0/1	0/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	100% 7/7	N/A	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	0% 0/6	N/A	0/1	0/1	0/1	0/1	N/A	0/1	0/1	N/A
e.	If the individual has need for restorative work, it is completed in a timely manner.	60% 3/5	N/A	1/1	N/A	1/1	1/1	N/A	0/1	0/1	N/A

f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.

Comments: a. though e. Individual #298 and Individual #249 were edentulous. Since the last review, it was positive that the Center held a number of TIVA clinics. As a result, a number of the individuals received some of their needed dental treatment. However, six of the seven applicable individuals reviewed still did not receive all of their needed dental care. The following describes concerns noted:

- Six of seven applicable individuals and/or their staff did not receive twice-yearly tooth brushing instruction.
- None of six applicable individuals with a medium or high caries risk rating received at least two topical fluoride applications per year.
- In addition to not receiving needed tooth brushing instruction and two topical fluoride treatments, Individual #182 did not receive any prophylactic care and had not received needed restorative work. His last annual dental examination occurred on 4/17/17. Based on documentation submitted, he required general anesthesia for dental treatment; however, the Center did not have a contract to provide it, and this was an issue that had been ongoing for some time. Center staff needed to identify and address the barriers to finalizing a contract.

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

Summary: For one of two dental emergencies reviewed, Dental Department staff needed to provide improved documentation about the nature of the emergency, when it occurred, as well as the timing of notifications. The remaining indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 298	134	354	209	203	249	226	182	241
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	0/1	N/A	N/A	N/A	N/A	N/A	1/1
b.	If the dental emergency requires dental treatment, the treatment is provided.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs	N/A									

Comments: a. and c. Dental Department staff provided needed emergency dental services for one of two individuals reviewed. For Individual #354, the documentation provided for review indicated that, on 5/26/21, Dental Department staff saw him and stated that he did not have pain. However, the dental integrated progress note (IPN) did not provide any other detail about the nature of the dental emergency for which he was seen, the time symptoms started, or the time and date the Dental Department received notification. The Center did not submit a related nursing IPN for review.

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

The Monitoring Team no longer rates this outcome. The Center's responsibilities for suction tooth brushing plans and their implementation are now assessed as part of the Section F – ISP audit tool.

Outcome 9 – Individuals who need them have dentures.											
Summary: Given that over the last three reviews, the Center sustained its progress with regard to clinical justifications for denture recommendations (Round 15 – 88%, Round 16 – 89%, and Round 17 – 100%), Indicator a will move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	100% 3/3	1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. It was positive that for the three applicable individuals reviewed with missing teeth, the Dental Department provided clinical justification for not recommending dentures.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Nursing assessments at the onset of signs and symptoms of acute illnesses/occurrences that are in alignment with applicable guidelines, as well as on an ongoing basis for acute illnesses/occurrences remained areas on which the Center needs to focus. It was positive that in most instances reviewed, nursing staff timely notified the practitioner/physician, but work was needed to ensure they completed and documented this in accordance with the nursing guidelines for notification. For the five acute illnesses/occurrences reviewed, nursing staff developed acute care plans. All of them included some of the necessary interventions, but all were missing key interventions. Nurses thoroughly implemented one of the six acute care plans. Currently, these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	20% 1/5	0/1	0/1	0/1	1/1	N/R	N/R	N/A	0/1	N/R

b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	20% 1/5	0/1	0/1	0/1	0/1				1/1	
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/1	0/1	N/A	N/A	N/A				N/A	
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	25% 1/4	N/A	0/1	0/1	1/1				0/1	
e.	The individual has an acute care plan that meets his/her needs.	0% 0/5	0/1	0/1	0/1	0/1				0/1	
f.	The individual's acute care plan is implemented.	20% 1/5	0/1	0/1	0/1	0/1				1/1	

Comments: The Monitoring Team reviewed five acute illnesses and/or acute occurrences for five individuals, including: Individual #298 – UTI on 9/9/21, Individual #134 – cellulitis on 9/21/21, Individual #354 – hospitalization for jejunostomy tube (J-tube) dislodgement on 8/7/21, Individual #209 – fracture of left tibia on 8/23/21, and Individual #182 – G-tube dislodgement on 4/12/21. In the six months prior to the Monitoring Team's review, Individual #226 did not have any acute illnesses/ occurrences until the date of his death (i.e., on 7/9/21, when he had and apneic episode).

a. The acute illness/occurrence for which a nurse performed an initial nursing assessment in accordance with applicable nursing guidelines was for Individual #209 – fracture of left tibia on 8/23/21.

b. The acute illness/occurrence for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms in accordance with the SSLC nursing guidelines entitled: "When contacting the PCP" was: Individual #182 – G-tube dislodgement on 4/12/21.

For the following examples, nurses notified the PCP/on-call provider, but did not document the notification according to the guidelines: Individual #134 – cellulitis on 9/21/21, Individual #354 – hospitalization for J-tube dislodgement on 8/7/21, and Individual #209 – fracture of left tibia on 8/23/21.

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

- On 9/9/21, Individual #298 had a urinalysis (UA) done, but the notes submitted did not indicate why it was done. Nursing staff did not document any symptoms. The UA revealed an infection, and the PCP ordered Macrobid. At 7:23 p.m., a nurse documented an assessment, noting the individual's LOC, color, pain, respirations, and that she was eating/drinking, and propelling her wheelchair. The nurse documented that the individual exhibited no signs of distress. The nurse did not conduct an abdominal assessment, or an analysis of I&O per the nursing guidelines for a UTI. The nurse noted the inability to "visualize urine," but then did not review this at a later time. No documentation was found to show if/when the symptoms were identified or if the PCP was informed.

On 9/9/21, nursing staff initiated an acute care plan, which was discontinued on 9/15/21. It included an intervention to monitor the individual's vital signs, pain, and urine each shift. However, this was not consistent with the nursing guidelines for a UTI, and was not specific as to what nurses should monitor with regard to the individual's urine. The goal also was not specific and focused only on "clear mild smelling urine."

Even though nursing staff used the UTI template to conduct follow-up nursing assessments, nurses were not consistent in implementing the assessments included in the nursing guidelines. The nurses did not complete all of the elements. For example, they were missing assessments each shift of the individual's abdomen, I&O, urine characteristics, orientation, and vital signs, including oxygen saturation. In addition, no direct support professional (DSP) instructions were found for this acute care plan.

- On 9/16/21, at 5:15 p.m., staff identified a red raised bump on Individual #134's left upper eyebrow. A nurse's initial assessment was brief and included a notation that the area had no redness or bruising. The individual did not have a history of a fall, self-injurious behavior (SIB), or banging his head. The nurse took vital signs, but did not complete and/or document measurements or complete the assessment outlined in the nursing guidelines for skin impairment. It was not until 9/17/21, at 1:10 a.m., that a nurse completed a full assessment with measurements. At that time, the nurse cleaned the area and took measurements. Until 9/20/21, nursing staff conducted no further assessments, at which time, the individual now had increased swelling over to the middle of his head and between his eyes. At this time, a nurse called the PCP, and the individual was sent to the ED. He returned to the Center with a diagnosis of cellulitis. Prior to and following the individual's transfer to the ED, nursing staff did not follow the applicable guideline for assessments.

  Upon his return from the ED, nurses initiated an acute care plan, but it did not coincide with related nursing guidelines. Nurses also did not implement the template for skin impairment, which would have assisted in making sure the acute care plan included the necessary interventions. The goal was not measurable, specific, or timebound. The ongoing assessment intervention was to monitor the individual's vital signs, but it did not include monitoring the affected area to identify changes of worsening or improvement. Although nurses took and documented his vital signs each shift, due to deficiencies with the interventions, the records did not show ongoing monitoring of the status of his acute illness/injury, and did not show that nurses sufficiently followed the acute issue through to resolution.
- On 8/7/21, at 1:15 a.m., staff found that Individual #354's J-tube had leaked and been dislodged. Upon being informed, a nurse assessed him and found formula on the dressing. When the nurse removed the dressing, the J-tube slid out. The nurse noted that the individual's respirations were even and unlabored, he exhibited no signs of distress, and he had no pain or breathing difficulty. The nurse documented his vital signs, and cleaned the area. However, the nurse did not check his bowel sounds, and provided no documentation of the condition of the site, which was inconsistent with nursing standards of practice.

  Although the nurse did report the problem to the provider as soon as possible, the corresponding note stated: "report j tube coming out." This did not provide evidence that the nurse reported according to nursing guidelines for PCP notification. He was sent to the ED.

Upon the individual's return on 8/11/21, at 2:40 p.m., following reinsertion of the J-tube, nursing staff did not assess his abdomen for bowel sounds until 11:30 p.m., and then only noted the description as "normal for age/size." They assessed the incision site, but did not note if they completed any other skin assessment.

With regard to the acute care plan, the goals were clinically relevant, but related interventions were not measurable and were missing elements to support the goal. For example, a goal was to for the individual to have pain less than 3, but no interventions were included to measure his pain levels, but rather only to monitor for signs and symptoms of pain. The plan included an intervention to assess the individual's temperature, and the edges of the incision, but did not define how often nurses should conduct these assessments. In the IPNs submitted, no nursing IPNs existed for the time period between 8/12/21 and 8/14/21. Based on review of IPNs, and IView entries, nursing staff did not assess his abdomen each shift. There was also a lack of documentation until 8/15/21, regarding daily dressing changes.

It appeared that nurses discontinued the acute care plan prior to the full healing of the wound. More specifically, on 8/23/21, the plan was discontinued, but the individual still had 19 staples, and required daily dressing changes.

- Individual #209's acute care plan met most of the criteria for quality, which was positive. However, for this individual with an incision, the plan did not include an intervention for nurses to assess the dressing and incision line. As a result, it was not consistent with the nursing guidelines for skin impairment.

  Nursing staff did not document according to the acute care plan interventions. For example, on 9/1/21, no documentation was submitted for any shift related to assessing his lungs, staples, or wound care. On 9/2/21, on the second shift, no documentation was included related to assessing his staples; and on the first shift, there was no documentation of a lung assessment, and nursing staff did not assess his pain using the FLACC scale to ensure the individual met the goal of less than 1. In addition, when a nurse did conduct a lung assessment, they only assessed anterior lung sounds.
- On 4/12/21, at 6:40 a.m., staff discovered that Individual #182's G-tube had become dislodged. The nurse did not complete an assessment according to applicable nursing guidelines. Specifically, the nurse did not conduct and/or document a thorough abdominal assessment, and only noted "normal for age/size." The nurse did assess the individual's vital signs, level of consciousness, and pupils. At 7:05 a.m., with individual up in chair, the nurse assessed his respirations. The nurse notified the PCP and completed documentation in alignment with the nursing guidelines. He was sent to the ED.

  The acute care plan included a goal that the individual would not exhibit signs and symptoms of infection, and referenced a temperature of less than 100.0, which was not clinically correct. The interventions in the plan were not in alignment with the nursing guidelines for enteral tube documentation and skin integrity, because they did not include conducting abdominal and/or lung assessments. It was positive that nurses implemented the interventions included in the plan.

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.

The Monitoring Team no longer rates this outcome. The Center's responsibilities for these goals/objectives are now assessed as part of the Section F – ISP audit tool.

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

Summary: As noted above, although improvements continued, for individuals with medium and high mental health and physical health risks, most IHCPs did not fully meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not nurses implemented them. 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 nurses implemented the interventions thoroughly.

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: 298	134	354	209	203	249	226	182	241
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need.	0% 0/12	0/2	0/2	0/2	0/2	N/R	N/R	0/2	0/2	N/R
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	20% 2/10	0/2	0/2	0/2	0/2			N/A	2/2	
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/12	0/2	1/2	0/2	0/2			1/2	0/2	

Comments: As noted above, the Monitoring Team reviewed a total of 12 specific risk areas for six individuals, and the IHCPs to address them.

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

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

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

- Between 7/15/21, and 8/20/21, Individual #298 had three hypotensive events. No evidence was found to show that the IDT met to discuss them, and/or review and revise the IHCP as appropriate.
- In the six months prior to the Monitoring Team's review, Individual #298 fell at least six times. Two of these falls resulted in serious injuries, including a fall on 5/18/21, from which she sustained a laceration to her left eyebrow requiring staples, and on 8/28/21, from which she sustained a laceration to her left eyebrow requiring Dermabond. On 8/28/21, 9/6/21, and 9/22/21, the individual fell (i.e., three falls in 30 days). According to the quarterly nursing assessment, the individual was referred to the PNMT. However, no evidence was found that the IDT held an ISPA meeting to discuss the falls, and review and/or revise the IHCP, as needed. As noted elsewhere in this report, her IHCP for falls did not include necessary preventative interventions. For example, the interventions did not include preventative measures, such as ensuring her living/programming areas were free of clutter or how staff should address the individual sliding out of her wheelchair.
- According to Document #TX-LB-2111-II.P.1-20, between 4/3/21, and 9/19/21, Individual #134 fell 12 times. In December 2020, an assessment noted that the majority of the individual's falls were related to behaviors, but the IDT included no interventions in the IHCP, dated 1/7/21, to address the behaviors that increased his risk of falls. In a revision to the IHCP on 3/23/21, the IDT noted staff should intervene for unsafe behaviors affecting his fall risk, but the IDT provided no specifics about what such interventions should include. Based on the ISPAs submitted, the IDT met to discuss falls on 8/31/21, 9/10/21, 9/13/21, and 9/24/21. However, the IDT did not make any changes to his IHCP to address the ongoing falls. For example, they did not conduct a review of his medications, or develop other interventions to avoid falls to the extent possible.
- On 6/2/21, Individual #134's IDT met following his hospitalization for neuroleptic malignant syndrome and rhabdomyolysis. They identified Haldol and Zyprexa as medication to avoid giving him due to allergies. The psychiatrist discontinued Haldol and Zyprexa and ordered new medications. The IDT did not discuss the new medication regimen or potential side effects. They noted that he was now engaging in hypersexuality behaviors and agreed to alert female staff. However, they did not develop interventions or identify other ways to address this behavior.
- On 3/30/21, Individual #354 was diagnosed with esophageal cancer. On 4/7/21, the IDT met and discussed his new diagnosis. On 4/15/21, they changed his aspiration/respiratory compromise risk from medium to high risk due to the new diagnoses of dysphagia; a submucosal, partially obstructing esophageal tumor in lower third of the esophagus; and adenocarcinoma. However, the IDT did not make any changes to intervention to his IHCP. On 4/23/21, they held a change-of-status (CoS) ISPA meeting to add an Other - Cancer risk. The IDT noted that the individual would have weekly chemo therapy, and consults for oncology. They did not identify interventions for an IHCP. At a CoS ISPA meeting on 5/14/21, they did not address his aspiration/respiratory risk. With the addition of chemo and radiation treatment, the IDT needed to address his increased risk for emesis as well as an increased risk for aspiration. Some of the problems with the existing IHCP included that the IDT did not address his tube feedings with interventions; did not include preventive measures, such as administering anti-emetics; and did not reference that the individual could consume liquids for pleasure.
- On 5/14/21, Individual #354's IDT met to discuss an increase in his risk for medication side effects from low to high due to chemo therapy and radiation treatment. On 5/24/21, a port was placed for IV chemotherapy, and on 5/27/21, upon his return to the Center, the IDT met, but at that point, he had not received chemotherapy or radiation. The IDT did not meet after the

initiation of radiation treatment or chemo (i.e., the first week of June 2021) to review the individual's response, and make changes as needed to his IHCP to address his increased nausea and vomiting. In addition, it would have been important for them to address specific medication side effects, which would have included some of the following thrombocytopenia, leukopenia, alopecia, infections, hemorrhage, peripheral neuropathy, and low sodium, potassium, calcium, and magnesium.

- Based on a nursing IPN, on 5/17/21, Individual #209 had two episodes of emesis, and on 5/18/21, he had another episode. The provider ordered pro re nata (PRN, or "as needed) Zofran. No evidence was found to show that the IDT discussed the impact of the emesis on his risk for aspiration/respiratory compromise, and/or the need to make modifications to his IHCP.
- Within a two-month period, Individual #209 had multiple hospitalizations for UTIs/sepsis (i.e., from 2/3/21 to 2/10/21, from 2/18/21 to 2/22/21, from 3/2/21 to 3/19/21, and from 3/26/21 to 4/5/21). On 4/6/21, the IDT met to discuss the recent hospitalization. The IDT concluded that no changes were needed to the individual's PNMP, but they made a few changes to the interventions related to his infection risk. Based on the IHCPs submitted, though, it was not clear that it was updated to include these revised interventions that the IDT discussed. None of the additional interventions included monitoring his fluid intake, or adding additional fluids. The IDT also did not document and/or discuss that the individual had four hospitalizations for UTIs in 60 days, and/or analyze the potential causes to identify actions to reduce recurrence to the extent possible.

The following provides a positive example in which the IDT took necessary actions to review an individual's changes in status:

- On 7/27/21, Individual #182 was hospitalized with a diagnosis of aspiration pneumonia. On 8/2/21, his IDT met to review this event. The team noted the individual's history of hospitalizations related to aspiration and pneumonia. They attributed the event to an MBSS that had been conducted earlier in the day. They concluded that as such no changes were needed to the aspiration/respiratory distress or infections IHCP.

Outcome 7 – Individuals receive medications prescribed in a safe manner.	
Summary: Given that during recent reviews, nurses generally followed individuals' PNMPs during medication observations [Round 15 – N/R, and Round 16 – 88%, and Round 17 – 86%], Indicator f will move to the category requiring less oversight. Of note, during the last review, the problems noted with regard to nurses following the nine rights related to not using the correct amount of fluid with MiraLAX and Psyllium. The Center's nurse auditor did not identify those issues. A similar problem was noted during this review, and the Center's nurse auditor also did not identify it. It was positive to see improvement in the inclusion in IHCPs of respiratory assessments for individuals at high risk for respiratory compromise that were consistent with the individuals' level of need. However, nurses need to implement these interventions thoroughly and consistently. More work is needed as well to	Individuals:

ensure that nurses adhere to infection control standards during medication administration.											
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	325
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R							N/A		
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	88% 7/8	1/1	1/1	1/1	0/1	1/1	1/1		1/1	1/1
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A		N/A	N/A
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A		N/A	N/A
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	0% 0/4	N/A	N/A	0/1	0/1	N/A	N/A	0/1	0/1	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.	43% 3/7	N/A	N/A	0/1	1/2	N/A	1/1	0/1	1/2	N/A
	a. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	b. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	86% 6/7	1/1	1/1	1/1	1/1	0/1	1/1		1/1	N/A
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A		N/A	N/A
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A		N/A	N/A
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	25% 2/8	0/1	0/1	0/1	0/1	1/1	0/1		0/1	1/1
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	83% 5/6	1/1	1/1	1/1	1/1	N/A	0/1		1/1	N/A
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	83% 5/6	1/1	1/1	1/1	1/1	N/A	0/1		1/1	N/A
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of eight individuals, including Individual #298, Individual #134, Individual #354, Individual #209, Individual #203, Individual #249, Individual #182, and Individual #325. Prior to the remote review, Individual #226 died. During the remote review, Individual #241 was hospitalized.											

c. It was positive that for the seven of the eight individuals that the Monitoring Team member observed during medication passes, nursing staff followed the nine rights of medication administration. The following problem was noted:

- Individual #209 was to receive MiraLAX with four to eight ounces of water. The nurse only dissolved it in one ounce of water. The Center's nurse auditor did not identify this issue. Of note, during the last review, the problems noted with regard to nurses following the nine rights also related to not using the correct amount of fluid with MiraLAX and Psyllium. The Center's nurse auditor also did not identify those issues.

d. For the individuals reviewed, the Monitoring Team identified a number of concerns related to necessary respiratory assessments. The following provide examples of the Monitoring Team's findings:

- Individual #354 had a J-tube. A PCP order required nursing staff to check his lung sounds if he coughed. However, his IHCP did not reflect the need for this nursing intervention.
- Individual #209 was at high risk for aspiration/respiratory compromise, and had a G-tube. His IHCP included interventions for nursing staff to conduct lung assessments every shift, and for nurses to check the gastric residual prior to any G-tube use, and call the PCP if the residual was greater than 100 ml and hold the feeding. Based on a sample of documentation, nurses often did not conduct lung assessments each shift, and when they did, they often only assessed anterior lung sounds. It was positive that during the medication pass the Monitoring Team member observed, the nurse checked the individual's residuals, and reported that the record showed that a nurse assessed his lung sounds earlier during the shift.
- Individual #226 was at high risk for aspiration/respiratory compromise, and had a G-tube. His IHCP included interventions for nurses to auscultate and aspirate the G-tube with each use, and document residual amounts, as well as to assess his lung sounds every eight hours. Based on a review of a sample of documentation, nurses frequently did not assess and/or document residuals. In addition, nurses did not consistently document auscultation and aspiration prior to administering medications.
- Individual #182 was at high risk for aspiration/respiratory compromise, and had a G-tube. His IHCP included interventions for nursing staff to check lung sounds before and after G-tube use, as well as to ensure tube placement, auscultate, and aspirate prior to each use. Based on a review of a sample of documentation, nurses did not implement this intervention as written. On 7/27/21, at 7:40 p.m., he exhibited a cough, and had a fever. He was diagnosed with aspiration pneumonia. It was positive that during the medication pass that the Monitoring Team observed, the medication nurse checked his lung sounds.
- Individual #249 was at medium risk for aspiration/respiratory compromise. However, she coughed during the observed medication pass, and said: "It went down the wrong pipe." It was positive that the medication nurse immediately checked the individual's lung sounds.

f. For the most part, medication nurses followed the individuals' PNMPs, including checking the positions of the individuals prior to medication administration. The following concerns were noted:

- Individual #203's PNMP included instructions to check his mouth before he exited the medication room. The medication nurse did not do this, and the Center's nurse auditor did not identify the problem.

g. For the individuals observed, nursing staff often did not follow infection control practices. It was positive, though, that when problems did occur, the Center's nurse auditor often identified them, and took corrective action as needed. The following concerns were noted:

- The medication nurse for Individual #298 engaged in a number of practices that were inconsistent with infection control standards. For example, the nurse washed their hands twice, including once for 25 seconds, but during this hand washing, they did not wash between their fingers. The second hand washing only occurred for five seconds. The nurse did not clean the mouse or water bottle, but used both. The nurse touched the PNMP that had not been cleaned, and then touched top surfaces and medications without sanitizing. The nurse did not gel before donning gloves. The Center's nurse auditor identified these concerns, and took follow-up action.
- During Individual #134's medication pass, the medication nurse did not change gloves and/or apply gel after touching the bottom of the drawer of the medication cart, which had not been cleaned. The nurse touched the inside of the crush bag, and did not clean the crush portion of the crusher. The Center's nurse auditor identified these concerns, and took follow-up action.
- Individual #354 touched the plunger of the syringe, and then, the nurse used it to push fluids as opposed to discarding it. Also, the nurse did not clean the stethoscope prior to use. The Center's nurse auditor identified these concerns, and took follow-up action.
- The medication nurse did not cover Individual #209's g-tube with a cap. The tubing dangled and touched other items. The nurse also did not apply gel between glove exchanges. After their gloves touched multiple dirty surfaces, the nurse did not change gloves or sanitize. The nurse touched the inside of the medication crushing bag when putting in the cup. The nurse also did not the clean the stethoscope or the water bottle prior to use. The Center's nurse auditor identified these concerns, and took follow-up action.
- During Individual #249's medication pass, the nurse did not clean the stethoscope prior to use, and the Center's nurse auditor did not identify the issue.
- During Individual #182's medication pass, the nurse touched their mask and glasses, and reached into the drawer to obtain a spoon with dirty gloves. The Center's nurse auditor identified these concerns, and took follow-up action.

Physical and Nutritional Management

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

The Monitoring Team no longer rates most of the indicators related to this outcome. The Center's responsibilities for PNM-related personal goals/objectives are now assessed as part of the Section F – ISP audit tool. Information about the Center's compliance related to the referral of individuals to the PNMT is provided below

Summary: In comparison with previous reviews, Center staff made improvements with regard to referral of individuals meeting criteria to the PNMT.		Individuals									
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
b.	Individuals are referred to the PNMT as appropriate:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	89% 8/9	1/1	2/2	1/1	2/2	0/1	1/1	1/1	N/A	N/A

Comments: b.i. The Monitoring Team reviewed nine areas of need for seven individuals that met criteria for PNMT involvement. These areas of need included those for: Individual #298 – falls; Individual #134 – falls in April 2021, and falls in September 2021; Individual

#354 – aspiration; Individual #209 – aspiration, and fractures; Individual #203 – falls; Individual #249 – GI problems; and Individual #226 – weight.

On the following dates, Individual #203 fell: 4/9/21, 4/12/21, 4/17/21, 4/30/21, 5/12/21, 6/1/21, 6/3/21, 6/4/21, 6/13/21, and 6/17/21. According to Habilitation Therapy notes, on 5/20/21, 6/17/21, and 9/2/21, he met criteria for referral to the PNMT, but his IDT did not refer him, and the PNMT did not make a self-referral. The Habilitation Therapy note, dated 9/2/21, referenced a past PNMT assessment and that falls were due to his startle reflex. However, in the documents available, the only past assessment was referenced as having been completed in 2016.

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

Summary: None of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Many of the PNM action steps that were included were not measurable, making it difficult to collect specific data. Substantially more work is needed to document that individuals receive the PNM supports they require. In addition, in numerous instances, IDTs did not take immediate action, when individuals' PNM risk increased or they experienced changes of status. At this time, these indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 298	134	354	209	203	249	226	182	241
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	44% 4/9	1/2	1/1	0/1	1/2	0/1	N/A	N/A	0/1	1/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	75% 3/4	0/1	1/1	N/A	1/1	N/A	N/A	1/1	N/A	N/A

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

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

- On 5/21/21, the OT and SLP assessed Individual #298 after she fell and was prescribed pain medication. Staff reported that the individual was lethargic. The OT/SLP consult recommended a temporary PNMP continue; it included instructions for staff assistance.
- On 3/1/21, Individual #134 sustained bilateral calcaneus fractures. Habilitation Therapy staff worked with the IDT to initiate and then monitor the implementation of a temporary PNMP.
- On 8/23/21, Individual #209 fell out of the ARJO lift, and fractured his tibia. On 8/31/21, he returned to the Center from the hospital. The IDT developed and implemented a temporary PNMP. The PNMT assessed his mattress and head-of-bed elevation (HOBE).
- On 10/29/21, Individual #241 returned to the Center from a hospitalization due to respiratory distress related to COVID-19. Upon his return, he presented with lethargy and overall deconditioning. The PT, OT, and SLP assessed him. According to the post-hospital ISPA, the IDT implemented a temporary PNMP, as well as a plan to obtain weekly weights due to weight loss at the hospital, along with an increased level of supervision to ensure his safety. The PCP ordered Ensure to assist with the individual's intake and help with nutrition to meet his increased energy needs.

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

- On 5/18/21, Individual #298 sustained a serious injury (i.e., a laceration to her left eyebrow that required staples) when she fell while attempting to open a heavy bathroom door. Based on the ISPA, the IDT did not discuss ways to reduce her risk. For example, no discussion was documented related to ways to better bridge the individual's ability to communicate to staff when she needed the door opened, or whether or not the door could be modified so that she could more easily operate it independently. The IDT provided no clear assessment of the impact of her footwear on the falls. During the Monitoring Team's observation, she was wearing open-toed slippers, which might contribute to her falls.
- On 5/24/21, Individual #354 had a J-tube placed. Upon his return from the hospital, Habilitation Therapy staff provided a wedge, which was positive. However, on 3/1/21, clinical staff had downgraded his diet texture from regular to chopped, and again, on 3/10/21, from chopped to ground. Since the esophageal mass was identified and he experienced increased difficulty in swallowing in March 2021, no MBSS had been scheduled.
- During a hospitalization, on 9/6/20, Individual #209 had a G-tube placed due to a failed MBSS. On 10/22/20, the individual's IDT met to review his PNMP and discuss possible changes to his aspiration/respiratory compromise IHCP. The IDT recommended a repeat MBSS tentatively scheduled for 12/1/20, but the PCP indicated that it should not be completed due to weight concerns at the time. On 1/6/21, the IDT stated that they would follow up with the PCP about completing another MBSS. No evidence was found to show follow-up regarding this subject.
- Overall, the PT did a nice job assessing and reassessing Individual #203's gait to determine changes in status, and modifying and adding supports. For example:
    - On 5/21/21, the PT completed a gait consult in response to falls on 4/9/21, 4/12/21, 4/17/21, 4/30/21, and 5/12/21. The PT recommended a potential increase in the use of a wheelchair, because his gait remained at baseline. The PT recommended removing the bean bag chair, because it resulted in difficulties during transfers.
    - On 6/17/21, the PT added a vinyl belt during bathing.
    - On 7/9/21, the IDT requested a PT gait assessment due to falls. It resulted in recommendations for one-to-one staffing when the individual was walking due to his instability, secondary reflex, and limited therapy prognosis. Habilitation Therapy staff also were to provide him with a personal wheelchair, and they provided a loaner in the interim.

- On 8/17/21, the PT revised the PNMP to remove the leg rests when the individual was at home due to their hitting his ankles. A new wheelchair was on order.

Missing from the overall IDT response, though, was the potential to manage the fall issue or improve the individual's instability/startle reflex with medication. Additionally, the PNMT notes stated that some of the falls were due to peer-to-peer aggression or running from staff (e.g., on 4/9/21), but the IDT/PNMT documented no discussion with BHS staff to determine how they could assist.

- From 2/11/21 to 2/18/21, Individual #182 was hospitalized for community acquired pneumonia, and from 7/27/21 to 7/29/21, he was hospitalized for aspiration pneumonia. The IDT met timely after these hospitalizations, and reviewed supports. However, the IDT did not set forth a clear plan focused on improving the individual's tolerance to wear the CPAP device, which the IDT noted as a barrier in multiple ISPAs. For example, the IDT documented no outreach to BHS staff to develop a plan to address the individual's inconsistency in wearing the device.

c. For the individuals reviewed whom the PNMT had discharged, the IDTs often held ISPA meetings during which the PNMT shared information from its reviews/assessments. The exception was for:

- No ISPA was found to show the IDT met to discuss the results of the review of Individual #298's falls.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: Based on two observations, staff completed transfers correctly. However, efforts are needed to continue to improve Dining Plan implementation, as well as positioning. Often, the errors that occurred (e.g., staff not intervening when individuals took large bites, and/or ate at an unsafe rate) placed individuals at significant risk of harm. Center staff, including Habilitation Therapies, as well as Residential and Day Program/Vocational staff, and Skill Acquisition/Behavioral Health staff should determine the issues preventing staff from implementing PNMPs correctly or effectively (e.g., competence, accountability, need for skill training for individuals, need to change ineffective strategies, etc.), and address them. This indicator will continue in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	66% 23/35	
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.	N/R	

Comments: a. The Monitoring Team conducted 35 observations of the implementation of PNMPs/Dining Plans. Based on these observations, individuals were positioned correctly during seven out of 10 observations (70%). Staff followed individuals' dining plans during 14 out of 23 mealtime observations (61%). Staff completed transfers correctly during two out of two observations (100%).

The following provides more specifics about the problems noted:

- With regard to Dining Plan implementation, the great majority of the errors related to staff not using correct techniques (e.g., cues for slowing, presentation of food and drink, prompting, etc.). Individuals were at increased risk due to staff's failure, for example, to intervene when they took large unsafe bites, overfilled their mouths, ate at too fast a rate, or staff did not provide liquids in between bites, or did not cue individuals to take smaller sips. It was good to see that texture/consistency was correct, and that adaptive equipment was correct. With one exception, staff and the individuals observed were positioned correctly at mealtime.
- With regard to positioning, two individuals were not positioned correctly. In about 30% of the observations, staff had not used equipment correctly. It was positive that for all of the observations, necessary adaptive equipment/supports were present.
- For the two transfers observed, staff followed correct procedures.

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A			N/A	N/A			N/A	N/A	
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: For individuals reviewed, some progress was noted since the previous review with regard to the development of measurable goals/objectives to address their needs for formal OT/PT services. However, significant improvement was still needed to ensure individuals' goals/objectives were clinically relevant to their needs. In addition, even when individuals had measurable goals/objectives, IDTs did not integrate them into their ISPs or include data and data analysis in the QIDP interim reviews. As a result, IDTs did not have information in an integrated format	Individuals:

related to individuals' progress or lack thereof. These indicators will remain in active oversight.											
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	17% 1/6	0/1	1/1	0/2	N/A	N/A	N/A	N/A	0/2	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	33% 2/6	0/1	0/1	0/2					2/2	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/6	0/1	0/1	0/2					0/2	
d.	Individual has made progress on his/her OT/PT goal.	0% 0/6	0/1	0/1	0/2					0/2	
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	0/2					0/2	

Comments: a. and b. Five of nine individuals had OT/PT supports in place (e.g., a PNMP), but did not otherwise require formal goals/objectives. The remaining five individuals did have needs requiring OT/PT goals/objectives.

For Individual #134's goal/objective to grasp an item using his left hand, the criteria for achievement was not clear. In its comments on the draft report, the State disputed this finding, and stated: "For individual # 134 (TX-LB-2111-II.99.134 pg. 3), the criteria used to measure progression is as follows 'individual #134's response to verbal/gestural/tactile prompts to reach for an item and/or assistance required to grasp an item 6-12 inches away from him on a tabletop for 5 trials in a session.'" The problem was that the overall goal mastery criteria were unclear. For example, as written, it was not clear whether the individual would master the goal after just one session during which he successfully completed five trials of grasping items, or whether consistency over a specific number of sessions (e.g., two consecutive sessions) was needed to demonstrate mastery.

The goals/objectives that were measurable were for Individual #182 (i.e., complete stand-pivot transfers, and complete static stance for 10 seconds). However, the goals/objectives were not clinically relevant because they did not describe a frequency of performance that would demonstrate achievement of a meaningful clinical outcome. Instead, the goals/objectives appeared to imply that the ability to perform the skill just once would be sufficient.

It was positive that Individual #182 had goals/objectives that were measurable. However, his IDT did not integrate those into his ISPA/ISPA. In addition, for the remaining individuals who had goals/objectives, none of their IDTs integrated their goals/objectives into the individuals' ISPs/ISPAs. This was an important missing piece to ensure that an individual's IDT approved the OT/PT goals/objectives, and was aware of the progress with regard to their implementation, and could build upon and integrate those goals/objectives into a cohesive overall plan.

c. through e. Although therapists' notes often offered evidence of implementation for therapy goals/objectives, overall, QIDP monthly integrated progress reports, including data and analysis of the data, were often not available to IDTs in an integrated format and/or in a

timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

The Monitoring Team conducted full reviews for all nine individuals. As described above, this included Individual #209, Individual #203, Individual #249, Individual #226, and Individual #241, all of whom had OT/PT supports in place, but did not require formal OT/PT goals/objectives.

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

Summary: For the individuals reviewed, evidence was not found in ISP integrated reviews to show that OT/PT supports were implemented. However, it was positive that IDTs met to review and approve recommendations for termination of OT/PT services and supports. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 298	134	354	209	203	249	226	182	241
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	N/A									
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	100% 3/3	N/A	1/1	2/2	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to OT/PT needs were implemented. As noted above with regard to Outcome 1, individuals reviewed did not have measurable goals/objectives that were also included in their ISPs/ISPAs. In addition, regardless of whether existing goals/objectives met criteria for measurability, the QIDP monthly integrated progress notes did not document implementation. At times, therapists included data related to the implementation of goals/objectives in IPNs, but this information was not summarized and included in the monthly reviews. OTs and PTs should work with IDTs to ensure that goals/objectives, including formal therapy plans, meet criteria for measurability and are integrated in individuals' ISPs through a specific action plan.

b. It was positive that for the two applicable individuals for whom OT/PT services were terminated, the IDTs met to discuss and approve those changes.

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, this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators.

[**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	105	164	267	184	47	298	275	241	270
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance, these indicators 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.	84% 31/37	1/1	2/2	2/2	2/3	1/2	1/2	1/1	0/1	1/1
		Individuals:									
#	Indicator		73	8	277	199	233	190	232	174	203
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	2/2	1/2	1/1	2/2
		Individuals:									
#	Indicator		37	120	311	3	294	62	280	197	284
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	2/2	0/1	1/1	1/1	1/1	1/1	1/1

Comments: c. The Monitoring Team conducted observations of 37 pieces of adaptive equipment. Based on observations, for most individuals the assistive/adaptive equipment identified in the individual's PNMP appeared to be the proper fit. The following describes concerns noted:

- For Individual #184, the seat cushion of her adapted meal chair was collapsing, causing her to lean to the right with increased pressure on her hip.
- For Individual #298, due to her history of falls, resulting in part from getting up out of her wheelchair to walk, the PNMP called for rubber grip socks or socks and shoes. During the observation, she was wearing rubber grip socks, but under open-toed slipper shoes. This would tend to negate the purpose of the rubber grip socks and would not serve to ensure stability in gait and balance.
- For Individual #47 and Individual #241, the outcome was that they were not positioned correctly (i.e., leaning to the side and/or slumping forward). It is the Center's responsibility to determine whether or not the issues were due to the equipment, or staff not positioning the individuals correctly, or other factors.
- Individual #232's four-ounce adaptive nosey cup appeared too large to prevent him from taking large gulps of liquid, instead of the small sips the PNMP prescribed. He might instead benefit from a two-ounce nosey cup to help assist with sip size.
- Individual #3 was not wearing his finger protector and hand splint, so it was not possible to evaluate proper fit. Center staff stated he was to wear the equipment as tolerated, but did not have any methodology in place to establish the criteria for tolerance or to track how often and how long he was wearing it. Not only does this impact overall future decision-making if the

	desired outcome is not reached, it also could inhibit Center staff from evaluating whether the fit was impacting his tolerance for wear.

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 10 outcomes and 26 underlying indicators in the areas of skill acquisition, and communication. At the time of the last review, four of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, no additional indicators 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.

In skill acquisition, better implementation and data collection and improved reliability were needed in order to be able to assess progress (and for progress to be more likely to occur).

Most SAPs contained most components. Some improvements in some of the required components were needed.

About two-thirds of SAPs were implemented as written, the highest percentage yet seen at Lubbock SSLC.

About half of the SAPs meet criteria for proper monthly review.

There was one individual at the Center who was enrolled in public school. Some, but not all, of the various requirements for coordination and integration of Center and ISD activities were occurring.

As applicable, eleven of thirteen individuals observed had their AAC devices with them. SLPs should continue to work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner.

ISPs

Outcome 2 (indicators 4-7) and Outcome 8 (indicators 39-40) now appear within domain #2 above.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Better implementation and data collection and improved reliability were needed in order to be able to assess progress (and for progress to be more likely to occur). These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	328	386	325	99	399	298	174	134	236
6	The individual is progressing on his/her SAPs.	3% 1/14			0/1	1/3	0/3	0/1	0/2	0/3	0/1
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A									
8	If the individual was not making progress, actions were taken.	18% 2/11			0/1	1/2	0/3	0/1	1/2	0/2	
9	(No longer scored)										

Comments:

6. Based upon a review of the data presented in the Client SAP Training Progress Note, it was determined that progress was being made on three of 14 SAPs. These were Individual #99's choice board SAP, Individual #134's Nintendo switch SAP, and Individual #236's mug cake SAP. But that being said, only Individual #99's choice board SAP had been monitored with a form that allowed for determining data reliability.

The individuals were not making progress on 11 other SAPs.

Six SAPs were excluded from this analysis due to limited data. These were Individual #386's use of the Internet, Individual #328's making a cake, Individual #325's taking photographs, Individual #298's sorting clothing, and Individual #236's charging and cleaning his Dynavox.

Data reflected poor implementation of scheduled teaching sessions for many SAPs.

7. In no case had the individual met the established goal.

8. For nine of the 11 SAPs on which the individual was not making progress, there was no evidence that the individual's team had identified actions to improve skill acquisition. For the remaining two SAPs (Individual #99 use an art spinner and Individual #174 sign drink), the team agreed to discontinue the SAP. So, even though this was scored 1 for these two SAPs (because the team took an action), there were no other actions taken prior to this decision to discontinue (e.g., modify procedures, modify SAP). A replacement SAP was not identified for either.

Outcome 4- All individuals have SAPs that contain the required components.												
Summary: Most SAPs contained most components. Some improvements in some of the required components were needed. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	328	386	325	99	399	298	174	134	236
13	The individual's SAPs are complete.	5% 1/20	0/1 7/10	0/1 9/10	0/2 14/19	1/3 27/30	0/3 23/28	0/2 15/20	0/2 17/20	0/3 26/30	0/3 26/ 30

Comments:

13. While only one SAP (Individual #99 - sign movie) included all necessary components, better than 85% of the 20 SAPs included the following elements:

- a task analysis where appropriate;
- a behavioral objective;
- an operational definition of the skill to be performed;
- a relevant discriminative stimulus;
- a teaching schedule;
- specific consequences for both correct and incorrect responding; and
- documentation methodology.

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.

Individual specific feedback is provided below.

- Be sure that the task analysis is complete. Individual #328 was learning to make a cake, but he was not learning to gather needed materials or set the timer on the microwave. Individual #325 was learning to photograph food she prepared, so that she could create a cookbook. The task analysis did not address setting up the food for the photograph.
- The operational definition should match the objective. Individual #298 was learning to apply stickers, but the skill was described as smearing glue.
- Consider a discriminative stimulus that will support the SAP purpose. For example, Individual #174 was learning to sign 'drink in response to an instruction from staff to do so. This will likely not result in his independently requesting a drink when thirsty. It would be more natural for him to learn to sign drink when drinks are present without a verbal instruction from staff.
- The instructions were not always clear. Be sure to describe how materials are set up (e.g., Individual #99 - use art spinner), identify the individual's dominant hand (e.g., Individual #134 - write last name), keep the identified training location consistent throughout the SAP (e.g., Individual #99 - choice board), and include guidelines for staff to follow should the individual not complete steps that have been identified as mastered (e.g., Individual #134 - write last name).
- Be sure that plans for generalization involve the individual learning to use the skill in novel environments, with different people, with new materials, etc.

Outcome 5- SAPs are implemented with integrity.											
Summary: Indicator 14 scored higher than ever before. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	328	386	325	99	399	298	174	134	236
14	SAPs are implemented as written.	63% 5/8	1/1	Attempted	1/1	1/1	1/1	0/1	0/1	0/1	1/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	24% 4/17		0/1	0/2	2/3	1/3	0/2	0/2	1/3	0/1

Comments:

14. An observations of one SAP teaching session was completed for each of the nine individuals. Five of these were implemented as written. These were Individual #328 - make a mug cake, Individual #325 - photograph a prepared food, Individual #99 - use of a choice board, Individual #399 - count pennies, and Individual #236 - charge his Dynavox.

Four of these five individuals (Individual #328, Individual #325, Individual #399, Individual #236) demonstrated mastery of the skill during the observation. Each IDT, including the individual, should meet to determine the next appropriate skill to introduce. Individual #386's SAP observation was not scored because it was difficult to see the computer screen during the video presentation.

Individual specific comments are provided below.

- The staff member working with Individual #99 on his choice board SAP first presented the discriminative stimulus, followed up with a verbal prompt, and then pointed to the three options as noted in the SAP. Individual #99 opted not to choose a drink.
- As noted above, Individual #399 was able to complete all steps of the SAP not just the one on which he was working. When he was encouraged to count a greater number of pennies, he was able to do this as well. Staff should probe his counting skills to ensure that he moves on to a more functional and meaningful SAP in a timely manner.
- The staff member had the materials placed on a flat surface as indicated in Individual #298's apply stickers SAP. She then removed the backing before presenting this to Individual #298 who was able to turn it over and place it on the paper. Praise was provided, but Individual #298 was not provided time to enjoy her scrapbook as indicated in the SAP. Staff explained that this was reserved for times of active engagement.
- Individual #174's SAP was identified as his learning to make a milkshake. However, the materials were not presented as indicated in the SAP as they were already in the blender. Individual #174 was not seated at the table, rather he was seated sideways slightly away from the table. He required assistance to put the blender together.
- The staff member was pleasant and supportive as he worked with Individual #134, but he did not follow the prompting hierarchy as written in the SAP. The initial discriminative stimulus was presented and then represented in a variety of ways. Eventually, verbal and pointing prompts were used. The SAP indicated he was to learn to open a lock box so that he could secure his valuables, but during the observation, he opened the lock box to obtain a bag of snacks.

15. Per state policy, SAP integrity should be assessed at a minimum of twice annually. However, the facility had established a schedule of assessing SAP integrity 30 days after implementation, and then three, six, and eight months after that. Goal levels were established at 80% or better. Based upon the documentation provided, it was determined that four of 17 SAPs had been monitored with adequate integrity at least once over the previous six month period. Three SAPs (Individual #328 - mug cake, and Individual #236 - charge Dynavox and clean Dynavox) were excluded from this analysis because they had been implemented for one month or less. It will be important to ensure that SAPs are implemented when assessing treatment integrity. If the individual refuses to participate, or is unavailable due to absence or illness, it will be important to acknowledge that monitoring could not occur. Staff interview or role play is not an acceptable alternative to observing the staff member implementing the SAP with the individual. The facility had reported that SAP integrity measures were not available for Individual #386, Individual #328, Individual #325, and Individual #236.

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

Summary: Performance has remained the same for a number of consecutive reviews, that is, that about half of the SAPs meet criteria for proper monthly review. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 328	386	325	99	399	298	174	134	236
16	There is evidence that SAPs are reviewed monthly.	53% 10/19		1/1	1/2	0/3	3/3	2/2	2/2	0/3	1/3
17	SAP outcomes are graphed.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
16. There was evidence that a data-based review of 10 of 19 SAPs was completed monthly in the individual's QIDP Monthly Report. These were the following SAPs: Individual #386 - search the Internet; Individual #325 - photograph a prepared food; Individual #399 - count pennies, medication, and identify a letter; Individual #298 - sort clothing and apply a sticker; Individual #174 - make a milkshake and sign drink; and Individual #236 - charge his Dynavox.

For the remaining nine SAPs, either data were not provided or the current step was not identified. Individual #328's make a cake SAP was excluded from this analysis because it had just been implemented a few weeks before the review.

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

Summary: These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 328	386	325	99	399	298	174	134	236
18	The individual is meaningfully engaged in residential and treatment sites.	22% 2/9	0/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									

20	The day and treatment sites of the individual have goal engagement level scores.										
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
18. During the remote review, a minimum of three observations were conducted of all nine individuals in their home, day program, and/or work sites. In some cases, the individual was not at his/her day program or work site when scheduled, or he/she was asleep when a visit was made to the home. Based upon these observations, it was determined that Individual #386 and Individual #399 were regularly engaged in some meaningful activity.

21. Facility staff provided engagement monitoring data for the homes only. Based on this information, it was determined that monitoring had occurred every other month or more frequently with goal levels achieved in the home of Individual #328 and Individual #399. In the homes of the other seven individuals, either monitoring did not occur as scheduled and/or the goal levels were not achieved. Due to the absence of monitoring in any day program or work sites, this indicator is rated zero for all nine individuals.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: These indicators will be monitored and scored at the next review. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	328	386	325	99	399	298	174	134	236
22	For the individual, goal frequencies of community recreational activities are established and achieved.	Not scored due to CV-19									
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	Not scored due to CV-19									
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	Not scored due to CV-19									

Comments:
22-24. Due to the restrictions necessitated by the COVID-19 pandemic, these three indicators were scored as not applicable. Four of the nine individuals had experienced at least one community recreational activity between April and September of 2021. These were Individual #386, Individual #328, Individual #325, and Individual #399.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.												
Summary: There was one individual at the Center who was enrolled in public school. Some, but not all, of the various requirements for coordination and integration of Center and ISD activities were occurring. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	328	386	325	99	399	298	174	134	236
25	The student receives educational services that are integrated with the ISP.	0% 0/1									
Comments: 25. At the time of the review, one individual residing at the facility, Individual #327, was enrolled in public school. From the information provided, it was determined that he was receiving vocational training from a public school teacher five days per week for one half hour each day. The date this service began was not provided. His original ISP, completed in November 2020, had not been amended to include information about his public school enrollment or action plans taken by the team to support his public education. The evidence provided in his IEP indicated that the least restrictive environment had been considered, with discussion regarding an extended school year deferred to a later date. Documentation indicated that two behavioral health services staff and his registered nurse case manager had participated in his IEP. There was no evidence that his QIDP had participated. Lastly, facility staff reported that no report cards or progress notes had been provided by the local public school.											

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.
The Monitoring Team no longer rates this outcome. The Center's responsibilities for these goals/objectives are now assessed as part of the Section F – ISP audit tool.

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: Work is still needed to improve the clinical relevance and measurability 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, and to request IDT meetings to discuss goals and objectives when data show that an individual is not making progress, or there are	Individuals:

problems with implementation. These indicators will remain under active oversight.											
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
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	0/1	0/1	N/A	0/2	0/1	N/A	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	38% 3/8	0/1	0/1	0/1		2/2	0/1		1/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/8	0/1	0/1	0/1		0/2	0/1		0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/8	0/1	0/1	0/1		0/2	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% 0/8	0/1	0/1	0/1		0/2	0/1		0/1	0/1

Comments: a. and b. Individual #209 and Individual #226 had their communication needs addressed through the use of a communication dictionary and their PNMPs, and did not require formal communication goals/objectives. The remaining seven individuals did have communication needs that required formal goals/objectives.

The goal/objective that was clinically relevant was for Individual #298 (i.e., when given verbal instructions, independently sort her clothes by type). However, it was not measurable because it did not provide the number of tops, bottoms, and undergarments to be presented. The goals/objectives that were measurable, but not clinically relevant were for Individual #203 (i.e., independently sign eat, and independently sign book), and for Individual #182 (i.e., request dominos using an adaptive switch).

It was positive that some individuals had goals/objectives that were either clinically relevant or measurable. It was also positive that overall, for the four individuals who had communication goals/objectives, their IDTs integrated these goals/objectives into their respective ISPs/ISPAs. This is an important element to ensure that an individual's IDT approved the communication goals/objectives, and was aware of the progress with regard to their implementation, and could build upon and integrate those goals/objectives into a cohesive overall plan

c. through e. For Individual #203, the monthly progress reports did not include specific data or meaningful analysis. For the other three applicable individuals, the QIDPs monthly integrated progress reports included some data, but no meaningful analysis. For example, for all four individuals, the monthly integrated progress reports showed that Center staff were not implementing their respective SAPs at the required frequency. The QIDPs did not provide analysis to assist the IDT to understand why, or how this was impacting progress. In addition, the IDTs did not take steps to address the lack of required frequency or the lack of progress.

The Monitoring Team completed full reviews for all nine individuals, including Individual #209 and Individual #226, who did not require formal communication goals/objectives, but did have communication supports.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: To move forward, QIDPs and SLPs should work together to make sure QIDP monthly reviews include relevant data and analysis of data related to the implementation of communication strategies and SAPs, and that those strategies are implemented timely and completely. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	298	134	354	209	203	249	226	182	241
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/3	N/A	N/A	N/A	N/A	0/2	N/A	N/A	0/1	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated monthly reviews to determine whether or not the measurable strategies related to communication were implemented. As described above with regard to Outcome 1, two individuals (i.e., Individual #203 and Individual #182) had measurable goals/objectives integrated into their respective ISPs/ISPAs. Based on the QIDP monthly integrated progress reports and SAP data submitted for review, Center staff did not implement the SAPs at the required frequencies. In addition, the remaining applicable individuals reviewed (i.e., who needed formal communication supports) did not have measurable goals/objectives integrated in their ISPs/ISPAs.										

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: As applicable, eleven of thirteen individuals observed had their AAC devices with them. SLPs should continue to 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	222	305	99	315	175	164	198	236	158
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	85% 11/13	1/1	0/1	1/1	1/1	1/1	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.	58% 7/12	0/1	0/1	1/1	N/A	1/1	1/1	1/1	0/1	1/1
			Individuals:								

#	Indicator		275	35	290	327	285				
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		1/1	1/1	1/1	0/1	N/A				
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		1/1	N/A	1/1	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.	N/R									

Comments: a. and b. Based on observations, two of 13 individuals did not have their AAC devices with them, and five of 12 individuals were not using their language-based supports in a functional manner. The following describes concerns noted:

- For Individual #222, the Communication Plan directions did not match Center staff presentation. The directions indicated Center staff should prompt the individual push the button on the AAC device (i.e., Big Talk 4) to request an activity from four choices. Instead, Center staff instructed him to "push" a specific button. This turned it into an object recognition activity instead of its intended function to support choice-making.
- Individual #305 did not have his sign poster and book with him for use at work.

  In its comments on the draft report, the State asked for clarification for Individual #305 and Individual #327 in relation to the availability of their communication supports. They stated: "For Individual #305, per his Communication Instructions page, the Picture/Sign Language Communication Board should remain in the day room. His 'Learn American Sign Language Book' is to remain in the aide station and is for staff to utilize." Communication supports should be available where they are needed to help bridge the communication gap between staff/others and the individual.
- For Individual #236, Center staff were not prompting him to use his AAC device (i.e., Dynavox) as indicated in the instruction page/guidance to expand his functional expressive or receptive communication. Staff stated: "I never see him use them," which would appear to indicate staff did not have the needed training to implement this communication support.
- Individual #327 did not have his sign language book available. In addition, during mealtime, he was observed to sign "more," but the full request should have been "more meat." Rather than modeling the use of the full request, which would have modeled functional expressive language, Center staff only verbalized the word "meat," and then proceeded to give him more meat.
- Individual #284 did not have an AAC device, but did use sign language for communication. During observations, he signed the word "more," but Center staff only responded with verbalizations rather than modeling his sign for more and then pairing it with the sign to complete the request. An example would be pairing the sign for milk with his sign for "more."

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. Prior to this review, three indicators moved to the category requiring less oversight. Presently, one additional indicator will move to this category.

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:

Overall, it was good that Center staff continued to implement a number of improvement efforts with regard to transitions. This included continuing providing training to IDTs about the expectations for discipline transition assessments, with the goal of improving pre-move training and provider competency testing. It was also positive that discipline heads were involved in the review and approval of transition assessments.

Most importantly, Lubbock SSLC made significant progress in organizing their pre-move training. While Center staff did not yet define competency criteria in the pre-move training supports, for each training area (e.g., residential, behavioral, nursing, etc.), they put together a packet for each topic that described the training content and included a corresponding competency test. Overall, the content was well-organized, and it appeared the staff had taken time to think about what really needed to be included rather than including extraneous material that was not important. Still, the pre-move competency training supports reviewed did not identify the expected provider staff knowledge or competencies that needed to be demonstrated, and competency testing did not consistently cover all important support needs. As the Monitoring Team has consistently pointed out, the success of the Community Living Discharge Plan (CLDP) relies heavily on whether IDTs have developed clear and measurable supports and that provider staff are trained to competency on those supports. Center staff are encouraged to continue making improvements in the development of a comprehensive set of supports, with particular emphasis on identifying supports to address all important requirements with regard to pre-move training for provider staff and for behavioral, safety, healthcare, therapeutic, and supervision needs. It was again good to see the IDTs continued to frequently develop pre-move supports for Center clinicians to collaborate and share information with their community counterparts, but those still needed to clearly identify the expected knowledge that needed to be imparted.

It was positive transition staff were continuing to work toward improving the assessment format, content and recommendations in discipline assessments, and continued improvement was noted. To ensure provider staff were prepared to meet individuals' needs, IDT members should be sure to include specific and measurable recommendations for pre-move training, including the specific competency criteria, in their assessments. Although Center staff provided training to community provider staff, the

CLDPs did not yet define the training thoroughly, and Center staff still were not able to confirm that community provider staff were competent to meet individuals' needs at the time of transition.

Post-move monitoring continued to be an area of relative strength, particularly in terms of taking persistent and timely follow-up action when transition concerns were identified. It was also positive that the Post-Move Monitor (PMM) regularly engaged the IDT in reviewing the PMM Checklists and carefully documented the resulting deliberations and any modifications to supports that IDTs approved. Still, some improvements were needed in the areas of the PMM basing decisions about supports on reliable and valid data, providing complete documentation to substantiate the findings, and ensuring follow-up was sufficiently comprehensive.

The Center reported that one of the two individuals experienced a Potentially Disrupted Community Transition (PDCT) event. It was not possible to confirm that the Center had adequately identified, developed, and taken needed actions that might have reduced the likelihood of the negative event occurring.

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: It was good to see Center staff had made significant progress in organizing their pre-move training. That being said, more work was needed to make these supports, as well as post-move supports, in the CLDPs measurable. In addition, 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	341	220							
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1							
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1							
Comments: Since the last review, two individuals (i.e., Individual #341 and Individual #220) transitioned from the Center to Home and Community Services (HCS) settings in the community. Both were included in this review. The Monitoring Team reviewed these two transitions and discussed them in detail with the Lubbock SSLC Admissions and Placement staff. Overall, it was good to hear that Center staff had continued to implement a number of improvement efforts with regard to transitions. Most importantly, Lubbock SSLC made significant progress in organizing their pre-move training, as described further below. While Center staff did not yet define competency criteria in the pre-move training supports, for each training area (e.g., residential, behavioral, nursing, etc.), they put together a packet that included the training content and a corresponding competency test. Overall, the content was well-organized, and it appeared the staff had taken time to think about what really needed to be included rather than including extraneous material that was											

not important. With these steps, the Center moved closer to defining competency criteria and adequately testing provider staff competency.

1. IDTs need to 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 need to continue to focus on identifying the measurable criteria upon which the 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 22 pre-move supports for Individual #341, and 27 pre-move supports for Individual #220. Some were measurable (e.g., the provision of documents, equipment and various items), but the important pre-move supports for training and sharing information with provider staff were not. Examples of concerns noted included the following:
    - For Individual #341, the CLDP included pre-move supports for one-to-one consultations with the board-certified behavior analyst (BCBA) and the registered nurse case manager (RNCM). This was positive. The supports described expectations for the type of documentation to be completed as evidence (i.e., an IRIS note), but the supports did not provide measurable criteria with regard to the purpose of the consultations. While the pre-move support for the one-to-one between the two BCBAs included some specific topics (i.e., a review of the target behaviors, including disruptive behavior, physical aggression and verbal aggression), the nursing one-to-one only stated the collaboration would occur, but included no details about content.
    - For Individual #220, the CLDP included pre-move supports for one-to-one consultations between Center staff in the areas of nursing and psychiatry. For both, the pre-move supports indicated the Center discipline was provided with instruction about the one-to-one collaboration, including identification of the reason the collaboration was needed. However, the supports did not provide the specific reasons by which they could be measured for completion.
    - Overall, for both individuals, pre-move training supports identified who would be trained, but did not specify who would do the training or the training methodologies. In addition, they did not include any detail with regard to training topics or provide any competency criteria by which implementation could be measured.
    - However, while the pre-move supports themselves did not specify content or competency criteria, the training and testing materials provided a summary of training content that often laid out expected provider staff knowledge in a clear and easily digestible manner. In addition, the related quizzes often, but not always, addressed much of the content, and many required the provider staff to actually show they acquired the knowledge (i.e., open-ended questions requiring a narrative response, not just True/False or multiple choice). The Admissions Placement Coordinator (APC) reported they had really taken the Monitoring Team's feedback from last visit to heart, and they often went back and forth with the disciplines, sometimes 10 to 15 times, to develop the training content and related quizzes. She also reported that involving the discipline leads in reviewing the assessment and quizzes was another important factor in their success. This progress was good to see, but additional improvement was still needed. The following provides examples of concerns noted:
        - The provider staff training did not always address all important needs for the individuals reviewed. For example, Individual #341's behavioral health training provided a brief description of his behavioral and

psychiatric history, but the training for Individual #220 did not provide any information about his history of suicidal gestures/threats and unauthorized departures.

- In addition, when the CLDP includes post-move supports that require staff knowledge and/or skill, the pre-move supports must be designed to ensure staff know about the responsibilities and how to implement them. There were a number of instances in which this did not occur, so that the pre-move training did not cover all of the individual's important needs. For example, Individual #341's provider training did not address constipation, but a post-move support required provider staff to report any signs of constipation (i.e., straining, hard stools, sensation of complete evacuation, and decrease of stool frequency). Similarly, for Individual #220, the CLDP included several supports that detailed lengthy signs and symptoms (e.g., chest pain, shortness of breath, changes in balance, agitation, excessive sweating, thinning hair, etc.) for which provider staff would have responsibilities for monitoring and reporting to nursing, but the pre-move training and competency testing did not address them.
- For Individual #341, the behavioral health testing consisted of 16 questions, but they were largely in a multiple choice format. On the other hand, the behavioral health quiz for Individual #220 had fewer questions, but the open-ended and fill-in-the-blank questions more reliably tested that provider staff had achieved learning.
- For Individual #341, the nursing testing included 18 questions, most of which required the provider to provide narrative responses, rather than being limited to true/false and/or multiple-choice responses. This was positive. However, for some important needs covered in the training materials, the quiz often only tested partial knowledge. For example, with regard to the individual's dietary history, the quiz required provider staff to identify that he received a regular diet texture, and state his recommended caloric intake and the rationale for this (i.e., to lose weight), but did not ask provider staff to describe the actions the training covered that they should take to support him in the effort. For Individual #220, the provider staff training indicated he should not have grapefruit products, because they could lead to lithium toxicity, but the 19-question competency quiz did not test provider staff knowledge of this need.

- Post-Move: The respective IDTs developed 73 post-move supports for Individual #341, and 100 post-move supports for Individual #220. Some post-move supports were measurable, but this continued to be an area that needed improvement. Examples included, but were not limited to:
  - Related to measurability, the post-move training supports had the same deficiencies as the pre-move training supports.
  - For Individual #341, the IDT sometimes constructed supports that did not clearly define the expected outcome. One such support indicated that the provider should track "any" training or classes provided with regard to positive relationships, but did not state an expectation that any should occur. Another similar support called for the provider to explain "any" progress he had made with regard to independent living, but did not cite any expectation what would define progress, or even that any was expected.
  - IDTs needed to describe required evidence that would provide the PMM with clear measurable indicators of the providers' conformance with the expectations. Frequently, post-move supports were written in a manner that did not provide specific and measurable indicators. For example, for Individual #220, the CLDP included a support for Center

staff to verify that staff "knows what needs to be written down for" the individual at each visit, instead of stating specifically what provider staff needed to write down. Center staff framed numerous other supports (e.g., that the PMM would verify staff knowledge about lab draws, what to do when he was interrupting or upset, how he communicated, etc.) in a similar manner that did not provide the specific criteria the PMM should apply.

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 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. IDTs should continue to make improvement toward developing comprehensive supports that address behavioral and psychiatric history and needs. Findings included:
    - As reported at the time of the previous review, the IDTs for both individuals failed to develop post-move supports with clear expectations for implementation of the positive behavior support plan (PBSP), or for the specific behavioral strategies for prevention and intervention contained therein. For example, Individual #341's CLDP included only a broad support for the PMM to verify knowledge of his target behaviors at each PMM visit, but did not state what the target behaviors were or what provider staff needed to be able to articulate about them. For Individual #220, the CLDP included one post-move support stating that his PBSP would be continued, and several additional supports that called for the PMM to verify staff knowledge of challenging behaviors, but none of these described the specific information provider staff needed to know. Of note, for both individuals, the pre-move supports also did not provide the needed specific criteria.
    - Neither of the CLDPs included post-move supports to ensure staff knowledge of the individual's pertinent behavioral and psychiatric history. For example, for Individual #341, the psychiatric assessment documented that signs and symptoms of his psychiatric disorder included being sad, exhibiting depressed mood with disturbance of sleep. In addition, the psychiatric assessment noted the individual might also exhibit symptoms such as low energy, decreased concentration, and loss of interest in activities previously enjoyed, an increased and/or decreased appetite, abnormal feelings of guilt and/or feelings of worthlessness or hopelessness, psychomotor retardation or agitation, anxiety and worrying and/or ideas or intent to harm himself and/or others. Further, the psychiatric assessment documented that, in November 2017, the individual was admitted to the Center after a two-year stay a psychiatric hospital, after his mother found a shotgun, a flack vest, a map of his school, and a "hit list" of students at his school and family members at a local church. Further psychiatric, medical and neurological evaluations at that time revealed that he felt depressed and was hearing "voices inside his head" that were telling him to shoot his classmates and then to commit "suicide by cop." It was positive the pre-move training for provider staff included some of this information. However, the CLDP did not include supports for staff knowledge of these signs or symptoms or this history. For Individual #220, historical behaviors included suicidal gestures/threats and unauthorized departures, but the CLDP supports did not address staff knowledge of these issues.
- 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:

- As the Monitoring Team has previously reported, CLDPs should include supports that define an individual's needs for nursing monitoring. This should be based on the requirements for nursing monitoring at the Center, which the IDT should then modify as needed for a community setting. This will need to take into account the fact that many group home/community settings do not have 24-hour on-site nursing, but should describe the minimum nursing oversight and monitoring appropriate to each of the individual's specific needs. For example, for Individual #220, the CLDP narrative identified the following nursing monitoring needs: a medication regimen review every 180 days to identify possible side effects of constipation, and weekly monitoring for pain, apical heart rate (i.e., for arrythmias or changes in baseline), and blood pressure. The narrative also indicated Center nursing staff monitored for changes in skin integrity, appearance and temperature. The CLDP did not include specific supports in any of these areas or otherwise indicate why they were not necessary. The CLDP included only broad support for quarterly nursing assessments, but it did not provide any specific expectations.
- For Individual #341, it was positive the CLDP included post-move supports for provider staff to document and report to the psychiatrist specific signs and symptoms of metabolic syndrome, tardive dyskinesia, orthostatic hypotension, and/or constipation. These supports could be improved by clearly specifying the roles of the provider direct support staff (DSP) versus those of the provider nurse, and providing clear timelines for needed notifications. The CLDP also included a support calling for provider staff to document any medication side effects on the medication administration record (MAR), but did not indicate any other symptoms that might be attributed to non-psychiatric medication (e.g., allergy medications).
- Individual #341's CLDP did not include any supports for provider staff knowledge of his communication needs. Instead, one post-move support called for his fluency-shaping strategies to be available at the home and another called for the primary care practitioner (PCP) to refer the individual for speech therapy "if needed." No supports called for provider staff to demonstrate knowledge of or use his fluency-shaping strategies. In addition, it was unclear how the PCP would be able to ascertain if speech therapy was needed, especially if provider staff were not versed in his communication needs/supports and able to recognize if his needs changed.
- For Individual #220, in many instances, the post-move supports called for the PMM to verify that provider staff had needed knowledge in the areas of medical, healthcare, therapeutic, risk, and supervision needs, but did not specify what knowledge was required. For example, supports asked the PMM to verify the individual's diet texture, but did not state what the provider staff response should be.

- 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 listed the outcomes important to the individual. Neither CLDP met criteria.
  - For Individual #341, the CLDP documented many personal goals, preferences, and important outcomes. For example, the Profile section stated that he liked being outdoors and riding his bike, playing and reading about video games, cooking, and talking to his father, step-mother and twin brother. It also noted he liked working at his community job and being independent. The CLDP Outcomes section stated that he wanted to go to trade school to become a mechanic, as well as to eventually move into a host home and then his own apartment. The CLDP provided supports for provider staff to document his work schedule, including if he was late to work and why, and if any changes in his work hours occurred, and for weekly contact with his family. The CLDP also included supports for provider staff to document guiding the individual around his neighborhood for places to ride his bike, as well as when they encouraged the

individual to wear his protective gear while riding. There were no specific supports for attending trade school, cooking or other specific independent living skills (i.e., as further described below with regard to teaching, maintenance, participation, and acquisition of specific skills). Of note, under the Preferences and Strengths section, the CLDP indicated that the IDT discussed fishing as a reward for him, but that he would need a fishing license and that he would like to help cook in the group home, but the IDT concluded that these would not need to be formal supports, because they were things he wanted to accomplish for himself and he could do what he wanted, when he wanted. This appeared to presume he would require no staff support to access a fishing license or locating fishing sites, or that he would be able to engage in all food preparation tasks independently (e.g., planning, shopping, reading recipes, chopping, measuring, etc.), and that group home staff would provide free access to the kitchen at any time.

- For Individual #220, the CLDP documented he was excited to have more visits with his family. He also wanted to make sure his camera, film, photo albums, and bed accompanied him. The CLDP included pre- and post-move supports for these outcomes, which was positive. The CLDP also noted that he had a "special friend" that he and Center staff had been unable to contact. The CLDP narrative further stated that another staff person indicated a desire to become the special friend and that the behavioral health specialist (BHS) would speak with the person about completing the needed paperwork. The CLDP did not include any related supports.

- Need/desire for employment, and/or other meaningful day activities:
  - As described above for Individual #341, the CLDP included several supports for regular work attendance at his pre-existing community job, which was positive. In addition, a pre-move support called for Center staff to make a referral to the Texas Workforce Commission (TWC) prior to transition. However, there were no specific post-move supports for continuing to engage with the TWC or to further his goal of becoming a mechanic.

    In its comments on the draft report, the State disputed this finding, and stated: "Prior to individual #341 transitioning, the center staff was to make a referral to TWC as discussed in the CLDP document (TX-2111-LB-1.68.341 pg 28). The referral was confirmed and still active per the Pre-Move Site Review (TX-LB-2111-I.69.134, pg 5) support #18. In the Post Move Monitoring Report, (TX-LB-2111-I.71.134, pgs. 44-45), support #63 support a referral by the provider to support his request to become a mechanic in which the provder [sic] stated that they use Radar Support, an extension of TWC, and will reach out to them. (TX-2111-LB-1.68.341 pg 28). Radar Support (an extension of TWC) services on 7/1/21. The document also reports that he had spoken with Radar Support and denied their services. The facility is requesting that the score be changed as there were specific post-move supports to continue to engage with TWC."

    Support #68 stated that the provider would refer Individual #341 to Radar Support within 60 days of transition, with the evidence to be interview documentation/verification of referral. The IDT made no actual reference to his goal of being a mechanic or going to trade school. As the Center's notes on the draft report indicated, once the IDT made a referral (and it was denied), no further action was planned/taken. While the narrative in the CLDP seemed to link the individual's desire to be a mechanic/go to trade school to a referral to Radar Supports, the post-move supports themselves did not specifically support this goal. The IDT included no post-move support to continue to engage with TWC. Moreover, the Monitoring Team could not find any evidence to substantiate that Radar Supports is an extension of TWC. While it does appear to be a multi-services DD agency that provides job placement services, among a myriad

of others, it is not a trade school that teaches one how to be a mechanic and does not have any obligation (unlike TWC) to provide employment services.

The CLDP otherwise did not include supports for meaningful day activities in integrated community settings. While his CLDP did call for outings once a week, it did not define any supports for meaningful community participation and integration, or expectations that any would occur following the lifting of restrictions.

  - For Individual #220, the vocational assessment noted that he understood the concept of making money and that more work equaled more pay, and enjoyed being able to purchase things as a result of his earnings. In addition, the documentation indicated that he had worked on many contracts at the Center, albeit with poor attendance. His BHA and Skills Acquisition Assessment also recommended that the individual have the opportunity to work and earn money in the community. The CLDP only included a support for day habilitation attendance and a vague support that indicated he "could" enroll in part-time work, based on "availability by the provider." This did not provide any specific outcome expectation.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success:
  - Individual #341's PBSP included related strategies for positive reinforcement, but the CLDP did not include specific post-move supports for implementation of these. Instead, it included only a single support requiring provider staff to document when he self-rewarded (i.e., by outings taken and items purchased).
  - For Individual #220, it was positive that the CLDP included supports to test staff knowledge of how to support him if he became upset or when he had blood draws. Other supports called for provider staff to document if they implemented reinforcing or motivating components (i.e., management staff discussing concerns with him) or for the PMM to observe staff for implementation of reinforcement (i.e., observing staff praising him). However, these supports did not specifically require implementation of these components, or for the PMM to probe related provider staff knowledge. Center staff should both ensure the supports define the expected outcome and probe staff knowledge. In addition, his BHA noted that, when prompting the individual to start his day, provider staff should remind him that he can purchase things that he desires with his work earnings. The CLDP did not reference this motivating factor.
- Teaching, maintenance, participation, and acquisition of specific skills:
  - The IDT for Individual #341 provided pre-move training with regard to skill acquisition programs (SAPs) for counting change and identifying street signs, but did not develop any specific post-move supports that required implementation of those. Of note, his Skills Acquisition Assessment noted that he already knew most traffic signs and could learn any new ones he might encounter by just being told one time, so it was not clear that was a meaningful SAP. As also described above, his CLDP did not include any supports to assist with learning how to cook in a full community kitchen. The CLDP narrative noted that provider staff stated they would teach him how to cook meals, home maintenance skills, and other skills he would need to live alone one day, but the CLDP did not include these in the post-move supports. Instead, a single support called only for the provider to explain any progress the individual made in the area of independent living. This support did not describe a specific outcome expectation for the individual and could have been satisfied even if the provider stated he had not made any such progress.
  - The CLDP for Individual #220 included one post-move support for skill acquisition, a SAP for checking his food for the right temperature. Based on his ISP and the Skills Assessment, focusing solely on this SAP, which did not require any other cooking activity did not fully address the recommendations related to learning food preparation (i.e., to be

exposed to other methods of cooking, and different recipes and food dishes). His Residential Assessment also recommended that provider staff allow him, on a daily basis, to clean his own room, wash his own clothes, and help in the kitchen to prepare meals while still providing support to him as he requested it, and to document these skill maintenance activities in a log. 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. The following provides examples of concerns noted:
  - The IDT discussed that the Center nurse noted she irrigated Individual #341's ears twice a year. The provider nurse stated she did not have the equipment to irrigate his ears, but could request that the PCP do this at quarterly visits. The CLDP did not include related supports.
  - Individual #341's IDT discussed that AIMS side effects screening be completed every six months, but the CLDP did not include a support for this screening.
  - For Individual #220, the dietary recommendations included one for the provider to continue provision of his diet to include 2200 Calories with a lactose restriction and nutritional supplements to include multivitamin/mineral, Vitamin D, and fiber gummies. The IDT had a discussion about the lactose restriction and provided a reasonable rationale for discontinuing it. In addition, the CLDP included post-move supports for the nutritional supplements. However, none of the post-move supports referenced the need for a 2200-calorie diet or probing of staff knowledge in this regard. Instead, the IDT developed a support for him to be encouraged to stay compliant with his high-calorie diet, for which the evidence would be "any issues" noted in home logs or nursing notes. This did not adequately address his needs.

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

Summary: Some of the areas in which further efforts were needed related to the PMM basing decisions about supports on reliable and valid data, and the PMM providing complete documentation to substantiate the findings. In addition, while the PMM was typically diligent in following up in a thorough manner when noting problems with the provision of supports, including involving and informing the IDT, some improvement was still needed. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	341	220							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1							

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

Comments: 4. The PMM Checklists provided many good examples of documenting valid and reliable data, but this was not yet consistent. 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. The following provide examples of progress and concerns noted:

- As described above in relation to Indicator #1, for both individuals, the provider staff pre-move training supports, as well as many post-move supports, did not specify the criteria the PMM needed in order to collect valid and reliable data about provider staff competence. IDTs needed to continue to work toward improving measurability of supports to provide guidance to the PMM as to what criteria would constitute the presence of various supports.
- IDTs also needed to continue to work on developing comprehensive pre- and post-move supports for verifying provider staff knowledge and competence, thereby ensuring that the PMM would have the necessary prompts to assess whether provider staff were able to meet individuals' needs, as well as needed benchmarks for making an accurate assessment. As described with regard to Indicator #2 above, both individuals had significant behavioral health and/or health care needs for which the IDTs did not develop supports.
- The PMM sometimes only interviewed provider managers or supervisors rather than the direct support staff who had primary responsibility for implementation of supports. For example, as described above for Individual #220, several post-move support called for provider DSPs to report a lengthy list of certain signs and symptoms. The PMM only documented interviewing the provider nurse, but should have interviewed a provider DSP.
- It was a positive practice that the PMM Checklist for Individual #341 typically highlighted the evidence reviewed by the type of evidence required (i.e., interview, observation, and/or documentation). This made it easy to determine if all evidentiary requirements were present.

5. Based on information the PMM collected, both individuals frequently received supports as listed and/or described in the CLDP, but there were still a number of supports that were not in place as required. In addition, as described above, the Monitoring Team also could not always 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 concerns included, but were not limited to, the following:

- For Individual #341, the PMM's documentation indicated the following supports were not in place:
  - At the time of the seven-day PMM visit, Individual #341's provider did not ensure that his PCP visit occurred as needed, or provide documentation to show family contact.
  - At the time of the 45-day PMM visit, the provider did not document changes to his work schedule or attendance, as required, and had not obtained a revision to his PBSP. In addition, the one-to-one collaboration between the Center and community psychiatrists had not occurred timely.
- For Individual #220, the PMM documented the following supports were not in place at the time of the seven-day PMM visit:
  - Provider staff did not provide documentation to show he applied lotion as needed, obtained his weight within two days, documented communication with friends and family, or implemented his SAP.
  - Provider staff could not demonstrate what to do when the individual was arguing or interrupting.
  - Provider staff did not document or report to nursing when the individual developed a stomachache.
  - The PMM documented an unmet need when provider staff failed to show the individual tried new appliances. However, as described above, the support did not specifically call for provider staff to implement this, but only to be able to report which appliances he tried. This further demonstrated the importance of constructing supports in a manner that clearly defines the measurable expectation. It was positive, though, that the PMM made an effort to correct this discrepancy.

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 Indicator #4 above.

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. Lubbock SSLC transition staff typically took persistent and timely follow-up action toward resolution when they identified supports were not in place, including involving and informing the IDT. This remained an area of relative strength. However, whether follow-up is completed as needed relies heavily on the accuracy of the PMM's assessment of whether supports were, or were not, in place. This, in turn, relies on accuracy, completeness, and measurability of the supports. As described in the indicators above, this remained an area of concern. The following provides examples of concerns noted:

- For Individual #341, at the time of the 45-day and 90-day PMM visits, transition staff noted that provider staff were not documenting work attendance as required. While it was positive that transition staff reported reviewing the importance of this documentation with provider staff, the PMM Checklist did not provide any plan for follow-up to ensure implementation. This was concerning because the next review was several months in the future, and the individual had already experienced a PDCT potentially related to anxiety about work (i.e., as described with regard to Outcome #3 below).
- Also for Individual #341, the 90-day PMM Checklist documented that there was no home log documentation to review with regard to a support to record anytime he digressed from his diet. Transition staff noted requesting the documentation, but that

none had been received. Transition staff did not capture this follow-up need in the Areas of Concern section of the PMM Checklist, and had not documented resolution.

- At the time of the pre-move site review (PMSR) for Individual #220, Center staff documented that the Center had not delivered the correct film and that Center transition staff would follow-up. The seven-day PMM did not document any follow-up. It was otherwise positive that, at the time of the seven-day PMM visit, Center transition staff met with Individual #220's provider to follow-up on all other noted areas of concern.

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: The Center reported that one of the two individuals experienced a Potentially Disrupted Community Transition (PDCT) event. It was not possible to confirm that the Center had adequately identified, developed, and taken needed actions that might have reduced the likelihood of the negative event occurring.

Individuals:

#	Indicator	Overall Score	341	220							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	50% 1/2	0/1	1/1							

Comments: 11. The Center reported that Individual #220 did not experience a PDCT event.

On or about 8/16/21, Individual #341 experienced an Emergency Department (ED) visit after experiencing an elevated heart rate while at work. The employer did not have contact information for the provider, but did contact Center staff who, in turn, relayed the information to the provider. However, in the interim, the employer called for an ambulance to transport the individual to the ED. The ISPA documentation indicated that the incident was likely to have been anxiety-related, and that the individual concurred with that conclusion. The IDT noted that experiencing such an anxiety episode was not anticipated, but that the CLDP did include post-move supports for ongoing counseling, regular exercise and monitoring of changes in his work schedule. For the purpose of identifying things that could have been done differently to prevent the problem, it was primarily notable that CLDP post-move supports did not require the PMM to probe and confirm staff knowledge and competency with regard to recognizing his psychiatric symptoms, which included anxiety.

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: The APC Department's practice of carefully reviewing assessments and providing feedback to the disciplines was a good one. Although some continuing improvement was noted, the content and recommendations generated from transition assessments still required improvement. Although Center staff provided training to community provider staff, 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. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	341	220							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Due to the Center's sustained performance with this indicator, it had moved to the category requiring less oversight.									
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/2	0/1	0/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/1	1/1							

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.	Due to the Center's sustained performance with this indicator, it had moved to the category requiring less oversight.									
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. However, at the time of the previous review, the Center had implemented some improved processes in this area, which they continued prior to this review. This included providing training to IDTs about the expectations for discipline transition assessments and to improve pre-move training and provider competency testing. Most, but not all, disciplines also used a discharge-specific format that focused their assessment on what was most needed to effectuate a successful transition. For example, this included a section devoted to Collaboration, Transition Activities, and In-services. The Monitoring Team considers four sub-indicators when evaluating substantial compliance.

- Assessments updated within 45 Days of transition: Assessments provided for review met criterion for timeliness. For Individual #341, his BHA did not consistently include updated information (e.g., behavioral graphs covered a period from June 2019 to May 2020).
- Assessments provided a summary of relevant facts of the individual's stay at the Center: Overall, for both individuals, it appeared that discipline assessments generally provided a summary of relevant facts.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community, and assessments specifically address/focus on the new community home and day/work settings: Overall, assessments did not fully address/focus on the training and competencies provider staff would need in order to effect successful transitions and to provide continued supports for individuals after transitions occurred. It was positive that some assessments (e.g., the communication assessment for Individual #220) included a summary of training provided to provider staff, but they typically did not make recommendations for or specify the needed competency criteria.

14. Center staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required: Center staff made significant progress with regard to defining competency criteria, although these were not yet clearly defined in the pre-move supports, and developing testing methodologies. However, training did not yet meet criterion for these two CLDPs, as described with regard to Indicator #1 above and further below.

- The IDTs did not clearly identify the expected provider staff knowledge or competencies that needed to be demonstrated. The pre-move training supports did not identify the needed content of pre-move training or the competency criteria, although it was positive the training packets provided some of that detail.
- Competency testing did not consistently cover important support needs in a comprehensive manner. 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.
- Center staff did not provide clear documentation of these provider training efforts when they included competency demonstration other than written quizzes (e.g., return demonstration).

15. When necessary, Center staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The IDT should include in the CLDP a specific statement as whether any collaboration was needed, and if any was

completed, summarize the findings and outcomes. Overall, these CLDPs simply stated that certain collaborations took place, but did not state why they were needed or summarize the findings and outcomes. While it was good to see the IDTs continued to develop pre-move and/or post-supports for Center clinicians to collaborate and share information with their community counterparts, they continued to need to clearly identify the expected knowledge that Center staff needed to be imparted. However, it was positive that the disciplines' documentation regarding contacts with their community counterparts provided specific and detailed information about the content of the collaboration and information exchanged. While the IDTs generally did not specify any expectation for the content of the collaborations, it appeared the information described in the IPNs often addressed many of the individuals' important needs. Moving forward, Center staff should ensure they also provide the needed statements in the CLDPs.

16. SSLC clinicians (e.g., OT/PT) complete assessments 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. Although it was positive that Center staff requested settings assessments for both individuals, neither CLDP described the IDT discussion about whether settings assessments were needed or defined the specific purposes, based on the individuals' needs. For Individual #341, the IDT only documented that settings assessments were scheduled for completion, but provided no further detail. For Individual #220, the CLDP indicated that core IDT members completed an assessment of setting at the home, and agreed it was a good fit the individual. The CLDP noted that these Center staff documented their findings, but the CLDP did not otherwise provide a meaningful summary of their findings. Upon request, Center staff provided the relevant IPNs, and it was good to see they provided substantial detail. However, because the CLDP did not specify the purpose of or expectations for the assessments, it was not clear they met the individuals' needs. In other words, this indicator requires the CLDP to evidence that the IDT considered and discussed the need for settings assessments, based on the individual's specific needs, and that Center staff completed the required assessments in a manner that addressed the identified needs.

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 in which SSLC and community provider staff should engage, based on the individual's needs and preferences, including any such activities that occurred and their results. Examples include provider DSPs spending time at the Center, Center DSPs spending time with the individual in the community, and Center and provider DSPs discussing the individual's needs. These CLDPs did not provide a statement of the IDTs' considerations, but did provide a list of activities that facilitated interactions between provider and Center DSPs. For Individual #341, it appeared that Center DSPs accompanied him to several visits, but did not provide any detail about how they interacted with provider DSPs to discuss his needs. For Individual #220, the list of activities included one for which a Center DSP accompanied him to a home visit, but again provided no detail about how they interacted with provider DSPs to discuss his needs.

19. The Pre-move Site Reviews (PMSRs) for both individuals were completed in a timely manner. It is essential the Center 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. The CLDP pre-move supports for pre-move training did not meet criterion for ensuring that provider staff were competent for either individual, as described under Indicator #1 and Indicator #2.

Outcome 5 – Individuals have timely transition planning and implementation.											
Summary: Due to the Center's sustained progress (Round 14 – 100%, Round 15 – N/A. Round 16 – 100%, and Round 17 – 100%), Indicator 20 will move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	289	109							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	100% 2/2	1/1	1/1							

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

- Individual #341was referred on 12/7/20, and transitioned on 6/29/20. This slightly exceeded 180 days, but documentation indicated ongoing efforts to facilitate the transition.
- Individual #220 was referred on 6/17/20, and transitioned 9/21/21. This also exceeded 180 days, but the Center provided adequate justification and documented ongoing community exploration.

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

    - Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
    - In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic);
    - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
    - In the past six months, individuals with dental emergencies;
    - Individuals with Do Not Resuscitate Orders, including qualifying condition; and
    - In the past six months, individuals with adverse drug reactions, including date of discovery.
- Lists of:
    - Crisis intervention restraints.
    - Medical restraints.
    - Protective devices.
    - Any injuries to individuals that occurred during restraint.
    - HHSC PI cases.
    - All serious injuries.
    - All injuries from individual-to-individual aggression.
    - All serious incidents other than ANE and serious injuries.
    - Non-serious Injury Investigations (NSIs).
    - Lists of individuals who:
        - Have a PBSP
        - Have a crisis intervention plan
        - Have had more than three restraints in a rolling 30 days
        - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
        - Were reviewed by internal peer review
        - Were under age 22
    - Individuals who receive psychiatry services and their medications, diagnoses, etc.

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

d. Nursing
e. Pharmacy
f. Dental

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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