United States v. State of Texas

Monitoring Team Report

Lubbock State Supported Living Center

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

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

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

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

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

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

Methodology

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

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

Organization of Report

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

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

Executive Summary

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

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

Status of Compliance with the Settlement Agreement

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

This Domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, mortality review, and quality assurance. At the time of the last review, 26 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, four additional indicators in the areas of restraint, and abuse, neglect, and incident management will move to the category of less oversight. As a result, the entirety of Outcome #5 related to restraint, and Outcome #3 related to abuse and neglect will move to the less oversight 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.

Restraint

Overall, usage of crisis intervention restraint at Lubbock SSLC decreased since the last review and showed a decreasing trend for the first time since the Monitoring Team began reporting on this variable in 2015. The average duration of a crisis intervention physical restraint also decreased, to less than two minutes. There were fewer numbers of individuals each month who had one or more crisis intervention restraint.

The Center reported no instances of the use of protective mechanical restraint for self-injurious behavior (PMR-SIB), however, the Monitoring Team identified four individuals for whom restrictive aspects of their programming needed to be evaluated to see if they should be treated as PMR-SIB.

For two consecutive reviews, one or more or more instances of crisis intervention chemical restraint utilized more than one medication. If so, a justification or rationale for using more than one medication is required.

It was positive that for the five physical restraints reviewed, nurses performed physical assessments, documented whether there were any restraint-related injuries or other negative health effects, and took action, as needed to meet the needs of the individuals. However, for the three chemical restraints reviewed, nurses did not consistently provide detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline, document the site of the injections, and/or follow-up on abnormal vital signs.

Abuse, Neglect, and Incident Management

Overall, the Monitoring Team's review showed incident management practices were very good. The review did not detect any issues that would be characterized as systemic or pervasive. Many of the indicators were in the category of requiring less oversight, others were moved to this category after this monitoring review, and others showed progress and/or had high performance scores.

Staff who regularly worked with the individuals were knowledgeable about abuse, neglect, and exploitation (ANE) and incident reporting. Investigation content met requirements and the conclusions drawn from each investigation were acceptable.

The recommendations that were made following each investigation demonstrated thoughtful consideration of even minor elements of the investigation and improvements in Center practices that could be made. This suggested that each review of each investigation report was used as an opportunity for initiating continuous improvement in Center practices.

The Trend Analysis included all of the required data sets. As is the case at most Centers, analysis did not look at possible interdependent variables (e.g., particular shift, unit, day of week of injuries).

Two investigations included information that indicated late reporting. The Unusual Incident Reports (UIRs) for these two did not provide any explanation or exploration of the circumstances of this apparent late reporting. Reporting was timely and correct for the other eight incidents.

Other

For pretreatment sedation, IDTs were reviewing the use of pretreatment sedation and determining whether a plan should be created. When determined to be a needed support, plans were created, but were then not implemented or monitored.

It was good to see that for the one Drug Utilization Evaluation (DUE) reviewed that identified areas in need of improvement, Center staff had taken steps to correct issues identified.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.	
Summary: Overall, usage of crisis intervention restraint at Lubbock SSLC decreased since the last review and showed a decreasing trend for the first time since the Monitoring Team began reporting on this variable in 2015. The average duration of a crisis intervention physical restraint also decreased, to less than two minutes. There were fewer numbers of individuals each month who had one or more crisis intervention restraint.	Individuals:

The Center reported no instances of the use of protective mechanical restraint for self-injurious behavior (PMR-SIB), however, the Monitoring Team identified four individuals for whom restrictive aspects of their programming needed to be evaluated to see if they should be treated as PMR-SIB.

There was little usage of non-chemical restraint or pretreatment sedation for medical and dental procedures. TIVA usage was low, but because there was no treatment provider for many months, not because there was less need.

The Center scored better on these two indicators than ever before. These indicators will remain in active monitoring.

#	Indicator	Overall Score	440	117	234	277	321	165	4	121	262
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	92% 11/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (July 2018 through March 2019) were reviewed. The overall usage of crisis intervention restraint at Lubbock SSLC showed a decreasing trend for this first time since the Monitoring Team began reporting on this variable in 2015. There was a steady decrease from about 50 occurrences per month to about 10 per month. This decrease also coincided with initiation of the statewide SUR and Ukeru programs. The Center provided thoughtful commentary for each of the graphs in this set of graphs.

The use of crisis intervention physical restraints paralleled the overall usage of crisis intervention restraints because most crisis intervention restraints were crisis intervention physical restraints. The average duration of a crisis intervention physical restraint decreased the lowest since the Monitoring Team began reporting on this variable, too, to just under two minutes. The frequency of usage of crisis intervention chemical restraint was showing a decreasing trend and there were no usages of crisis intervention mechanical restraint.

There were also fewer numbers of individuals who had one or more restraints each month and few injuries were reported as a result of restraint application.

Regarding PMR-SIB: The Center reported that there were no usages of protective mechanical restraint for self-injurious behavior (PMR-SIB) at the Center. During the onsite week, however, the Monitoring Team identified the usage of procedures for four individuals of the nine individuals in the review group (44% of the individuals) that might be PMR-SIB and, if so, should be subjected to the

protocol requirements of using PMR-SIB. These must have IDT/Center review:

- Individual #4 wore a helmet. A description of this was found in his PNMP with the rationale that this was provided to protect him from falls. Guidelines for using the helmet were not included in his PNMP or PBSP. Staff were not documenting when his helmet was on or off. Staff, however, repeatedly noted that the helmet was to help protect him from head banging. Thus, the helmet might be a protective mechanical restraint for self-injurious behavior (PMR-SIB) rather than a supportive/protective device. If so, proper PMR-SIB protocols need to be put into place. The Center should review this.
- Individual #165's PBSP included guidelines to turn off the power on his wheelchair when he became aggressive, particularly when he was moving his wheelchair into people. This seemed to be a form of restraint, and if so, should be treated as such. In the period between the onsite visit and submission of this report, the Center reported that it had discontinued this procedure.
- Individual #321's behavioral health assessment noted that he wore a fitted undershirt to prevent his pulling his g-tube. When consent information was requested, the Center reported that he did not wear a fitted shirt. Conflicting information regarding this potential PMR-SIB needs to be clarified.
- Individual #277's staff in the education building put a clothing protector on her when she repeatedly placed her shirt in her mouth. This was a restrictive practice that was not included in her PBSP. Staff should review this to ensure staff are following appropriate protocols.

There were no instances of the use of non-chemical restraint for conducting medical or dental procedures. There was a decreasing trend in the use of pretreatment sedation for medical procedures, and few instances for dental procedures. TIVA usage was less than in the past, but that was primarily due to no availability of a treatment provider who could administer TIVA. Thus, many individuals went without needed dental treatment. Recently, a treatment provider was hired, and also recently, the Center created a mock dental treatment room to give individuals more practice with experiencing dental protocols.

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

2. Five of the individuals reviewed by the Monitoring Team were subject to restraint. All five received crisis intervention physical restraints (Individual #440, Individual #117, Individual #4, Individual #121, Individual #262), and three also received crisis intervention chemical restraint (Individual #440, Individual #4, Individual #121). The other four individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period.

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.	
Summary: Due to sustained performance for this and the previous two reviews (i.e. 100% for all individuals with one exception, at the last review), indicator 11 will be moved to the category of requiring less oversight. Indicator 9 will remain in active	Individuals:

monitoring.											
#	Indicator	Overall Score	440	117	4	121	262				
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The restraint was a method approved in facility policy.										
5	The individual posed an immediate and serious risk of harm to him/herself or others.										
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.										
7	There was no injury to the individual as a result of implementation of the restraint.										
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.										
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated				
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 5/5	1/1	1/1	1/1	1/1	1/1				

Comments:
The Monitoring Team chose to review eight restraint incidents that occurred for five different individuals (Individual #440, Individual #117, Individual #4, Individual #121, Individual #262). Of these, five were crisis intervention physical restraints, and three were crisis intervention chemical restraints. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

9. Because criterion for indicator #2 was met for all five of the individuals, this indicator was not scored for them.

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

Comments:

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.											
Summary: Indicator 14 will remain in active monitoring for possible review during the next onsite visit, especially given the potential re-classification of protocols as PMR-SIB.			Individuals:								
#	Indicator	Overall Score	440	117	4	121	262				
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A									
Comments:											

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
Summary: It was positive that for the five physical restraints reviewed, nurses performed physical assessments, documented whether there were any restraint-related injuries or other negative health effects, and took action, as needed to meet the needs of the individuals. For the three chemical restraints reviewed, nurses did not consistently provide detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline, document the site of the injections, and/or follow-up on abnormal vital signs. Although it was good to see some progress, these indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	440	117	4	121	262				
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	75% 6/8	1/2	1/1	1/2	2/2	1/1				
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	63% 5/8	1/2	1/1	1/2	1/2	1/1				
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	63% 5/8	1/2	1/1	1/2	1/2	1/1				
Comments: The restraints reviewed included those for: Individual #440 on 9/18/18 at 8:45 a.m. (chemical), and 3/4/19 at 7:58 p.m.;											

Individual #117 on 1/6/19 at 7:46 p.m.; Individual #4 on 12/12/18 at 11:48 a.m. (chemical), and 1/28/19 at 1:48 p.m.; Individual #121 on 11/1/18 at 4:01 p.m., and 2/11/19 at 10:45 a.m. (chemical); and Individual #262 on 1/5/19 at 1:20 p.m.

a. through c. It was good to see that for five of the restraints reviewed, nurses performed physical assessments, documented whether there were any restraint-related injuries or other negative health effects, and took action, as needed to meet the needs of the individuals. These were the restraints for: Individual #440 on 3/4/19 at 7:58 p.m., Individual #117 on 1/6/19 at 7:46 p.m., Individual #4 on 1/28/19 at 1:48 p.m., Individual #121 on 11/1/18 at 4:01 p.m., and Individual #262 on 1/5/19 at 1:20 p.m.

The following provide examples of problems noted:

- For Individual #440's chemical restraint on 9/18/18, an IPN, dated 9/18/18, at 2:00 p.m., noted that the individual received a chemical restraint. However, the nurse did not include in the IPN the medication, dose, route, site of the intramuscular injection (IM), and/or description of the individual's behavior during the injection. It was unclear if the nurse who wrote this IPN was the nurse that actually gave the injection. An IPN, dated 9/19/18, at 6:28 a.m., indicated that it was a late entry. However, it did not identify the date and time of the incident that the IPN was written to record. This note indicated the individual received Ativan 2 milligrams (mg), but did not note the site, the specific reason/behaviors, or if staff had to restrain the individual while the nurse administered the injection. Another IPN, dated 9/20/18, at 4:42 p.m. (i.e., an addendum), noted the Behavioral Health Services (BHS) staff notified the Registered Nurse Case Manager (RNCM) of the "need for chemical restraint on 9/18/18 at about 0845 am." This IPN appeared to be another late entry regarding the episode on 9/18/18. The number of late entries on the days following the incident made it difficult to determine who actually gave the chemical restraint and who was monitoring the individual. The Flowsheet indicated that the individual's pulse was elevated (i.e., 109) at 8:50 a.m., but based on documents submitted, a nurse did not retake it. The nurse documented mental status as "uncooperative," but listed no specific behaviors.
- An IPN, dated 12/12/18, at 2:19 p.m., indicated that the PCP diverted the RNCM from giving Individual #4 a chemical restraint. The noted indicated: "[The] BHS just got off phone with [the psychiatrist]. She informed this RNCM [Individual #4] can have Haldol 5mg/Ativan 2mg IM injection as chemical restraint due to imminent danger to self and others. Called [psychiatrist] to obtain order. [The] PCP on the home. She agrees to give chemical restraint. This RNCM attempted to gather supplies and medication to administer to [the individual] but [the PCP] insisted this RNCM assist her with assessments. [The] BHS called [an] LVN for this RNCM to administer the medication." The IPN, dated 12/12/18, at 12:10 p.m., noted the LVN gave the individual the chemical restraint, but the nurse did not identify the site, or if the individual had to be restrained to administer the chemical restraint. However, an addendum, dated 12/15/18, at 8:30 a.m., noted the "chemical restraint administered to left gluteal." The documentation from the Medication Administration Record (MAR) that the Center provided indicated that both injections were given in the left deltoid. In addition to the discrepancies regarding the site of the injections, the nurse(s) provided no explanation as to why both injections were given in the same site. Also, based on the documentation submitted, nursing staff did not assess the individual for injuries.
- For Individual #121's chemical restraint on 2/11/19, Center staff did not provide a PCP order, or an IPN from the nurse who administered the chemical restraint justifying the reason for the chemical restraint.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.											
Summary: Performance remained high, though documentation was missing for one chemical restraint (proper procedural implementation did occur). Given sustained high performance for this and the previous two reviews, too, indicator 15 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	440	117	4	121	262				
15	Restraint was documented in compliance with Appendix A.	88% 7/8	2/2	1/1	1/2	2/2	1/1				
Comments: 15. For Individual #4 12/12/18, IRIS form did not include customary entry showing name/title of staff who administered the chemical restraint. During the onsite week, the Center provided a nursing note showing that a nurse administered the chemical restraint. It was good to see that proper protocol was followed.											

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
Summary: For one restraint, unit and IMRT reviews were not properly documented within the IRIS forms, however, the reviews did occur. All recommendations were implemented, an improvement from the last review. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	440	117	4	121	262				
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	88% 7/8	2/2	1/1	2/2	1/2	1/1				
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 4/4		1/1	1/1	2/2					
Comments: 16. For Individual #121 2/11/19, unit and IMRT reviews were not properly documented within the IRIS forms, however, the reviews did occur.											

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)	
Summary: For two consecutive reviews, one or more or more instances of crisis intervention chemical restraint utilized more than one medication. If so, a justification or rationale for using more than one medication is required. This indicator (48) will remain in the category of requiring less oversight, but this should	Individuals:

be corrected for future instances of crisis intervention chemical restraint if it is to remain in this category after the next review.											
#	Indicator	Overall Score									
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
48	Multiple medications were not used during chemical restraint.										
49	Psychiatry follow-up occurred following chemical restraint.										
Comments:											

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
Summary: Protections regarding staff background checks and duty to report forms were in place. The Center also regularly reviewed prior occurrences and history when an incident occurred. Plans were developed when needed, however, they were not implemented correctly or all the time for some individuals. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	440	117	321	4	121	173			
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	80% 8/10	2/3	1/1	1/1	1/2	2/2	1/1			

Comments:

The Monitoring Team reviewed 10 investigations that occurred for six individuals. Of these 10 investigations, five were HHSC PI investigations of abuse-neglect allegations (two confirmed, one unconfirmed, one inconclusive, one administrative referral). The other five were for facility investigations of serious injury, unauthorized departure, and suicide threat. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #440, UIR 19-009, HHSC PI 47436457, confirmed allegation of neglect, 9/15/18
- Individual #440, UIR 19-139, HHSC PI 47647073, unconfirmed allegation of verbal abuse, 2/22/19
- Individual #440, UIR 19-076, suicidal threat, date unknown
- Individual #117, UIR 19-054, HHSC PI 47513196, administrative referral of a neglect allegation, 11/6/18
- Individual #321, UIR 19-059, HHSC PI 47519889, confirmed allegation of neglect, 11/14/18
- Individual #4, UIR 19-082, HHSC PI 47554137, inconclusive allegation of physical abuse category 2, 12/12/18

- Individual #4, UIR 19-111, serious injury, eyelid laceration, witnessed, 1/20/19
- Individual #121, UIR 19-126, unauthorized departure, alleged offender, date unknown
- Individual #121, UIR 19-016, sexual incident, date unknown
- Individual #173, UIR 19-112, serious injury, peer to peer aggression, fracture finger and nose, witnessed, 1/21/19

1. For all 10 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes (a) the occurrence of staff criminal background checks and signing of duty to report forms, (b) facility and IDT review of trends of prior incidents and related occurrences, and the (c) development, implementation, and (d) revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator and other facility staff met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

For all investigations, criteria for sub-indicator a were met, that is, for staff-related activities. Also, criteria for sub-indicator b were met for all of the incidents for all individuals. That is, prior occurrences were trended and evaluated. For sub-indicators c and d, eight of the 10, plans (e.g., PBSP) were either developed or were not needed. For the other two, plans were developed, but not implemented correctly or at the time of the incident (Individual #440 UIR 19-076, Individual #4 UIR 19-111).

One individual at Lubbock SSLC was designated for streamlined investigations by DFPS (Individual #154). This was the same as at the last review. The individual made frequent calls. For instance, in the tier 1 document that listed all allegations during the previous six months, 523 were made by this individual and most were subjected to the streamlined investigation protocol. HHSC PI reviewed the individual within the past quarter. The SSLC requirement was met because there was a plan in place to address his frequent calling (within his PBSP).

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

Summary: Two investigations included information that indicated late reporting. The UIRs for these two did not provide any explanation or exploration of the circumstances of this apparent late reporting. Reporting was timely and correct for the other eight incidents. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	440	117	321	4	121	173			
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	80% 8/10	3/3	0/1	0/1	2/2	2/2	1/1			

Comments:

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

Those not meeting criteria are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself

should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

- For Individual #117 UIR 19-054, the incident occurred on 11/6/18 and was reported to DFPS Intake as an allegation of neglect on 11/9/18 at 3:38 am. There was nothing in the UIR to explain any circumstances around this late reporting.
- For Individual #321 UIR 19-059, the HHSC PI report said the incident occurred at 11:30 am and was reported to DFPS Intake at 12:36 pm (six minutes past the one hour requirement). The UIR said the incident occurred at 11:36 am, and with a notification of the facility director/designee at 1:17 pm. The UIR did not explain the incident occurrence discrepancy or the actual reporting sequence.

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

Summary: All staff interviewed were knowledgeable as required by indicator 3 for the two individuals as were other staff with whom the Monitoring Team spoke during the onsite week. Given this high performance, indicator 3 will be returned to the category of requiring less oversight. In addition, indicator 4 scored at 100% for this and the last two reviews, too, with one exception. Therefore, indicator 4 will be moved to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	440	117	321	4	121	173			
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 2/2	1/1	Not rated	Not rated	1/1	Not rated	Not rated			
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

3. Because indicator #1 was met for four of the individuals, this indicator was not scored for them. For the other two, all staff interviewed correctly answered the Monitoring Team's questions regarding abuse/neglect reporting requirements.

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

Summary:

Individuals:

#	Indicator	Overall Score									
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

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

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.												
Summary:			Individuals:									
#	Indicator	Overall Score										
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.											
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)											
Comments:												

Outcome 7– Investigations are conducted and reviewed as required.												
Summary: With improved/sustained high performance, indicator 12 might be moved to the category of requiring less oversight after the next review. Supervisory review (indicator 13) also showed continued improving performance. Both indicators will remain in active monitoring			Individuals:									
#	Indicator	Overall Score	440	117	321	4	121	173				
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor/QA specialist (unless a written extension documenting extraordinary circumstances was	90% 9/10	3/3	1/1	1/1	1/2	2/2	1/1				

	approved in writing).										
13	There was evidence that the supervisor/QA specialist had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	80% 8/10	3/3	0/1	0/1	2/2	2/2	1/1			

Comments:
12. For Individual #4 UIR 19-082, the investigation took 14 days to complete, with no extension requests provided. HHSCI PI reported that it will be addressing timeliness of investigation completion and extension submissions with the district.

13. The supervisory review did not detect the late reporting identified in indicator 2 above. This was an improvement from last review when a variety of different issues were not identified by the Center's review process.

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

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.

Summary: Non-serious injury investigations were conducted appropriately and when needed. If this performance maintains after the next review, indicator 15 might be moved to the category of requiring less oversight. It will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	440	117	321	4	121	173			
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			

Comments:

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.

Summary: The investigations included many recommendations and good evidence to demonstrate completion.

Individuals:

#	Indicator	Overall Score									
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.										
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.										
Comments: 17. There was one investigation that included two confirmed for physical abuse category 2. The employment of the involved staff was terminated (or was in the process of being terminated).											

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
Summary: This outcome consists of facility indicators. Data trending and analysis remained about the same as at the last review. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	Over the past two quarters, the facility's trend analyses contained the required content.										
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	No									
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No									
23	Action plans were appropriately developed, implemented, and tracked to completion.	No									
Comments: 21-23. QAQI Council minutes showed a limited number action plans and those were related to individual-specific issues. This was identified by the Center, as shown in the March 2019 QAQI Council meeting notes: "Council agreed the data presented does not provide the council with any information that is helpful to determine if things are better or worse, identify trends or make recommendations. Processes are being changed with Essential Elements identified and the report needs to better align with these expectations."											

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. For the single instance of the use of TIVA, informed consent was present, nothing-by-mouth status was confirmed, and an operative note defined procedures and assessment completed. In addition, nursing staff conducted pre- and post vital signs in accordance with the applicable nursing guidelines.

With regard to medical clearance for TIVA, however, the Center's policies need to be expanded and improved. The term "medical clearance" incorrectly implies the procedure carries no risk for the individual. Dental surgery is considered a low-risk procedure; however, the 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 also should address perioperative management, which includes information on perioperative management of the individual's routine medications. Given the risks involved with TIVA, it is essential that such policies be developed and implemented. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures. Given the risks involved with TIVA, it is essential that such policies be developed and implemented.

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

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/13	0/1	0/2	N/A	0/3	N/A	N/A	0/2	N/A	0/5

Comments: a. Based on the documentation submitted, the following individuals had pre-treatment sedation for medical treatment: Individual #165 for a computed tomography (CT) scan on 10/25/18; Individual #4 for a gastroenterology (GI) appointment on 12/5/18, and an esophagogastroduodenoscopy (EGD) on 1/17/19; Individual #284 for a surgical follow-up appointment on 1/2/19, an

ultrasound on 3/13/19, and an ultrasound on 3/21/19; Individual #3 for an EGD on 12/12/18, and an EGD on 1/17/19; and Individual #116 for a DEXA scan on 10/29/18, a CT on 11/8/18, an ultrasound on 1/9/19, a CT on 2/28/19, and a mammogram on 3/11/19.

Findings with regard to these uses of pre-treatment sedation included:

- None of the applicable ISPs or IHCPs showed that the PCP discussed the individuals' need for pre-treatment sedation and/or the medication and dosage range with the IDTs. The AMAs for these individuals also did not discuss the need for pre-treatment sedation for medical procedures.
- Informed consent was present with the following exceptions: Individual #4 for a GI appointment on 12/5/18, and Individual #284 for a surgical follow-up appointment on 1/2/19.
- Nurses generally documented pre-procedure vital signs. However, documentation for this could not be found for Individual #4 for an EGD on 1/17/19.
- For the following four uses of pre-treatment medical sedation, nurses followed the nursing guidelines for post-procedure vital signs: Individual #4 for an EGD on 1/17/19, Individual #3 for an EGD on 1/17/19, and Individual #116 for a DEXA scan on 10/29/18, and a CT on 11/8/18. It was concerning that for the remainder, nurses did not adhere to the set schedule.

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: It was good to see that IDTs were reviewing the use of PTS and determining whether a plan should be created. When determined to be a needed support, plans were created, but were then not implemented or monitored. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 440	117	234	277	321	165	4	121	262
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	100% 3/3					1/1	1/1	1/1		
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	100% 3/3					1/1	1/1	1/1		
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	100% 2/2					1/1		1/1		
4	Action plans were implemented.	0% 0/2					0/1		0/1		

5	If implemented, progress was monitored.	0% 0/2					0/1		0/1		
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/2					0/1		0/1		

Comments:

1. Based upon the documentation provided, it was determined that three of the nine individuals had required pretreatment sedation over the previous 12 month period. These were Individual #321, Individual #165, and Individual #4. This restriction for dental procedures was addressed at each individual's ISP. Additionally, a rights restriction determination had been completed for all three individuals in which the Human Rights Committee and LAR agreed that the restriction was necessary for dental procedures for Individual #321, and medical and dental procedures for Individual #165 and Individual #4. There was also a copy of the completed consent form from the LAR for pretreatment sedation for both medical and dental procedures for Individual #321. For all three individuals, it was noted that familiar and/or preferred staff would accompany the individual to exams/procedures. Additionally, Individual #165 was to have preferred Dallas Cowboys items, and Individual #4 was to have his preferred music and edible reinforcement when appropriate.

2-6. Action plans to address tooth brushing were identified in either the ISP or IHCP for both Individual #321 and Individual #4. However, in neither case was there evidence that these had been implemented. Individual #321's QIDP monthly review noted that he was refusing tooth brushing in November 2018, but thereafter, the only information that was provided was "no issues." In Individual #4's QIDP monthly review, no data were provided from May 2018 through February 2019 regarding tooth brushing.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: The Monitoring Team will provide findings for this outcome at a later date.			Individuals:								
#	Indicator	Overall Score									
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.										
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.										
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across										

	disciplines that require improvement.										
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.										
e.	Recommendations are followed through to closure.										
Comments: The Monitoring Team will provide findings for this outcome at a later date.											

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: For the two potential ADRs reviewed, Center staff took necessary action. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	ADRs are reported immediately.	100% 2/2	2/2	N/A	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% 2/2	2/2								
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	100% 2/2	2/2								
d.	Reportable ADRs are sent to MedWatch.	N/A	N/A								
Comments: a. through d. For both potential ADRs for Individual #165 (i.e., on 1/30/19, and 3/4/19), Center staff reported them timely, conducted necessary clinical follow-up, and discussed them in the Pharmacy and Therapeutics Committee meeting.											

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
Summary: For the one DUE reviewed that identified areas in need of improvement, Center staff had taken steps to correct issues identified. Indicator b will remain in active monitoring.		
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 1/1
Comments: b. Since the last review, Lubbock SSLC completed three DUEs, and discussed and followed up on a fourth DUE, including:		

- On 6/1/18, a DUE on proton pump inhibitors (PPIs) was completed, and on 9/28/18, it was presented to the P&T Committee. On 3/25/19, follow-up was discussed at the P&T Committee meeting. Specifically, the DUE concluded that PCPs were not consistently ordering B12 and magnesium levels for those individuals on PPIs. The PCPs completed an in-service, and a follow-up DUE was scheduled for completion in June 2019;
- On 10/17/18, a DUE on Levetiracetam was completed, and on 12/11/18, it was presented to the P&T Committee. The DUE identified no opportunities for improvements;
- On 12/3/18, a DUE on HMG-CoA Reductase inhibitors (i.e., statins) was completed, and on 12/11/18, it was presented to the P&T Committee. The DUE identified no opportunities for improvements; and
- On 3/5/19, a DUE on Carbamazepine was completed, and on 3/25/19, it was presented to the P&T Committee. The DUE identified no opportunities for improvements.

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the time of the last review, 27 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, seven additional indicators in the areas of ISPs, psychiatry, behavioral health, and communication will move to the category of less oversight. One indicator related to dental will return to active oversight.

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

Assessment

Most of the IDTs considered what assessments the individual needed prior to the annual meeting. About two-thirds of the IDTs arranged for and obtained all needed, relevant assessments prior to the IDT meeting.

In psychiatry, the annual comprehensive psychiatric evaluations (CPEs), the annual psychiatric treatment plans, and the quarterly reviews were all completed in a timely manner and contained the required content.

In behavioral health, some individuals had restrictions in their programming and/or behavior problems that needed to be evaluated to determine if a Positive Behavior Support Plan (PBSP) was necessary (and/or if the restrictions would more appropriately be classified as PMR-SIB).

Although additional work is needed, the Center made progress with regard to the quality of medical assessments. For example, during this review, more of the annual medical assessments (AMAs) included, as applicable, pre-natal histories, family history, childhood illnesses, allergies or severe side effects of medications, and updated active problem lists. However, moving forward, the Medical Department needs to focus on ensuring medical assessments include thorough plans of care for each active medical problem, when appropriate.

Individuals did not have timely annual dental exams, and as a result, annual dental summaries often did not include up-to-date information. The indicator related to the timeliness of dental summaries will return to active oversight. Improvement also was needed in the quality of both the annual dental exams and annual dental summaries. On a positive note, the Dental Department was now fully staffed. However, due to the considerable outdated exams and documentation, it likely will take at least a full year

to see improvements in the audit scores. Early signs of recovery from this prior gap in dental care were evident, and the Monitoring Team is hopeful the trend will continue to show improvement.

The Center should focus on improving the referral of all individuals that meet criteria for Physical and Nutritional Management Team (PNMT) review, completion of PNMT comprehensive assessments for individuals needing them, and the quality of the PNMT reviews and comprehensive assessments.

The Center performed well with regard to the timeliness of Occupational Therapy/Physical Therapy (OT/PT) assessments, as well as the provision of the type of OT/PT assessment in accordance with the individuals' needs. The quality of OT/PT assessments continues to be an area on which Center staff should focus.

It was positive that for this review, and the previous two reviews, individuals reviewed received the type of communication assessments that were in accordance with their needs, and that Speech Language Pathologists (SLPs) completed these assessments timely. The related indicator will move to the category requiring less oversight. However, significant work is needed to improve the quality of communication assessments in order to ensure that SLPs provide IDTs with clear understandings of individuals' functional communication status; 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.

In skill acquisition, about two-thirds of individuals had a current Functional Skills Assessment (FSA), Preferences and Strengths Inventory (PSI), and vocational assessment. Recommendations for skill acquisition were found in both the FSA and vocational or day program assessments for one-third of the individuals. Vocational, assessments included a very limited number and range of recommended Skill Acquisition Plans (SAPs). This often resulted in very limited skill development for the individuals.

<u>Individualized Support Plans</u>

Lubbock SSLC developed a number of meaningful and individualized personal goals, but did not define/write most of them in measurable terminology and/or implement and/or collect reliable data. To be more specific, 13 goals met criteria for meaningfulness and individualization. Two of the 13 had action plans that supported the achievement of those goals.

Progress was seen in most integrated setting practices section of the ISPs. For instance, for two individuals, all of the indicators met criteria for this outcome (i.e., Outcome #4).

IDTs met often and often they made recommendations. There was, however, little follow-up to ensure implementation and effectiveness of plans. Goals were not consistently implemented, and IDTs did not address barriers to implementation. Qualified

Intellectual and Developmental Disability Professional (QIDP) monthly reviews were occurring, but were not generating any meaningful analyses or resultant actions.

Psychiatric indicators existed (i.e., were identified). Rationale for how the chosen psychiatric indicators related to the diagnoses needed improvement. Likewise, there were goals for some of the psychiatric indicators. They were not yet included within the ISP documentation. There were also not yet any data on the occurrence/presentation of psychiatric indicators.

The consents for psychotropic medications were obtained in a timely manner, however, the section related to the risk benefit discussion was simply a brief statement asserting that the benefits outweighed the risk with no data or information to support that conclusion.

In behavioral health, attention to ensuring data are reliably recorded is an important area of focus for the Behavioral Health Services Department. During the onsite review, five individuals were observed engaging in problem behavior. Data were recorded for one of the five.

For PBSPs, the majority of the plans included operational definitions of both targeted problem behaviors and replacement behaviors, antecedent and consequent strategies, the training/reinforcement of functionally equivalent replacement behaviors, and clear, precise interventions. On the other hand, problems with the content were evident in many PBSPs. That is, PBSPs need to be more specific when reinforcement strategies are identified in plans, token economies and behavior contracts need more specificity to ensure correct implementation, and materials noted for reinforcement cannot include items that the individual has a right to access without approved restriction, such as clothing and hygiene items.

Concerns regarding Center-wide pica data reliability and validity, and with treatment protocols were raised during discussions with staff.

All individuals had at least one SAP, though the individuals would have benefited from additional SAPs. It was very positive to see that about two-thirds of the SAPs had data and that those data were deemed to be reliable.

With regard to physical and nutritional management (PNM) interventions, although some improvements were noted, Individual Support Plans (ISPs)/Integrated Health Care Plans (IHCPs) still did not comprehensively set forth plans to address individuals' PNM needs. In some cases, IDTs had included a number of necessary PNM interventions in individuals' ISPs/IHCPs, which was movement in the right direction. However, the plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps. In addition, often action steps were not measurable.

Improvements were noted with the quality of Physical and Nutritional Management Plans (PNMPs)/Dining Plans. Center staff should continue to make the needed changes to these important staff instructions.

Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: Performance on these indicators was about the same (or a little lower) than at the last review. This shows that Lubbock SSLC can, and did, develop many meaningful and individualized personal goals, but again did not define/write some of them in measurable terminology and/or implement and/or collect reliable data. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	165	4	277	262	94	91			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	2/6	2/6	1/6	3/6	3/6	2/6			
2	The personal goals are measurable.	0% 0/6	2/6	1/6	1/6	3/6	2/6	1/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	1/6	1/6	1/6	1/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #4, Individual #165, Individual #277, Individual #262, Individual #91, and Individual #94. The Monitoring Team reviewed in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Lubbock SSLC campus.

1. The ISP relies on the development personal goals as a foundation. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish.

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

Below is detail regarding the different categories of personal goals:

- Leisure goals for three individuals met criteria. These were:

    - Individual #165's goal to attend sporting events in the community.
    - Individual #277's goal to go out to eat at three different restaurants in the community.
    - Individual #94's goal to play the happy birthday song for three of her peer at birthday parties.
- Leisure goals that did not meet criteria were:
    - Individual #4's goal to host a karaoke event on campus and Individual #262's goal to host a basketball game two times per quarter were based on activities that they enjoyed, however, it was not clear what hosting events for their peers would entail or how it would be accomplished or even that it was a priority for either individual.
    - Individual #91's goal to choose superhero/animated movies to view in a theater. Individual #91 indicated that he routinely chose movies that he wanted to see.

- Three relationship goals met criteria:
    - Individual #4's goal to take trips on a monthly basis to visit with his family.
    - Individual #262's goal to independently call his grandparents.
    - Individual #94's goal to invite a friend to eat in the community.
- These relationship goals did not meet criteria:
    - Individual #165's goal to host a sporting event on campus.
    - Individual #277's goal to go on 12 outings on campus with her long-term friend. According to her monthly reviews, she did not have a long-term friend, so it was not clear how the IDT had determined what she might like to do with a friend.
    - Individual #91's goal to go shopping with his peers was an activity that he routinely was able to do.

- Work/School/Day goals for Individual #262 and Individual #91 met criteria.
    - Both had goals to obtain employment in the community.
- These work/school/day goals did not meet criterion:
    - Individual #4 had a goal to work up to two hours per day on campus. The IDT had not identified his vocational preferences.
    - Individual #165's goal to earn $25 per quarter was not based on vocational preferences.
    - Individual #277 had a goal to complete ADL lesson plans at the day program. The IDT did not define which ADL skills would be included. Her preferences for functional engagement during the day had also not been defined through an adequate assessment process.
    - Individual #94 had a goal to work full time at the work center for four consecutive weeks. This appeared to be a compliance goal unrelated to her preferences.

- Four of six individuals had a greater independence goal to make their own snack. While this appeared to be a skill that Individual #4 and Individual #165 were interested in learning, staff reported that this was not a priority for Individual #277 and Individual #262.
    - Individual #91 and Individual #94 had goals to complete their hygiene task daily. Both of their functional skill assessments indicated that they could independently complete hygiene tasks.

- Living options goals for three individuals were aspirational and individualized. Individual #262, Individual #91, and Individual #94 had aspirational goals to move into the community based on their stated preferences.
    - Individual #4, Individual #165, and Individual #277 had goals to remain at the facility. These goals were not aspirational and would not lead towards living in the most integrated setting.

2. When personal goals for the ISPs did not meet the criterion described above in indicator 1, there can be no basis for assessing compliance with measurability or the individual's progress towards its achievement. The presence of a personal goal that meets criterion is a prerequisite to this process. In order to meet criterion for measurability, personal goals must be measurable in a stand-alone manner, that is, a review of the ISP and action plans is not needed to make this determination. The outcome of the goal must be observable and measurable, and the goal must be specific, clearly defining the conditions under which the goal would be achieved. Vague terminology, such as participation, does not describe actions on the part of the individual working toward goal-achievement.

Of the 13 personal goals that met criterion for indicator 1, 10 met criterion for measurability.

- Individual #165's goal to independently prepare a snack in his home by July 2018 was not measurable. It was not clear what Individual #165 would have to do to complete his goal. Depending on staff interpretation, completion might mean making a snack one time or making a snack daily until July. One staff member might give him credit for opening a bag of chips, while another might expect him to independently cook a snack.
- Similarly, Individual #91's goal to work in the community by 2021 did not clearly define completion criteria.
- Individual #94's goal to play the Happy Birthday song did not define how she would play the song.

3. Four of the 10 goals that were measurable had reliable data to determine if the individual was making progress. QIDP monthly reviews and SAP data sheets indicated that a majority of the action plans were never implemented. For those that were implemented, consistent data were often not available to determine progress towards goals. In most cases, service objectives lacked specific staff instructions for implementation, thus, staff lacked guidance needed to implement action plans. Data were available for:

- Individual #165 and Individual #277's recreation/leisure goals.
- Individual #262 and Individual #94's relationship goals.

Some examples where data were not reliable and/or available included:

- Individual #4's relationship goal was never implemented. There was some data for his greater independence goal, however, it was not clear what the data indicated and what specific progress was being made.
- For Individual #262's goal to work at a car wash in the community, data indicated that he was working with the supported employment program at 100% for three months. It was not clear if staff were strictly recording attendance or if he was learning skills that would move him closer to achieving his goal.
- Data were either not available or not specific as to progress that Individual #262, Individual #91, and Individual #94 were making towards their goals to move into the community.

As noted throughout this report, for all of the other goals, it was not possible to determine if ISP supports and services were being

regularly implemented or to determine the status of goals because of the lack of reliable data and documentation provided by the Center. While there were some data collected showing implementation of some action plans, there was not enough information documented to clearly determine the status of goals.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: This set of indicators speaks directly to the overall quality of the ISP for the individual's upcoming year. The Monitoring Team looks across the entire ISP when scoring each of these indicators. Performance remained about the same as at the time of the last review, indicating that some focus or specialized approach to improvement is warranted. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	165	4	277	262	94	91			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	1/6	0/6	1/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	33% 2/6	0/1	0/1	0/1	1/1	0/1	1/1			
12	ISP action plans integrated strategies to minimize risks.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to	0%	0/1	0/1	0/1	0/1	0/1	0/1			

	achieving goals.	0/6									
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	1/6	0/6	1/6	0/6	0/6			

Comments:

8. Thirteen of the personal goals met criterion in the ISPs, as described above in indicator 1, therefore, those action plans could be evaluated in this context (i.e., for this indicator 8). A personal goal that meets criterion is a prerequisite for such an evaluation. Action plans are evaluated further below in terms of how they may address other requirements of the ISP process.

Two of 13 goals had action plans that supported the achievement of those goals. These were:

- Individual #262's relationship goal.
- Individual #91's greater living option goal.

Most of the action plans were written as service objectives and did not include staff instructions or implementation strategies that would ensure staff could consistently teach a new skill or accurately collect data on progress. Many action plans stated what staff would do, but not what action the individual would take to show progress towards accomplishing his or her goal, thus, data often indicated how many times staff had implemented the plan instead of measuring specific progress towards the goal. IDTs still needed to focus on laying out a clear path of assertive action plans to meet each goal. Some goals had no action plans that were clearly related.

Examples of goals that did not have action plans that would lead to achievement of the goal included:

- Individual #165 had a goal to attend sporting events in the community. Action plans to support that goal were (1) have a large laminated calendar to plan events, (2) a SAP for counting days until the event, (3) HT to inform IDT regarding new wheelchair, (4) QIDP to submit a trust fund request for snacks, (5) matching community signs, and (6) identifying a nickel. His barrier to making progress appeared to be lack of planning by his support team. This had not been addressed.
- Individual #277 had a goal to go out to eat in the community three times over the next year. Supporting action plans were (1) she will use her adaptive equipment at the new restaurant, (2) will have access to her trust fund, (3) DSP will give her two food options when eating in the community, and (4) she can sign when requesting music or when she hears music in the community. Similarly, her greatest barrier to achieving her goal appeared to be lack of implementation by her team.

9. One of the ISPs had action plans that integrated preferences and opportunities for choice. For the most part, goals and action plans were based on individual preferences, however, opportunities for making choices were limited. Action plans ensuring opportunities for work and day programming based on preferences and supported by exposure to new activities were particularly limited. Individual #91's ISP did minimally offer opportunities to make choices. This included his action plans to choose a peer to go shopping with and choose a movie to go watch.

IDTs were generally not identifying preferences in a way that might guide the development of activities that would offer opportunities to learn new skills and build on developing a plan for meaningful days. For the most part, ISPs listed general preferences related to food, music, television, and activities routinely offered at the facility.

Opportunities to make meaningful choices were limited. Expanding choices may result in discovering new preferences.

10. None of the ISPs clearly addressed strengths, needs, and barriers related to informed decision-making.
A basis to making informed decisions is offering individuals exposure to a variety of new experiences and opportunities to make choices throughout their day. These opportunities were not included in action plans for five individuals in any substantial way.

11. Two of the ISPs met criterion for this indicator to support the individual's overall independence. Examples of ISPs that included action plans to promote greater independence in a meaningful way were:

- Individual #262 had action plans for independently calling his grandparents. This was clearly based on his preferences and would support him to be more independent.
- Individual #91 had an action to learn to wash his clothes independently. He had a greater independence goal to complete his hygiene task, however, his FSA indicated that he already was able to do this independently. Action plans to support this goal included plans for the QIDP and residential coordinator to purchase his hygiene items. Supporting him to purchase his own hygiene items would have supported greater independence.

12. One of the ISPs integrated strategies to minimize risks in ISP action plans. While risks were addressed through action plans included in the IHCP, supports were not routinely integrated into other action plans when relevant, and risks were not always identified by the IDT. Rarely were SAPs written to provide staff with strategies for implementing plans and, when SAPs were written, they did not include specific mobility, behavioral, and safe eating supports.

- Individual #262's ISP addressed his risks with action plans related to his PBSP, psychiatric treatment plan, counseling, cutting his food to address his risk for choking, and learning to use his CPAP machine.

Example where risks were not addressed included:

- Individual #4 wore a helmet. A description of this was found in his Physical and Nutritional Management Plan (PNMP) with the rationale that this was provided to protect him from falls. Guidelines for using the helmet were not included in his PNMP or Positive Behavior Support Plan (PBSP). Staff were not documenting when his helmet was on or off. Staff, however, repeatedly noted that the helmet was to help protect him from head banging. Thus, the helmet might be a PMR-SIB rather than a supportive/protective device. If so, proper PMR-SIB protocols need to be put into place.
- During observations in the day program, staff were observed putting a clothing protector on Individual #277 when she repeatedly placed her shirt in her mouth. This restrictive practice was not included in her ISP or PBSP.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well integrated in ISPs. In most cases, supports were fragmented, with little evidence that IDT members were sharing data and collaborating on developing supports. While IDTs were attempting to integrate behavioral objectives into action plans to support goals, for the most part, they became stand-alone action plans and were not truly integrated into action plans for functional skill building. For example,

- Individual #277's ISP and assessments included conflicting information regarding her visual acuity. While some assessments indicated that she had cortical blindness, staff reported that she had no problem seeing. Visual supports were not addressed in her ISP. Her communication goals were not currently integrated into her ISP, however, it was positive to see that a robust

conversation occurred at her ISP preparation meeting regarding integrating her communication strategies into skill development for the upcoming ISP year.

- Individual #91 had an action plan to receive speech therapy, however, his speech goals were not integrated into other action plans to support his goals.
- Individual #165's assessments noted that he has some difficulty communicating with people not familiar with him. This was not addressed in his ISP.
- Individual #4's ISP and assessments included conflicting information regarding the use of his helmet. In some places, it was noted that the helmet was used for protection from injury from falls, other documentation noted it was used for protection from injury due to SIB. There was no plan in place to monitor the use of his helmet or provide information on protecting him from injury when he was not using his helmet.

ISPs summarized assessment results, however, assessments offered few recommendations for supporting new skill development. When there were recommendations, they were rarely integrated into action plans for learning new skills. This was particularly true for communication skills.

14. None of the ISPs included action plans to support meaningful integration into the community.
Although individuals had goals to live and work in the community, action plans did not support community integration. Individuals did not have goals for banking, volunteering, getting haircuts, joining a church, or joining a gym in the community. Outings were limited to specific events, such as eating out, going to the movies, or attending a sporting event. While these types of activities support community exposure, they are unlikely to lead to meaningful integration.

15. None of the ISPs documented the IDT's consideration of opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs

Action plans did not address preferences in regard to work/day programming. Action plans were not present that would support skill development which might lead to work/day programming in a less restricted setting. Vocational assessments were not adequate for identifying preferences outside of the limited vocational opportunities offered at the facility and assessing skills that might lead towards work in a more integrated setting.

Individual #262, Individual #117, and Individual #94 had goals to work in the community, however, it was not clear that job choices were based on an adequate assessment that included exposure to a variety of jobs to determine their preferences. Additionally, none had action plans that were likely to lead to employment in the community.

16. ISPs did not support substantial opportunities for functional engagement described with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Overall, the ISPs provided limited opportunities for learning and functional skill development. IDTs need to expand the preference assessment to offer more opportunities to try new things and identify new interests, then build on skills related to those preferences.

- Individual #94 was observed during the day engaged in work at the sheltered workshop. She could easily complete the task assigned to her. There was no documentation that she was learning new skills that might lead towards meaningful

employment.

- Individual #91 spent a majority of his day not engaged in any meaningful activity. He often refused to go to his assigned work center. It was not evident that the IDT had considered a comprehensive vocational assessment that might identify employment based on his preference and/or skills he might need to work at a more challenging job.
- During observations, Individual #262 was learning new employment related skills as he worked on painting pet feeders, however, his ISP did not address functional skill building that might lead towards more meaningful employment.
- Individual #4's ISP did address functional training to be provided during the day program. His vocational assessment noted that he would complete work trials with the litter crew. There were no findings or recommendations from work trials including in his ISP. Staff reported that he infrequently attended day programs. He was observed in the day program during one of three observations, however, he was not engaged in functional training during that observation.
- Individual #165 had a work goal to earn $25 per month. His goal did not focus on training that might lead to more meaningful work in a less restrictive environment and opportunities to earn a realistic wage.
- Individual #277 spends a majority of her day at home, not engaged in training of any kind. Her IDT needs to consider updating her preference assessment to discover new interest and new opportunities to learn skills that might lead towards a more meaningful day.

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

18. One of the goals had a set of action plans with enough detail to ensure consistent implementation, data collection, and review (Individual #262's relationship goal). Overall, ISPs did not usually include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action plans were broadly stated, not individualized, and, in most cases, skill acquisition plans were not developed when needed to ensure consistent training strategies were implemented. When skill acquisition plans were developed, they also were not adequate for providing staff with guidance to implement plans.

Although IDTs had created some goals that were more individualized and based on known preferences, few had specific teaching strategies to ensure staff were implementing them and measuring success consistently. Additionally, few had been fully implemented. Thus, individuals did not have person-centered ISPs that were really leading them towards achieving their personal goals. The Center needs to focus on barriers that are preventing individuals from achieving their goals and develop action plans to address those barriers.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.	
Summary: Progress was seen in this aspect of the ISPs (i.e., most integrated setting practices). For instance, for two individuals, all of the indicators met criteria. Further, two indicators maintained high performance scoring 100% for this and the previous two reviews, too, with one exception. Therefore, these two indicators (21 and 22) will be moved to the category of requiring less oversight. The other	Individuals:

indicators will remain in active monitoring.											
#	Indicator	Overall Score	165	4	277	262	94	91			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	83% 5/6	1/1	0/1	1/1	1/1	1/1	1/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	N/A									
21	The ISP included the opinions and recommendation of the IDT's staff members.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	33% 2/6	0/1	0/1	0/1	1/1	1/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	N/A									
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	33% 2/6	0/1	0/1	0/1	1/1	1/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	N/A									
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/3	0/1	0/1	0/1						
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A									
Comments: 19. Five ISPs included a description of the individual's preference for where to live and how that preference was determined by the IDT. Individual #4's ISP noted that he was mostly nonverbal and could not communicate where he wanted to live. The ISP did not document discussion by staff of his known living option preferences (i.e., environmental preferences).											

21. All of the ISPs included the opinions and recommendations of staff members, along with a summary statement of those recommendations.

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

23. Two of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths (Individual #262, Individual #94). The other four ISPs did not indicate that the IDT had considered other living options that specifically supported their preferences and support needs.

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

26. Two of the individuals had individualized, measurable action plans to address obstacles to referral, or were referred if obstacles were not identified. For Individual #262 and Individual #94, the IDT identified specific behaviors that were considered barriers to referral. Those specific behaviors were addressed in their positive behavior support plans and action plans related to their living option goal.

28. Individuals did not have individualized and measurable action plans to educate the individual and/or LAR on living options that might be available to support their needs. ISPs included action plans for the individual to attend a provider fair and group home tours, however, these were not individualized based on the individual or LAR's current knowledge regarding living options or specific to living options that could provide identified supports needed in the community. This indicator was not rated for three individuals who were familiar with their living options due to past placements (Individual #262, Individual #91, Individual #94).

29. Barriers were identified to referral for all individuals.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
Summary: At Lubbock SSLC, individuals almost always attended their own ISP meetings. Given this was the case for this and the previous two reviews, too, indicator 33 will be moved to the category of requiring less oversight. Indicators 32 and 34, regarding timely implementation and team attendance/composition, will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	165	4	277	262	94	91			
30	The ISP was revised at least annually.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.										

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

Comments:

32. Documentation was not submitted that showed that action plans were implemented within a timely basis for any of the individuals. Some examples of action plans that were not implemented within 30 days of development included:

- For Individual #4, action plans to support his recreation/leisure goal including purchasing a karaoke machine for the home within 30 days, scheduling times for karaoke parties, and making invitations were not implemented. Action plans to support his relationship goal to visit with his family were not implemented.
- Action plans to support Individual #165's relationship goal were not implemented within 30 days and still have not been implemented seven months into his ISP year. His action plan to begin signing into work within 14 days should have been implemented in August 2018, implementation was not documented until October 2018. He had an action plan to complete a trial for greeting at the diner within 60 days (September 2018). His QIDP monthly review indicated that a work trial at the diner had not been implemented as of this review. His action plan to prepare a snack was also never implemented.
- Individual #91's action plans to support completing his hygiene/grooming check list were not implemented within 30 days.
- Action plans to support Individual #277's relationship goal were never implemented. Her action plan to purchase ice cream at the diner monthly has not been implemented. Implementation should have started in September 2018.
- Individual #94's action plans to be assessed by a job coach for more duties and complete trials with different contracts should have been implemented by October 2018. The QIDP monthly reviews do not document implementation of these action plans. Action plans to support her greater independence goal were also not implemented within 30 days.
- Action plans to support Individual #262's recreation/leisure goal were not implemented within 30 days of ISP development. His action plan to purchase a wallet within 30 days (by November 2018) has not been completed. Action plans to support his greater independence goal also were never implemented.

33. All individuals attended their ISP meetings.

34. One of the individuals (Individual #94) had an appropriately constituted IDT based on the individual's strengths, needs, and preferences, who participated in the planning process.

- OT/PT did not attend Individual #4's ISP meeting. He has had a number of falls over the past year. Input on mobility supports would benefit the IDT.
- Individual #165's LAR did not participate in his annual ISP meeting.
- Individual #277's SLP did not attend her meeting. The IDT has noted the need for significant communication supports.
- All team members were present at Individual #262's annual meeting, however, it was not clear through interviews that they

were knowledgeable regarding his needs articulated in the ISP. His QIDP was not knowledgeable regarding specific progress and barriers related to his goals. Specific skills needed to accomplish his work goal had not been identified.

- Individual #91's SLP did not attend his meeting. He had speech therapy goals that were not integrated into his ISP.

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

Summary: Performance improved since the last review. Defining and obtaining relevant assessments prior to the IDT remains an area that needs additional attention. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 165	4	277	262	94	91			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	83% 5/6	1/1	1/1	1/1	1/1	0/1	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	67% 4/6	1/1	0/1	1/1	0/1	1/1	1/1			

Comments:

35. Five IDTs considered what the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting.

- Individual #94's ISP included action plans to complete additional work assessments to determine her vocational interests and support needs. These assessments should have been requested at her ISP preparation meeting to be completed prior to her ISP, so that the team could develop work goals based on her preferences and needs.

36. Four of the IDTs arranged for and obtained all needed, relevant assessments prior to the IDT meeting.

- Individual #4's annual medical assessment was not submitted 10 days prior to his annual ISP meeting for team review.
- Individual #262's medical and nursing assessments were not submitted 10 days prior to his ISP meeting.

Without relevant assessments for the IDT to review, comprehensive supports and services were not developed, and all risks were not addressed. Having information from assessments would greatly assist the IDTs in developing meaningful goals with action plans to address needed supports. The facility needs to continue to make obtaining assessments a priority going forward.

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

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

#	Indicator	Overall Score	Individuals: 165	4	277	262	94	91			

37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

37. The IDTs routinely met to review supports, services, and serious incidents during ISPA meetings. IDTs did not routinely revise supports or goals or address barriers when progress was not evident. As noted throughout this report, data were not available to support consistent implementation. Without adequate data, IDTs were unable to make decisions regarding progress or lack of progress towards goals.

- For all individuals, action plans to support one or more goals were never implemented months into the ISP year. There was rarely documentation to support aggressive action by the IDT to address lack of implementation.
- When additional assessments and/or supports were requested throughout the year, QIDP monthly reviews and ISPAs did not document that assessments were completed or that the IDT met again to review assessment results and incorporate any recommendations into the current ISP. Some examples included:
    - Individual #4's IDT requested a consultation with an allergist to determine a possible cause for his headaches.
    - Individual #165's IDT recommended a tilt in space wheelchair to address pressure ulcers. Status towards obtaining the new wheelchair was not clearly documented.

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

For the most part, monthly reviews were completed and included a cursory review of all services. They included little meaningful information regarding progress towards goals and efficacy of supports.

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

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

Outcome 1 – Individuals at-risk conditions are properly identified.											
Summary: The Monitoring Team will provide findings for this outcome at a later date.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	The individual's risk rating is accurate.										
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.										
Comments: The Monitoring Team will provide findings for this outcome at a later date.											

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: Lubbock SSLC psychiatry department continued to make progress on some of these indicators and sub-indicators. To be more specific, it was good to see that psychiatric indicators existed (i.e., were identified). Rationale for how the chosen psychiatric indicators related to the diagnoses needed improvement. Likewise, there were goals for some of the psychiatric indicators and many times they were updated. They were not yet included within the ISP documentation. And finally, ensuring that there are data on the occurrence/presentation of psychiatric indicators and demonstrating that those data are reliable remained areas still in need of improvement. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	440	117	234	277	321	165	4	121	262
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	0% 0/8	0/2	0/2	0/2	1/2		0/2	0/2	0/2	0/2
5	The individual has goals related to psychiatric status.	0% 0/8	0/2	1/2	0/2	1/2		1/2	1/2	0/2	0/2
6	Psychiatry goals are documented correctly.	0% 0/8	0/2	0/2	0/2	0/2		0/2	0/2	0/2	0/2
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8	0/2	0/2	0/2	0/2		0/2	0/2	0/2	0/2
Comments: The scoring in the above boxes has a denominator of 2, which is comprised of whether criteria were met for all sub-indicators for psychiatric indicators/goals for (1) reduction and for (2) increase. Note that there are various sub-indicators. All sub-indicators must											

meet criterion for the indicator to be scored positively.

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

In behavioral health services positive behavior support plans (PBSPs), the focus is upon what are called target behaviors and replacement behaviors.

In psychiatry, the focus is upon what have come to be called psychiatric indicators. Psychiatric indicators can be measured via recordings of occurrences of indicators directly observed by SSLC staff and/or with psychometrically sound rating scales that are designed specifically for the psychiatric disorder and normed for this population.

The Monitoring Team looks for:

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

Lubbock SSLC showed progress in this area, though with additional focus on the specifics of these three sub-indicators, more progress towards meeting criteria with indicator 4 would be more likely.

- For sub-indicator 4a, there was at least one psychiatric indicator identified for decrease for each individual, and there was also at least one psychiatric indicator identified for increase for each individual. This was progress since the last review.
- For sub-indicator 4b, the relevance of the psychiatric indicators for decrease to the individual's diagnosis was clear for two individuals, Individual #277 and Individual #121. It was not clear, evident, or explained as to link of the psychiatric indicator for increase for any of the individuals.
- For sub-indicator 4c, the indicators for reduction were defined in observable terms for eight of the individuals in the review group, that is, all except Individual #121. The psychiatric indicators for increase were described in observable terminology for Individual #440, Individual #117, Individual #4, and Individual #262.

Thus, criteria were met for all three sub-indicators (a, b, c) for psychiatric indicators for reduction for one of the individuals in the review group (Individual #277), and for none of the individuals for psychiatric indicators for increase.

5. Psychiatric goals:
The Monitoring Team looks for:

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

There was also continued progress on these two sub-indicators.

- For sub-indicator 5d, a goal for the psychiatric indicator to decrease was written for eight of the individuals, all except Individual #121. Similarly, a goal for psychiatric indicators for increase were also written for all individuals, except for Individual #121.
- For sub-indicator 5e, there were further instructions for how and when the data were to be collected beyond the initial description of the indicator (for decrease) for one of the individuals, Individual #277. The type of data and how to collect that data for psychiatric indicators for increase was written in an understandable manner for Individual #117, Individual #165, and Individual #4.

Thus, both sub-indicators were met for one of the individuals for goals for reduction (Individual #277) and for none of the individuals for goals for increase. Both sub-indicators were met for three individuals (Individual #117, Individual #165, Individual #4).

6. Documentation:
The Monitoring Team looks for:

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

This indicator and sub-indicators address a somewhat clerical activity, but one that is important for integrated supports and service provision. It was good to see

- For sub-indicator 6f, the goals for reduction did not yet appear in the IHCP section of the ISP. The psychiatry department continued to explore methods to make it possible to have the goal grids appear in the IHCP section in the same manner as other goals. Similarly, the goals for the psychiatric indicators to increase did not appear in the IHCP in the ISP for any of the individuals.
- For sub-indicator 6g, there was documentation that the goals for the indicators to reduce were updated in the quarterly reviews for all of the individuals for whom this was relevant. Individual #121 had recently been readmitted, so this was not applicable to her. The nature of the changes was related to the target frequency for the goal to decrease. The psychiatrist updated this at each quarterly review based on the data generated in the prior three months. The goals for the psychiatric indicators to increase were modified over the year for all of the individuals (again, except Individual #121 for whom this was not applicable because she was recently been readmitted to the facility). These updates were carried out in the context of the quarterly psychiatric reviews. The psychiatrist working with the IDT would modify the objectives for the behaviors to increase based on the data from the prior three-month period.

Thus, both sub-indicators were not met for any individual for psychiatric indicators for decrease or for increase. However, to look at these two sub-indicators from a different angle, sub-indicator 6f was not met for any individual for either type of psychiatric indicator, whereas sub-indicator 6g was met for all individuals for both types of psychiatric indicators.

7. Data:
Reliable and valid data need to be available so that the psychiatrist can use the data to make treatment decisions. Data are typically presented in graphic or tabular format for the psychiatrist. Data need to be shown to be reliable.

Data on psychiatric indicators were not shown to be reliable.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: CPE content met criteria for all individuals, an improvement since the last review. For about one-third of the individuals, was there consistency in the diagnostic documentation across various sections of the individual's record. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 440	117	234	277	321	165	4	121	262
12	The individual has a CPE.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B										
14	CPE content is comprehensive.	100% 8/8	1/1	1/1	1/1	1/1		1/1	1/1	1/1	1/1
15	If admitted within two years prior to the onsite review, and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	38% 3/8	0/1	1/1	0/1	1/1		0/1	0/1	1/1	0/1

Comments:
14. The content of the CPEs was comprehensive and contained the required information for all of the individuals.

16. The psychiatric diagnoses were consistent in the medical, behavioral health, and psychiatric sections of the record for three of the individuals: Individual #117, Individual #277, and Individual #121.

Outcome 5 – Individuals' status and treatment are reviewed annually.											
Summary: Performance again increased on indicators 18-20. Sustained high performance was shown for indicator 19, regarding submission of psychiatric documentation, for this and the previous two reviews, too. Therefore, indicator 19 will be moved to the category of requiring less oversight. Improvements remained needed in the content of the final ISP document. Indicators 18, 20, and 21 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	440	117	234	277	321	165	4	121	262
17	Status and treatment document was updated within past 12 months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	100% 8/8	1/1	1/1	1/1	1/1		1/1	1/1	1/1	1/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	100% 8/8	1/1	1/1	1/1	1/1		1/1	1/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	88% 7/8	1/1	0/1	1/1	1/1		1/1	1/1	1/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	25% 2/8	0/1	0/1	0/1	0/1		0/1	0/1	1/1	1/1

Comments:

18. The information contained in the CPE updates was comprehensive and met the content requirements.

19. The CPE updates were prepared and submitted to the ISP team in a timely manner at least 10 days prior to the ISP for all of the individuals.

20. The psychiatrist attended the ISP for all of the individuals, except Individual #117.

21. The ISP met the content requirements for two of the individuals in the review group, Individual #121 and Individual #262. The content of the ISP for Individual #4 contained the required content, but a reference to the psychiatrist's participation in the meeting could not be found. A consistent finding in the other ISPs was the lack of empirical evidence to support the conclusion that the psychotropic medication was the most effective, least intrusive form of treatment for the individual. In addition, there were no references to the psychiatrist's participation in the meeting.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.												
Summary:			Individuals:									
#	Indicator	Overall Score										
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments:												

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.												
Summary: For indicator 30, the risk benefit discussion contained in the consent for each of the individuals simply and solely stated "the risk of illness is greater than the risk of medication." There was no individualized discussion that presented empirical evidence to support this conclusion. This should be corrected if this indicator is to remain in the category of requiring less oversight after the next review.			Individuals:									
#	Indicator	Overall Score										
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.											
30	A risk versus benefit discussion is in the consent documentation.											
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.											
32	HRC review was obtained prior to implementation and annually.											
Comments:												

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.	
Summary: Indicators 1, 2, and 4 were in the category of requiring less oversight for a number of consecutive reviews. For the first time since being moved to that category, criteria were not met for some individuals for these three indicators. These three indicators will remain in the category of less oversight and the Monitor	Individuals:

has no intention of returning them to active monitoring, however, the Center's behavioral health services department should attend to them to ensure that these were isolated cases.

Indicator 5, regarding reliable and valid PBSP data again scored zero for all individuals. Attention to ensuring data are reliably recorded is an important area of focus for the behavioral health department. It is also a foundational/pivotal activity for meeting other outcomes and indicators in the Settlement Agreement monitoring tool. It will remain in active monitoring.

#	Indicator	Overall Score	440	117	234	277	321	165	4	121	262
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.	0% 0/8	0/1	0/1	0/1	0/1		0/1	0/1	0/1	0/1

Comments:

1. One individual in the behavioral health monitoring review group, Individual #321, did not have a PBSP. However, both his ISP and Behavioral Health Assessment noted several problem behaviors, such as hitting/kicking/scratching others, hitting his wheelchair, pulling his g-tube when agitated, scratching himself, picking at his nose, and screaming. Thus, staff are advised to complete a functional behavior assessment to determine whether a PBSP is warranted.

Further, Individual #321's BHA noted that he wore a fitted undershirt to prevent his pulling his g-tube. But when documentation of Human Rights Committee approval was requested, the Center reported that he did not wear a fitted undershirt. However, when talking with staff in his home, it was reported that he wore this every day. This is a restrictive practice that should be reviewed with proper consents obtained (e.g., PMR-SIB).

2. Individual #440 had goals for counseling services and goals for four of eight targeted problem behaviors, but she did not have goals for self-injurious behavior, inappropriate sexual behavior, suicidal threats/gestures, property destruction, or identified replacement behaviors. The Center also presented a draft version of an updated plan that was presented at BSC during the onsite week. At that

meeting, the committee recommended inclusion of these goals. The Center reported that since the onsite week (and the BSC meeting), these changes had been made.

Individual #121 also had goals for counseling and most of the behaviors targeted in her PBSP, however, there was no goal for practicing anger management. Staff are advised to review the goal for Individual #121 to verbalize her emotions because 300 times per week seems excessive.

4. Goals were not developed for four of Individual #440's targeted problem behaviors identified in her functional behavior assessment.

5. Due to problems with the system for assessing data timeliness, the discrepancy noted later in this report in reporting inter-observer agreement, and problems with measurement systems, it was determined that the data were not reliable (or valid). Further, during the onsite review, several individuals were observed engaging in problem behavior. A request was made for PBSP data for these individuals to determine whether documentation occurred. A summary is provided below.

- On Tuesday, at 11:35 am in her home, Individual #277 was observed engaging in her inappropriate oral behavior. This behavior was not documented.
- On Wednesday between 8:25 am and 8:31 am in her educational program, Individual #277 was observed engaging in her inappropriate oral behavior. This behavior was not documented.
- On Wednesday at approximately 1:37 pm, Individual #290 was observed screaming. This behavior was not documented, however, it appeared that this was not one of his PBSP target behaviors.
- On Wednesday at 3:05 pm, Individual #73 was observed hitting her head at least nine times. These behaviors were not recorded.
- On Wednesday, Individual #116 was observed screaming during and after she was changed at approximately 3:05 pm. This behavior was recorded.

An additional issue was raised regarding data reliability and validity when reviewing the PBSP progress notes for Individual #284. The reports for November 2018 and December 2018 indicated that he had had zero occurrences of pica. However, he required surgical removal of two latex gloves in the latter part of November 2018.

Regarding pica: Concerns regarding Center-wide pica data reliability and validity were raised during discussions with staff. The Quality Improvement department stated that an individual ingesting nonedible items in an attempt to gain attention did not meet the definition of pica. This was an incorrect interpretation because the hypothesized function of the behavior should not be relevant to the topographical description of the behavior (i.e., pica).

Staff reported that there were 15 individuals with a diagnosis of pica. It is advisable to review the current census to determine whether other individuals should be added to this list.

During the Pica Corrective Action Plan meeting, staff noted that Individual #135's rates of pica were likely higher than reported because he will engage in this behavior when alone in the bathroom. During this same meeting, staff noted that there was often a large quantity of cigarette butts found in the parking lot where new staff parked for orientation. This matter must be addressed because it is also near

one of the identified "pica homes."

Further discussion indicated that the Elm home was a major problem with staff not appearing to understand or accept the significance of this problem. In fact, it was noted that the home supervisor kept his office door unlocked because he had lost his keys and did not want to pay for their replacement. While some plans were identified to increase inspections of the facility's grounds, it would be advisable for members of this committee to make regular inspections particularly in areas of high concern. While onsite, the Monitoring Team found debris, including latex gloves, in plain sight throughout this area.

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

Summary: Performance remained low on both indicators, showing that criteria were met for about half of the individuals. Attention should be paid to the way FBAs are conducted. Also, to reiterate from the comments below and from previous reports, references to individuals' behaviors as "junk behavior" should be discontinued. The term is not used in applied behavior analysis. In fact, behaviors occur because they serve some function. Determining that function and developing relevant interventions is one of the hallmarks of applied behavior analysis. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 440	117	234	277	321	165	4	121	262
10	The individual has a current, and complete annual behavioral health update.	44% 4/9	0/1	1/1	1/1	0/1	0/1	1/1	0/1	0/1	1/1
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.	50% 4/8	1/1	1/1	0/1	1/1		1/1	0/1	0/1	0/1

Comments:

10. Eight of the nine individuals had a current behavioral health assessment (BHA). (Individual #262's assessment was not dated, however, it was considered current based upon the contents of the report.) The exception was Individual #440. Although a draft assessment was included in the document request, the facility identified a March 2018 report as her current assessment.

Assessments for four of the remaining eight individuals (Individual #117, Individual #234, Individual #165, Individual #262) were considered complete. Assessments for Individual #277, Individual #321, Individual #4, and Individual #121 did not include a review of the individual's physical health over the previous year.

12. The FBAs for four individuals (Individual #440, Individual #117, Individual #277, Individual #165) were considered complete. Although direct observations were completed for Individual #234, Individual #121, and Individual #262, no target behaviors were observed. There was no explanation provided as to why additional observations were not necessary. It should be noted that in most

cases, just one observation of 30 minutes was completed. Individual specific comments are outlined below.

- Individual #234's FBA did not identify antecedents and consequences to his targeted problem behaviors.
- Staff continued to use the term "junk" behavior in Individual #165's FBA. This provided no valuable information when trying to determine behavioral function. Further, during the observation, BHS staff turned off his wheelchair, thus preventing him from moving.
- In Individual #4's FBA, it was noted that indirect assessment was not completed for head banging or dropping to the floor because there were no baseline data. Lack of data should not preclude completing this assessment. Two observations noted the presence of yelling, however, in the second observation of one minute, no antecedents were observed or identified. Due to concerns with his aggression, self-injurious behavior, and dropping to the floor, additional observations were warranted

The draft BHA for Individual #4 presented at the meeting of the Behavior Support Committee held during the onsite visit indicated that one Functional Analysis Screening Tool (FAST) had been completed for all of his targeted problem behaviors. As noted by staff who were present, it is important to complete this indirect assessment for each individual targeted problem behavior. Similarly, it would be advisable to have this assessment completed by multiple staff who are familiar with the individual. In one observation, it was noted that staff told Individual #4 that in order to go on a van outing, he must eat his snacks. Unless this contingency is clearly stated in his plan, staff should not be restricting his access to community outings.

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

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

Individuals:

#	Indicator	Overall Score	440	117	234	277	321	165	4	121	262
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	75% 6/8	1/1	0/1	1/1	1/1		1/1	0/1	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% 0/8	0/1	0/1	0/1	0/1		0/1	0/1	0/1	0/1

Comments:

13. Based upon the documents provided, there was evidence that the PBSP was implemented within 14 days of all consents for six of the eight individuals (Individual #440, Individual #234, Individual #277, Individual #121, Individual #262, Individual #165). The exceptions were Individual #117 and Individual #4 whose plans were implemented prior to the approval of the Behavior Support Committee. Tier 2 document 21 showed implementation on 7/18/18 and BSC approval on 11/16/18 for Individual #4, and implementation on 12/20/18 and BSC approval on 1/31/19 for Individual #117.

15. While none of the PBSPs were considered complete, the majority of the plans included operational definitions of both targeted

problem behaviors and replacement behaviors, antecedent and consequent strategies, the training/reinforcement of functionally equivalent replacement behaviors, and clear, precise interventions. Individual specific feedback is provided below.

Regarding positive reinforcement programming:

- While it was positive to review PBSPs that included some type of reinforcement system, these required greater specificity to ensure appropriate implementation.
- When token economies were cited, instructions often noted that tokens could be given for specified behaviors or that the individual could participate in the token store. This implied that staff could use their discretion in implementing this component of the plan. Examples included plans for Individual #440, Individual #121, and Individual #262.
- Similarly, Individual #117's plan noted that he could participate in behavioral contracts deemed appropriate by his home BCBA. Again, if a contract is used, it should include specifications regarding the behavior to be reinforced, the reinforcer to be delivered, and timelines for delivery. There should also be timelines for implementation and review.
- When a copy of Individual #262's contract was requested, a one page document was provided. Under Individual #262's name, the following was written: work one hour AM and PM, shower. This did not give any indication of the date the contract was initiated, how frequently it would be reviewed, how data were tracked, the menu of reinforcers, or the time of exchange.
- A draft behavioral contract was presented for Individual #235 at the Behavior Support Committee meeting held during the onsite visit. The primary focus was for Individual #235 to work five hours each day. If he met this contingency, he would obtain a work note that he could exchange for a snack from the reinforcer store. There were then eight behaviors listed that would result in his inability to access the reinforcer store. These were using profanity, disruptive behavior, visiting homes other than his own, property destruction, taking others' food, taking items belonging to others, aggression, and engaging in behavior that resulted in a call to the behavior coaches. In sum, this was a very negative contingency. Contracts should focus on positive behavior, with reinforcement contingencies clearly delineated. As written, there appeared to be very little reason for Individual #235 to be motivated to attend work. It is suggested that staff first review his work interests and abilities, identify a job to match the same, and then begin with more frequent reinforcement for participating in the activity. As with any contingency, the efficacy of the contract should be reviewed frequently, so that it may be adjusted as needed to ensure success.
- In other plans, directions indicated staff could provide some tangible item to the individual for participating in non-preferred activities (e.g., Individual #165). Again, greater specificity is advised because this suggests that staff can use their discretion in providing reinforcement.
- Materials identified in plans as reinforcers often listed clothing, including socks, shoes, and hats, hygiene items, such as shampoo and conditioner, and basic daily items, including cups. These identified items were found in the plans for Individual #440, Individual #117, and Individual #121. As noted following the last onsite visit, these items constitute basic rights for all individuals. Unless prohibitively expensive, individuals should be allowed to use preferred hygiene products. Similarly, they should be allowed to wear preferred clothing. Staff are advised to either omit these items as identified reinforcers or provide further clarification. For example, one might want to consider accessories that would be considered a special item or purchase by a typically developing consumer.
  In a comment on the draft version of this report, the State wrote that the PBSP needed to include these broad categories even if they really wanted to utilize very specific items, such as Dallas Cowboy drinking cups. That can make sense, but this should be explained clearly in the PBSP so that staff who read the plan do not mistakenly err and make these basic items (clothing, shampoo) contingent.

- Staff are advised to review token economy and behavioral contract guidelines reviewed in *Applied Behavior Analysis* by Cooper, Heron, and Heward (2007).

Regarding antecedent intervening:

- Some good antecedent strategies were found in several plans. Examples included
  - Individual #117's plan which advised staff to "be considerate of his fluid restriction, do not drink or consume beverages in front of him," and guidelines for polite interactions. (Be sure these components of his plan are followed as several staff were observed drinking fluids during his psychiatric clinic.)
  - Individual #234's plan included reducing noise levels or encouraging him to move to a quieter environment when he exhibited precursors to targeted problem behavior, and offering him an alternative activity and/or teaching and reinforcing a request for a break when he did not want to engage in an activity.
- Staff are advised to be careful of developing a chain of behavior in which Individual #234 displays targeted behavior, such as aggression, and then is given a break (an identified function is escape).
- Several plans included guidelines for the use of weighted vests and/or blankets. Staff are advised to carefully analyze the efficacy of these strategies because there is little to no evidence in the research literature that desired outcomes are achieved.

Regarding consequent intervening:

- Concerns were raised following the last visit regarding plans that indicated that PMAB techniques and/or boat pads could be used when necessary. As these had been replaced by SUR techniques and Ukeru pads, respectively, it is suggested that the PBSPs for Individual #234 and Individual #4 should have been revised when these changes were implemented. Further, the draft plan for Individual #440 also referenced boat pads.
- Individual #165's plan included a provision to turn off his wheelchair when he was using this to harm others (i.e., driving into people) or to knock down privacy screens. As this restricts his movement, it is a form of restraint and should be documented accordingly. This was not occurring, nor were data being collected on its use. It was noted that there is a plan to remove the restriction based on the rate of aggression, but the plan of action had not been met. Staff are advised to complete restraint reporting whenever this is used to address aggression. Further, the plan should be revised to remove the use of this strategy when he knocks down privacy screens as this is not putting others at risk of imminent harm.

Regarding other aspects of the PBSPs:

- As has been noted in past reports, staff should stop using the term "junk" behaviors. This term does not operationally define the behaviors for staff and displays a level of disrespect for the individual because these behaviors likely serve an important function. This term was found in the plan for Individual #165.
- Staff are advised to ensure that all PBSPs include the individual's name in the header. The current plans for Individual #165, Individual #121, and Individual #262 included this information.
- In Individual #235's proposed PBSP (also presented at the Behavior Support Committee meeting), it was noted that he was "allowed" in the administration meeting on Tuesdays and Fridays after 3:00 pm. It is suggested that he should be allowed to arrange times to visit with members of the administration so that he may discuss any matters or concerns that he may want addressed.
- In some cases, objectives were not identified for all targeted behaviors. This was true for Individual #440. One of Individual

#277's objectives addressed four different behaviors including insomnia, weight change, food/drink refusal, and crying. As these are documented separately, it would be advisable to have separate goals for each.

- An updated/revised plan was presented for Individual #4 at the Behavior Support Committee meeting. During the discussion, it was recommended that inappropriate sexual behavior be included in disruptive behavior. Staff are advised to reconsider this because the current PBSP notes that these two behaviors serve different functions. It will also be important to identify rates of inappropriate sexual behavior because this could significantly impact his participation in community activities and possible transition to a less restrictive environment.

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

Summary: Counseling was provided to all individuals for whom the IDT it is a needed support. Treatment plans and other documentation existed for all individuals and the content met criteria. This has been the case for all individuals for this review and the previous three reviews, too, with one exception. Therefore, indicator 25 will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 440	117	234	277	321	165	4	121	262
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 4/4	1/1	1/1						1/1	1/1

Comments:

25. Each of the four individuals enrolled in counseling had a complete treatment plan that included measurable, goal directed services. Plans included a data-based criterion for triggering review and identified strategies that would be employed to help the individual generalize learned skills beyond therapy sessions. Cognitive Behavior Therapy was the identified approach. Progress notes included both a narrative and data-based review of the individual's progress.

Unfortunately, the counselor had resigned from his position. The director of behavioral health services reported that the individuals were informed of this matter, with informal counseling services being provided by their assigned behavior health specialists, two of whom were licensed professional counselors. The position was posted with several qualified individuals responding. It was anticipated that the position would be filled by July 2019. In the weeks before submission of this finalized report, the Center wrote that this position was filled with two practitioners beginning employment 6/16/19. One practitioner was a licensed professional counselor and will see approximately 75% of the counseling clients. The second practitioner was a LPC and ASOTP and will see approximately 25% of counseling clients.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Medical Department staff should continue to focus on ensuring the timely completion of annual medical assessments. Center staff also should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
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.	67% 6/9	1/1	1/1	1/1	1/1	0/1	1/1	0/1	0/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: b. For Individual #104, and Individual #91, PCPs did not complete AMAs within 365 days of the previous ones. For Individual #3, the PCP assigned in 2017 did not complete an AMA. Subsequently, a different PCP was assigned to the individual, and this PCP completed the overdue AMA on 7/18/18. On 8/31/18, the PCP then completed the most current AMA. In other words, the individual never had an AMA in 2017, which would have been the AMA used to determine timely completion of the 2018 AMA. The PCP then completed two AMAs in short succession.

c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." Interim reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interim reviews will need to occur more frequently. The IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Center staff should continue to improve the quality of the medical assessments, particularly the plans of care for active medical problems. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116

a.	Individual receives quality AMA.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, family history, social/smoking histories, childhood illnesses, past medical histories, interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, pertinent laboratory information, and updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments include thorough plans of care for each active medical problem, when appropriate.

c. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions [i.e., Individual #165 – cardiac disease, and skin integrity; Individual #4 – weight, and other: headaches; Individual #94 – circulatory, and weight; Individual #284 – constipation/bowel obstruction, and other: pica; Individual #104 – gastrointestinal (GI) problems, and skin integrity; Individual #120 – urinary tract infections (UTIs), and seizures; Individual #3 – UTIs, and GI problems; Individual #91 – cardiac disease, and falls; and Individual #116 – weight, and falls].

As noted above, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.

Summary: 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	165	4	94	284	104	120	3	91	116
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.	17% 3/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	2/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions (i.e., Individual #165 – cardiac disease, and skin integrity; Individual #4 – weight, and other: headaches; Individual #94 – circulatory, and weight; Individual #284 – constipation/bowel obstruction, and other: pica; Individual #104 – GI problems, and skin

integrity; Individual #120 – UTIs, and seizures; Individual #3 – UTIs, and GI problems; Individual #91 – cardiac disease, and falls; and Individual #116 – weight, and falls).

The following IHCPs included action steps to sufficiently address the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations: Individual #104 – skin integrity, and Individual #91 – cardiac disease, and falls.

b. None of the ISPs/IHCPs reviewed defined the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: Individuals did not have timely annual dental exams, and improvement was needed in the quality of both the annual dental exams and annual dental summaries. In assessing Indicator c, the Monitoring Team noticed that a significant number of individuals had not received timely dental summaries. As a result, Indicator a.iii indicator will return to active oversight. On a positive note, the Dental Department was now fully staffed. However, due to the considerable outdated exams and documentation, it likely will take at least a full year to see improvements in the audit scores. Early signs of recovery from this prior gap in dental care were evident, and the Monitoring Team hopes the trend will continue to show improvement.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
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	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	Due to the Center's sustained performance with this indicator, it had moved to the category requiring less oversight. In assessing Indicator c, the Monitoring Team noticed that a significant									

		number of individuals had not received timely dental summaries. As a result, this indicator will return to active oversight.									
b.	Individual receives a comprehensive dental examination.	33% 3/9	0/1	0/1	0/1	1/1	1/1	1/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. For all of the nine individuals reviewed, successful/completed annual dental exams (ADEs) did not occur in a timely manner. Concerns were noted with regard to the following:

- In some cases, individuals did not have exams since 2017 (i.e., Individual #165, Individual #4, Individual #94, Individual #3, and Individual #116.)
- Some of the ADEs reviewed were not in synchrony with the ISPs, in that they occurred after the ISPs were completed.
- In addition, often, the annual dental summaries (ADSs) referred to information from an ADE that was more than 90 days old, which did not provide the IDTs with the information they needed.

On a positive note, the Dental Department was now fully staffed. However, due to the considerable outdated exams and documentation, it likely will take at least a full year to see improvements in the audit scores. Early signs of recovery from this prior gap in dental care were evident, and the Monitoring Team hopes the trend will continue to show improvement.

b. As noted above, for a number of individuals, the most recent dental exams occurred in 2017. It was positive that for three of the nine individuals reviewed who had more recent exams, the dental exams included all of the required components. To provide the Center with feedback, the Monitoring Team reviewed all of the dental exams, even those that were considerably out-of-date. Most, but not all included the following:

- A description of the individual's cooperation;
- An oral hygiene rating completed prior to treatment;
- Periodontal condition/type;
- The recall frequency;
- Caries risk;
- Periodontal risk;
- An oral cancer screening;
- Sedation use;
- A summary of the number of teeth present/missing;
- Treatment provided/completed;
- An odontogram; and,
- A treatment plan.

Moving forward, the Center should focus on ensuring dental exams include, as applicable:

- Information regarding last x-ray(s) and type of x-ray, including the date; and,
- Periodontal charting, updated within the last year, or a justification for not completing it with a plan to complete it.

c. Although some of the dental summaries submitted included many or all of the required components, most of them were based on exams that occurred more than 90 days prior to the ISP meeting with some up to two years old. This meant that the information was largely outdated and of minimal use to the IDTs. To provide the Center with some feedback on the quality of the dental summaries, all of the dental summaries reviewed included the following:

- Effectiveness of pre-treatment sedation;
- Recommendation of need for desensitization or another plan. It remained concerning, though, that when the Dental Department requested a desensitization program, sometimes the Behavioral Health Services (BHS) staff indicated the individual did not qualify for a plan, but did not provide a sound rationale for not developing one;
- The number of teeth present/missing;
- Dental care recommendations;
- Treatment plan, including the recall frequency;
- Provision of written oral hygiene instructions; and
- Recommendations for the risk level for the IRRF.

Most, but not all also included the following:

- A description of the treatment provided (i.e., treatment completed); and,
- Dental conditions that could cause systemic health issues or are caused by systemic health issues.

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.											
Summary: The Monitoring Team will provide findings for this outcome at a later date.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
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.										
	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.										
Summary: The Monitoring Team will provide findings for this outcome at a later date.											

Outcome 4 – Individuals have quality nursing assessments to inform care planning.											
Summary: The Monitoring Team will provide findings for this outcome at a later date.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	Individual receives a quality annual nursing record review.										
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.										
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.										
d.	Individual receives a quality quarterly nursing record review.										
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.										
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.										
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.										

Comments: The Monitoring Team will provide findings for this outcome at a later date.

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: The Monitoring Team will provide findings for this outcome at a later date.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
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.										
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.										
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).										
d.	The IHCP action steps support the goal/objective.										
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).										
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.										
Comments: The Monitoring Team will provide findings for this outcome at a later date.											

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: Since the last review, the Center's performance on these indicators did not improve. As previously recommended, the Center should focus on improving the referral of all individuals that meet criteria for PNMT review, completion of PNMT comprehensive assessments for individuals needing them, and the quality of the PNMT reviews and comprehensive assessments. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall	165	4	94	284	104	120	3	91	116

		Score									
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	20% 1/5	0/1	0/1	N/A	0/1	1/1	N/A	N/A	N/A	0/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	25% 1/4	0/1	1/1		0/1	N/A				0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	25% 1/4	0/1	0/1		0/1	1/1				N/A
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	20% 1/5	0/1	0/1		0/1	1/1				0/1
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.	0% 0/5	0/1	0/1		0/1	0/1				0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/1	N/A	N/A		N/A	N/A				0/1
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4	0/1	0/1		0/1	0/1				N/A

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

- On 5/19/18, staff identified that Individual #165 had a Stage 3 pressure ulcer with osteomyelitis. The Stage 3 ulcer is a criterion for referral to the PNMT. It was not until 12/6/18, that the IDT referred him to the PNMT. During this period, PNMT minutes reflected a commentary on his status that was not based on observations or the other components of a review. Once the IDT made the referral, on 12/6/18, the PNMT completed an assessment quickly and finalized it on 12/12/18. The quality of the assessment is discussed below.
- On 12/19/18, Individual #4 was referred to the PNMT due to weight loss/inability to gain weight. However, according to the weight graph submitted, on 5/3/18, he weighed 108 pounds, and on 6/1/18, his weight had dropped to 102 pounds. This six-pound weight loss in one month represented a 5.6% loss, which should have resulted in an earlier referral to the PNMT, particularly because he already was below his Estimated Desired Weight Range (EDWR) of 111 to 149 pounds. It appeared

that during this time, the PNMT followed him, but did not make a self-referral or conduct a review. He also had a significant history of problems with PNM-related issues, such as swallowing, decreased intake (i.e., in February 2018, it decreased to 69%), falls (i.e., 12 from 2/8/18 to 6/4/18, and seven from 11/2/18 to 3/21/19) and increased use of a wheelchair (i.e., per his "preference"). These multiple issues should have triggered a PNMT comprehensive assessment.

- On 12/13/18, Individual #284 returned from the hospital having had surgery to remove two gloves that were causing a bowel obstruction. On 12/14/18, his IDT referred him to the PNMT. However, the referral/PNMT review did not include the at least 10% weight loss he experienced (i.e., while in the hospital, he lost 14.2 pounds). The ISPA, dated 12/14/18, indicated that the cause of the weight loss was due to his hospitalization. However, the PNMT should have reviewed the weight loss in the context of its potential impact on other PNM-related issues, such as skin integrity, strength, GI issues, etc. On 12/14/18, the PNMT conducted a review of the pica event, but no one from Behavioral Health Services participated in the review. The review lacked detail. For example, the review stated that from a PT perspective, Individual #284 appeared to be at baseline, but provided no functional description or expansion of this statement. The recommendations did not address the need for additional PNMT review for the weight loss. The PNMT concluded that an assessment was not needed, because in 2013, the PNMT completed one. Given that the last assessment was six years prior, Individual #284 engaged in the ingestion of gloves, which placed him at high risk for asphyxiation as well as bowel obstruction, and the weight loss, the PNMT should have conducted a comprehensive assessment.
- From 12/24/18 to 1/16/19, Individual #104 was hospitalized due to a gastrostomy-tube dislodgement and a fistula for which he required a new gastrostomy-tube (G-tube) site and seven clips. During this hospitalization, he also was diagnosed with osteomyelitis of his left foot. On 1/16/19, he returned to the Center, but the following day, he was re-hospitalized and admitted for a GI fistula, which required placement of three more clips. On 1/25/19, he returned to the Center. On 1/28/19, Individual #104's IDT referred him to the PNMT. Appropriately, the PNMT immediately began conducting an assessment, and completed it timely. The quality of the assessment is discussed below.
- In November 2018, Individual #116 was 22 pounds below her EDWR of 110 to 150 pounds. Her IDT did not refer her to the PNMT, nor did the PNMT make a self-referral. From November until April 2019, her weight continued to decrease, but then in May 2019, it increased. On 2/15/19, when her weight reached a low of 81.08 pounds, the PNMT documented: "PNMT assessment or review not warranted due to [Individual #116] having cancer and that is likely the cause." At least a PNMT review was warranted to address the impact of the cancer and cancer treatment on her weight, swallowing, skin integrity, etc.

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

h. As noted above, two individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #4, and Individual

#284).

It was positive that the two assessments the Monitoring Team reviewed included:

- Presenting problem(s);
- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs;
- Review of the applicable risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification; and
- Discussion of medications that might be pertinent to the problem, and discussion of relevance to PNM supports and services.

The following summarizes some of the concerns as well as additional strengths the Monitoring Team noted with the two assessments the PNMT completed:

- For Individual #165, it was good to see that the PNMT observed him in his home/program areas, conducted a thorough review of his current physical status, reviewed his current supports, and identified the need for a new wheelchair to increase alternate positioning due to difficulty with the use of his recliner, and as well as the need for new boots. However, the PNMT assessment did not provide any information about his behavioral concerns, and their potential impact on his PNM-related issues. In identifying potential causes of the Stage 3 pressure ulcer, they only stated that the "root" cause was most likely related to poor circulation requiring a new intervention plan. This analysis did not identify the contributing factors to the development of the pressure ulcer or the delay in identifying it until it was a Stage 3 ulcer. The PNMT concluded that a new plan with medication resulted in improvement with wound healing, but the PNMT provided little information about the specifics of the new plan, or what steps the IDT had in place to prevent the recurrence and/or to ensure early identification of any skin integrity issues.
- For Individual #104, the assessment was primarily a reiteration of Subjective, Objective, Assessment, and Plan (SOAP) notes from other sources, and as such, the PNMT did not provide an actual assessment of the individual's current physical status, and/or conduct its own observation of the individual in various program settings. The PNMT concluded that the current supports were effective, but did not provide data, or information from observations to justify this conclusion.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: Overall, although some improvements were noted, ISPs/IHCPs still did not comprehensively set forth plans to address individuals' PNM needs. In some cases, IDTs had included a number of necessary PNM interventions in individuals' ISPs/IHCPs, which was movement in the right direction. However, the plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps. In addition, often action steps were not measurable. Improvements were noted with the quality of PNMPs/Dining Plans. Center staff should continue to make the needed changes to these important staff instructions. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116

a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	41% 7/17	1/2	1/2	2/2	0/2	2/2	0/2	0/2	1/2	0/1
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	11% 2/18	0/2	0/2	1/2	0/2	0/2	0/2	0/2	1/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	56% 5/9	1/1	0/1	1/1	0/1	1/1	0/1	1/1	0/1	1/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/17	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	41% 7/17	2/2	0/2	1/1	0/2	0/2	0/2	2/2	1/2	1/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	22% 4/18	1/2	1/2	0/2	0/2	0/2	0/2	0/2	1/2	1/2

Comments: The Monitoring Team reviewed 18 PNM issues and as available, the related IHCPs that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: Individual #165 – aspiration, and skin integrity; Individual #4 – aspiration, and weight; Individual #94 – falls, and GI problems; Individual #284 – GI problems, and weight; Individual #104 – GI problems, and aspiration; Individual #120 – aspiration, and choking; Individual #3 – aspiration, and GI problems; Individual #91 – choking, and falls; and Individual #116 – falls, and weight.

a. and b. Although since the last review, some good improvement was noted, ISPs/IHCPs reviewed still frequently did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP. Those that did were for: Individual #165 – skin integrity; Individual #4 – weight; Individual #94 – falls, and GI problems; Individual #104 – GI problems, and aspiration; and Individual #91 – choking.

b. Substantially more work is needed to ensure that IHCPs include the preventative physical and nutritional management interventions to minimize the individuals' risks to the extent possible. In some cases, IDTs had included a number of necessary PNM interventions in individuals' ISPs/IHCPs, which was movement in the right direction. However, the plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps (e.g., if an individual's behavior was a frequent cause of falls, measurable interventions to address the behaviors should be included; or if an individual was at increased risk of choking due to a fast eating pace or improper positioning during meals, then measurable action steps are needed to address these factors). In addition, many action steps were not measurable (e.g., "encourage upright positioning during and after medication pass," "encourage the individual to take small bites," etc.). Those that did include preventative measures were for: Individual #94 – GI problems; and Individual #91 – choking.

c. All individuals reviewed had PNMPs and/or Dining Plans. It was positive that five of the nine individuals had PNMPs and/or Dining Plans that met their needs.

- It also was positive that IDTs reviewed and/or updated all nine PNMPs within the last 12 months, and, as applicable to the individuals' needs, the PNMPs included:
  - Positioning instructions;
  - Transfer instructions;
  - Bathing instructions;
  - Toileting/personal care instructions;
  - Handling precautions or moving instructions; and
  - Medication administration instructions.
- As applicable to the individuals, most, but not all of the PNMPs reviewed included:
  - All applicable risks;
  - Relevant pictures, including those showing the individual properly positioned in bed;
  - Descriptions of assistive/adaptive equipment;
  - Mobility instructions;
  - Mealtime instructions;
  - Oral hygiene instructions; and
  - Complete communication strategies.

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

d. The IHCP that included the steps necessary to meet the measurable goal/objective was for: Individual #91 – choking.

f. The IHCPs that identified triggers and actions to take should they occur were those for: Individual #165 – aspiration, and skin integrity; Individual #94 – GI problems; Individual #3 – aspiration, and GI problems; Individual #91 – choking; and Individual #116 – weight.

g. Often, the IHCPs reviewed did not include the frequency of PNMP monitoring. Those that did were for: Individual #165 – skin integrity, Individual #4 – weight, Individual #91 – choking, and Individual #116 – weight.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	If the individual receives total or supplemental enteral nutrition, the	67%	1/1	N/A	N/A	N/A	0/1	N/A	1/1	N/A	N/A

	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.	2/3									
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.	50% 1/2	1/1				0/1		N/A		
Comments: a. and b. For Individual #104, the IDT's reasoning for not providing therapy or conducting trials of intake by mouth (PO) was not clear. The last Modified Barium Swallow Study (MBSS) noted in the records submitted was completed in 1992, and it showed penetration and aspiration only with thin liquids.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: During this review and the last one, the Center performed well with regard to the timeliness of OT/PT assessments, as well as the provision of the type of OT/PT assessments in accordance with the individuals' needs. If this continues, after the next review, Indicators a.iii, and b might move to the category of less oversight. The quality of OT/PT assessments continues to be an area on which Center staff should focus. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
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.	89% 8/9	0/1	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.	89% 8/9	0/1	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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	N/A									

Comments: a. and b. Eight of the nine individuals reviewed for this indicator received timely OT/PT assessments and/or reassessments based on changes of status. For Individual #165, the Center did not provide evidence that the IDT PT completed a timely assessment for his wheelchair. More specifically, on 5/19/18, staff identified that he had a Stage 3 pressure ulcer. It was not until 12/6/18, that the IDT referred him to the PNMT. During this time, it did not appear that the IDT PT completed an assessment of the individual's wheelchair. An ISPA, dated 12/12/18, indicated that he needed a new wheelchair.

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

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths were used in the development of OT/PT supports and services; and,
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;

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

- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living; and,
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments.

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

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

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

Summary: 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. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 165	4	94	284	104	120	3	91	116
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	Due to the Center's sustained performance with this indicator, it has moved to the category of 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.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	100% 6/6	1/1	1/1	1/1	1/1	1/1	N/A	N/A	N/A	1/1

Comments: a. The ISPs reviewed did not include concise, but thorough descriptions of individuals' OT/PT functional statuses. Overall, the ISPs lacked a cohesive summary of OT/PT related skills and status. Therapists should work with QIDPs to make improvements.

c. Individual #284's OT/PT assessment referenced a consult for an adult tricycle, dated 3/8/18, with recommendations to wear a helmet when riding, as well as for consultation with the behavioral health staff to encourage him to use the equipment. PT provided the equipment, but ISP monthly notes provided no data reflecting that he was encouraged to ride from July 2018 through November

2018.

d. For six of six individuals, IDTs held ISPA meetings as needed to review and approve OT/PT assessment recommendations for the initiation of or modification to therapy services and supports. Examples included, but were not limited to, the IDT meeting in response to Individual #165's fall that occurred on 9/22/18, during which the IDT included a review of and change to his transfer methods; Individual #4's IDT met on 11/2/18, to discuss the use of a wedge to allow him to take naps after meals; and 94's IDT met on 3/6/19, to review the PT's recommendation for the care of the cast.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.

Summary: It was positive that for this review, and the previous two reviews, individuals reviewed received the type of assessments that were in accordance with their needs (Round 12 – 100%, Round 13 – 100%, and Round 14 – 100%), and that SLPs completed these assessments timely (Round 12 – 100%, Round 13 – 100%, and Round 14 – 100%). As a result, Indicator a.iii, and Indicator b will move to the category requiring less oversight. However, significant work is needed to improve the quality of communication assessments in order to ensure that SLPs provide IDTs with clear understandings of individuals' functional communication status; AAC options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated. The remaining indicators will continue in active oversight.

Individuals:

#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									

	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	N/A									

Comments: d. It was positive that all of the nine comprehensive assessments reviewed met criteria, as applicable, with regard to:

- The individual's preferences and strengths are used in the development of communication supports and services; and,
- Evidence of collaboration between Speech Therapy and Behavioral Health Services, as indicated.

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

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- 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; and,
- A comparative analysis of current communication function with previous assessments.

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

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and

services;

- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs [including AAC, EC, or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services; and,
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

Summary: It was good to see that all ISPs reviewed included a description of how the individual communicates and how staff should communicate with the individual. If Center staff sustain this progress, after the next review, Indicator a might move to the category of less oversight. QIDPs and SLPs should work together to make sure IDTs also discuss and include information related to individuals' Communication Dictionaries in ISPs. Although ISPs included strategies and programs recommended in assessments, as discussed elsewhere, assessments were incomplete, and did not fully identify and address individuals' needs. These indicators will continue in active oversight.

Individuals:

#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/7	0/1	0/1	N/A	N/A	0/1	0/1	0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: a. ISPs reviewed for all nine individuals included functional descriptions of their communication skills.

b. None of the ISPs reviewed for nine individuals provided clear evidence of what the IDT reviewed, revised, and/or approved, and/or whether the current Communication Dictionary was effective at bridging the communication gap.

c. Although ISPs included strategies and programs recommended in assessments, as discussed elsewhere, assessments were incomplete, and did not fully identify and address individuals' needs.

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: All individuals had at least one SAP, though the individuals would have benefited from additional SAPs. The Monitoring Team looks to score three of each individual's SAPs. One-third of the individuals had three or more SAPs; two-thirds had one or two SAPs. Indicator 1 will remain in active monitoring. More SAPs were based on assessments than in previous reviews (indicator 3), but even so, many did not meet criteria for being practical, functional, and meaningful (indicator 4). It was very positive to see that about two-thirds of the SAPs had data and that those data were deemed to be reliable. This was the first time the Center scored anything other than 0% for this indicator (5). Indicators 3, 4, and 5 will also remain in active monitoring.

Individuals:

#	Indicator	Overall Score	440	117	234	277	321	165	4	121	262
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
3	The individual's SAPs were based on assessment results.	95% 19/20	1/2	3/3	2/2	2/2	1/1	2/2	2/2	3/3	3/3
4	SAPs are practical, functional, and meaningful.	35% 7/20	0/2	0/3	1/2	0/2	0/1	0/2	2/2	1/3	3/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	70% 14/20	2/2	3/3	0/2	1/2	1/1	1/2	2/2	3/3	1/3

Comments:
1-2. All of the individuals had skill acquisition plans (SAPs). Three SAPs were reviewed for Individual #117, Individual #121, and Individual #262. Five of the remaining six individuals (Individual #440, Individual #234, Individual #277, Individual #165, Individual

#4), had two SAPs. Individual #321 had one SAP.

3. Nineteen of the 20 SAPs were based on assessment results. The exception was Individual #440's count money SAP. Both her FSA and current level of performance identified in the SAP suggested that she already had good money skills.

4. Seven of the 20 SAPs were considered practical, functional, and/or meaningful. These were the following:

- Individual #234's tie bag SAP that could increase his independence in both vocational and domestic skills;
- Individual #4's storing his belongings SAP, so he can find preferred items easily, and make a pizza SAP, a preferred food;
- Individual #121's administering her medication SAP; and
- Individual #262's cut food, safety signs, and breathing treatment SAPs, all of which will increase his independence and prepare him for a move to the community.

The remaining 13 SAPs were not practical, functional, and/or meaningful for the following reasons: the individual demonstrated all or most of the skill components, suggesting the terminal objective could be met through incidental teaching; the SAP, as written, was very confusing with contradictory information throughout; the same level of prompting was required after two years of teaching; the SAP did not address the identified goal; or the SAP focused on a non-preferred activity.

5. Of the 20 SAPs, there was evidence that all had been monitored at least once in the past six months for data reliability. Inter-observer agreement averaged better than 80% in all, but six, SAPs. The exceptions were the two SAPs for Individual #234, the mix Jell-O SAP for Individual #277, the calendar SAP for Individual #165, and the cut food and breathing treatment SAPs for Individual #262. This was a nice improvement, the first time that Lubbock SSLC did not score 0% on this indicator.

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: Indicators 10 and 11 did not maintain high performance; for the first time for indicator 10 and for the second consecutive time for indicator 11. Performance must be improved or these two indicators might be moved back to active monitoring after the next review. The Monitor has provided detailed comments on these two indicators below.

Performance on indicator 12 remained about the same as at the last review. That is, at about one-third. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 440	117	234	277	321	165	4	121	262
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	1/1	1/1	0/1	0/1	0/1	1/1

Comments:

10. Seven of the nine individuals had a current FSA, PSI, and vocational assessment. The exceptions were Individual #277 and Individual #321, both of whom had a day program assessment in lieu of a vocational assessment. As Individual #277 was in her 50s, it is suggested that a vocational assessment is warranted. Individual #321's day program assessment referenced another individual throughout much of the report, therefore, this did not meet this indicator.

Staff are also advised to ensure that the vocational assessment explores a range of work skills, in a variety of environments, and includes situational assessments. The current assessments were quite limited in scope, particularly for Individual #234, Individual #165, and Individual #262, with very little information provided regarding the individual's skills and preferences.

11. According to the QIDP tracking document, the FSA, PSI, and vocational assessment was available to the IDT 10 days prior to the ISP meeting for six of the nine individuals. The exceptions were Individual #440, Individual #165, and Individual #121. For each of these individuals, the FSA was submitted after the identified due date.

12. Recommendations for skill acquisition were found in both the FSA and vocational or day program assessments for three of the nine individuals (Individual #277, Individual #321, Individual #262). It should be noted, however, that even for these three individuals, these recommendations were limited in number and scope. In fact, both of Individual #321's assessments included the same, single recommendation for him to learn to open a door. For the remaining six individuals, their vocational assessments did not include recommendations for skill acquisition. As has been noted previously, the FSA assesses skills across 13 domains. Identifying needs across a range of skill areas would make this assessment more meaningful and useful to the individual's 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.

This domain contains 40 outcomes and 176 underlying indicators related to the provision of clinical services. At the time of the last review, 30 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, two additional indicators in the area of psychiatry will move to the category of less oversight. One in dental will return to active oversight.

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

Goals/Objectives and Review of Progress

Psychiatry quarterly review documentation contained the required content for all individuals.

The notes of the behavioral health and the psychiatric teams indicated that there was collaboration between the departments. The BHS documentation routinely referenced the psychiatric aspects of treatment and vice-versa. The psychiatrists routinely attend the clinics of both of the neurologists.

In behavioral health, there were problems with the content of the progress notes (detailed comments are provided in that section of the report below). Graphs continued to not meet criteria.

There was good discussion and interaction at the Behavior Support Committee meeting. Staff participated, offering suggestions and asking questions for clarification. Staff were willing to listen to recommendations without any defensiveness.

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

Acute Illnesses/Occurrences

Since the last review, improvements were noted with regard to PCPs' follow-up upon individuals' returns from hospital visits. However, work is still needed with regard to PCPs' follow-up for acute issues addressed at the Center, and PCPs' assessments of individuals prior to their transfer to hospitals.

Based on the two dental emergencies reviewed for one individual, the Dentist provided the individual with needed dental care. However, the Dental Department needs to document the exact time that staff or an individual notifies them of a possible dental emergency. This is important so that the Dental Department can then initiate timely dental services.

In psychiatry, when Lubbock SSLC collects reliable data on psychiatric indicators, progress can be determined. Even so, when individuals were clearly experiencing problems with their psychiatric condition, psychiatrists (and IDTs) took action.

Implementation of Plans

Psychiatrist participation in the development of the PBSP improved, due at least in part, to the procedures put into place after the last review.

In behavioral health, without data that met criteria with indicator 5, the Monitoring Team could not determine progress. The Center's data, however, reported that some individuals were making progress (none had yet met their goals). When Center data showed no progress, actions were not proposed (and then there were no actions taken).

For one-quarter of the individuals, sufficient numbers of staff were trained in their PBSPs, a slight increase from the last review. Behavioral health data collection systems needed improvement. Treatment integrity assessment protocols need to be improved, too.

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

Since the last review, some improvements were noted with regard to PCPs' timely review of non-Facility consultations. However, considerable attention still is needed to ensure that PCPs write orders for agreed-upon recommendations.

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

Of significant concern, only one IHCP reviewed included action steps for the PCP to complete. Although the PCP implemented the few action steps in this one IHCP, the Center's performance on the implementation of medical interventions cannot fully be judged until IHCPs include full sets of related action steps.

Vacancies and staff changes as well as individuals' refusals to participate in dental treatment contributed to lapses in dental care. The Dental Department was now fully staffed and was working to address individuals' dental needs, but the backlog of needed care was significant. The Center should continue to focus on the provision and quality of dental treatment.

In comparison with the last few reviews, the Clinical Pharmacist has continued to make improvements with regard to the quality of the Quarterly Drug Regimen Reviews (QDRRs), which is good to see. The few issues identified related to fully addressing the most recent lab values.

As has been the case for the last several reviews, the large majority of IHCPs reviewed did not include 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.

Proper fit of adaptive equipment was sometimes still an issue.

Based on observations, there were still numerous instances (45% of 38 observations) in which staff were not implementing individuals' PNMPs/Dining Plans or were implementing them incorrectly. PNMPs/Dining Plans are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Their implementation is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
Summary: It was good to see that three of the four review content indicators met criteria (20, 21, 23). Across the other indicators, some improved and some decreased. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	4								
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	0% 0/1	0/1								
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs	100% 1/1	1/1								

	existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.										
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 1/1	1/1								
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 1/1	1/1								
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	0% 0/1	0/1								
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	100% 1/1	1/1								
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).										
26	The PBSP was complete.	N/A									
27	The crisis intervention plan was complete.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	100% 1/1	1/1								
29	If the individual was placed in crisis intervention restraint more than	0%	0/1								

	three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	0/1									

Comments:
18-19. Between 12/9/18 and 12/12/18, physical restraint had been implemented with Individual #4 three times. Additionally, on each of these days, chemical restraint was administered. The IDT met on 1/3/19, more than 10 business days following the fourth restraint. The IDT did meet a sufficient number of times to address these repeated restraints.

20. The minutes from the ISPA meeting did reflect a discussion of Individual #4's adaptive skills, and biological, medical, and psychosocial issues. The minutes, however, suggest a misunderstanding of adaptive skills because these were noted as one variable that "may lead to attacking his peers or staff." Additionally, it was noted that the PBSP was reviewed with staff "as needed to prevent further adaptive behaviors." Adaptive behaviors are desirable skills that increase an individual's ability to function more effectively and independently in his or her environment.

Individual #4's communication abilities were reviewed and the IDT agreed to continue to use a visual communication card that would allow Individual #4 to choose a preferred activity and reinforcer once each hour. It is suggested that additional steps be taken to expand Individual #4's communication repertoire. Regarding biological or medical issues, the IDT did pursue a gastrointestinal consult for Individual #4. Action steps were pending the results of the completed exam and procedures.

21. When reviewing environmental conditions, it was noted that his living area was crowded with furniture that could cause Individual #4 to trip and fall. This could result in his becoming agitated. The plan was to "declutter" the environment by replacing sofas, tables, and chairs with recliners. This would result in reducing the furniture that he might run into and limit the items available for him to hit his head against. This is a residence for several individuals, so staff must assure that they are providing both a safe and home-like environment for all.

22. One environmental antecedent that was identified in a review of these restraints was the presence of unfamiliar staff. It was suggested that "pulled" or substitute staff should not be assigned to work with Individual #4. As it was not always possible to assign veteran staff to work with Individual #4, staff were advised to contact behavioral health services staff for training and/or assistance. The review of the restraints implemented on 12/12/18 and 12/17/18 did not identify immediate antecedents.

23. The consequences of Individual #4's behaviors that resulted in restraint were identified as access to preferred items and escape from non-preferred activities or tasks. His PBSP did indicate that his communication card should be used at least once every hour and that he should be offered a break when he states "No" or shakes his head. While these are good strategies, additional communication training is recommended.

26. Individual #4's PBSP was reviewed in detail in the Psychology/Behavioral Health section of this report.

27. Individual #4's CIP specified the maximum duration of restraint and identified the criteria for termination of the restraint. But specific types of authorized restraint were not delineated, so this indicator was rated zero (it noted that all approved SUR restraints could be used.) The CIP did not clearly define a behavioral crisis that would warrant physical restraint. The definition was not

significantly different than the operational definitions provided of targeted problem behaviors in his PBSP. While circumstances warranting the use of chemical restraint were outlined, there were concerns with one identified situation. It was noted that "if a physical restraint has been attempted or successfully used" chemical restraint may be requested. If the crisis has been successfully managed, there would be no reason to pursue a chemical restraint.

28. Individual #4's progress notes indicated that treatment integrity was assessed once each month between November 2018 and January 2019.

29. Although the PBSP was reviewed by the team, identified changes were not evident in the plan that was in place at the time of the onsite visit. Specifically, the minutes from the ISPA noted that Individual #4 would have to wait 20 minutes rather than 30 minutes to receive edible reinforcement following an occurrence of problem behavior. His PBSP had not been revised to reflect this change.

Additional comments:

- Included in the minutes from the ISPA meeting were reviews of the restraints implemented in December 2018. In the description of events, it was noted that behavioral health services staff provided Individual #4 with a drink (i.e., a Coke or Kool-Aid) and a radio head set shortly after he stopped exhibiting targeted problem behaviors. As his PBSP clearly indicated that edible reinforcers should be delayed 30 minutes after the occurrence of problem behavior, professional staff were not following his plan. It is essential that behavioral health services staff follow plans as written, so that appropriate modeling is provided to all direct support professionals.
- Helmet: Part of Individual #4's PNMP was for him to wear a soft-shell helmet for safety due to his history of falling. There were no additional guidelines for using the helmet. It was unclear when the helmet should be placed on, times when the helmet should be removed, or strategies to use when Individual #4 refused to wear the helmet. Further, when data were requested regarding the use of the helmet, the facility reported that this was a support, not a restriction, and therefore data were not required. However, at an ISPA on 8/24/18, the IDT discussed a plan for when he refused to wear his helmet. It was noted that the helmet was implemented as a protective device on 4/30/18 due to a trend of unintentional falls. However, the IDT also noted that the helmet was helpful for when Individual #4 was displaying targeted problem behaviors including head banging although this was not the intended purpose. The IDT then discussed that staff can encourage him to place his helmet on when he is displaying targeted problem behaviors, and if he refuses, staff should wait five minutes before re-prompting. The team agreed to collect data and meet again to determine whether the helmet should be implemented for behavioral reasons. At an ISPA meeting on 10/24/18, the IDT reviewed Individual #4's continuing to remove his helmet particularly when upset. It was reported that over one month's time, he removed his helmet 16 times while exhibiting problem behaviors. No injuries occurred and while the helmet continued to be used to address his history of unintentional falls, this had not occurred since 6/30/18. The team agreed to continue the use of the helmet, due to his history, and agreed it was not a mechanical restraint because Ukeru pads can be utilized when he engages in self-injurious behavior. At this same meeting, it was reported that a helmet tracking sheet was to be completed by direct support professionals. It was also noted at an ISPA meeting on 1/29/19 that staff would document times when Individual #4 was not wearing the helmet. But, no data were available when requested.
    - It is suggested that habilitation therapies and behavioral health services staff work collaboratively with direct support professionals to try to teach Individual #4 safer walking practices. Resorting to a helmet for protection may be too intrusive without making every effort to teach him to walk more slowly and skillfully.

- Several staff reported that the helmet was used to protect Individual #4 from his self-injurious behavior, however, ISPA minutes and the director of behavioral health services indicated that this was not the primary purpose. Based upon the documentation reviewed and discussions with staff, it remained unclear whether or not the helmet was, in fact, being used for dual purposes (i.e., falls and problem behaviors). It would be wise to ensure staff have a clear understanding of the purpose of the helmet with specific guidelines provided regarding its use.

- In ISPA minutes and in his PNMP it was noted that staff could offer Individual #4 a wheelchair when he was unsteady or as he preferred. This is a young man who can ambulate independently. As has been observed with other individuals, over time this may lead to his walking less and relying on a wheelchair as his primary means of navigating his environment. Walking is a skill that needs to be maintained and supported. When data on the use of the wheelchair was requested, the facility noted that this was a support rather than a restriction and therefore data were not required.

Psychiatry

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

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: When Lubbock SSLC collects reliable data on psychiatric indicators, progress can be determined. Even so, when individuals were clearly experiencing problems with their psychiatric condition, psychiatrists (and IDTs) took action. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	440	117	234	277	321	165	4	121	262
8	The individual is making progress and/or maintaining stability.	0% 0/8	0/2	0/2	0/2	0/2		0/2	0/2	0/2	0/2
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/8	0/1	0/1	0/1	0/1		0/1	0/1	0/1	0/1

10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 8/8	1/1	1/1	1/1	1/1		1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 8/8	1/1	1/1	1/1	1/1		1/1	1/1	1/1	1/1

Comments:
8. There was insufficient information for Individual #121 because she was recently readmitted. Without reliable data on psychiatric indicators (indicator 7), however, true determination of progress could not be made. That being said, based on the Center's own report, of the other seven individuals Individual #277, Individual #165, and Individual #262 were considered to be improving, while Individual #440 and Individual #117 were determined to be stable. Individual #234 and Individual #4 were not considered to be stable or improving.

9. The individuals who had met objectives, based on the Center's data, were Individual #277, Individual #165, and Individual #262. The objectives were changed based on this progress. The changes were made in the quarterly reviews based on the data generated during the prior three months.

10. There was ample evidence in the psychiatric interim notes as well as the quarterlies that when an individual's status was deteriorating, the psychiatric team would intervene and make revisions to the individual's treatment.

11. These interventions were routinely implemented.

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

Summary: The cross-documentation requirements of indicator 23 were met for all individuals for this review and for the past two reviews, too, with one exception. Due to this sustained high performance, indicator 23 will be moved to the category of requiring less oversight. Performance improved for indicator 24, regarding psychiatrist participation in the development of the PBSP, due at least in part, to the procedures put into place after the last review. Indicator 24 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	440	117	234	277	321	165	4	121	262
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	100% 8/8	1/1	1/1	1/1	1/1		1/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	88% 7/8	1/1	1/1	1/1	1/1		0/1	1/1	1/1	1/1

Comments:

23. There was detailed documentation in the behavioral sections of the record that referred to the psychiatric diagnosis and its relevance to the individual's behavioral prevention. There were also references in the psychiatric sections of the record to the behavioral data and the influence of environmental factors.

24. The psychiatrist regularly attended the meetings of the Behavioral Support Committee during which the behavioral plans were reviewed, edited, and finalized. The 5/8/19 meeting was attended by the Monitoring Team. Both of the facility psychiatrists attended this meeting. The psychiatrist signed the final behavioral support authorization plan. These signed forms were the primary evidence of the psychiatrist's participation in the development of the behavioral plans and were present for all of the individuals in the review group, except Individual #165.

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

Summary:			Individuals:								
#	Indicator	Overall Score									
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
26	Frequency was at least annual.										
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.										

Comments:

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.

Summary: Quarterly psychiatric review documentation contained the required content for all individuals. This was the case for this previous two reviews, too. Therefore, indicator 34 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	440	117	234	277	321	165	4	121	262
33	Quarterly reviews were completed quarterly.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
34	Quarterly reviews contained required content.	100% 8/8	1/1	1/1	1/1	1/1		1/1	1/1	1/1	1/1
35	The individual's psychiatric clinic, as observed, included the standard components.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

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

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.												
Summary: The MOSES and AIMS were performed and reviewed in a timely manner for most of the individuals, but for Individual #117 there were more than three months between AIMS evaluations, and for Individual #4 there was a delayed review of a MOSES evaluation. This indicator will remain in the category of less oversight.			Individuals:									
#	Indicator	Overall Score										
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments:												

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

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.												
Summary: These indicators remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	440	117	234	277	321	165	4	121	262	
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 8/8	1/1	1/1	1/1	1/1		1/1	1/1	1/1	1/1	
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 8/8	1/1	1/1	1/1	1/1		1/1	1/1	1/1	1/1	
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 8/8	1/1	1/1	1/1	1/1		1/1	1/1	1/1	1/1	

43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A									
Comments:											

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

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.										
Summary: Without data that met criteria with indicator 5, progress could not be determined by the Monitoring Team. The Center's data, however, reported that some individuals were making progress (none had yet met their goals). When Center data showed no progress, actions were not proposed (and then there were no actions taken). This set of indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	440	117	234	277	321	165	4	121	262
6	The individual is making expected progress	0% 0/8	0/1	0/1	0/1	0/1		0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A									
8	If the individual was not making progress, worsening, and/or not	0%	0/1	0/1	0/1	0/1		0/1	0/1	0/1	0/1

	stable, corrective actions were identified/suggested.	0/8									
9	Activity and/or revisions to treatment were implemented.	N/A									

Comments:
6. The graphs for Individual #4 and Individual #262 suggested that most of their targeted problem behaviors and replacement behaviors were progressing. The raw data included in Individual #4's process notes suggested improvement, however, the graphs were incomplete and did not reflect the same measure. For the remaining five individuals, data suggested that they were not making progress on at least half of their targeted problem behaviors and replacement behavior(s). For all eight individuals, data reliability was not demonstrated, thus, it is impossible to determine progress, which results in a zero score for each individual.

7. This indicator is rated as not applicable because none of the individuals had met their objectives according to the Center's own data.

8. The progress notes did not identify or suggest corrective actions when the individual was reported by the Center to not be making progress.

9. Corrective actions were not identified, so this indicator is rated not applicable.

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

Summary: For one-quarter of the individuals, sufficient numbers of staff were trained in their PBSPs, a slight increase from the last review. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 440	117	234	277	321	165	4	121	262
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.	25% 2/8	1/1	0/1	0/1	0/1		0/1	0/1	1/1	0/1
17	There was a PBSP summary for float staff.	Due to the Center's sustained performance, this indicator was 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 #440 and Individual #121. For the remaining six individuals, documentation indicated that between 40% (Individual #262) and 78% (Individual #165) of their assigned staff had received training on the PBSP.

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

Summary: For the first time, Lubbock SSLC scored less than 100% on indicator 19 regarding the completion of progress notes. Due to the history of high performance, the indicator will remain in the category of requiring less oversight. The Monitoring Team, however, also found problems with the content of the progress notes and has provided some detailed comments regarding this below.

Graphs (indicator 20) continued to not meet criteria. Performance on the other three indicators, regarding team reviews and data, continued to show fluctuation from one monitoring review to the next, that is, up and down. These four indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 440	117	234	277	321	165	4	121	262
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% 0/8	0/1	0/1	0/1	0/1		0/1	0/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 2/2		1/1					1/1		
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	50% 1/2	1/1						0/1		
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100%									

Comments:

19. Six of the eight individuals with PBSPs had monthly progress notes. The exceptions were Individual #165 and Individual #262. While the progress notes did comment on the individual's progress, there was not timely analysis of progress. Individual #277 and Individual #4 were the only individuals for whom a review of progress was completed each month.

For all others, progress was not consistently assessed within one month's time. In Individual #121's case, progress notes for September 2018 through February 2019 were completed in April 2019 after the document request was submitted. Progress notes have utility only when there is ongoing review of the efficacy of all interventions. Comments are provided below.

- The graphs displayed in Individual #165's progress notes did not always correspond to the identified targeted problem behaviors and replacement behaviors.

- Although Individual #4's PBSP was implemented in July 2018, there were still no reported baseline measures for head banging and dropping to the floor by February 2019.
- As depicted in the progress notes for Individual #121, graphs suggested zero rates of identified behaviors before September 2018 and after February 2019. She was readmitted to the facility in September 2018, therefore, the only data reviewed should have been from September 2018 through February 2019.
- There was an increase in Individual #262's disruptive behavior following his grandmother's visits. However, according to an ISPA held in April 2019, the behavior health specialist was going to collect data to assess this hypothesized correlation. Further, rather than addressing what occurred after these visits and developing a strategy to help, it was determined that his grandmother would visit every two weeks rather than every week.

20. Although it was positive to review graphs that presented weekly data, none of the graphs were useful for making treatment decisions. The graphs for Individual #234, Individual #277, and Individual #4 were too small to be easily read. For seven of the eight individuals, graphs were labeled as number/frequency per week/month, yet at least one of their targeted problem behaviors was measured as episodes. Similarly, Individual #165's graphs were labeled intervals per week, yet episodes were documented. In no case were phase change lines consistently used to indicate the introduction of a new or revised PBSP, changes in medication, a significant event, a change in home, etc.

21. During the onsite visit, an observation was conducted during Individual #117's psychiatric clinic and during the Behavior Support Committee meeting at which Individual #4 was presented. In both cases, data were presented and reviewed.

22. Individual #440 and Individual #4 were presented in internal peer review meetings since September 2018. Although the master list of individuals presented in external peer review in the time period from October 2018 through March 2019 included Individual #440, when the minutes were requested, the Center reported that she was last presented to this committee in June 2018.

Individual #440 was reviewed by IPR in February 2019. Two of the recommendations, use of a weighted vest and exercise, were found in her draft PBSP.

Although the minutes from the IPR meeting held in November 2018 included very few recommendations for Individual #4, one was for a dental appointment with TIVA to be set up as soon as possible. When a provider who could administer TIVA was identified following five months without, Individual #4 was not one of the individuals placed on the priority list for dental work. Further, another recommendation was to have chemical restraint medication available on the home, so it could be administered when needed. It is unclear whether this is an approved practice.

23. Over the most recent six-month period (November 2018 through April 2019), internal peer review was held three times each month and external peer review was held once each month.

Outcome 8 – Data are collected correctly and reliably.											
Summary: Data collection systems need improvement to meet criteria with indicator 26. Likely, this will then contribute to obtaining reliable data (indicator 5), too. Treatment integrity assessment protocols need to be improved, too. This set of indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	440	117	234	277	321	165	4	121	262
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	0% 0/8	0/1	0/1	0/1	0/1		0/1	0/1	0/1	0/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	75% 6/8	1/1	1/1	1/1	0/1		1/1	1/1	0/1	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/8	0/1	0/1	0/1	0/1		0/1	0/1	0/1	0/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 8/8	1/1	1/1	1/1	1/1		1/1	1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	38% 3/8	0/1	0/1	0/1	1/1		0/1	0/1	1/1	1/1

Comments:

26. For each of the eight individuals who had a PBSP, at least one of their targeted problem behaviors was defined as an episode. Episodes were separated by two minutes, three minutes, five minutes, or 15 minutes without the occurrence of the behavior. This allows for a great deal of variation in length of reported episodes. Because this included target behaviors that could potentially cause harm to the individual (e.g., self-injury) or others (e.g., physical aggression), a more sensitive measure is advised. It would be more accurate to use a duration measure or a partial interval recording system of short intervals. Similar concerns were raised following the last onsite visit. Additional comments are below:

- Individual #440's suicidal threats/gestures were measured by noting each time these were assessed by behavioral health services staff. This measures staff behavior rather than the individual's behavior.
- Measurement of Individual #117's unauthorized departures was based upon the incident management data base. It is unclear whether the reliability of these data is regularly assessed.

27. It was determined that the data collection systems adequately measured six of the eight individual's replacement behaviors. The exceptions were Individual #277 and Individual #121. Individual #277's plan required clarification as to whether staff were to record her engagement in an approved object use for one minute or two minutes. Clarification was also needed in Individual #121's plan because it was unclear whether staff were to record statements or conversations. Assigned behavioral health specialists are advised to review the data systems found in the plans for Individual #117 and Individual #234 because these may prove cumbersome for staff.

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 problem behavior(s) as indicated in the PBSP.

A request was made for the most recently completed monitoring forms for the eight individuals. The Center provided information for April 2019. For Individual #440, Individual #117, Individual #4, Individual #121, and Individual #262, none of their targeted problem behaviors were observed, yet all received treatment integrity of 100%. The form, as currently designed, only assesses the appropriate use of consequent strategies, there is no review of reinforcement systems, antecedent management, or prevention strategies. These are critical components of all PBSPs. Data timeliness was determined by checking to see that documentation occurred within two hours of this monthly observation. This was not an adequate measure of data timeliness when one considers that data should be recorded at least 12 times each day for every day of the month.

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

30. According to facility guidelines and based upon the data provided in the document request, data timeliness, inter-observer agreement, and treatment integrity were assessed once each month with scores of 80% or better for Individual #277, Individual #121, and Individual #262. However, discrepancies were found when comparing this information to that found in monthly progress notes. In no case, were the scores identical. This raised additional questions about reporting accuracy.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	28% 5/18	0/2	1/2	1/2	0/2	0/2	0/2	0/2	1/2	2/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	necessary action.	0/18									

Comments: a. and b. For nine individuals, the Monitoring Team selected two of their chronic and/or at-risk diagnoses for review (i.e., Individual #165 – cardiac disease, and skin integrity; Individual #4 – weight, and other: headaches; Individual #94 – circulatory, and weight; Individual #284 – constipation/bowel obstruction, and other: pica; Individual #104 – GI problems, and skin integrity; Individual #120 – UTIs, and seizures; Individual #3 – UTIs, and GI problems; Individual #91 – cardiac disease, and falls; and Individual #116 – weight, and falls).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #4 – weight, Individual #94 – weight, Individual #91 – falls, and Individual #116 – weight, and falls.

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

Outcome 4 – Individuals receive preventative care.

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

Individuals:

#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	Individual receives timely preventative care:										
	i. Immunizations	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 3/3	N/A	N/A	N/A	N/A	N/A	1/1	1/1	N/A	1/1
	iii. Breast cancer screening	50% 1/2	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	1/1
	iv. Vision screen	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

		9/9									
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	1/1
	vii. Cervical cancer screening	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1

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

- On 2/22/18, Individual #94 had a mammogram, and an annual follow-up was recommended. Although the Medical Compliance Nurse requested the PCP write an order, at the time of the onsite review, the PCP had not done so.
- On 2/9/00, and 3/22/00, Individual #284 had the varicella vaccine. However, on 5/5/12, a titer showed he was not immune. No further action was taken, according to submitted documentation.

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.

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	165	4	94	284	104	120	3	91	116
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1

Comments: a. As of 4/2/19, Individual #116 had a qualifying condition of incurable cancer for which the oncologist agreed with DNR status, as the risk of further aggressive measures outweighed their benefit. Additionally, palliative care consultation provided several comfort care options.

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Since the last review, improvements were noted with regard to PCPs' follow-up upon individuals' returns from hospital visits. However, work is still needed with regard to PCPs' follow-up for acute issues addressed at the Center, and PCPs' assessments of individuals prior to their transfer to hospitals. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
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.	100% 17/17	2/2	2/2	1/1	2/2	2/2	2/2	2/2	2/2	2/2
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	73% 8/11	0/2	N/A	N/A	2/2	1/1	1/1	2/2	0/1	2/2
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.	86% 6/7	N/A	N/A	1/1	1/2	2/2	1/1	N/A	N/A	1/1
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	25% 1/4			1/1	N/A	0/2	N/A			0/1
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% 7/7			1/1	2/2	2/2	1/1			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% 3/3			N/A	1/1	1/1	1/1			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	100% 7/7			1/1	2/2	2/2	1/1			1/1

	consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.										

Comments: a. For the nine individuals reviewed, the Monitoring Team reviewed 17 acute illnesses addressed at the Center, including: Individual #165 (stasis dermatitis on 3/4/19, and fungal dermatitis on 1/30/19), Individual #4 (emesis on 2/25/19, and unsteady gait on 2/26/19), Individual #94 (rash on 2/14/19), Individual #284 (fever on 2/25/19, and emesis on 3/14/19), Individual #104 (emesis on 12/10/18, and emesis on 1/31/19), Individual #120 (seizure on 2/15/19, and seizure on 3/1/19), Individual #3 (UTI on 12/19/18, and upper respiratory infection on 1/16/19), Individual #91 (emesis on 1/11/19, and anal pain on 3/8/19), and Individual #116 (UTI on 2/27/19, and finger swelling on 2/7/19).

It was good to see that for the individuals reviewed, PCPs assessed the acute issues addressed at the Center according to accepted clinical practice.

b. However, PCPs did not always conduct and/or document needed follow-up. The following provide examples of concerns noted:

- On 3/4/19, the PCP diagnosed Individual #165 with stasis dermatitis, and ordered continued use of Lidex, as well as the addition of a Cetaphil wash of the right leg. The PCP indicated follow-up would occur the following week. According to a PCP IPN, dated 3/8/19, at 7:12 p.m., an exam showed a similar rash, but now desquamation. The PCP ordered continuation of the current medications, and follow-up the following week. However, Center staff submitted no follow-up PCP IPN.
- On 1/30/19, the PCP saw Individual #165 for a rash to his abdomen, and ordered Clotrimazole with follow-up in two weeks. According to a PCP IPN, dated 2/14/19, the Clotrimazole treatment was finished, and the PCP ordered terbinafine. Although a nursing IPN, dated 2/27/19, indicated the PCP saw the individual and ordered EPC cream to the G-tube site, and triamcinolone to the abdomen, and held the Lidex, the PCP did not write a note showing an exam or a treatment plan.
- According to a nursing IPN, dated 3/8/19 at 9:29 a.m., Individual #91 complained of anal pain. In an IPN, dated 3/8/19, at 4:34 p.m., the PCP documented an exam, and the prescription of Anusol, and Colace, with follow-up scheduled in a week. No follow-up PCP IPN was submitted. A nursing IPN, dated 4/2/19, indicated that the last dose of Anusol was scheduled for 4/7/19, but the individual was not complaining of discomfort or pain, when having a bowel movement.

c. For five of the nine individuals reviewed, the Monitoring Team reviewed seven acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #94 (wrist fracture on 3/5/19), Individual #284 (hospitalization for bowel obstruction due to pica on 11/23/18, and ED visit for a seizure on 2/16/19), Individual #104 (hospitalization for health care acquired pneumonia, sepsis, cellulitis, and osteomyelitis of the left foot on 12/24/18; and hospitalization for leaking stoma site, acute respiratory distress, sinus tachycardia, cellulitis of left foot, and osteomyelitis of the foot on 1/17/19), Individual #120 (hospitalization for seizures on 12/9/18), and Individual #116 (ED visit for fall on 11/5/18).

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

- It was positive to see that the following individuals displaying signs/symptoms of acute illness received timely acute medical care, and follow-up care: Individual #94 (wrist fracture on 3/5/19), Individual #284 (ED visit for seizure on 2/16/19), and Individual #120 (hospitalization for seizures on 12/9/18).
- On 11/23/18, Individual #284 was admitted to the hospital for a bowel obstruction due to the ingestion of gloves. The transfer occurred on a holiday, but on the following business day, the PCP did not document a review of the hospital admission. It was

positive, that upon the individual's return from the hospital, the IDT met to discuss a number of strategies that they needed to put in place immediately to address his recovery from surgery, as well as some steps to prevent to the extent possible a recurrence of pica. However, as discussed elsewhere in this report, the IDT/PNMT did not develop and implement a thorough IHCP to address the ongoing risk of this individual's pica behavior. In this case, the PCP conducted needed follow-up to address the individual's recovery from major surgery.

- In assessments that occurred prior to Individual #104's hospitalizations, the PCP did not assess and/or address the individual's vital signs.
- Similarly, on 11/5/18, when Individual #116 went to the ED for a fall, the PCP did not document an assessment of the individual's vital signs, or provide a reason for sending the individual to the ED.

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

Summary: Since the last review, some improvements were noted with regard to PCPs' timely review of non-Facility consultations. However, considerable attention still is needed to ensure that PCPs write orders for agreed-upon recommendations. The remaining indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 165	4	94	284	104	120	3	91	116
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, this indicator moved to the category requiring less oversight.									
b.	PCP completes review within five business days, or sooner if clinically indicated.	87% 13/15	2/2	2/2	2/2	2/2	N/A	1/2	2/2	0/1	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	80% 12/15	2/2	1/2	2/2	0/2		2/2	2/2	1/1	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	57% 8/14	1/2	1/2	1/2	0/1		2/2	1/2	0/1	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	100% 1/1	N/A	N/A	N/A	N/A		N/A	N/A	N/A	1/1

Comments: For eight of the nine individuals reviewed, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed included those for Individual #165 for dermatology on 12/20/18, and wound care on 1/31/19; Individual #4 for GI on 12/5/18, and neurology on 4/10/19; Individual #94 for orthopedics on 4/2/19, and orthopedics on 3/13/19; Individual #284 for neurology on 3/20/19, and surgery on 1/2/19; Individual #120 for neurology on 3/29/19, and endocrinology on 2/6/19; Individual #3 for GI on 1/2/19, and urology on 2/13/19; Individual #91 for neurology on 11/14/18; and Individual #116 for hematology/oncology on 2/14/19, and palliative medicine on 3/25/19.

b. Only two of these reviews did not occur timely (i.e., those for Individual #120 for neurology on 3/29/19, and Individual #91 for neurology on 11/14/18).

c. For the three IPNs that did not meet criterion, the PCP did not indicate whether or not referral to the IDT was warranted.

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:

- For Individual #165 for dermatology on 12/20/18, the PCP did not write an order for Cetaphil until 3/4/19;
- For Individual#4 for neurology on 4/10/19, the PCP did not write an order to recheck blood levels in three months;
- For Individual #94 for orthopedics on 3/13/19, the PCP did not write an order for no weight bearing activities with the right upper extremity;
- On 3/20/19, the neurologist recommended Individual #284 return in three months, but the PCP did not write an order for the follow-up appointment;
- For Individual #3 for urology on 2/13/19, the PCP did not write orders to address the recommendation to push fluids as tolerated, provide good skin care every two hours and pro re nata (PRN, or as needed), provide a daily bath/shower, and administer Aquaphor twice a day; and
- On 11/14/18, the neurologist recommended Individual #91 return in one year, but the PCP did not write an order for the follow-up appointment.

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

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

#	Indicator	Overall Score	Individuals: 165	4	94	284	104	120	3	91	116
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.	33% 6/18	1/2	0/2	0/2	0/2	1/2	1/2	0/2	2/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #165 – cardiac disease, and skin integrity; Individual #4 – weight, and other: headaches; Individual #94 – circulatory, and weight; Individual #284 – constipation/bowel obstruction, and other: pica; Individual #104 – GI problems, and skin integrity; Individual #120 – UTIs, and seizures; Individual #3 – UTIs, and GI problems; Individual #91 – cardiac disease, and falls; and Individual #116 – weight, and falls).

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 PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #165 – skin integrity; Individual #104 – skin integrity; Individual #120 – seizures; Individual #91 – cardiac disease, and falls;

and Individual #116 – falls. The following provide examples of concerns noted:

- In January 2014, Individual #165 was diagnosed with bacterial endocarditis. An echocardiogram, completed on 1/8/14, showed small vegetations on his aortic valve. At that time, he was undergoing treatment for osteomyelitis of his left great toe. On 11/25/15, a follow-up cardiology consult indicated no persistent valvulopathy after antibiotic treatment, and the plan was to recheck the individual yearly. Although the information in the AMA was difficult to follow, the PCP listed many consultations and follow-up tests, but after 2015, no follow-up with cardiology was listed.

- Individual #4 had a history of being underweight, and although a number of tests and interventions had been tried, his PCP with the involvement of his IDT had not fully addressed his underweight status. His EDWR was 111 to 149 pounds. Between July 2018 and April 2019, his weight range was between 102 pounds in July, to 110.12 pounds in April 2019. As discussed below, the accuracy of weight was an issue. The following provides a summary of testing and interventions:
    - In 2018, he was treated twice for H pylori.
    - He was prescribed omeprazole for GERD/gastritis.
    - Celiac disease and pancreatitis were ruled out.
    - He was prescribed cyproheptadine as an appetite stimulant, although according to an ISPA, dated 12/4/18, the IDT did not consider this an effective treatment.
    - On 12/19/18, an MBSS indicated that he aspirated on all liquid consistencies. However, due to his inability to cooperate with a feeding tube, the therapist recommended thin liquids and a chopped diet.

  Some of the specific problems with regard to the evaluation process as well as the development of a treatment plan included:
    - Questions arose about the accuracy of the weights (e.g., September 2018, 105 pounds; October 2018, 112.8 pounds, and November 2018, 108 pounds). The issues were attributed to staff weighing him at different times of the day, wearing different clothing, and using a different scale. A better system for accurate recording of weights was needed, because the lack of accurate weights made it difficult to track his progress or lack thereof.
    - An ISPA, dated 11/8/18, indicated that the IDT was to schedule a dental appointment under sedation to ensure his dental needs were addressed. He had a history of dental decay. However, there was a gap in time when TIVA was not available at the Center. At the time of the Monitoring Team's onsite visit, TIVA had been resumed, but Individual #4 was not on the schedule. When the Monitoring Team member inquired, Dental Department staff were not aware of his priority need. Follow-up was needed to ensure he had a dental exam, and treatment, if needed.
    - It was also hypothesized that he had headaches, associated, at times, with emesis. Although the IDT initially believed that treatment with Excedrin was effective, staff had not consistently documented results over time concerning his neurological symptomatology.
    - A PCP note, dated 11/20/18, indicated that sinus x-rays were ordered, a Gastric Emptying Study was ordered, and an MBSS was pending. The AMA, dated 4/10/19, did not mention the results of a sinus x-ray series, and the individual did not tolerate the Gastric Emptying Study, resulting in emesis.
    - An ISPA, dated 12/4/18, indicated that many dietary changes had been made to accommodate his preferences. However, in reviewing the nutritional section of the AMA, on 6/4/18, the QIDP provided a list of his preferences, and the Dietitian contacted the kitchen. The kitchen staff provided a list that they could accommodate, which reflected only some of these preferences. The IDT noted that when he went home, he ate well. This could be attributed to a better

mood when he visited his parents, or it could have been due to the varied items available at home that were not available through the kitchen. It was not clear that the IDT, with the leadership of the PCP, pursued whether or not his food preferences were a driving factor with his weight issues, and if so, that they developed solutions to the inability of the kitchen to accommodate his needs.

- An IPN, dated 2/23/19, indicated he had emesis when he ate too fast, with staff indicating this was a common occurrence. According to an ISPA, dated 9/19/18, emesis also occurred when staff prompted him to eat large meal portions. At that time, the Dietitian learned that staff had not offered recommended Ensure Plus supplements at meals, even though they were calculated into the caloric intake of his diet. Monitoring of dietary supplements was an outstanding need.
- The location of where he ate apparently affected his mood and behavior, and the ISPA, dated 11/20/18, discussed offering him the option to eat where he would like. Although IDT members raised this issue at the 9/19/18 ISPA meeting, the IDT had not addressed it until the 11/20/18 ISPA meeting.
- An ISPA, dated 1/29/19, noted his ongoing constipation requiring the use of a suppository. On 2/27/19 he had a KUB (i.e., abdominal x-ray), which showed stool throughout his entire colon. The PCP already had prescribed Linzess, and added docusate, and Miralax. A repeat KUB, dated 3/19/19, showed similar findings with stool throughout the entire splenic flexure to the rectum. Miralax dosing was then increased to BID, and a follow up KUB, dated 5/1/19, did not show significant stool burden in the colon. A more reliable method of tracking his bowel movements was needed, so that he does not continue to have discomfort and anorexia from a distended abdomen.
- The SLP also identified esophageal dysmotility as a concern, but there was no further clinical information about this finding. The PCP needed to pursue this potential issue.

- Individual #4 had symptoms and gestures suggesting periodic headaches. A neurology consultation indicated he might have chronic traumatic encephalopathy, due to his head banging behaviors and frequent falls. A helmet was available for his use, but he often removed it and threw it. On 4/28/18, 6/29/18, 11/2/18, 11/12/18, and 1/23/19, he experienced head trauma. At times, he held his head, as if in pain. An 8/1/18 ISPA indicated that he did not have regular medication for pain, but at times, when he exhibited problem behaviors and nursing staff gave him Tylenol, it appeared to calm him. The documentation stated that when the PRN Tylenol was delayed for some reason, he remained aggressive. The 8/1/18 ISPA also stated that with the agreement of the Legally Authorized Representative (LAR), the psychiatrist prescribed Haldol. The PCP ordered Excedrin as a trial, with temporary improvement in his mood. The neurologist recommended a trial of magnesium, and this was ordered, but over time did not indicate benefit. The ISPA, dated 9/7/18, recorded the results of the initial trial of Excedrin with positive effect on his behavior and mood. Over time, the use of Excedrin appeared to have less impact on his mood, behaviors, and gestures that suggested he had headaches. On 2/27/19, an x-ray series of his sinuses was completed and showed he did not have sinusitis. The AMA indicated a magnetic resonance imaging (MRI) scan would be scheduled, but the PCP then believed Individual #4 would not be able lie still, so a CT of the head was completed. This did not show any acute pathology. At ISPA meetings on 7/11/18, and 8/1/18, the IDT agreed to an ongoing referral to an allergist (i.e., originally ordered on 8/1/18). At the 10/11/18 ISPA meeting, the PCP again agreed to refer him to an allergist. An 11/20/18 ISPA indicated that an appointment would not be scheduled until the allergist discussed the case with the PCP. At that time, the Registered Nurse Case Manager (RNCM) notified the PCP and provided paperwork on which the PCP needed to follow up. An ISPA, dated 12/11/18, indicated that Medical Department staff had reminded the PCP several times to follow up, but the appointment was still pending.

Subsequently, this referral was not completed, and at the time of the Monitoring Team's visit, had been discontinued.

On 4/10/19, the SLP recommended increasing his sign language options, including training opportunities. On 6/2/06, Individual #4 was admitted to Lubbock SSLC. Although it is positive that the SLP was now taking this important step, it is unfortunate that 13 years passed, and he did not have an expanded way of communicating. This might allow him to better communicate if he is having headaches or other periodic pain/discomfort, and/or if medication helped. This remained a work in progress.

The evaluation of potential headaches or other discomfort affecting his behaviors was incomplete at this time (i.e. food/environmental allergies). If ongoing evaluation indicates traumatic brain injury/chronic traumatic encephalopathy, then staff need to be trained on signs and symptoms to expect and/or report.

- Individual #94 had all five risks for metabolic syndrome. She was overweight, and had dyslipidemia with low high-density lipoprotein (HDL), above normal diastolic blood pressure, and glucose greater than 100. She was administered lipid-lowering medication, which was effective in controlling her lipid disorder. A lipid panel, dated 7/2/18, reported an HDL of 43, and triglycerides (TG) of 147. A more recent lipid panel, dated 1/8/19, reported an HDL of 39 (goal >50) and TG of 191 (goal <150). An electrocardiogram (EKG), dated 7/5/18, was considered normal. The IHCP indicated variation in her blood pressure, with some readings elevated. However, a comment in the IHCP questioned whether nurses rechecked the elevated blood pressure readings. Consequently, the accuracy of her blood pressure readings remained unclear. In the QDRRs, the Clinical Pharmacist assessed her metabolic risks. Her hemoglobin (Hgb) A1C was monitored every six months. A lipid panel was obtained every six months. Nursing staff measured her waist circumference quarterly.

  Nursing staff provided the psychiatrist her weekly weights. Her body mass index (BMI) from her most recent AMA, dated of 8/2/18, was 32. Her EDWR was 115 to 159 pounds. Over the past year her weight varied from 203.4 pounds in August 2018 to 214 pounds in February 2019, and most recently 204.6 pounds on 5/6/19. She was prescribed a 1200-calorie heart healthy diet with no concentrated sweets, but documentation indicated she did not follow it. She was hypothyroid and received thyroid replacement therapy. The plan of care in the AMA mentioned: "we continue to encourage her to increase her daily physical activity," but there were no specific interventions/programs noted. The IHCP only included an action step for direct support staff to "offer" preferred activities (i.e., to incorporate her stated preferences of swimming, walking, and basketball). No data were found to show the implementation and/or effectiveness of this action step. An ISPA, dated 12/17/18, reported that the IDT set up a reward system to improve her personal hygiene, but that it focused on providing tokens to earn sodas at the diner. This type of reward/motivational system was not helpful in controlling her weight and needed further review. It was unclear if the Dietitian met with the PCP, behavioral health services staff, and the psychiatrist at the same time to address her diet, and the challenges of adhering to the diet. A formal exercise program to increase her HDL and lower weight did not occur or was not included in submitted documents. She was in need of a clear plan to address each of the risk factors, and nursing staff needed to address the accuracy of her blood pressure readings.

- Individual #284 had a history of constipation. An IPN, dated 10/22/18, noted the PCP prescribed Amitiza and Miralax. At that time, a fluid restriction was discontinued (i.e., he had been walking to the residential services building and drinking from the

water fountain, and drinking from the hand washing sinks in the bathroom as well as from shower water). The PCP's plan was to monitor sodium levels. In addition, at that time, the psychiatrist increased Zyprexa due to daily aggression, adding to the anticholinergic burden. The Pharmacist noted that the individual was not receiving the recommended doses of Miralax. On 1/4/19, a KUB indicated possible constipation. On 2/6/19, a KUB showed a possible fecal impaction. He had intermittently required bisacodyl suppositories. From the results of the KUBs and ongoing use of bisacodyl suppositories, further review of his treatment for constipation is needed to address the concern that he is sub-optimally treated.

- Individual #284 had a history of pica. On 8/31/09, during a colonoscopy, a pack of paper was removed from his colon. On 1/8/13, during an EGD, three gloves were removed. On 11/6/18, an ISPA documented an incident on 11/2/18, during which he removed wrapped candy from the pocket of a direct support professional, and rapidly swallowed it without unwrapping it. At that time, staff noted he was wandering all over the home, and to other homes seeking food and drink, grabbing any food items he found, and quickly eating them before staff could stop him and retrieve the item. He then had serial emesis, and on 11/23/18, he was transferred to the ED. An exploratory laparotomy was performed and found gloves in his GI tract. An ISPA, dated 11/26/18, documented the IDT's review of his pica ingestion. The IDT noted that the staffing in his home was less than ICF guidelines. The IDT also indicated that it did not appear that staff completed the pica sweeps of the home correctly each day. To prevent further pica ingestion, in part due to the staples used to close his wound, Individual #284 was to have one-to-one staffing. Staff were to complete in-service training, and the IDT was also to sweep the house four times daily. The IDT was to discuss any items found. The IDT noted that he had access to the entire campus, because he was on routine supervision. The campus had monthly clean-up days already scheduled. The IDT observed considerable trash adjacent to his home and staff were to park across the street. The IDT enlisted behavior coaches to assist with the pica sweeps in the home. Trash cans were removed from the day room in the home, and the IDT requested new bear-proof trashcans for the bathroom.

  An ISPA, dated 12/11/18, reviewed his level of supervision and the number of pica checks per shift the home needed. An ISPA, dated 12/13/18, indicated that upon his return from the hospital, he would require one-to-one staffing while awake, and enhanced staffing once asleep for at least 30 minutes. An ISPA, dated 12/14/18, documented that staff found gloves in the home after he went to the hospital. An ISPA, dated 1/14/19, indicated that once he had no pica incidents (attempts or ingestion) for six consecutive months, that this level of supervision would be reduced or removed. An ISPA, dated 1/2/19, documented that the doors would have delayed egress locks, that signs would be placed on doors for visitors, that pica sweeps would include checking trashcan chutes for items that might have become stuck, and that receptacles would be emptied when 50% full. In addition, staff would increase the environmental awareness days on campus, and paper cups, paper flyers, and water bottles would not be used. Staff were to schedule Individual #284's snack offerings evenly. Although the IDT implemented a number of necessary steps to minimize the recurrence of pica events, they also had missed a number of important ones. For example, it was concerning that scheduled pica sweeps had not been done prior to the event, and that the IDT had not initiated a mechanism (e.g., involvement of QA staff) to double check their thorough completion. The IDT did not address his ability to move about the campus freely. Given that other homes and buildings on campus did not have the frequent pica sweep schedule and the swiftness with which he could identify, obtain, and ingest non-food items, allowing him to enter these buildings increased his risk for a repeat event. Given his history of removing and ingesting items from staff's pockets, it did not appear that the IDT/administration considered requiring staff in the home to not carry items in their pockets or on their person that he could ingest. Monthly campus awareness sweeps appeared insufficient to meet his safety needs.

That the IDT was willing to review decreasing his level of supervision (LOS) after six months of no events was concerning, because the LOS likely assisted in the success of a pica-free interval of time, but once it is removed, his lifelong habit is apt to return. The food foraging suggested that he was frequently hungry, and it might be that the volume of snacks was insufficient to satisfy his appetite. This needed further review.

As the Monitoring Team has repeatedly stressed in previous reports and during conversations with staff on site, the ingestion of inedible objects, particularly items such as gloves, place this individual and others at significant risk of choking, bowel obstruction/perforation, and/or death. The IDT, with the leadership of the PCP, should develop and implement additional steps to prevent pica ingestions to the extent possible.

- Individual #120 had a history of UTIs associated with seizures (i.e., 12/2/15, and 2/11/17). On 7/15/17, a CT of the abdomen and pelvis found no evidence of renal, bladder, or ureteral stones; no hydronephrosis; and no perinephric fluid collection to suggest a cause(s) or complications of recurrent UTIs. There was concentric thickening of the urinary bladder wall suggestive that the individual might have had bladder infections in the past. Information the Center provided for his seizure activity on 12/9/19, did not indicate whether staff observed other signs or symptoms to suggest a UTI [e.g., fever, pre-seizure elevated white blood count (WBC), etc.]. However, a UTI was interpreted as the cause of the seizure [i.e., hospital lab reported that the complete blood count (CBC) indicated normal to low WBC, and a urinalysis (UA) indicated no bacteria, but WBCs were present and leukocyte esterase was moderate]. In the hospital, he started on an antibiotic, and on 12/23/18, this antibiotic was finished. A PCP IPN, dated 1/2/19, indicated that a UA and culture had been repeated, and he was clear of infection. Although he might have had a UTI leading to a seizure, repeating urine cultures for proof of cure is generally not consistent with current antibiotic stewardship program recommendations, as it can lead to resistant UTIs. The rationale for this proof of cure was not indicated in submitted documents. Considering the low WBC and lack of bacteria in the UA, along with pyuria, an infectious disease specialist consultation might provide guidance to the Center staff to address the current practice of test for cure, as well as steps to prevent a future UTI, given the association with a prolonged seizure requiring hospitalization.

- Similarly, for Individual #3, the PCPs did not follow current antibiotic stewardship program recommendations. On 1/5/18, he was treated with Bactrim for a UTI. On 2/9/18, he then was treated with Nitrofurantoin for a UTI, and later switched to Levaquin, based on urine culture results. On 12/17/18, he was diagnosed with pyuria, and started on Bactrim. On 12/19/18, this was changed to Levaquin. On 2/13/19, urology saw him for recurrent UTIs, although no signs or symptoms were listed on the consult request form to indicate active infection, with recommendations to push fluids, control constipation, use of sitz bath and daily showers, application of Aquaphor twice daily, and nitrofurantoin preventive treatment for three months. He was found to have a normal post-void residual, and an abnormal urinalysis. At that time, he was scheduled to have a CT urogram in six weeks. On 2/19/19, he was started on Augmentin, presumably based on a urine culture report. On 3/21/19, a follow-up UA reportedly was negative. However, on 3/26/19, the PCP started him on Cipro after a culture was reported. Plans were to re-culture after completion of the antibiotic. On 4/3/19, he completed a CT urogram. A subsequent urine culture indicated significant bacterial growth, and on 4/4/19, he was placed on Cipro. For these several antibiotic treatment orders, no documentation was found of signs or symptoms of a UTI. In fact, throughout Individual #3's clinical course, there was a paucity of information that the individual had signs or symptoms to suggest ongoing UTIs. Rather, he might simply have been colonized with bacteria.

Based on submitted documentation, the Center Medical Department staff are not prescribing antibiotics consistent with current national antibiotic stewardship protocols. Given the complexities of the intellectual and developmental disability (IDD) population and the additional challenges of supporting many individuals who do not communicate verbally and have multiple comorbidities, an infectious disease specialist might be helpful in developing protocols for judicious use of antibiotics, as well as assisting with antibiotic recommendations from specialists and hospitalists. This individual already had Verona Integron-Mediated Carbapenem-Resistant Pseudomonas Aeruginosa (VIM-CRPA). The ongoing prescriptions of many months of antibiotics in an attempt to sterilize urine was a continuous challenge, and had the potential to lead to resistant organisms. Additionally, although he had "recurrent UTIs" in the past, the PCP did not include a plan of care for UTIs in the AMA, dated 8/31/18.

- Individual #3 had a history of Barrett's esophagus. During a gastric emptying study on 2/4/11, he was noted to have gastroparesis. On 3/22/11, an EGD showed moderate chronic gastritis negative or H pylori, and Barrett's esophagus. On 4/25/11, he underwent circumferential thermal ablation of his long segment Barrett's esophagus. An EGD report, dated 12/16/14, again indicated Barrett's esophagus and chronic gastritis. On 5/16/15, he underwent HALO radiofrequency ablation of his Barrett's esophagus. On 9/6/15, 12/19/15, and 2/26/16, he was hospitalized for GI bleeding. On 12/19/15, a PPI was started to treat a gastric ulcer. On 2/26/17, a G-tube was placed due to the individual's medication refusal, meal refusal, and inability to meet oral hydration needs. He also had dysphagia. On 6/13/17, an EGD found LA grade C reflux esophagitis, and gastritis. On 12/12/18, an EGD report indicated the individual had a medium sized hiatal hernia, Barrett's esophagus negative for dysplasia or malignancy, and acute gastritis, despite ongoing treatment with a PPI and Carafate. On 1/17/19, a G-tube was replaced due to non-function. Overall, a gastroenterologist followed him closely, especially in monitoring the Barrett's esophagus and prescribing medication. However, given the long standing upper gastrointestinal (UGI) pathology (i.e., esophagitis, Barrett's esophagus, and hiatal hernia), in the submitted documentation, the PCP did not discuss with the gastroenterologist whether Individual #3 would be a candidate for surgical treatment, such as a fundoplication, which might reduce reflux and its complications, or whether such consideration was ruled out. Referral to a tertiary care center with specific expertise in this area might be indicated.

- Individual #116 had a history of periods of weight loss in the past as well as presently. For example, in 2007, she was prescribed Cyproheptadine for appetite stimulation, nutritional supplements were given, and she underwent an EGD and colonoscopy due to weight loss. At that time, she was found to have a Barrett's esophagus. In 2010, she had a 15-pound weight loss in one year. An EGD, dated 1/3/11, indicated Barrett's esophagus, but no metaplasia or atypia. In 2014, she again was referred to GI for weight loss, and an elevated carcinoembryonic antigen (CEA). An EGD was done, which again was suspicious for Barret's esophagus. On 10/5/16, an EGD revealed chronic reactive gastropathy of the antral mucosa, but no H pylori infection. Again, Barrett's esophagus was found without dysplasia.

  On 3/24/17, she underwent a left breast mastectomy due to invasive ductal carcinoma. This was followed by dissection of the left axillary lymph nodes. She was placed on tamoxifen. Starting in September 2017, she again began to lose weight. From 98 pounds in September 2017, she has steadily dropped to 81.08 pounds on 2/15/19. On 10/9/18, a nutritional assessment was completed with recommendations for a high-calorie/high-protein diet, which provided 498% of her estimated caloric needs

and 384% of her estimated protein needs per day. On 11/20/18, the IDT documented that the LAR did not agree to a feeding tube, in part because Individual #116 would not tolerate such an invasive step. Documentation indicated that if she was in a "bad" mood, she would refuse meals. On 11/21/18, an ISPA indicated that staff should "encourage" her to consume all her offered food and fluid, and all her Ensure supplement. Staff were to prompt her to eat at a slower pace, and additional preferred snacks would be added. Staff tracked meal refusals (i.e., 15 in October 2018, 11 in November 2018, and three through mid-December 2018). Staff noted that when she ate, she always ate at least 50% of her meals. On 12/19/18, she developed a Stage 1 pressure wound on her sacrum, which as of 1/2/19, had healed.

On 3/25/19, a palliative care consult occurred that suggested pain management was needed. An oncology consult, dated 3/27/19, concurred with a DNR status due to progressive weight loss due to her cancer. Although all completed scans did not show recurrent cancer, her continued weight loss and cancer marker suggested recurrence had occurred. A PCP IPN, dated 3/13/19, noted a low thyroid stimulating hormone (TSH), suggesting hyperthyroid status. The Nurse Practitioner (NP) made a referral to endocrinology, but the consultant's office indicated the first available opening was in December 2019. A referral to another community specialist was then made, but other residents of LBSSLC were already on the list for that provider to see first. A physician did not provide timely guidance to the NP to repeat the test to verify the thyroid function, or to begin medication to treat a potential hyperthyroid state, which were steps that a Medical Director would/should have taken. The Center had been without a Medical Director for several months. Given this individual's continual and significant weight loss and the use of the weight loss to diagnose cancer, confirmation of her hyperthyroid status and treatment, if appropriate, were needed on an urgent basis, but had not occurred prior to the Monitoring Team's visit. In addition, she was on Desmopressin for bedwetting. A side effect of this medication is anorexia/nausea. Oxybutynin has significant anticholinergic side effects, including dry mouth, which can make eating difficult, along with affecting the sense of taste and texture. A review of current medications and their potential impact on her intake also was indicated.

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

Summary: This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1

Comments: a. Of significant concern, only one IHCP reviewed included action steps for the PCP to complete. Although the PCP implemented the few action steps in Individual #116's IHCP for falls, the Center's performance on this indicator cannot fully be judged until IHCPs include full sets of action steps related to medical interventions.

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; recommendations are made about any necessary additional laboratory testing regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.											
Summary: N/R			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	Not rated (N/R)									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: a. and b. The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.											

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
Summary: In comparison with the last few reviews, the Clinical Pharmacist has continued to make improvements with regard to the quality of the QDRRs, which is good to see. The few issues identified related to fully addressing the most recent lab values. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	QDRRs are completed quarterly by the pharmacist.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	83% 15/18	2/2	2/2	2/2	0/2	2/2	1/2	2/2	2/2	2/2
	ii. Benzodiazepine use;	100% 8/8	2/2	2/2	N/A	N/A	N/A	2/2	2/2	N/A	N/A
	iii. Medication polypharmacy;	100% 7/7	2/2	2/2	N/A	N/A	N/A	2/2	N/A	1/1	N/A

	iv. New generation antipsychotic use; and	100% 7/7	2/2	2/2	N/A	2/2	N/A	N/A	N/A	1/1	N/A
	v. Anticholinergic burden.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.										
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	N/R									

Comments: b. In a few instances, the Clinical Pharmacist had not addressed the most recent laboratory results fully. For example:

- For Individual #284, the Clinical Pharmacist did not comment on the olanzapine lab results in either of the QDRRs reviewed.
- For Individual #120, in the QDRR, dated 2/11/19, the Clinical Pharmacist did not use/comment on the most recent lab values for valproic acid, thyroid free T3 and free T4, vimpat/lacosamide, and keppra.

e. As noted with regard to Outcome #1, the Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved and the Monitoring Team is able to identify the full scope of new medications requiring interventions, this indicator is not being rated.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. The Monitoring Team reviewed seven individuals for whom the respective IDTs had determined medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to these dental needs. The IDTs had determined two individuals (Individual #165 and Individual #284) to be at low risk, but the documentation for both indicated they had required TIVA for dental care. As a result of this finding, the IDTs should have identified an elevated risk.

- For Individual #165, the Integrated Risk Rating Form (IRRF), dated 6/27/18, indicated he had required TIVA-assisted dentistry in the past due to uncooperative behavior. His IRRF further indicated the dentist would attempt the next exam without TIVA, but would recommend it for future dental needs if that was unsuccessful. His IDT did develop a dental goal for him, but it was not clinically relevant, achievable, and/or measurable.
- Per the IRRF, dated 2/4/19, Individual #284 required TIVA for his most recent exam due to behavior. The IRRF further stated TIVA would also be considered for future exams if he continued to be uncooperative. The IDT should have developed a goal to address the risk, but did not.

Overall, the respective IDTs developed goals that focused solely on improving or maintaining oral hygiene ratings, but did not address the causes of individuals' dental concerns. The Monitoring Team will be working with State Office on this issue so that State Office can provide more guidance to the Centers. A good way to think about it, though, is: "what would the dentist tell the individual he/she or staff should work on between now and the next visit?" For different individuals, the causes of their dental problems are different, and so the solution or goal should be tailored to the problem. For example, should an individual reduce the amounts of sugary snacks he/she consumes, should an individual brush his/her teeth twice a day for two minutes instead of once a day, should a goal revolve around the individual tolerating tooth brushing for 30 seconds leading up to an eventual two minutes? These are the type of questions IDTs should be asking themselves when deciding upon a goal.

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

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	N/R									
Comments: c. As indicated in the dental audit tool, this indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will be marked "N/R." At the time of the review, State Office had not yet developed and implemented a process to ensure inter-rater reliability with the Centers.											

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: As Center staff are aware, vacancies and staff changes as well as individuals' refusals to participate in dental treatment contributed to lapses in dental care. The Dental Department was now fully staffed and was working to address individuals' dental needs, but the backlog of needed care was significant. The Center should continue to focus on the provision and quality of dental treatment.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
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.	33% 3/9	0/1	0/1	0/1	1/1	1/1	1/1	0/1	0/1	0/1
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	11% 1/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	33% 3/9	0/1	0/1	0/1	1/1	1/1	1/1	0/1	0/1	0/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	0% 0/6	0/1	0/1	0/1	N/A	N/A	N/A	0/1	0/1	0/1
e.	If the individual has need for restorative work, it is completed in a timely manner.	38% 3/8	0/1	0/1	0/1	1/1	N/A	1/1	1/1	0/1	0/1
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.										
Comments: a. through e. Most individuals reviewed had not had some needed dental treatment. Improvement was needed for all											

indicators. As noted above, the Dental Department was now fully staffed and was working to address individuals' dental needs, but the backlog of needed care was significant.

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

Summary: Based on the two dental emergencies reviewed for one individual, the dentist provided the individual with needed dental care. However, the Dental Department needs to document the exact time that staff or an individual notifies them of a possible dental emergency. This is important so that the Dental Department can then initiate timely dental services. These indicators will continue in active monitoring.

#	Indicator	Overall Score	Individuals: 165	4	94	284	104	120	3	91	116
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	50% 1/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/2	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 2/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2/2	N/A
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	100% 2/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2/2	N/A

Comments: a. Based on a review of two dental emergencies for Individual #91, the Center clearly initiated dental services in a timely manner for one of two such emergencies. The Dental Department did not keep or provide clear documentation with regard to this indicator. On site, the Monitoring Team member requested that the Dental Department identify when it was notified of these emergencies, but it was unable to provide that information. The Monitoring Team was able to determine from a review of nursing integrated progress notes (IPNs) that services were initiated in a timely manner for the emergency that occurred on 1/9/19 (i.e., broken tooth), but the Center did not provide IPNs with regard to the occurrence on 10/5/18 (i.e., complaint of sore teeth).

b. through c. In both instances, Individual #91 received needed treatment and pain management consistent with his needs.

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

Summary: In the last report, the Monitoring Team stated: "In order to sustain this [Indicator c] in the category of less oversight, IDTs should ensure that individuals with suction tooth brushing have IHCPs that define the frequency of monitoring (i.e., for quality as well as safety) and it is implemented according to the schedule." For the individuals reviewed, IDTs did not make the needed changes. As a result, Indicator c will return to active oversight. The remaining indicators also will continue in active oversight.

#	Indicator	Overall	Individuals: 165	4	94	284	104	120	3	91	116

		Score									
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	0% 0/4	0/1	N/A	N/A	N/A	0/1	0/1	0/1	N/A	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/4	0/1				0/1	0/1	0/1		
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	Due to the Center's sustained performance with this indicator, it had moved to the category requiring less oversight. However, due to concerns discussed below, it will return to active oversight.									
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/4	0/1				0/1	0/1	0/1		

Comments: a. IDTs included suction tooth brushing strategies/plans in ISPs/IHCPs for each of the four applicable individuals, but the problem was that none of the plans were measurable (i.e., none included the needed duration of brushing).

b. Based on documentation submitted for the period from 1/1/19 to 4/4/19, for three individuals, extensive gaps occurred in the provision of suction tooth brushing, with only a few entries occurring in late March 2019. For Individual #165, the record from 1/1/19 to 4/4/19 did not include any entries to document that suction tooth brushing had occurred. Reasons were not provided for the days/times that staff did not provide individuals with the required tooth brushing support.

c. Although it appeared that Dental Department staff conducted some monitoring of suction tooth brushing equipment, the monitoring was focused on equipment and did not appear to include observation of staff completing the suction tooth brushing to ensure effectiveness of brushing and safety to individuals. In addition, the ISP action plans did not define the frequency of monitoring expected to meet the individuals' needs. As a result, the Monitoring Team could not determine whether or not the frequency was sufficient.

Since the inception of the Dental Audit Tool, in January 2015, the interpretive guidelines for this indicator have read: "Frequency of monitoring should be identified in the individual's ISP/IHCP, and should reflect the clinical intensity necessary to reduce the individual's risk to the extent possible." In the last report, the Monitoring Team explained that IDTs needed to ensure that individuals with suction tooth brushing have IHCPs that define the frequency of monitoring and it is implemented according to the schedule. Based on this review, IDTs did not add this information to IHCPs, so as a result, Indicator c will return to active monitoring.

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

Outcome 9 – Individuals who need them have dentures.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	67% 4/6	N/A	1/1	N/A	N/A	0/1	1/1	1/1	0/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. For four of six individuals reviewed with missing teeth, the Dental Department provided clinical justification for not recommending dentures. For Individual #104 and Individual #91, the assessments did not provide a reason.											

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: The Monitoring Team will provide findings for this outcome at a later date.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.										
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.										
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.										
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.										
e.	The individual has an acute care plan that meets his/her needs.										

f.	The individual's acute care plan is implemented.										
Comments: The Monitoring Team will provide findings for this outcome at a later date.											

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: The Monitoring Team will provide findings for this outcome at a later date.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.										
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.										
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.										
d.	Individual has made progress on his/her goal/objective.										
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.										
Comments: The Monitoring Team will provide findings for this outcome at a later date.											

Outcome 6 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.											
Summary: The Monitoring Team will provide findings for this outcome at a later date.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
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										
b.	When the risk to the individual warranted, there is evidence the team took immediate action.										
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).										
Comments: The Monitoring Team will provide findings for this outcome at a later date.											

Outcome 7 – Individuals receive medications prescribed in a safe manner.											
Summary: The Monitoring Team will provide findings for this outcome at a later date.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R									
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).										
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.										
	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.										
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.										
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.										
h.	Instructions are provided to the individual and staff regarding new	N/R									

	orders or when orders change.										
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: The Monitoring Team will provide findings for this outcome at a later date.											

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: As noted in the last report, the IDTs of a number of individuals reviewed should have made referrals to the PNMT, or the PNMT should have made self-referrals, but this did not occur. In addition, overall, IDTs and/or the PNMT did not have a way to measure clinically relevant goals/outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/12	0/1	0/1	0/2	N/A	0/1	0/2	0/2	0/2	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	33% 4/12	0/1	0/1	1/2		0/1	0/2	0/2	2/2	1/1
	iii. Integrated ISP progress reports include specific data	17%	0/1	0/1	0/2		0/1	0/2	0/2	2/2	0/1

	reflective of the measurable goal/objective;	2/12									
	iv. Individual has made progress on his/her goal/objective; and	0% 0/12	0/1	0/1	0/2		0/1	0/2	0/2	0/2	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/12	0/1	0/1	0/2		0/1	0/2	0/2	0/2	0/1
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	33% 2/6	0/1	0/1	N/A	1/2	1/1	N/A	N/A	N/A	0/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	0/1	0/1		0/2	0/1				0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	17% 1/6	0/1	1/1		0/2	0/1				0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	17% 1/6	0/1	1/1		0/2	0/1				0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/6	0/1	0/1		0/2	0/1				0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/1	0/1		0/2	0/1				0/1

Comments: The Monitoring Team reviewed 12 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: Individual #165 – aspiration; Individual #4 – aspiration; Individual #94 – falls, and GI problems; Individual #104 – GI problems; Individual #120 – aspiration, and choking; Individual #3 – aspiration, and GI problems; Individual #91 – choking, and falls; and Individual #116 - falls.

a.i. and a.ii. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #94 – falls; Individual #91 – choking, and falls; and Individual #116 - falls.

b.i. The Monitoring Team reviewed six areas of need for five individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goals/objectives were included. These areas of need included for: Individual #165 – skin integrity; Individual #4 - weight; Individual #284 – GI problems, and weight; Individual #104 - aspiration; and Individual #116 - weight.

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

- On 5/19/18, staff identified that Individual #165 had a Stage 3 pressure ulcer. It was not until 12/6/18, that the IDT referred

him to the PNMT.

- On 12/19/18, Individual #4 was referred to the PNMT due to weight loss/inability to gain weight. However, according to the weight graph submitted, on 5/3/18, he weighed 108 pounds, and on 6/1/18, his weight had dropped to 102 pounds. This six-pound weight loss in one month represented a 5.6% loss, which should have resulted in a referral to the PNMT, particularly because he already was below his Estimated Desired Weight Range (EDWR) of 111 to 149 pounds. It appeared that during this time, the PNMT followed him, but did not make a self-referral or conduct a review.
- On 12/13/18, Individual #284 returned from the hospital having had surgery to remove two gloves that were causing a bowel obstruction. On 12/14/18, his IDT referred him to the PNMT. However, the referral/PNMT review did not include the at least 10% weight loss he experienced (i.e., while in the hospital, he lost 14.2 pounds). The ISPA, dated 12/14/18, indicated that the cause of the weight loss was due to his hospitalization. However, the PNMT should have reviewed the weight loss in the context of its potential impact on other PNM-related issues, such as skin integrity, strength, GI issues, etc.
- In November 2018, Individual #116 was 22 pounds below her EDWR of 111 to 150 pounds. Her IDT did not refer her to the PNMT, nor did the PNMT make a self-referral. From November until April 2019, her weight continued to decrease, but then in May it increased. On 2/15/19, when her weight had reached a low of 81.08 pounds, the PNMT documented: "PNMT assessment or review not warranted due to [Individual #116] having cancer and that is likely the cause." At least a PNMT review was warranted to address the impact of the cancer and cancer treatment on her weight, swallowing, skin integrity, etc.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT did not develop clinically relevant, achievable, and measurable goals/objectives for these individuals. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #4 - weight.

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

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

Summary: As has been the case for the last several reviews, the large majority of IHCPs reviewed did not include all of the necessary PNM action steps to meet individuals' needs. Many of the PNM action steps that were included were not measurable, making it difficult to collect specific data. Substantially more work is needed to document that individuals receive the PNM supports they require. In addition, in numerous instances, IDTs did not take immediate action, when individuals' PNM risk increased or they experienced changes of status. At this time, these indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116

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.	11% 2/18	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	33% 3/9	0/1	0/2	N/A	0/2	2/2	N/A	N/A	N/A	1/2
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	50% 1/2	1/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. In addition, monthly integrated reviews often did not provide specific information or data about the status of the implementation of the action steps. However, the IHCPs for which documentation was found to confirm the implementation of the PNM action steps that were included were for Individual #165 – aspiration, and Individual #116 - weight.

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

- As discussed elsewhere in this report, on 5/19/18, staff identified that Individual #165 had a Stage 3 pressure ulcer with osteomyelitis, which is a criterion for referral to the PNMT. It was not until 12/6/18, that the IDT referred him to the PNMT. During this time, it did not appear that the IDT PT completed an assessment of the individual's wheelchair. An ISPA, dated 12/12/18, indicated that he needed a new wheelchair. However, although according to Habilitation Therapy staff, they ordered one, as of 5/9/19, Individual #165 did not have a wheelchair that met his current needs. This was particularly concerning, because the PNMT identified that the "root cause" of his pressure ulcer was most likely related to poor circulation, and they recommended the new wheelchair to increase alternate positioning.
- Based on review of PNMT minutes, on 10/11/18, the PNMT discussed the possible need for Individual #4 to undergo an MBSS, but one was not conducted until 12/19/18. It found the individual experienced silent aspiration of thin liquids. The recommendation was to continue with thin liquids and to wait until an EGD was completed before making further decisions. Recommendations such as the use of a spout cup or small sips were not clearly trialed in the MBSS to determine their effectiveness, and the individual's aspiration was silent so staff would not see overt signs and symptoms. An EGD was originally scheduled for 12/27/18, but was accidently cancelled, and on 1/17/19, it was eventually completed. No evidence was found that Habilitation Therapy staff and/or nursing staff completed increased monitoring given the increased risk to the individual during this period.
- In January 2018, when Individual #4 began to lose weight, his IDT failed to investigate all avenues of potential causes or etiologies. For example, even as he continued to have weight issues, the IDT did not take timely action to conduct a swallow study, investigate any potential correlation between constipation and his loss of appetite, or increase the monitoring of meals to determine potential factors that might contribute to his weight loss.
- From 11/15/18 to 3/14/19, Individual #284 had 12 episodes of emesis. No evidence was found that the IDT completed a head-of-bed elevation (HOBE) evaluation.
- While in the hospital, for the removal of two gloves he ingested, Individual #284 lost 14.2 pounds. Although the IDT initiated weekly weights in response to the loss, no evidence was found to show they discussed the results of the meal time monitoring

the Speech Language Pathologist and Occupational Therapist conducted, dated 12/17/18. Additionally, they only conducted one observation, when the PNMT review stated there should be two observations.

- Since September 2018, Individual #116 had eight falls. The IDT provided no rationale for not providing training/therapy to improve her foot clearance and/or safety awareness.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: Based on observations, staff completed a transfer correctly. However, efforts are needed to continue to improve Dining Plan implementation, and positioning. Often, the errors that occurred (e.g., taking large bites, and/or eating at an unsafe rate) placed individuals at significant risk of harm. Implementation of PNMPs is non-negotiable. 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 (e.g., competence, accountability, etc.), and address them. These indicators will continue in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	53% 20/38	
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	50% 2/4	

Comments: a. The Monitoring Team conducted 38 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during eight out of 19 observations (42%). Staff followed individuals' dining plans during 11 out of 18 mealtime observations (61%). Staff completed transfers correctly during one out of one 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, or staff did not provide or prompt consumption of liquids in between bites. During the Monitoring Team's observations, it was good to see that texture/consistency was correct. Adaptive equipment was correct in all but one instance, and staff and the individuals observed were positioned correctly at mealtime in all but two observations.
- With regard to positioning, problems varied, but in approximately 30% of the observations, the individuals were not positioned correctly. In about 40% of the observations, staff had not used equipment correctly. During only one observation, the necessary adaptive equipment/supports were not present.

• For the one transfer observed, staff followed the PNMP instructions.

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A	N/A				N/A		N/A		
Comments: a. None.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Most individuals reviewed who had needs for formal OT/PT services did not have clinically relevant, and measurable goals/objectives to address these needs. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/4	N/A	0/1	N/A	N/A	N/A	0/1	N/A	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/4		0/1				0/1		0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/4		0/1				0/1		0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/4		0/1				0/1		0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/4		0/1				0/1		0/1	0/1
Comments: a. and b. Although Individual #165, Individual #94, Individual #284, Individual #104, and Individual #3 had OT/PT needs and supports, they did not require formal goals/objectives. A goal/objective that was measurable was for Individual #120 (i.e., dressing), but it was not clinically relevant and achievable, and											

based on the documents submitted, it was not included in the ISP. Three other individuals should have had goals to address their specific risk factors related to their high risk for falls, but did not. The following concerns were noted:

- For Individual #4, the IDT did not provide a rationale for not developing goals/objectives for improving his safety awareness or learning to walk with his head in more upright manner.
- For Individual #91, the IDT did not provide a rationale for not developing goals/objectives focused on improving his safety awareness during ambulation and to address his decreased active range of motion in his left leg.
- For Individual #116, the did not provide a rationale for not developing goals/objectives focused on improving her safety awareness and/or addressing the issue of foot clearance.

c. through e. While most individuals who needed OT/PT goals did not have them, it was positive that the integrated ISP progress notes for Individual#120 included specific data with regard to his goal/objective.

The Monitoring Team conducted full reviews, for all nine individuals.

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

Summary: For the individuals reviewed who had identified OT/PT needs, most did not have measurable strategies and action plans in their ISPs/ISPAs. For the individual identified with such strategies, the QIDP included data in ISP integrated reviews to show that OT/PT supports were implemented. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 165	4	94	284	104	120	3	91	116
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	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% 2/2	N/A	1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A

Comments: a. and b. For Individual #120, who had measurable strategies integrated in the ISP, it was positive monthly integrated reviews showed that OT/PT supports were implemented. It was good to see that the IDTs met as needed, when termination of supports was recommended.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's varying scores (Round 12 – 94%, Round 13 - 70%, and Round 14 – 81%), 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	104	12	62	168	53	242	181	21	27
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they have moved to the category of requiring less oversight.									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	81% 26/32	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
		Individuals:									
#	Indicator		311	77	172	265	184	86	252	8	47
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
		Individuals:									
#	Indicator		164	294	267	31	114	100	237	165	23
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	0/1	1/1	N/A	1/1	1/1	0/1	1/1	2/2
		Individuals:									
#	Indicator		223	160	272	109	234				
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	0/1	1/1				

Comments: c. The Monitoring Team conducted observations of 33 pieces of adaptive equipment. Based on observation of Individual #27, Individual #47, Individual #164, Individual #294, Individual #237, and Individual #109 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.

The Monitoring Team member observed Individual #31 with his adaptive cup. Although the Monitoring Team did not formally assess

the working condition of adaptive equipment, it is worth noting that the cup did not have the fill line marked to alert staff to the level past which they should not fill the cup.

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

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition. At the time of the last review, two of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, one indicator in the area of 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.

In the ISPs, one of the four goals for which there were reliable data was making progress. The other three were not, but no actions were taken to address barriers to implementation or to progress.

In skill acquisition, improvements in the collection of reliable data for most SAPs allowed for the SAPs to be rated for progress, this was good to see. The Center's IDTs were not, however, taking action when a SAP objective was met, or when there was no progress.

One of the 20 SAPs was considered complete. That being said, better than 75% of the remaining SAPs included many of the required minimum elements. Specific comments on many SAPs are provided below.

Staff were very pleasant in their teaching interactions when implementing SAPs. However, almost all of the SAPs were not implemented as written. In some cases, it might make sense to change the plan and in some cases the staff needed more training.

Engagement, both the Monitoring Team's own observations and the Center's own observations, showed low levels of engagement.

On a positive note, the Center had developed additional day and work programs that appeared to be more interesting to individuals and offered opportunities to learn new skills. Also, the Monitoring Team observed some very nice interactions between staff and individuals in Home 516.

Administrative offices were generally locked and not accessible to individuals. This was reportedly due to potentially aggressive or disruptive behavior. This, however, was a source of frustration and escalating agitation for some individuals who were observed trying to get into administrative buildings to talk with staff. IDTs need to address this restriction by teaching individuals appropriate skills for seeking assistance from staff and offering alternatives to individuals, such as calling the

switchboard to schedule appointments, making sure that other staff are available for immediate problem solving, and offering more opportunities for engagement during the day.

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

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

ISPs

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

Summary: One of the four goals for which there were reliable data was making progress. The other three were not, but no actions were taken to address barriers to implementation or to progress. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	165	4	277	262	94	91			
4	The individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	1/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/5	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/5	0/6	0/6			

Comments:
4-7. A personal goal that meets criteria for indicators 1 through 3 is a pre-requisite for evaluating whether progress has been made. For this review period, four goals met these three prerequisite criteria. Overall, data were not reliable and monthly reviews did not summarize progress made towards goals, so it was not possible to determine if individuals were making progress and achieving goals. Per QIDP interviews and observations, none of the goals reviewed had been met.

- Data indicated that Individual #262 was making progress towards his goal to independently call his grandparents.
- Data indicated that Individual #277 had been out to eat in the community one time in the past nine months. At Individual #277's ISP preparation meeting, the IDT acknowledged that she had made little progress towards her goal to eat at three restaurants in the community. The team agreed to continue the goal until her upcoming ISP meeting without addressing barriers to implementation.

- Individual #165's goal to attend 10 sporting events in the community was implemented in July 2018. Data indicated that he had attended one event in September 2018. The IDT had not addressed barriers to implementation.
- Individual #94's relationship goal to go out to eat with a friend was implemented in October 2018. QIDP monthly reviews indicated that this goal had not been implemented outside of that one event. The IDT had not addressed barriers to implementation.

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

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

Summary: These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 165	4	277	262	94	91			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

39. The Monitoring Team's evaluation of this indicator relies upon the input of all its members, based on observations, interviews, and review of documentation that reflects implementation. None of six ISPs had documentation that reflected consistent implementation. In addition, Monitoring Team observations and interviews identified significant gaps in staff knowledge and competence for five of six individuals. It was positive, though, for the most part, direct support professional staff interviewed and observed throughout the week were knowledgeable about individual's preferences.

Some examples observed where staff were not correctly implementing supports included:

- During two observations, Individual #165's boots to protect his feet from skin breakdown were incorrectly placed on his feet.
- Individual #94's behavior support plan included instructions for her to not have access to her belts due to past suicidal threats. It was reported at an IMRT meeting observed that she was found in her room with her belt around her neck in an apparent suicide attempt.
- Individual #277's staff were not aware of her vision impairment. Her ISP assessments indicated that she had been diagnosed with cortical blindness.

40. Action steps were not regularly and correctly implemented for all goals and/or action plans, as noted throughout this report. ISPs rarely included detailed instructions to guide staff when implementing the ISP. As noted throughout this section of the report, ISPs often included service objectives that did not have specific implementation methodologies and this contributed to the lack of implementation.

Going forward, IDTs need ensure all staff have instructions for carrying out action plans and then monitor the implementation of all

action plans and address barriers to implementation.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Improvements in the collection of reliable data for most SAPs allowed for the SAPs to be rated for progress, this was good to see. The Center's IDTs were not, however, taking action when a SAP objective was met or when there was no progress. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	440	117	234	277	321	165	4	121	262
6	The individual is progressing on his/her SAPs.	21% 4/19	0/2	1/3	0/2	0/2	0/1	0/2	0/2	2/3	1/2
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/1		0/1							
8	If the individual was not making progress, actions were taken.	0% 0/14	0/2	0/2	0/2	0/1	0/1	0/2	0/2	0/1	0/1
9	(No longer scored)										

Comments:

6. A review was completed of the data presented in the Client SAP Training Progress Note for all 20 SAPs. Although the graph for Individual #262's cutting food SAP suggested progress, it was omitted from this analysis because there were only two months of data.

Of the remaining 19 SAPs, progress was evident in the following: Individual #117's laundry SAP, Individual #121's labeling guitar parts and administrating medications SAPs, and Individual #262's safety signs SAP. Although the graph for Individual #277's mixing Jell-O SAP suggested progress, due to poor inter-observer scores, one could not be confident of data reliability.

7. Data indicated that Individual #117 had mastered his laundry SAP in November 2018. However, this SAP was still being implemented in February 2019. There was a note that the IDT needed to meet. Individual #121 had met the identified percentage correct in two of her SAPs (label guitar parts and administer medication), however, the scheduled number of trials had not been implemented. Staff are advised to observe this SAP to determine whether she can advance to the next step to maintain her motivation to participate in this skill development.

8. There was no evidence that IDTs had identified actions to take when the individual was not making progress on his/her SAPs.

Outcome 4- All individuals have SAPs that contain the required components.												
Summary: Performance remained about the same as at the last review. The SAP-specific comments provided below should be considered by the IDTs and SAP writers as they update the SAPs for these individuals and as they develop new SAPs for all individuals. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	440	117	234	277	321	165	4	121	262
13	The individual's SAPs are complete.	5% 1/20	1/2 17/19	0/3 20/28	0/2 17/20	0/2 14/20	0/1 5/10	0/2 11/18	0/2 18/20	0/3 22/28	0/3 25/29

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

13. One of the 20 SAPs (Individual #440 - sort clothing) was considered complete. That being said, better than 75% of the remaining SAPs included the following elements: a task analysis where appropriate, a behavioral objective, operational definition of the behavior, a relevant discriminative stimulus, specific consequences for both correct and incorrect responding, plans for maintenance and generalization, and documentation methodology.

More specific comments are provided below.

- It was unclear how the identified skill of completing her laundry related to the identified goal of Individual #440's learning to prepare a family meal.
- For several SAPs, the number of trials to conduct during each training session was not identified. This included Individual #117's calendar SAP, Individual #234's tie bag SAP, Individual #321's opening door SAP, Individual #121's label guitar SAP, and Individual #262's safety signs SAP.
- In Individual #117's match money SAP, the operational definition indicated that he would indicate that 20 nickels equal a dollar. However, all the steps indicated he would note the examples that did not match a sample. The instructions then indicated he will find the amount of coins that do match the sample. This contradictory information throughout the SAP resulted in a degree of confusion.
- Individual #234's make popcorn SAP was continued from at least the previous year, yet he still required full physical assistance (manipulation) to open the microwave door. One possible revision would be to increase the number of trials because he currently did this once each week.
- Individual #277's SAPs did not address her visual impairment. There were no accommodations or special instructions regarding this sensory deficit.
- Individual #321 was expected to activate a switch to open a door. The first step was to look at the switch, but the discriminative stimulus was "open the door." This did not match the behavior he was expected to exhibit. Further, it was repeatedly noted that he did not like to be touched and hand over hand assistance was not to be used when he did not make a correct response. It was unclear how he was to learn this skill.

- Individual #165's safety signs SAP required him to match identical picture cards. This was not teaching him the meaning of any community safety signs.
- Individual #262's safety signs SAP notes the use of edible reinforcers in the instruction section, but then notes that praise and a token should be provided contingent upon correct responding.
- As currently written, for Individual #262's breathing treatment SAP, staff are first directed to teach him to complete the sixth step (turning on the machine), after which they are advised to assist him with the first five steps. It is suggested that the SAP would be clearer if staff were first advised to help him complete steps one through five and then teach him to complete step six.

Outcome 5- SAPs are implemented with integrity.

Summary: SAPs were implemented, and staff were very pleasant in their teaching interactions. However, almost all of the SAPs were not implemented as written. In some cases, it might make sense to change the plan and in some cases the staff needed more training. The Center self-scored high, that is, that most (about two-thirds) of SAPs had regular and correct treatment integrity checks. This did not align with what the Monitoring Team observed (indicator 14). Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	440	117	234	277	321	165	4	121	262
14	SAPs are implemented as written.	17% 1/6	0/1	0/1	Attempted	0/1	0/1	Attempted	0/1	Attempted	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.	70% 14/20	2/2	3/3	0/2	1/2	1/1	1/2	2/2	3/3	1/3

Comments:

14. Although observations were scheduled for all nine individuals, six training sessions were observed. The exceptions were Individual #234 who was asleep at the scheduled observation time, and Individual #165 and Individual #121, neither of whom were home at the scheduled observation time. A review of the conducted observations is provided below.

- The SAP that was observed required Individual #440 to count coins to determine amounts. This did not match the SAP provided in the document request. However, the staff member did a very nice job, offering Individual #440 a choice of worksheets and providing praise and extra prompts as necessary. The worksheets were of poor quality, making it difficult to identify all of the coins depicted. A personal workbook might be a better tool to use. As Individual #440 has good money skills, the IDT is advised to review this SAP and consider replacing it with more complex and functional skills, such as opening and balancing a bank account. Staff should also consider allowing Individual #440 to use a calculator because this is a tool of choice for most adults.
- An observation was completed of Individual #117's learning to read the names of the months. The training took place in the living room, not in a quiet location with minimal distractions as noted in the SAP. Individual #117 was not asked to sit down.

The trainer did not review the month cards prior to having Individual #117 read them. Individual #117 read the months in order and then was able to correctly read three of five cards presented out of sequence. Edible reinforcement was not offered, but Individual #117 was interested in going outside to have a cigarette. Staff are advised to probe Individual #117's ability to read all of the months when presented out of sequence as he currently is still working on step 1, to read January.

- Although the staff member's instruction to Individual #277 was appropriate to the task, it was not the discriminative stimulus indicated in the SAP. Similarly, while her instructions were appropriate to the task, she did not have Individual #277 mix the Jell-O or pour it into a bowl. Rather she had Individual #277 scoop the Jell-O from an individual sized serving container into her own bowl. The staff member did provide additional prompting and noted the correct prompt to record. It would be more functional to teach Individual #277 to scoop food from a serving bowl onto her own dinnerware.
- Although the staff member interacted very nicely with Individual #321 and spoke in Spanish as she believed this was his preferred language, she employed correction procedures (hand over hand prompting) that were not indicated in the SAP. She did correctly note that she would record a refusal.
- When teaching Individual #4 to make a pizza, the instructor delivered the Sd (instruction) as written. She then encouraged Individual #4 to wash his hands before sitting down at a table in the dining area. Although not included in the SAP, she then instructed Individual #4 to remove the plate from the bin. Although he removed the bags of tortillas and pepperoni rather than the plate, she praised him. The instructor then removed the plate, cheese, and sauce from the bin. She then told him to take his pizza (tortilla) out. When he could not open the bag, she did this for him, and then he removed three tortillas. The instructor returned two to the bag. She then handed Individual #4 a spoon and used hand over hand assistance to have him remove a spoonful of sauce from the plastic bag. Individual #4 then removed a handful of cheese and a large handful of pepperoni from their respective plastic bags. The instructor then guided Individual #4 to press the correct buttons on the microwave, so that the ingredients would melt. He then returned to his seat prior to enjoying the pizza. When asked about prompting levels, the instructor appropriately identified manipulation. Although the instructor completed the SAP as written, she did add steps. It should be noted that this SAP could be taught in a much more functional manner. Using plastic bags to hold all of the ingredients, particularly the sauce, made this activity very cumbersome.
- Individual #262's staff member followed the SAP as written. He provided an appropriate discriminative stimulus, and once Individual #262 demonstrated an independent response with the current step, he provided increasing levels of support to teach Individual #262 to cut his food. One suggestion would be to stand behind Individual #262 when providing hand over hand assistance to actually cut the food. This will avoid blocking his vision of the action needed to ensure that his food is cut into manageable bites. As this SAP was reportedly developed due to his rapid eating rate, it may be more practical to teach Individual #262 a slow eating routine paired with this SAP.

15. Per state policy, SAP integrity should be assessed at a minimum of twice annually. Goal levels were established at 80% or better. Based upon the documentation provided, it was determined that 14 of the 20 SAPs had been monitored with adequate integrity at least once over the previous six-month period.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.												
Summary: Lubbock SSLC needed to do a better job of regularly and correctly reviewing every SAP every month. At the end of each month, however, the SAP data were graphed. This was the case 85%, 89%, and 100% for this and the previous two reviews, respectively, too. Therefore, indicator 17 will be moved to the category of requiring less oversight. Indicator 16 will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	440	117	234	277	321	165	4	121	262
16	There is evidence that SAPs are reviewed monthly.	35% 7/20	2/2	3/3	0/2	1/2	0/1	1/2	0/2	0/3	0/3
17	SAP outcomes are graphed.	85% 17/20	2/2	3/3	2/2	1/2	1/1	2/2	0/2	3/3	3/3
Comments: 16. There was evidence that a data-based review of seven of the 20 SAPs was completed monthly in the QIDP Monthly Report. These were all the SAPs for Individual #440 and Individual #117, the make Jell-O SAP for Individual #277, and the mark calendar SAP for Individual #165. In all other cases, either a review did not occur each month, or data were not reviewed. 17. Graphs were provided for all 20 SAPs. However, three of the 20 did not meet this indicator. The graph noted a single step program, but in fact, the SAP involved multiple steps. These were the applying lotion SAP for Individual #277, and both SAPs for Individual #4.												

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
Summary: Engagement, both the Monitoring Team's own observations and the Center's own observations, showed low levels of engagement. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	440	117	234	277	321	165	4	121	262
18	The individual is meaningfully engaged in residential and treatment sites.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1
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.	44% 4/9	1/1	1/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1
Comments: 18. During the onsite visit, individuals were observed in their work sites, day programs, and/or home environments. Monthly											

attendance records from February 2019 through April 2019 were also reviewed. Based on this information, Individual #121 and Individual #262 were meaningfully engaged.

- Individual #121 attended work regularly, was excited about attending her counseling session, and was rarely observed in her home.
- Individual #262 was engaged at work, interacting with staff on his home, and excited to attend a Sno-cone event with some other individuals from workshop.

Individual specific feedback for the six other individuals is provided below.

- Individual #440 was often observed sitting idly in her home. She reported that she did not like her job, therefore, she often declined to attend. Her three-month attendance records indicated she attended between 45% and 60% of her scheduled time, with a mean of 53%.
- Individual #117 was only observed in his home where he was usually not engaged. His work attendance records indicated he worked at one job between 20% and 75% of his scheduled times (mean of 42%). His attendance at his second job was between 34% and 55% of his scheduled times (mean of 45%).
- Individual #234 was not observed at either his day program or his work site because he either did not attend or remained present for only a short period. Records indicated he had good work attendance (range 95% to 100%, mean of 97%), although he was scheduled to attend just three days in February 2019. His day program attendance ranged between 56% and 95% (mean of 78%), but again it is important to note that, for the first two months, he was scheduled to attend day programming on a part time basis only.
- Although attendance records indicated that Individual #277 was present in her day program between 64% and 100% of her scheduled times (mean of 88%), there was very little active engagement observed. Staff presented her with a variety of different materials, each of which she tossed aside. There appeared to be no plan for her active treatment. When she was observed repeatedly placing her shirt in her mouth, a clothing protector was placed over her chest. This was not an identified strategy included in her PBSP to address this behavior.
- Over the identified three-month period, Individual #321 was scheduled to attend his day program on Fridays. Records indicated he attended for nine of 12 weeks.
- Individual #165 was scheduled to attend two different job sites. Records indicated he was present at his shredding job between 41% and 77% of the time (mean of 61%). At his second job, which he was scheduled to attend once each week, his attendance was between 0% and 50% (mean of 17%). He reportedly spent a great deal of his time in his room.
- Individual #4 was scheduled to attend two different job sites, along with a day program. At the workshop, where he was scheduled to attend four days each week, his attendance was between 25% and 50% (mean of 35%). His attendance at his second job, where by March 2019 and April 2019 he was scheduled for two days each week, was between 17% and 100% (mean of 68%). It is important to note that he was scheduled to attend once in February 2019. At his day program, where he was scheduled to attend between three and five times weekly over the identified three-month period, Individual #4 attended between 52% and 100% of the time (mean of 69%). When observed in this program, he was listening to his radio, the same activity observed on the home.

At Individual #277's ISP preparation meeting, a staff member noted that Individual #277's preference was to sleep in in the mornings. The issue was that her schedule at her day program had been changed to the morning in order to accommodate another individual in

the afternoon. As discussed, this was not a justifiable reason for changing Individual #277's schedule. Staff said that they would be exploring a return to her previous schedule.

19-20. The policy stated that the facility would measure engagement levels in all homes on odd months of the year and in all day program/work sites on even months of the year. Engagement level goals were established at 80%.

21. Engagement goal frequencies and levels were achieved in both the homes and work/day program sites for four individuals, Individual #440, Individual #117, Individual #121, and Individual #234. For all others, either the goal frequencies and/or the goal levels were not achieved.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.

Summary: Performance on indicator 22 fell to 0% for the first time. All three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 440	117	234	277	321	165	4	121	262
22	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
22. All of the individuals had identified goal frequencies for community recreational activities. However, based upon the data provided, these goals were not achieved for any of the nine individuals.

23. There was no evidence of SAP training in the community for any of the nine individuals.

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

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

Summary: There were no individuals at Lubbock SSLC who received educational services. This indicator will remain in active monitoring for possible review at the next onsite visit.

#	Indicator	Overall Score	Individuals:								

25	The student receives educational services that are integrated with the ISP.	N/A									
Comments:											

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/3	N/A	0/1	N/A	0/1	N/A	0/1	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/3		0/1		0/1		0/1			
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/3		0/1		0/1		0/1			
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/3		0/1		0/1		0/1			
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/3		0/1		0/1		0/1			
Comments: a. through d. For the three individuals who had refused dental services, their respective IDTs had not developed specific goals/objectives related to their refusals. Although Individual #4's IDT had developed a goal (i.e., refer for TIVA), it did not address the underlying cause of the dental refusals.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.	
Summary: Work is still needed to improve the clinical relevance and measurability of goals/objectives and to ensure their inclusion in the ISP. It also will be important for SLPs to work with QIDPs to include data and analysis of data on communication goals/objectives in the QIDP integrated reviews. These indicators will remain under active oversight.	Individuals:

#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	30% 3/10	0/1	0/1	0/1	2/2	1/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	50% 5/10	1/1	0/1	0/1	2/2	1/1	0/1	0/1	0/1	1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	20% 2/10	1/1	0/1	0/1	0/2	0/1	0/1	0/1	0/1	1/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/10	0/1	0/1	0/1	0/2	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/10	0/1	0/1	0/1	0/2	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. The goals/objectives that were clinically relevant, as well as measurable were for Individual #284 (sign shoe, and sign more), Individual #104 (communicate choices), and for Individual #91 (correctly produce initial consonants). However, for Individual #91, the ISP only included a broad action plan for speech therapy, but did not include the specific goals/objectives or even the purpose.

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #165 (i.e., match community signs), Individual #4 (i.e., make pizza), and Individual #116 (i.e., visual scheduler). In addition, some of these goals/objectives had not been specifically included in the individuals' ISPs/IHCPs or incorporated through an ISPA. The following concerns were noted:

- For Individual #284, the IDT did not document IDT discussion or approval of his goal/objective.
- Individual #4's IDT only included a broad action plan in his ISP stating that that he would have a skill acquisition plan (SAP) for "assembly of pizza." This action plan did not reference any measurable strategy for addressing his communication needs.

c. through e. It was good to see that the QIDP reviews included specific data and brief summary/analysis (e.g., noting progress or regression) for Individual #165 (i.e., match community signs"), and Individual #116 (i.e., visual scheduler).

The Monitoring Team completed full reviews for all nine individuals.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: To move forward, QIDPs and SLPs should work together to make sure QIDP monthly reviews include data and analysis of data related to the implementation of communication strategies and SAPs. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	165	4	94	284	104	120	3	91	116

a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	67% 4/6	1/1	1/1	N/A	1/1	0/1	N/A	N/A	0/1	1/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A

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

- No evidence was found that staff were completing Individual #104's service objectives for communication choices. The ISP integrated monthly progress reports only stated that his communication dictionary was with him, but did not include any other evidence of implementation or effectiveness.
- The QIDP monthly reviews for Individual #91 did not include completion of his speech therapy program.

b. For Individual #91, the IDT met as needed when the SLP made the recommendation to terminate speech therapy.

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.

Summary: The Center should continue to focus on ensuring individuals have their AAC devices with them. Most importantly, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner. These indicators will remain in active monitoring.

[**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."]

#	Indicator	Overall Score	Individuals: 53	198	234	164	160	58	4	Home 515	Home 528
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	60% 6/10	1/1	0/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	11% 1/10	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
#	Indicator	Overall Score	Home 518								
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		1/1								
b.	Individual is noted to be using the device or language-based support		0/1								

	in a functional manner in each observed setting.										
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.	25% 1/4									
Comments: a. through c. Based on observations during the onsite review, it was concerning that often individuals' AAC devices were not present or readily accessible. Staff often did not provide individuals with needed cues to use personal communication devices and/or all-served devices in the homes. Overall, staff had little knowledge about how all-served devices should be used.											

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. One indicator remained in the category requiring less oversight. At the time of the last review, one of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, one additional indicator will move to the category of less oversight.

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.

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. The Center continued to make incremental progress in both areas, but improvement was still needed. IDTs still did not consistently develop measurable pre-move supports. In particular, IDTs needed to focus on the clarity and measurability of pre-move supports intended to ensure provider staff were prepared to meet individuals' needs. Center staff are encouraged to continue making improvements in the development of a comprehensive set of supports, with particular emphasis on identifying supports to address all important requirements with regard to pre-move training for provider staff and for behavioral, safety, healthcare, therapeutic, and supervision needs. It was 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 also needed to clearly identify the expected knowledge that needed to be imparted.

Post-move monitoring generally remained an area of relative strength, particularly in terms of taking persistent and timely follow-up action when transition concerns were identified. The Post-Move Monitor (PMM) also did a good job of keeping the IDTs informed of any concerns that arose and seeking their input. 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 neither individual reviewed had experienced a Potentially Disrupted Community Transition (PDCT) event. This was good to see, in light of the PDCTs that occurred for both individuals reviewed at the time of the previous monitoring visit. In response to those previous events, transition staff had taken initiative to meet with Department heads to discuss what had gone right and gone wrong with those transitions. This was also good to see; such a critical analysis will support the identification of process improvements that might help to avoid any similar issues for future CLDPs.

It was positive transition staff were continuing to work toward improving assessment content and recommendations in various ways. They had adjusted the due dates for assessments to allow additional time for review and one-to-one technical assistance with IDT members to help them tweak their assessments to ensure they covered important needs and contained good recommendations. The Monitoring Team noted some improvement in discipline assessments, so they seemed to be on the right track; still, additional improvement was needed, particularly to ensure inclusion of comprehensive and community-appropriate recommendations. Although Center staff provided training to community provider staff, the CLDPs did not define the training thoroughly, and Center staff still were not able to confirm that community provider staff were competent to meet individuals' needs at the time of transition.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.

Summary: It was good to see the Center continuing to develop enhanced transition planning processes, including new training for IDTs. That being said, more work was needed to make supports in the CLDPs measurable. In addition, although improvement was noted, a number of essential supports were missing from the CLDPs reviewed, and Center staff should continue their focus in this area. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	148	201							
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 #148 and Individual #201) transitioned from the Center to the community. Both were included in this review. Individual #148 transitioned to live with her LAR in a host home setting, and Individual #201 transitioned to a community group home. The Monitoring Team reviewed these two transitions and discussed them in detail with the Lubbock SSLC Admissions and Placement staff. At the time of the previous monitoring visit, transition staff described several improvements to their planning processes, including meeting with the IDTs at the 14-Day referral ISPA meetings, and later in the process, for a pre-CLDP; training IDTs on the basics of the CLDP process as referrals were received; and meetings with selected providers to orient them to the CLDP process to help them prepare for post-move monitoring (PMM). Since then, transition staff had also been providing additional one-to-one training for IDTs on the development of recommendations to support transition and community living. It was good to see the Center continuing to develop these enhanced processes.

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 25 pre-move supports for Individual #148, and 30 pre-move supports for Individual #201. Some were measurable, but some important pre-move supports for training and sharing information with provider staff were not. Examples of concerns noted included the following:
    - For Individual #148, the CLDP included pre-move supports for one-to-one consultations with the following disciplines: primary care provider (PCP), board-certified behavior analyst (BCBA), registered nurse case manager (RNCM), and residential coordinator. This was positive, but the supports did not provide any measurable criteria or describe expectations for the documentation to be completed as evidence. For example, the one-to-one between the two PCPs should have included a requirement to address the Center PCP's concerns about not changing specific medications and why that was important, but it did not. Individual #201's pre-move supports for one-to-one consultations also reflected these concerns.
    - Individual #148's CLDP included four pre-move training supports in the areas of nursing, adaptive equipment, skill acquisition (i.e., budgeting), and behavioral health. All of these supports described who would be trained and who would do the training, but only broadly stated what the topics of training would be. None provided the specific competencies that needed to be tested/achieved. The training and testing materials submitted for review varied in terms of comprehensiveness, but the Monitoring Team did find some improvement, particularly in the areas of nursing and behavioral health. Still, even these did not cover all of Individual #148's important needs. Examples included:
        - The behavioral health testing consisted of six questions, including for identification of target behaviors, psychiatric diagnosis, replacement behaviors, and functions of behaviors, but did not test staff knowledge with regard to prevention of target behaviors or interventions when target behaviors occurred.
        - The nursing testing included nine questions, including several related to Individual #148's diabetes diagnosis. One question tested staff knowledge about how many times per day staff needed to check her blood sugar (i.e., four times a day), but did not also test staff knowledge about how to evaluate the readings and take appropriate responses. Per other documentation, these parameters included: If blood sugar is less than 70, give juice or regular soda and a protein snack, and recheck in 15 minutes; if after 15 minutes, blood sugar is still less than 70, call the PCP; and, if blood sugar is greater than 150 at any time, call the PCP for instruction. Testing should have included this critical knowledge.
    - Individual #201's CLDP also included four pre-move training supports in the areas of nursing, the physical and nutritional management plan (PNMP), behavioral health, and residential needs. These supports also identified who would be trained and who would do the training, but only broadly stated the topics of training and failed to provide the specific competencies that needed to be tested/achieved. Examples included:
        - The behavioral health testing did not test staff knowledge of important intervention strategies for attempted unauthorized departures or for the behavior of dropping to the floor.
        - The testing related to his PNMP posed a multiple-choice question asking, "(w)hich of the following are dining positioning and instructions for him: a. Encourage him to keep his head upright while drinking; b. encourage him to swallow his food before taking another bite and assist him not to overfill his mouth; c. fill mug half full and provide him with verbal and physical prompts to take a drink after every few bites; and d. all of the above." The correct answer was all of the above. Per the PNMP, however, it was also important to encourage him to feed himself as much as possible with verbal prompts and physical shaping, with staff assistance only if

needed. This would be important knowledge for provider staff to have to promote maintenance of self-feeding skills.
- Individual #201's PNMP indicated he used a gait belt and provided an illustration for its correct usage. The IDT should have considered whether this competency needed to be tested through return demonstration, but instead did not include any testing in this area.

- Post-Move: The respective IDTs developed 49 post-move supports for Individual #148, and 51 post-move supports for Individual #201. Some post-move supports were measurable, but this continued to be an area that needed improvement. Examples included, but were not limited to:
  - For both individuals, post-move supports for training any new staff did not meet criterion. Like the pre-move training supports, these did not consistently describe competency criteria or describe adequate competency testing.
  - IDTs needed to describe required evidence that would provide the PMM with clear measurable indicators of the providers' conformance with the expectations. Examples of post-move supports that did not meet this criterion included:
    - For Individual #148, a post-move support indicated the provider should follow up with all specialties as referred by the community PCP, but did not provide any guidance with regard to what her medical/health care specialty needs might be. For example, her Integrated Risk Rating Form (IRRF) indicated she had a high risk for cardiac problems and was being seen by a cardiac specialist while at the Center. The CLDP did not include a specific support for cardiology follow-up, nor was it referenced in this post-move support.
    - Similarly, Individual #148 had another post-move support for the provider to document monthly weights on the medication administration record (MAR), to be reviewed by the PMM at each monitoring visit "for diet follow up." This did not provide any guidance with regard to how the PMM should evaluate the data to determine if diet follow-up would be needed, or what form the follow-up should take.
    - For Individual #201, the CLDP included a post-move support calling for the provider to complete check and change forms to track the need for a toilet training program. This support did not provide any guidance that would have allowed the provider or the PMM to evaluate whether the data indicated a need for such a program.

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

- Past history, and recent and current behavioral and psychiatric problems: The CLDPs did not include supports that comprehensively addressed past history, and recent and current behavioral and psychiatric problems. To meet criterion, the IDTs should continue to make improvement toward developing comprehensive supports that address behavioral and psychiatric history and needs. Findings included:
  - As described above with regard to pre-move training supports in this area, behavioral health post-move training supports for new provider staff did not provide any competency criteria.
  - For Individual #148, the IDT 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. In addition, while one post-move support alluded to the possibility that she might make suicidal

threats, and require a higher level of supervision in such an event, the CLDP did not include any post-move supports to test the provider's knowledge of her pertinent history (e.g., cutting her arms) or what provider staff should watch for or otherwise do.

- With the exception of post-move supports for line of sight supervision and door security to prevent elopement, the IDT for Individual #201 also did not develop post-move supports with clear expectations for implementation of the PBSP or the specific behavioral strategies contained therein. For example, his behavioral health assessment (BHA) indicated it was very important for provider staff to know things to watch for when on community outings, such as entering parked cars, unresponsiveness to redirection, and a tendency to walk away from staff rapidly, and recommended more than one staff person be available. The IDT did not develop a specific support to ensure staff knowledge and implementation.

- 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:
  - For Individual #148, many support needs in this area were addressed, which was positive. Exceptions included the failure to identify her specific needs for specialty medical and health care consultations, as described above with regard to Indicator 1, and the failure to address communication strategies as identified in her ISP. With regard to the latter, even though Individual #148 could communicate verbally, the ISP indicated she would benefit from communication strategies, such as tasks that made her think and exposed her to new concepts, such as playing a board game; prompting to make choices throughout her day and offering new activities; and, opportunities to read and write to maintain her skills. The IDT did not develop any related supports. In addition, the CLDP did not provide a clear support with regard to her ongoing and regular need for supervision, but only referenced the need to increase supervision to one-to-one in the event of a suicide threat or gesture.
  - For Individual #201, it was concerning that a post-move support appeared to call for locked doors, in addition to door alarms, to prevent elopement. Locked doors present a significant danger in the event of an emergency, such as a fire, and should only be considered with substantial safeguards in place. The post-move support in this CLDP did not provide such safeguards.
  - Per his assessments, Individual #201 was at high risk for being unable to adequately convey his wants and needs effectively, making it crucial for provider staff to be aware of and anticipate his wants and needs. At the Center, he had informal communication strategies to assist with these needs (e.g., prompts, allowing choices, single-step directions, consistent daily routine to help him know what to expect), but these were not included as CLDP supports.
  - Individual #201 had been recently diagnosed with systemic lupus erythematosus (SLE), an autoimmune disease that could cause a wide range of signs and symptoms, per his IRRF. The CLDP did not include post-move supports describing needed provider staff knowledge with regard to these potential side effects and symptoms, or what and when to report to the provider nurse and/or PCP.

- 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. Both CLDPs included only a single outcome. For Individual #148, the CLDP documented only that she stated her goal was to continue living in the community with her LAR, and that she had nothing further to add. For Individual #201, the CLDP documented that he was happiest in the presence of his father and that the transition would allow

more frequent contact. The IDT developed a specific support for family visits at least twice each month. It would have been good to see the IDTs be more thoughtful about how community living could have supported a larger array of outcomes that were meaningful to these individuals.

- Need/desire for employment, and/or other meaningful day activities: Neither CLDP met criterion. While it was positive the IDT for Individual #148 developed several supports for employment, they did not address other needs for meaningful activities in integrated community environments. For example, the IDT could have developed supports for participation in community meditation and/or guitar classes, which would have addressed her preferences and strengths, while also promoting opportunities to participate in the community. For Individual #201, the CLDP only included a broad support to attend a day program Monday through Friday, but had no supports for community participation and integration.
- Positive reinforcement, incentives, and/or other motivating components to an individual's success. Neither CLDP addressed this assertively. For example, for Individual #148, the BHA and ISP provided some good information about reinforcing and motivating strategies (e.g., tangible reinforcement, a twenty-minute session of meditation each day), but the IDT did not develop specific related supports for these. For Individual #201, the IDT developed some supports for access to preferred items, but did not include recommended supports for reinforcement as indicated in the BHA.
- Teaching, maintenance, participation, and acquisition of specific skills: The IDT for Individual #148 did not provide assertive supports in this area, having only developed one post-move support for continuing a budgeting skill acquisition plan (SAP). Per her ISP and Functional Skills Assessment (FSA), she also had SAPs for self-administration of medication, learning to play the guitar, and learning to identify local streets in her planned community setting. All of these would have been appropriate for community living. On the other hand, the IDT for Individual #201, developed several supports for skill acquisition, including learning objectives for cleaning his sensory items, putting on his shoes, and bathing. This was positive.
- 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. Assessments still sometimes included important information about needed supports in the narrative that were not reflected in the recommendations section. As transition staff and the IDT review assessments prior to the CLDP meeting, they should ensure both the narrative and recommendation sections are reviewed and reconciled.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.	
Summary: It was positive that the Post-Move Monitor conducted timely monitoring for the individuals reviewed. If the Center sustains its progress in this area, after the next review, Indicator 3 might move to the category requiring less oversight. 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	Individuals:

with the provision of supports, including involving and informing the IDT, some improvement was still needed. These indicators will remain in active oversight.											
#	Indicator	Overall Score	148	201							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	100% 2/2	1/1	1/1							
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1							
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1							
6	The PMM's scoring is correct based on the evidence.	0% 0/2	0/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, the IDT/Facility implemented corrective actions in a timely manner.	0% 0/2	0/1	0/1							
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A	N/A	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A	N/A	N/A							

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

4. The PMM Checklists provided 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. Findings included:

- As described above in relation to Indicator #1, the provider staff training supports for both individuals did not specify the competency criteria the PMM needed in order to accurately collect valid data. For example, a post-move support for Individual #148 required the provider to have her behavioral in-service materials easily accessible for reference, but no supports required the PMM to probe whether the provider staff knew what was in the materials and how to implement them.
- The evidence the PMM provided did not always address all evidentiary requirements. Examples included, but were not limited

to:

- For Individual #148, the CLDP included a support for the provider to document testing blood sugar on the MAR, with instructions that the home host provider should contact the nurse if the readings were below 70 or above 150. At the time of the 45-day PMM, the PMM documented reviewing the MAR and interviewing the host home provider. The PMM found the support was met because the documentation demonstrated blood sugar readings had been taken four times a day. Per the PMM's comments, however, some readings were noted to be above 200, but the PMM did not provide any evidence with regard to whether nursing staff had been notified as required.
- Similarly, Individual #148's CLDP included a support calling for the host home provider to encourage her to walk on paved areas and avoid running on uneven ground to avoid falls. For both the seven-day and 45-day PMM visits, the PMM documented interviewing the host home provider with regard to whether falls had occurred and concluded that none had. The PMM marked the support as met at both PMM visits, but provided no documentation that she probed the host home provider's knowledge of the falls prevention precautions, which were a critical component of the support.
- For Individual #201, the CLDP included a support calling for the provider to maintain a "check and change" log to track the need for a toilet training program. For all three monitoring periods completed (i.e., seven, 45 and 90 day) the PMM formed a conclusion with regard to whether the support was met based only on evidence that the log was being kept. The comments did not reference the toileting program until the 90-day PMM visit. At that time, the PMM indicated she would follow-up after the visit to determine the provider's plan for this, but still marked the support as in place.

5. Based on information the PMM collected, both individuals had frequently received supports as listed and/or described in the CLDP, but there were a significant number of supports that were not in place as required. As described above, however, 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 #148, the PMM's documentation indicated the following supports were not in place:
  - At the time of the seven-day PMM visit, the MAR was not available to document that medication was given, evidence of blood sugar check before meals and bedtime was not available, vital signs had not been taken, employment supports were not in place, the Center had not provided the Social Security card and birth certificate, and monitoring for metabolic syndrome and hyperprolactinemia had not occurred.
  - At the time of the 45-day PMM visit, unmet needs included a lack of evidence to review of monitoring for metabolic syndrome, no documentation of needed labs, no evidence of required case management services, and no evidence of a monthly review of behavior by a mental health professional.
  - At the time of the 90-day PMM visit, the community PCP had made changes to supports for glucose and metabolic syndrome monitoring without justification, twice-daily tooth brushing was not occurring, and, the behavior support plan had not been updated.
- For Individual #201, the PMM documented the following supports were not in place:
  - At the time of the seven-day PMM visit, his diet texture had been changed, and provider staff did not have a clear

understanding of what it needed to be; line of sight supervision was not in place; provider staff working with him did not have documentation of in-service training; he was not wearing the needed non-skid socks for falls prevention; the provider had not kept documentation of twice-daily tooth brushing; the door alarms were not on as required; and, he did not have his voice recorder.

- At the time of the 45-day PMM, provider staff had not completed the check and change form needed, the MAR did not evidence the use of sunscreen, he had not received required dental care, a piece of his adaptive equipment was missing, he had not seen the psychiatrist within 30 days, and weight and MAR documentation were not available.
- At the time of the 90-day PMM visit, he had not had family visits, and a trip hazard was found at the home.

6. Based on the supports defined in the CLDP, the Post-Move Monitor's scoring was frequently correct, but there were still exceptions in which the evidence provided did not clearly substantiate the finding with valid and reliable data as described with regard to the Indicator 4 above. For example, for Individual #148's post-move support for falls precautions as described above, the PMM documented no falls had occurred, but failed to document evidence that the host home provider was knowledgeable. The PMM determined the support was met at the time of the seven-day PMM, but not applicable at the time of the 45-day PMM visit. Neither of these could have been considered correct, based on the evidence provided. The support called for provider knowledge, which would have been applicable at all PMM visits; further, without having probed that knowledge, the support could not be correctly considered to have been met.

7. through 8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed through to resolution. Whether follow-up is completed as needed relies heavily on the accuracy of the PMM's assessment of whether supports were, or were not, in place. This, in turn, relies on accuracy, completeness, and measurability of the supports. The Lubbock SSLC PMM typically took persistent and timely follow-up action toward resolution when she identified supports were not in place, including involving and informing the IDT. This was an area of relative strength. However, in addition to unidentified needs for follow-up (i.e., supports for which the PMM did not provide sufficient evidence to substantiate compliance), the Monitoring Team also did not always find the PMM's determination that concerns had been resolved to be supported by the evidence. Examples of concerns included the following:

- For Individual #148, the CLDP included a post-move support for the PBSP to be reviewed by a master's level mental health practitioner within 60 days, and revised, as necessary, within 90 days of transition. At the time of the 90-day PMM, the PMM's comments indicated the provider told her that a master's level mental health practitioner had reviewed the PBSP, although it was not clear whether revisions would be made. The PMM noted taking action to obtain the provider's follow-up with regard to the revisions, which was pending, but should not have relied solely on the provider's assertion that the PBSP had been reviewed to confirm that component of the support was resolved.
- For Individual #201, the PMM concluded the support for the check and change log was not met at the time of the 45-day visit, based on what appeared to be incomplete documentation with regard to the frequency of urination. Per the follow-up notations, the provider reported that provider staff were only required to document bowel movements, but that "most staff also document the urine." The provider further indicated she spoke with provider staff who worked the night shift, who reported that Individual #201 usually had urine output at least twice during the night hours. The PMM then marked the concern as resolved, but this did not clearly address whether provider staff would thereafter record urine in addition to bowel movements and for all shifts.

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: Neither individual had experienced a PDCT event.			Individuals:								
#	Indicator	Overall Score	148	201							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	100% 2/2	1/1	1/1							
Comments: 11. The Center reported that neither individual had experienced a PDCT event. This was good to see, in light of the PDCTs that occurred for both individuals at the time of the previous monitoring visit. Per interview, transition staff had taken initiative, in response to those events, to meet with Department heads to discuss what had gone right and gone wrong with those transitions. This was also good to see; such a critical analysis will support the identification of process improvements that might help to avoid any similar issues for future CLDPs.											

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. However, although some improvement was noted, the content and recommendations generated from transition assessments still required improvement. Although Center staff provided training to community provider staff and some improvement was noted, the CLDPs did not define the competency measures, important topics of training were not included, and prior to transitions, Center staff did not confirm provider staff had the necessary competencies to address individuals' health and safety needs. Given that over the last two review periods and during this review, for the individuals reviewed, IDT members actively participated in the transition planning process, the CLDP specified the staff responsible and timeframes for transition actions, and the CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making (Round 12 – 100%, Round 13 – 100%, and Round 14 – 100%), Indicator 13 will move to the category requiring less oversight. The	Individuals:

remaining indicators will continue in active oversight.											
#	Indicator	Overall Score	148	201							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	100% 2/2	1/1	1/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/2	0/1	0/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	50% 1/2	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, the Center had implemented some improved processes in this area. Transition staff were working to improve assessment content and recommendations in various ways. They had adjusted the due dates for assessments to allow additional time for review and one-to-one technical assistance with IDT members, for the purpose of helping them ensure the assessments covered important needs and contained good recommendations. The Monitoring Team noted some improvement in discipline assessments, so they seemed to be on the right track. The Monitoring Team considers the following four sub-indicators when evaluating compliance:											

- Assessments updated within 45 Days of transition: Overall, assessments provided for review met criterion for timeliness.
- Assessments provided a summary of relevant facts of the individual's stay at the Center: Many available discipline assessments 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: Some assessments provided a clear statement about the training provider staff would need to affect a successful transition (e.g., OT/PT for both individuals), but most did not.
- Assessments specifically address/focus on the new community home and day/work settings: Overall, assessments did not fully address/focus on the new community home and day/work settings; however, it was good to see some examples of specific recommendations. For example, Individual #201's BHA made specific recommendations about reinforcement techniques and safeguards provider staff would need to use on community outings, and his vocational assessment recommended some specific activities that would be beneficial for him in a day program. It was unfortunate that the IDT did not integrate these into community living supports.

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

14. 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: As reported at the time of the last monitoring visit, training still did not meet criterion for these two CLDPs, as described with regard to Indicator 1 above and further below, but some improvements were noted. Findings included:

- The Monitoring Team did observe some improvements in training content and testing for some disciplines, most notably for nursing and behavioral health.
- The IDTs did not clearly identify the expected provider staff knowledge or competencies that needed to be demonstrated.
- The Center did not provide sufficient evidence it had confirmed provider staff had the knowledge and competencies to address the individuals' health and safety needs or otherwise ensure supports were implemented as required.
- Some training materials, such as the behavioral training materials, still referenced Center-specific expectations that would not be applicable in the community.
- Competency testing did not consistently cover important support needs in a comprehensive manner.

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. It was 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 also needed to clearly identify the

expected knowledge that needed to be imparted. Overall, the IDTs did not specify an expectation for documenting the content covered or other outcomes of the collaborations. In addition, the disciplines' documentation regarding contacts with their community counterparts did not consistently provide evidence of a complete or successful collaboration. For example, for Individual #201, the documentation of the nursing collaboration stated only that it had been completed on 5/17/18, and that in-service and medical information had been emailed. It did not provide any description of the specific information imparted.

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. Neither CLDP met criterion.

- For Individual #148, the CLDP indicated she would need settings assessment to be completed by nursing, behavioral, and residential disciplines, although it did not specify the purpose or expectations for any of these. The CLDP did provide evidence that residential staff visited the home and completed an assessment, but did not provide evidence that behavioral and nursing staff had done so.

  In its comments on the draft report, the State disputed this finding, and stated: "The center submitted Assessment of Setting [sic] for both Behavioral and Nursing for #148 [sic]. TX-LB-1905-I.73.T. pgs 28-29." While the document the State referenced did include notes from a nurse and Behavioral Health Specialist, both included general comments about the environment (e.g., cleanliness, brief descriptions of rooms), but they did not provide a specific assessment of the setting in terms of meeting the individual's health care or behavioral needs. As noted in the Monitoring Team's draft report, the CLDP was not helpful in defining what the setting assessments would entail.
- For Individual #201, the CLDP documented that the occupational and physical therapists did not feel an assessment of setting was necessary because he did not have any special modifications for his ambulation. He did, however, need some assistance with stepping up or down and in and out of the tub and, per the IRRF, had an elevated risk for falls; in fact, the nursing assessment update indicated he had sustained sixteen falls in the past 12 months. The IDT should have documented a discussion of these risk factors as a part of determining his need for a settings assessment and justifying why he did or did not need one.

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 had occurred and their results. Examples include provider direct support professional staff (DSPs) spending time at the Center, Center DSPs spending time with the individual in the community, and Center and provider DSPs to discuss the individual's needs. Individual #148's CLDP did not address the consideration of involvement of Center DSPs. On the other hand, it was positive that Individual #201's IDT ensured that a DSP from the Center was available for both pre-selection visits to model for the provider staff.

In its comments on the draft report, the State disputed this finding, and stated: "It is the understanding of the LbSSLC A/P [Admissions and Placement] Dept that this statement includes all staff, not just DSPs. Staff were engaged in activities for each individual. In the beginning of the CLDP, it is explained #148 [sic] had been visiting and had once lived with her Provider/LAR [Legally Authorized Representative] years prior. Before the referral, DSPs did engage with the Provider for visits, yet the A/P department did not track, as

this was prior to their referral to the community. Three other staff (IDT members) did visit the home during the referral process, as documented. See attached Pre-CLDP and CLDP sign-in sheets; DSPs were present at both meetings for #148 [sic]. This document was not requested during the review."

In the Most Integrated Setting and Transition Practices audit tool, the interpretive guidelines provide examples of what is needed to meet criteria with regard to this indicator (i.e., "Examples include provider direct support staff spending time at the Facility, Facility direct support staff spending time with the individual in the community, and Facility and provider direct support staff meeting to discuss the individual's needs." In addition, the interpretive guidelines clearly require that the CLDP includes an explicit statement of the IDT's consideration in this regard. For Individual #148, the CLDP did not provide such a statement or otherwise provide any detail of DSP involvement.

The IDT needed to consider what role DSPs needed to play in the actual transition process, based on the individual's needs and preferences as identified in transition planning. While it was good to hear that DSPs had visited the home prior to Individual #148's referral, the IDT had yet to define their role in the transition process and it remained unclear in which activities they engaged at that time. Likewise, while it was good that DSPs participated in CLDP meetings, this did not relieve the IDT from specifically considering whether/how DSPs could otherwise contribute to the transition process through engaging with community provider staff.

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

- For both individuals, the PMM documented observing provider staff training and receiving the signed training rosters after its completion, but even with the progress made in provider training as described with regard to Indicator 14 above, testing remained insufficient as evidence that provider staff were competent.
- For both individuals, the Center did not have documentation that ensured the pre-move supports for discipline collaborations had been completed in an effective manner.
- For Individual #148, the PMSR documented her bicycle was available, but did not comment on the presence of her phone.

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary: This indicator will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	148	201								
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 #148 was referred on 7/19/18, and transitioned on 2/11/19. This exceeded 180 days, but the Center provided adequate justification.
- Individual #201 was referred on 2/13/18, and transitioned 12/18/18. This also exceeded 180 days, but the Center again provided adequate justification.

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

The individual-specific documents listed below:

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

- PNMT assessment, if any
- Nutrition Assessment(s) and consults within the last 12 months
- IPNs for last six months, including as applicable Hospitalization/ER/LTAC related records, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, Restraint Checklists Pre- and Post-Sedation, etc.
- ED transfer sheets, if any
- Any ED reports (i.e., not just the patient instruction sheet)
- Any hospitalization reports
- Immunization Record from the active record
- AVATAR Immunization Record
- Consents for immunizations
- Medication Variance forms and follow-up documentation for the last six months (i.e., include the form and Avatar Report)
- Annual Nursing Assessment, and associated documents (e.g., Braden Scale, weight record)
- Last two quarterly nursing assessments, and associated documents (e.g., Braden Scale, weight record)
- Acute care plans for the last six months
- Direct Support Professional Instruction Sheets, and documentation validating direct support professionals training on care plans, including IHCPs, and acute care plans
- Last three months Eternal Nutrition Flow Record, if applicable
- Last three months Aspiration Trigger Sheets, if applicable
- Last three months Bowel Tracking Sheets (if medium or high risk for constipation and bowel obstruction requiring a plan of care)
- Last three months Treatment Records, including current month
- Last three months Weight records (including current month), if unplanned weight gain or loss has occurred requiring a plan of care
- Last three months of Seizure Records (including current month) and corresponding documentation in the IPN note, if applicable
- To show implementation of the individual's IHCP, any flow sheets or other associated documentation not already provided in previous requests
- Last six months of Physician Orders (including most recent quarter of medication orders)
- Current MAR and last three months of MARs (i.e., including front and back of MARs)
- Last three months Self Administration of Medication (SAMs) Program Data Sheets, as implemented by Nursing
- Adverse Drug Reaction Forms and follow-up documentation
- For individuals that have been restrained (i.e., chemical or physical), the Crisis Intervention Restraint Checklist, Crisis Intervention Face-to-Face Assessment and Debriefing, Administration of Chemical Restraint Consult and Review Form, Physician notification, and order for restraint
- Signature page (including date) of previous Annual Medical Assessment (i.e., Annual Medical Assessment is requested in #5, please provide the previous one's signature page here)
- Last three quarterly medical reviews
- Preventative care flow sheet
- Annual dental examination and summary, including periodontal chart, and signature (including date) page of previous dental examination
- For last six months, dental progress notes and IPNs related to dental care
- Dental clinic notes for the last two clinic visits
- For individuals who received medical and/or dental pre-treatment sedation, all documentation of monitoring, including vital sign sheets, and nursing assessments, if not included in the IPNs.

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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