United States v. State of Texas

Monitoring Team Report

Lufkin State Supported Living Center

Dates of Onsite Review: January 28 to January 31, 2019

Date of Report: April 23, 2019

Submitted By:	Alan Harchik, Ph.D., BCBA-D Maria Laurence, MPA Independent Monitors
Monitoring Team:	Helen Badie, M.D., M.P.H, M.S. Carly Crawford, M.S., OTR/L Daphne Glindmeyer, M.D. Teka Harris, M.A., BCBA Marlenia Overholt, B.S., R.N. Gary Pace, Ph.D., BCBA-D Teri Towe, B.S. Scott Umbreit, M.S. Rebecca Wright, MSW

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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 Lufkin 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 last review, 18 of these indicators were moved to, or already in, the category of requiring less oversight. During this review, six other indicators had sustained high performance scores and will be moved to the category of requiring less oversight. These were in the area of restraint and quality assurance.

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

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

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

Restraint

Lufkin SSLC continued to be very attentive to the usage of crisis intervention restraint and the overall frequency of usage continued to decline, especially with implementation of the SUR program. Indicator 1 scored higher than at any other Lufkin SSLC review.

Overall, the rate of crisis intervention restraint continued its downward trend over the nine-month. The average duration of a crisis intervention physical restraint increased, though a deeper analysis by the director of behavioral health services pointed to that being the result of one individual's behavioral status.

The behavioral health services director managed restraint for the Center. This included attending to PBSPs, restraint documentation and follow-up, and graphic summaries and analyses. Restraint reduction committee remained active and included review of a large set of relevant (and clearly presented) data.

It was positive to see that for the one chemical restraint reviewed, the nurse conducted the necessary assessments, and took the necessary follow-up action. It was also positive that for most of the restraints reviewed, nurses initiated assessments timely. Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: for individuals with protective mechanical restraint for self-injurious behavior (PMR-SIB), defining needed nursing assessments and other requirements in IHCPs, and documenting their completion; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and completing and documenting assessments to determine if individuals sustained injuries or other negative health effects.

Abuse, Neglect, and Incident Management

For all but one of the investigations, supports were in place to have reduced the likelihood of the incident occurring. Protocols for individuals identified for streamlined investigations were being followed by HHSC PI and by the Center. ISPs include a detailed description of each injury/incident and a short summary (sub-indicator 4.2). This was very good to see, and they were done very well.

Most incidents were reported timely and correctly. During each of the last four reviews, from one to three incidents had a problem with reporting.

Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized. But, the sole clinical investigation was missing some protocols being followed correctly.

The investigation review process had improved since the last review. In fact, all of the investigations met criteria with indicator 13, but one. This was the clinical investigation, which identified potential issues for which actions should have been, but were not, recommended. For the other investigations, recommendations relevant and related to the circumstances of the investigation were made. This was good to see and the Center followed-up by implementing all recommendations in a timely manner.

During morning unit meetings, the group sometimes attributed minor injuries to cause without further explanation (e.g., bruise on a foot). In discussing this with the Center Director later in the week, morning meeting attendees should be doing a more thorough looking into the circumstances around these injuries prior to the meeting.

Other

Lufkin SSLC IDTs were not addressing the topics required regarding pretreatment sedation. As a result, IDTs did not discuss whether interventions or strategies should be implemented and, consequently, none were.

It was good to see that the Center completed clinically significant DUEs. Given the Center's performance during this review and the last two reviews, this indicator will move to the category requiring less oversight. The indicator related to follow-up on DUE recommendations will continue under active monitoring, because Center staff had not taken or documented necessary action.

Restraint

#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
Outcome 1- Restraint use decreases at the facility and for individuals.											
Summary: Lufkin SSLC continued to be very attentive to the usage of crisis intervention restraint and the overall frequency of usage continued to decline, especially with implementation of the SUR program. The behavioral health services director managed restraint for the Center. This included attending to PBSPs, restraint documentation and follow-up, and graphic summaries and analyses. Restraint reduction committee remained active and included review of a large set of relevant (and clearly presented) data. Indicator 1 scored higher than at any other Lufkin SSLC review. These two indicators remain in active monitoring.			Individuals:								
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	100% 12/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	92% 12/13	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 (April 2018 through December 2018) were reviewed. Overall, a decreasing trend in the usage of crisis intervention restraint continued at Lufkin SSLC, especially when looking across the past four nine-month periods. The rate across this nine-month period was the lowest since the Monitoring Team began looking at this indicator in 2015. Moreover, in the most recent three months, since the implementation of SUR, the occurrences decreased even further. The Center was now in the middle when compared with the other 12 Centers (i.e., now the fifth lowest of the 13). The Center had no individuals, at the time of the onsite visit, who had a CIP for usage of horizontal restraint.

The usage of crisis intervention physical restraint paralleled the overall usage of crisis intervention restraint at the Center because most crisis intervention restraints were crisis intervention physical restraints. The average duration of a crisis intervention restraint, however, had increased since the last review, to about 10 minutes, the highest in the state. The director of behavioral health services was well aware of this and provided a deeper analysis of the data for the Monitoring Team. This showed that the extended durations were primarily the result of restraints for one individual (Individual #410), who presented one of the more complex behavioral cases in the state. That being said, the frequency and duration of restraints for this individual had also decreased since implementation of SUR. And, when looking at the average duration since implementation of SUR across the Center, the duration was about three and a half minutes, more in line with the other SSLCs. So, although the nine-month duration data were high, the Monitoring Team was satisfied with the attention and management of this by the Center and by the director of behavioral services and, therefore, scored this sub-indicator positively, too.

The usage of crisis intervention chemical restraint was low and there were no occurrences of the usage of crisis intervention mechanical restraint. The number of individuals with protective mechanical restraint for self-injury (PMR-SIB) decreased to one (again this was for the same individual, Individual #410). The number of individuals who had any crisis intervention restraint each month also was decreasing. The director of behavioral services also shared a list of individuals for whom crisis intervention restraint was no longer needed or used (i.e., had not been used for many months or longer). The occurrence of any injuries during crisis intervention was also descending, and all were deemed to be non-serious (though see below for more detailed discussion under the outcome and indicators regarding nursing post-restraint assessments of individuals).

There was no usage of non-chemical restraints for conducting medical or dental procedures. There was a decreasing trend of usage of pretreatment sedation for medical procedures and no usage of pretreatment sedation for dental procedures. The usage of TIVA for dental procedures remained stable at about five per month (i.e., 60 per year). In future analyses of these data, the Center might explore whether individuals are progressing, or can progress, from TIVA to less intrusive pretreatment sedation and/or to less intrusive mild non-chemical restraints.

Thus, facility data showed low/zero usage and/or decreases in 12 of these 12 facility-wide measures (overall use of crisis intervention restraint; use of crisis intervention physical-chemical-mechanical restraints; duration of crisis intervention physical restraint; number of injuries during restraint; number of individuals with crisis intervention restraint each month; number of individuals with PMR-SIB), and use of non-chemical, pretreatment sedation, and/or TIVA for medical and/or dental procedures.

The usage and management of crisis intervention restraint and the Center's progress over the past few years is attributable to a number of factors, one of which is the attention paid to this by the Center, the behavioral health services director, behavioral health services staff, unit and day program management, and DSP staff. This was evident in the monthly restraint review meeting (called Risk and Safety Meeting) minutes and report prepared by director of behavioral services director. It was very detailed, included 28 sets of data (including the 12 in this indicator, some related to Ukeru usage, and many others regarding other restraint-related indicators reviewed by the Monitoring Team).

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. One of the individuals reviewed by the Monitoring Team was subject to restraint. In addition, four other individuals were included in this review for a total of five individuals. Four received crisis intervention physical restraints (Individual #410, Individual #48, Individual #318, Individual #107), one received crisis intervention chemical restraint (Individual #20), one received PMR-SIB (Individual #410). Data from state office and from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for four (Individual #410, Individual #48, Individual #318, Individual #107). The other eight individuals in the Monitoring Team's review group did not have any occurrences of crisis intervention restraint during this period.

The Center did not have a measurement of the amount of time that Individual #410's PMR-SIB was on (or off). The procedure for implementation had advanced over the nine-month period, with increasing amounts of time per hour that the helmet was removed, but there were no data measuring time on or off.

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: Both indicators scored at 100%. Both will remain in active monitoring, however, with sustained high performance, indicator 7 might be moved to the category of requiring less oversight after the next review.			Individuals:									
#	Indicator	Overall Score	410	48	318	20	107					
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.	100% 7/7	3/3	1/1	1/1	1/1	1/1					
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	100% 1/1	1/1									
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, these indicators were moved to the category of requiring less oversight.										
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.											
Comments:												

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.												
Summary: Due to sustained high performance, indicator 12 will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	410	48	318	20	107					

12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 2/2			1/1	1/1					
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: Given sustained high performance, indicators 13 and 14 will be moved to the category of requiring less oversight (the one zero score was because a restraint was not reported/determined until the next day, that is, whenever restraint was identified the restraint monitor was present timely).

Individuals:

#	Indicator	Overall Score	410	48	318	20	107				
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	83% 5/6	2/2	1/1	1/1	1/1	0/1				
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:
13. Individual #107 8/22/18 was not reported/determined until the next day.

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 to see that for the one chemical restraint reviewed, the nurse conducted the necessary assessments, and took the necessary follow-up action. It was also positive that for most of the restraints reviewed, nurses initiated assessments timely. Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: for individuals with PMR-SIB, defining needed nursing assessments and other requirements in IHCPs, and documenting their completion; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and completing and documenting assessments to determine if individuals sustained injuries or other negative health effects. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	410	48	318	20	107				

a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	14% 1/7	0/3	0/1	0/1	1/1	0/1				
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	29% 2/7	1/3	0/1	0/1	1/1	0/1				
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	29% 2/7	1/3	0/1	0/1	1/1	0/1				

Comments: The restraints reviewed included those for: Individual #410 on 11/5/18 at 11:10 a.m., 12/5/18 at 1:50 p.m., and 12/3/18 to 12/9/18 (PMR-SIB); Individual #48 on 7/10/18 at 12:24 p.m.; Individual #318 on 10/25/18 at 12:25 p.m.; Individual #20 on 11/20/18 at 4:23 p.m. (chemical); and Individual #107 on 8/22/18 at 5:50 p.m.

a. through c. Examples of nurses correctly addressing restraints included:

- For Individual #20's chemical restraint on 11/20/18 at 4:23 p.m., the nurse performed physical assessments according to standards of care, documented whether there were any restraint-related injuries or other negative health effects, and took action, as needed to meet the needs of the individual. In addition to clearly documenting the individual's behaviors/mental status prior to the chemical restraint, the nurse conducted vital sign assessments and mental status assessments after the administration of the chemical restraint, and implemented the head injury nursing guideline due to the fact that the individual had engaged in head-banging behavior.
- For most of the restraints reviewed, nurses initiated monitoring at least every 30 minutes from the initiation of the restraint. The exception for the timely initiation of restraint was for Individual #107, which is discussed in further detail below.
- According to a nursing IPN, dated 11/5/18, at 11:15 a.m., Individual #40 was riding his bike when he ran into another individual and began banging his head on the wall, chair, and trash can. Staff used Ukeru pads, as well as an arm hold. However, he sustained lacerations to his face and an abrasion to his left arm. Emergency Medical Services (EMS) took him to the ED for a head injury (i.e., two lacerations to the forehead with uncontrolled bleeding). Appropriately, a nursing IPN, dated 11/5/18, at 12:13 p.m., further described the measurements of his lacerations, and pupil response, which were noted as sluggish. The one issue with nursing assessments for this restraint was the lack of respirations as part of vital sign assessments.

The following provide examples of problems noted:

- For Individual #410's restraint on 12/5/18, at 1:50 p.m., a nursing IPN, dated 12/5/18, at 2:10 p.m., stated the individual was uncooperative, and the plan was to re-assess when the individual was calm and cooperative. The IView/Flowsheet, dated 12/5/18, at 3:00 p.m., indicated an elevated pulse rate. No follow-up IView or nursing IPN was found to address the abnormal finding. In addition, the initial post-restraint nursing IPN described that he was banging his head, but the nurse did not conduct and/or document an assessment for head injury.
- For Individual #410's PMR-SIB:
  - Paragraph IV.D.2.b of the State Office policy on restraint, effective 10/1/18, requires an IDT to develop an IHCP that describes the need for PMR-SIB. Although not outlined in the policy, the IHCP should include all needed physical assessment, monitoring activities, needed assistance with care, instructions for release, and documentation of behaviors during releases, and how often the PMR will be reviewed with the associated documentation.

        - Based on the documentation submitted, Individual #410's IDT did not have a current IHCP in place to address the use of the PMR-SIB.
    - In Paragraph IV.E.3, State Office policy indicates that: "The protective mechanical restraint plan describes the level of monitoring to be used when the mechanical restraints are in place and when the mechanical restraints are removed."
        - Individual #410 had a Protective Mechanical Restraint Plan for Self-Injurious Behavior, which defined some monitoring requirements for direct support professionals, such as every time he puts his helmet on, staff need to complete a circulation check (i.e., two fingers under the chinstrap) 15 minutes later. However, this plan did not define nursing assessments that needed to occur.
    - State Office policy in Paragraph IV.D.4, also requires that: "A nursing staff completes a check of the device once per shift and documents the individual's medical status. The restraint monitor and nursing staff document their information in IRIS."
        - In terms of nursing assessments, based on the documentation submitted, nurses did not complete vital signs every shift. Most entries with regard to mental status only said "alert," or "no change from baseline."
        - Most entries did not show that the nurses inspected the conditions of the device.
        - In IView, in the Mechanical Action Codes section, words were cut off from the printed version, resulting in an inability to fully assess the entries.
        - In response to the Monitoring Team's request for: "The Integrated Progress Note (IPN) related to the restraint, as well as any IPNs related to monitoring of restraint-related issues through to resolution," the Center submitted no documents.
    - In Paragraph V.E.3, State Office policy indicates: "For protective mechanical restraints for SIB, removal of restraints must follow the individual's protective mechanical restraint plan and fading schedule for SIB. The plan must include an opportunity for motion and exercise, safety permitting, for a period of not less than 10 minutes for a continuous two hours in which restraint is employed."
        - The Restraint Plan called for 25-minute hourly breaks from the helmet.
- For Individual #48's restraint on 7/10/18 at 12:24 p.m., although the nurse documented a respiratory rate at 12:40 p.m., the individual reportedly refused assessments at 12:40 p.m., 12:44 p.m., 12:48 p.m., and 12:52 p.m. Follow-up assessments were not documented.
- For a number of the restraints (e.g., Individual #318 on 10/25/18 at 12:25 p.m., Individual #48 on 7/10/18 at 12:24 p.m.), nurses described individuals' mental status as "alert and awake" or "at baseline" without provided a detailed description, including comparison to the individual's baseline.
- On 8/22/18, at 5:50 p.m., while in a vehicle returning from the hospital, staff restrained Individual #107 after she pulled staff's hair, tried to bite staff, and attempted to get out of a moving vehicle. Documentation indicated that the nurse was notified on 8/22/18, at 8:50 a.m., which could not have been accurate. On the Restraint Checklist, the time the nurse arrived was not listed. Although IView indicated that nursing progress notes were entered on 8/22/18 at 5:50 p.m., 6:15 p.m., and 6:23 p.m., the Center did not submit corresponding IPNs. Nursing IPNs/IView were noted for assessment prior to the restraint time. Without the IPNs, it is unknown whether or not staff notified the nurse of the occurrence of the restraint that occurred in the vehicle off campus. Although the injury report stated "none," it remained unclear whether or not the nurse completed an assessment in response to a report of a restraint.
- For most of the restraints reviewed, nurses had not completed and/or documented assessments for injuries.

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

Summary: This indicator will remain in active monitoring. Some documentation problems were occurring for PMR-SIB usage.

#	Indicator	Overall Score	Individuals: 410	48	318	20	107				
15	Restraint was documented in compliance with Appendix A.	86% 6/7	2/3	1/1	1/1	1/1	1/1				

Comments:
15. For Individual #410, PMR-SIB, helmet on/off information was not correctly recorded (sub-indicator j).

There was improvement in the documentation for crisis intervention chemical restraint. This was an improvement since the last review.

Outcome 6- Individuals’ restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.

Summary: Due to sustained high performance, indicator 17 will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 410	48	318	20	107				
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	Due to the Center’s sustained performance, this indicator was moved to the category of requiring less oversight.									
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 2/2		1/1		1/1					

Comments:

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: Correct follow-up to crisis intervention chemical restraint was done by the psychiatry department. Given sustained high performance, this indicator will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 410	48	318	20	107				
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.	100%				1/1					

		1/1									

Comments:
47-48. The above indicators applied to a chemical restraint regarding Individual #20. The Administration of Chemical Restraint: Consult and Review form was completed the day following the chemical restraint and there was documentation of psychiatric follow-up.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
Summary: For all but one of the investigations, supports were in place to have reduced the likelihood of the incident occurring. Protocols for individuals identified for streamlined investigations were being followed by HHSC PI and by the Center. This indicator remains in active monitoring.			Individuals:								
#	Indicator	Overall Score	18	410	38	586	71	3	132	318	
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	92% 11/12	1/1	3/3	1/1	1/1	1/1	2/2	1/2	1/1	

Comments:
The Monitoring Team reviewed 12 investigations that occurred for eight individuals. Of these 12 investigations, seven were HHSC PI investigations of abuse-neglect allegations (two confirmed, two unconfirmed, one inconclusive, one unfounded/streamlined, one referred back to Center for clinical investigation). The other five were for facility investigations of serious injury, choking, and unauthorized departure. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #18, UIR 38, HHSC PI 47494805, inconclusive allegations of physical and emotional abuse, 10/26/18
- Individual #410, UIR 293, HHSC PI 47402738, unconfirmed allegation of neglect, 8/23/18
- Individual #410, UIR 8, HHSC PI 47429914, unconfirmed allegation of physical abuse, 9/11/18
- Individual #410, UIR 59, serious injury, witnessed laceration, forehead/nose, 11/29/18
- Individual #38, UIR 15, HHSC PI 47440535, confirmed and inconclusive allegations of physical abuse category 2 and neglect, 9/18/18
- Individual #586, UIR 275, HHSC PI 47195139, clinical referral of an allegation of neglect, 6/29/18
- Individual #71, UIR 5, HHSC PI 47423904, confirmed allegation of physical abuse category 2, 9/16/18
- Individual #3, UIR 63, HHSC PI 47544036, unfounded allegation of physical abuse, streamlined investigation, 12/4/18
- Individual #3, UIR 273, unauthorized departure, date unknown
- Individual #132, UIR 277, choking incident, date unknown
- Individual #132, UIR 299, witnessed serious injury, fracture, ribs, 8/30/18

- Individual #318, UIR 65, discovered serious injury, fracture, hand, 12/6/18

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

For all 12 investigations, related background checks and duty to report forms were done correctly. For five of the 12, the investigation was regarding allegations of staff misconduct and for each of these, there were no relevant individual-related trends to be reviewed. For the other seven, behaviors that were related to the incident were already part of a PBSP or PNMP or relevant behaviors were added to a PBSP. Thus, sub-indicators b, c, and d were met.

For one investigation, Individual #132 UIR 277, the risk of choking was identified two weeks prior to the incident, but supports were not put into place (the IDT planned to do the review at the upcoming ISP meeting). After the incident, supports were put into place (i.e., in the PNMP). That being said, during the onsite week, the Monitoring Team saw that the old PNMP (from September 2018) was present for staff to use rather than the newer one (December 2018).

The Monitoring Team examined whether protocols were properly implemented for individuals who were identified by HHSC PI for streamlined investigations. Two individuals were chosen, Individual #73 and Individual #3. HHSC PI reviewed the appropriateness of the individual's placement on the list within the last quarter and Lufkin SSLC had addressed the frequent false accusation behaviors within PBSPs.

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

Summary: Overall, most incidents were reported timely and correctly. During each of the last four reviews, from one to three incidents had a problem with reporting. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 18	410	38	586	71	3	132	318	
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	92% 11/12	0/1	3/3	1/1	1/1	1/1	2/2	2/2	1/1	

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

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

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

- Individual #18 UIR 38: the Center provided an explanation as to why the reporting was late (the reporter's cellphone died). It was, therefore, not reported until the next morning. There were, presumably, other options for the employee to report it earlier than that.

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 of the requirement of indicator 4 were met. Sub-indicator 4.2 was especially thorough. With sustained high performance indicator 4 might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	18	410	38	586	71	3	132	318	
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments: 4.2. ISPs include a detailed description of each injury/incident and a short summary (sub-indicator 4.2). This was very good to see, and they were done very well. A suggestion is for the summary to also include data noting witnessed versus discovered injuries, and the number of injuries by shift and location.											

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.											
Summary: Individuals were protected after an allegation, though documentation in one case showed some discrepancies in times reported. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	18	410	38	586	71	3	132	318	
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	92% 11/12	0/1	3/3	1/1	1/1	1/1	2/2	2/2	1/1	
Comments:											

6. For Individual #18 UIR 38, there were a variety of time discrepancies in the UIR regarding when reported and when alleged perpetrator was reassigned. This should have been detected in documentation review.

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: Criteria were met for all but one investigation. This was good to see. The investigation that did not meet criteria was a clinical investigation that was missing some components. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	18	410	38	586	71	3	132	318	
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	92% 11/12	1/1	3/3	1/1	0/1	1/1	2/2	2/2	1/1	
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	92% 11/12	1/1	3/3	1/1	0/1	1/1	2/2	2/2	1/1	
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments: 8-9. For Individual #586 UIR 275, a clinical referral investigation was conducted. As such, the incident management department and the IMC do not conduct the investigation or review the contents of the investigation that is conducted by a clinical investigator. The Monitoring Team reviews the investigation for process, but not for clinical content. In this case, there were two aspects that did not meet procedural criteria: witness interviews were not documented, and potential systemic problems were not presented to the Center Director. The incident management department/IMC was notified by the clinical investigator that the investigation was complete and no action was necessary. Based on the Monitoring Team's review of the investigation, this was not the correct process. The clinical investigator should have let the IMC know that the investigation discovered allegations of potential systemic clinical issues and determined that no additional action was necessary, so that the IMC and Center Director could also determine if actions were needed (also the Monitoring Team disagreed with the clinical investigation determination that actions were not necessary, see indicator 16 below). The IMC, who was not privy to the content, then followed protocol correctly and closed the case.											

Outcome 7– Investigations are conducted and reviewed as required.											
Summary: The investigation review process had improved since the last review. In fact, all of the investigations met criteria with indicator 13, but one. That one was a clinical investigation, for which the review process did not identify problems with the investigation. With correction to that process, and demonstrated implementation and sustained high performance, indicator 13 might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	18	410	38	586	71	3	132	318	
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, these indicators were 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 (unless a written extension documenting extraordinary circumstances was approved in writing).										
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	92% 11/12	1/1	3/3	1/1	0/1	1/1	2/2	2/2	1/1	
Comments: 13. For the clinical investigation, Individual #586 UIR 275, the review process did not identify the problems identified by the Monitoring Team (see indicators 8 and 9 above and 16 below). 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:			Individuals:								
#	Indicator	Overall Score									
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.										
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.										

Comments:

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
Summary: The clinical investigation identified potential issues for which actions should have been, but were not, recommended. For the other investigations, recommendations relevant and related to the circumstances of the investigation were made. This was good to see and the Center followed-up by implementing all recommendations in a timely manner. Given this high level of performance, these three indicators, 16, 17, and 18, will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	18	410	38	586	71	3	132	318	
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	92% 11/12	1/1	3/3	1/1	0/1	1/1	2/2	2/2	1/1	
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 3/3	1/1		1/1		1/1				
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 9/9		3/3	1/1			2/2	2/2	1/1	

Comments:
16. For Individual #586 UIR 275, the investigation identified potential allegations and systemic issues that should have resulted in recommendations, but did not.

17. During this review period, staff in two cases were confirmed for physical abuse category 2. Employment was not maintained for any of these employees.

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 were collected and trended. Some corrective actions were developed. Also see the quality assurance and improvement section of this report. 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.	No									

20	Over the past two quarters, the facility's trend analyses contained the required content.	No									
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:
19. Six of the seven data sets were being tracked and trended. Data related to staff were not.

20. Regarding allegations, the Center (and their trend report) attributed most of the allegations to individuals who make false allegations. It would be useful to separate those data to get a better picture of what's happening at the Center.

21-23. There was considerable narrative following data tables. In some cases, actions were described, but there were not data based achievement goals or, in most cases, descriptions of specific action steps associated with an action plan.

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	0/1
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. As discussed in the last report, the Center's policies with regard to criteria for the use of TIVA, as well as medical clearance for TIVA, need to be expanded and improved. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures. Given the risks involved with TIVA, it is essential that such policies be developed and implemented. 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 may have co-morbid conditions that potentially put the individual at higher risk. Risks are specific to the individual, the specific procedure, and the type of anesthesia. The outcome of a preoperative assessment should be a statement of the risk level. The evaluation should also address, perioperative management, which includes information on

perioperative management of the individual's routine medications. A number of well-known organizations provide guidance on completion of perioperative evaluations for non-cardiac surgery.

The Center submitted a copy of the Dental Procedures Manual. The signature lines for the Dental Director and Medical Director were blank. Section J of the manual addressed Total Intravenous Anesthesia. It did not define the selection criteria for TIVA. The Dental Director reported that she and the Medical Director were in the process of drafting policies and procedures to address the issue of TIVA criteria and perioperative evaluations.

Individual #132 did not meet the criteria for the use of TIVA. While the Center did provide documentation for other procedures (e.g. obtaining informed consent; confirming nothing by mouth (NPO) status; completing an operative note; and, monitoring, and addressing as needed, post-operative vital signs), it should not have used TIVA without first demonstrating it was needed.

The Center had not defined in policy the criteria for use of TIVA. This individual was assigned a low risk rating even though she had Type 3 periodontal disease. It appeared that while she cooperated for basic treatment, she required anesthesia for extraction and deep cleaning.

Individual #107 had oral pre-treatment sedation, for which the Center obtained informed consent, confirmed NPO status, completed an operative note, documented post-operative vital signs, and completed the required documentation related to post-procedure vital signs. The Center did not ensure the dentist/primary care practitioner (PCP) obtained the input of the disciplinary committee/group with regard to determining the medication and dosage range. As the audit tool describes, the Center must ensure pre-treatment sedation is coordinated with other medications, services and supports, including as appropriate psychiatric, pharmacy, and medical services.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: Based on the findings for the one individual reviewed for whom pre-treatment sedation was used for medical procedures, staff had not taken steps to adequately protect him from harm. This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/2	N/A

Comments: a. By way of history, according to Individual #468's Integrated Risk Rating Form (IRRF), he was "hospitalized from 5/12/18 thru - 5/16/18 after having respiratory distress and multiple seizures on campus following sedation with Geodon 40mg IM [intramuscular] on 5/9/18. He was diagnosed with respiratory failure, pneumonia, UTI, seizure, hypoxia." The IDT determined the "root cause" to be "aspiration pneumonia related to dysphagia exacerbated by sedation secondary to anoxic brain injury at birth and long term antiepileptic use."

On 5/23/18, while at the Center, his blood pressure spiked to 210/95, and he was given a one-time dose of clonidine. The blood pressure decreased to 165/85. The individual became unresponsive and was sent to the ED, and was diagnosed with a subdural

hematoma. The computed tomography (CT) scan also showed multiple bleeds, some of which were old.

Due to the events of 5/12/18, as discussed above, it was recommended that a nurse attend the next CT appointment with the individual. On 6/22/18, he was administered Geodon 40 milligrams (mg) IM for the CT scan. The individual also had a history of hypertension that required treatment with two medications. On 6/22/18, his blood pressure prior to Geodon was 140/80. Blood pressure readings at the testing site were 98/58, 99/70, and 96/68.

On 6/24/18, at approximately around 3:00 a.m., he had a seizure and was transferred to the ED. He returned to the Center on 6/24/18. On 6/25/18, the PCP evaluated the individual. His blood pressure was 137/99. Per nursing documentation, on 6/25/18, Individual #468's two ED visits were discussed during morning meeting. The PCP notes did not mention any discussion regarding the problems documented following the use of IM Geodon for sedation.

For this administration of Geodon, no consent form was submitted. The Human Rights Committee (HRC) note stated that on 7/12/18, the guardian gave consent. A reference was made to the ISPA, also held on 7/12/18. The ISPA documentation noted that the PCP and Pharmacy Director did not believe that Geodon contributed to seizures. The ISPA further documented that the individual's guardian and IDT agreed to go forward with the next pre-treatment sedation in August 2018. This verbal consent from the guardian should have been completed in the usual manner, documenting that the PCP discussed the procedure, medication, risks, and benefits with the guardian. It should have been noted that the guardian provided verbal consent and the process should have been witnessed. Moreover, the HRC and ISPA documentation was dated 7/12/18, so it was not relevant for the June sedation.

It should be noted that Geodon is a long-acting intramuscular (IM) injection and all second-generation antipsychotics (SGAs) have the potential to lower the seizure threshold in addition to causing hypotension and prolonging the QTc interval. There was clear documentation that the individual had a significant drop in blood pressure following the administration of the Geodon.

Again, on 8/14/18, Individual #468 received Geodon 40 mg IM. Prior to the injection, his blood pressure was 115/79. After the injection, his BPs were 101/54, 101/63, 89/58, 98/58, 105/60, 103/62, 104/64, and 100/60.

On 8/14/18, nursing staff documented: "Attempts to dilate pupils for exam were unsuccessful and Dr… made the statement that [Individual #468] was sedated 'a little too much.'" The ophthalmologist was able to "perform a partial exam." The PCP was notified of the low vital signs, but there was no documentation that the PCP conducted an assessment.

Of note, as part of the Tier I document request, the Lead Monitors both ask for a "List of individuals who have had pretreatment sedation, with the following information (a) identify if PTS was for dental or medical, (b) what it was for (e.g., routine cleaning, hip surgery)…" Although the Center provided a list, these instances of the use of pre-treatment sedation were not included on the list.

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: Lufkin SSLC IDTs were not addressing the topics required regarding pretreatment sedation. As a result, IDTs did not discuss whether interventions or	Individuals:

strategies should be implemented and, consequently, none were. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	0% 0/3				0/1		0/1			0/1
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	0% 0/3				0/1		0/1			0/1
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.	N/A									
4	Action plans were implemented.	N/A									
5	If implemented, progress was monitored.	N/A									
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A									

Comments:
This outcome and its indicators applied to Individual #97, Individual #410, and Individual #38.

1. Available documentation reflected a discussion that Individual #97 's TIVA was restrictive. Individual #410's available documentation did not include a review by the IDT of PTS usage during the past 12 months, or a discussion of supports in place to prevent future PTS or risks and benefits of the procedure without PTS. Individual #38's available documentation did not include a discussion by the IDT of other supports to prevent future PTS, or a discussion of informed consent.

2-6. No treatments or strategies to minimize the need for PTS were documented.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	394	250	345	232					

a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 4/4	1/1	1/1	1/1	1/1					
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	50% 2/4	0/1	1/1	1/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	50% 2/4	0/1	1/1	1/1	0/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	50% 2/4	0/1	1/1	1/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1					

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

- On 5/3/18, Individual #394 died at the age of 59 with causes of death listed as acute respiratory failure, and bilateral aspiration pneumonia (i.e., the autopsy report indicated causes of death were septic shock as a result of severe acute necrotizing pancreatitis, bilateral pneumonia, and myocarditis).
- On 5/26/18, Individual #250 died at the age of 69 with cause of death listed as Alzheimer's Disease.
- On 6/11/18, Individual #345 died at the age of 67 with causes of death listed as aspiration pneumonia, and Parkinson's disease.
- On 6/18/18, Individual #52 died at the age of 68 with causes of death listed as sepsis, pneumonia, and chronic obstructive pulmonary disease.
- On 7/5/18, Individual #232 died at the age of 78 with cause of death listed as ruptured aortic aneurysm.
- On 12/30/18, Individual #201 died at the age of 75 with causes of death listed as dilated cardiomyopathy.

b. through d. Although for a couple of the mortality reviews that the Monitoring Team reviewed, some improvement was noted in their quality, this was not yet consistent. For others, evidence was not submitted to show the Center conducted thorough reviews of medical and nursing care, or an analysis of medical/nursing reviews to determine additional steps that should be incorporated in the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews.

For Individual #232, the Clinical Death Review noted that there were several incidental findings made during the review that were not included. The reason given was that they had been previously identified and addressed in mortality reviews. The fact that the same issues continued to occur even after being identified and addressed is cause for concern. The mortality review committee should have included recommendations to further address these issues.

e. The recommendations generally were not written in a way that ensured that Center practice had improved. For example, a recommendation that read: "The Social Workers and QIDPs will be retrained on the 'OOH DNR' [Out-of-Hospital Do Not Resuscitate] policy" resulted in an in-service training. This did not ensure that staff were competent or practice changed. The recommendation should have been written in a manner that required a competency check, at a minimum, as well as potentially review of other potentially impacted individuals' records.

Not all PCPs had signed training records for related recommendations.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	ADRs are reported immediately.	0% 0/2				0/1				0/1	
b.	Clinical follow-up action is completed, as necessary, with the individual.	0% 0/2				0/1				0/1	
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	0% 0/2				0/1				0/1	
d.	Reportable ADRs are sent to MedWatch.	0% 0/2				0/1				0/1	
Comments: a. through d. Center staff had not identified and/or reported adverse drug reactions for any of the individuals reviewed. However, for two individuals, potential ADRs should have been reported and reviewed, including for Individual #10 (i.e., hyponatremia that the QDRR identified as medication-related), and Individual #468 (i.e., related to the use of Geodon for pre-treatment sedation).											

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
Summary: Given that during the last two review periods and during this review, the Center completed clinically significant DUEs (Round 12 – 100%, Round 13 – 100%, and Round 14 – 100%), Indicator a will move to the category of requiring less oversight. Indicator b will remain in active monitoring.		Individuals:
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 2/2

b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/2

Comments: a. and b. In the six months prior to the review, Lufkin SSLC completed two DUEs, including:

- On 8/29/18, a DUE reviewing utilization at the Center of sodium chloride with respect to safety, efficacy, and appropriateness of therapy was presented to the Pharmacy and Therapeutics (P&T) Committee. There was no plan of correction documented. Per the minutes: "Dr.… will be sending out an email to the prescribers to identify the individuals for whom there were recommendations in the DUE."
- On 10/23/18, a DUE reviewing utilization at the Center of Tamiflu with respect to safety, efficacy, and appropriateness of therapy was presented to the P&T Committee. It should be noted that of the Center's medical staff, only four providers attended the meeting, including two psychiatry providers and two primary care providers. There were no representatives from the Nursing Department. It was unclear how the information presented was shared and discussed with the medical staff.

  There was no documentation that a plan of correction was developed. Per the minutes reviewed: "Further discussion of specific recommendations on facility practices with respect to Tamiflu use will include the medical director."

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 last review, 23 of these indicators were already in, or were moved to, the category of requiring less oversight. For this review, two other indicators were moved to this category, in ISPs and psychiatry.

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

<u>Assessments</u>
For about half of the individuals, IDTs identified and then sought out and obtained a set of relevant assessments prior to the annual ISP meeting.

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

For the individuals reviewed, the annual medical assessments (AMAs) continued to need significant improvement, particularly with regard to family history, childhood illnesses, pertinent laboratory information, and thorough plans of care for each active medical problem, when appropriate. At the State's request, the Monitoring Team reviewed some of the most recently developed AMAs. Overall, there was some improvement in the quality of these sample AMAs. This was primarily observed in the assessment and plan for the active medical problems and the documentation of childhood illnesses. However, most of these sample AMAs did not document the attempts to update the family history. Laboratory data was incomplete for most. Immunization data also were incomplete, and difficult to interpret.

The Center should continue its focus on completing timely annual dental exams, as well as improving the quality of dental exams and summaries. The assessments done in the past two to three months demonstrated improvement in quality, but additional improvement was still needed. In June 2018, the Center hired a new Dental Director, who conducted a needs assessment for the clinic. This has allowed for the identification of gaps in practices and in the care provided to individuals. The clinic is working to correct these gaps. As noted in previous reports, over the past several years, dental services had declined. Correcting the problems will take time and the continued efforts of the clinic staff.

For the nine individuals reviewed, nurses completed timely annual nursing reviews and physical assessments, as well as quarterly nursing record reviews and/or physical assessments. However, work is needed to ensure that nurses complete annual and quarterly physical assessments that address the necessary components. Work is also needed to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to individuals' at-risk conditions. Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk.

It was good to see that in some instances, when individuals experienced changes of status, nurses completed assessments in accordance with current standards of practice, but this is also an area in which improvements are still needed.

Since the last review, it was good to see some improvement with regard to individuals being referred to the PNMT, when their needs required referral. However, often the referrals were late. The Center should also focus on timely completion of the PNMT initial reviews, completion of PNMT comprehensive assessments for individuals needing them, and significant improvements to the quality of the PNMT comprehensive assessments.

The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied, but demonstrated improvement since the last review. The quality of OT/PT assessments continues to be an area on which Center staff should focus considerable efforts.

Significant work is needed to improve timeliness and quality of communication assessments and updates 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.

Of note, as part of the onsite review week, the Monitoring Team appreciated the Habilitation Therapy Director's willingness to conduct an objective review of one individual's OT/PT assessment and another individual's communication assessment, review the findings with the Center therapists, and then discuss her findings openly with the members of the Monitoring Team and State Office staff. This effort showed Center staff's ability to identify strengths, as well as weaknesses in the assessments, as well as to identify potential solutions to the significant improvements that are needed with regard to the assessments. The Monitoring Team is hopeful that the Habilitation Therapy Director's ongoing auditing of assessments with feedback provided to therapists will assist in improving the quality of the assessments.

In psychiatry, new admissions had a CPE completed in a timely manner as well as required admission notes. Content of CPEs, however, needed some attention to ensure that all of the required components were completed as per criteria.

Behavioral health assessments were consistently timely. PBSPs had measurable behavioral objectives that were based on the results of assessments.

All but one functional assessment was current and complete. Although this showed high performance, the individual for whom the assessment was not complete was an individual who demonstrated complex behavioral challenges.

All individuals had SAPs, though two-thirds of the individuals had but two SAPs, even though they all had many skills deficits for which programming would have been beneficial to improving their independence, participation, and quality of life.

Two-thirds of SAPs remained not practical, functional, and/or meaningful. The selection of meaningful and functional SAPs needs to improve. Many SAPs were compliance plans or skills that were not clearly related to the individual's ISP vision statement.

Individualized Support Plans

The Monitoring Team attended annual ISP meetings, ISP preparation meetings, ISPA meetings, and a variety of other meetings during which individuals' services and supports were discussed. All individuals were visited at their homes and in their day programs.

The Monitoring Team observed positive interaction with DSPs and individuals. They were knowledgeable regarding basic risks, supports, and routines. Many of the homes, however, were loud, crowded, and chaotic. As noted in the past, individuals had little personal space or privacy, bedrooms did not reflect personal choices, and furniture was old, worn, and in bad repair.

Unit directors remained a strong part of the management at Lufkin SSLC. Each shared a special project or initiative with the Monitoring Team: Castle Pines: new dining room and improving mealtime procedures. Woodland Crossing: roundtable informal discussions with behavioral health services. Oak Hill: reducing peer to peer aggression. Lone Pine: implementing the SOS skin integrity program.

Regarding personal goals in ISPs, performance remained about the same as at the last two reviews for goals, measurability, and reliable data. Half of the individuals had goals that met criteria in four or five of the areas, including one who's goals met criteria in five areas (all except health/wellness).

Regarding the overall ISP, none of the indicators in outcome 3 showed improvement since the last review, and some scored lower than at the last review. The aspects of the ISP that are targeted by these indicators speak directly to the overall quality of the ISPs. The Center should consider some way to ensure that these aspects get addressed in the ISPs.

Action plans did not support achievement of personal goals, that is, they did not show a path towards ultimately meeting the goal. For a majority of the action plans, data were not being collected. Further, many action plans were not implemented, and action was not taken by the IDT to address barriers or revise supports.

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

At this juncture of the implementation of the Settlement Agreement, the lack of relevant nursing care plans in individuals' IHCPs indicates that Nursing Department administrators are not supervising and/or holding RN Case Managers accountable.

There was some very positive individualized programming with some individuals. Examples included working in the community and working in the garden and woodshop on campus.

The Lufkin SSLC psychiatry department made progress in the development of psychiatric indicators as evidenced in the eight 1/2 scores in the table below. That is, the Center had created psychiatric indicators for decrease for all individuals and, for some individuals (less than half), the indicators were related to the individual's diagnoses and were written in observable terminology. This was not the case for the psychiatric indicators for increase.

Psychiatrists attended the annual ISP meeting for every individual. Documentation continued to be prepared for the annual ISP, but every one was missing some components. Similarly, the final ISP documents did not contain all the required content regarding psychiatry. Psychiatric support plans were scored positively for all individuals for the first time at Lufkin SSLC.

The behavioral health services department remained a strong component of the Lufkin SSLC clinical services. It was under good, and long-term leadership, and there were almost a dozen certified BCBAs in the department.

Many (three quarters) of PBSPs had complete and correct content. It was good to see that Lufkin SSLC regularly assessed PBSP target and replacement behavior reliability (IOA and DCT). The assessments, however, showed that more than half of the individuals' data were not reliable (i.e., did not meet the reliability standard).

None of the individuals were receiving counseling services. The Monitoring Team, however, observed a group session and was impressed with the quality of the session and the participation of the individuals.

About half of the SAPs had data shown to be reliable. This was a good improvement from the last two reviews, when none were.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.												
Summary: Performance remained about the same as at the last two reviews for goals, measurability, and reliable data. Half of the individuals had goals that met criteria in four or five of the areas, including one who's goals met criteria in five areas (all except health/wellness). These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	36	78	227	97	132	107				
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	1/6	4/6	5/6	1/6	3/6	4/6				
2	The personal goals are measurable.	0% 0/6	1/6	4/6	2/6	1/6	1/6	2/6				
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	1/6	0/6	0/6	1/6				

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #36, Individual #78, Individual #227, Individual #97, Individual #132, and Individual #107. 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 Lufkin 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.

The IDTs continued to work toward developing individualized, aspirational personal goals. For this review period, none of the six ISPs contained individualized goals in all areas, therefore, none had a comprehensive set of goals that met criterion. However, each of the ISPs contained an individualized goal in at least one area. Across the six individuals, there was variability. For instance, two individuals had goals that met criteria in one area, whereas one individual (Individual #227) had goals that met criteria in five areas (i.e., all except health/wellness).

Eighteen 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. This compares with 20 at the last review.

The personal goals that met criterion were:

- Leisure goals for Individual #78, Individual #227, Individual #132, and Individual #107.
- Relationship goals for Individual #78, Individual #227, Individual #132, and Individual #107.
- Work/School/Day goals for Individual #227 and Individual #107 (both were in school).
- Independence goal for Individual #78, Individual #227, Individual #132 and Individual #107.
- Living options goals for Individual #36, Individual #78, Individual #227, and Individual #97.

2. Of the 18 personal goals that met criterion for indicator 1, 11 also met criterion for measurability. Those that did not meet criteria were:

- Individual #227's recreation and relationship goal and greater independence goals were not measurable. Although her combined recreation and relationship goal was aspirational and based on her preferences, it was not clear what Individual #227 would have to do to plan an outing with her peers. Similarly, it was not clear how the IDT would determine completion for her independence goal.
- Individual #132's relationship and greater independence goals did not include a measurable objective.
- Individual #107's recreation and relationship goals did not include a measurable objective.

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

3. Two of the goals had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals. These were Individual #227's school/day goal to graduate from high school and Individual #107's greater independence goal to make a snack.

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: Scoring overall remained low for this set of indicators. None of the indicators showed improvement since the last review, and some scored lower than at the last review. The aspects of the ISP that are targeted by these indicators speak directly to the overall quality of the ISPs. The Center should consider some way to ensure that these aspects get addressed in the ISPs. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	36	78	227	97	132	107			

		Score									
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	1/6	0/6	1/6	1/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	17% 1/6	0/1	0/1	0/1	0/1	1/1	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 achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	0/6	0/6	1/6			

Comments:

8. Eighteen 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). 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.

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. Three of the goals in the six ISPs met criterion. Those were:

- Individual #227's day/school goal.
- Individual #132's recreation/leisure goal.

- Individual #107's greater independence 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/her goal, thus, data often indicated how many times staff had implemented the plan instead of measuring specific progress towards the goal.

9. One of the ISPs (Individual #132) 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 was particularly limited.

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, tv, and activities routinely offered at the facility.

Opportunities to make meaningful choices were limited, for the most part. 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 in any substantial way.

Self-advocacy committee continued to operate each month. The HRO, who facilitated the meeting, continued to explore new ways of increasing attendance and participation. Self-advocacy activities can also be incorporated into individuals' ISPs.

11. One of the ISPs met criterion for this indicator to support the individual's overall independence. Individual #107 had skill acquisition plans for cooking, money management, learning her address, and learning about her medication.

Assessments and interviews indicated that many of the action plans were compliance plans written for skills that the individual could already complete independently. For example, Individual #97's action plan to put on his shoes and leave them on. Similarly, Individual #36 had an action plan to choose her nail polish color. Her FSA indicated that she was able to make simple choices.

12. None of the ISPs integrated strategies to minimize risks in ISP action plans. While risks were addressed through action plans included in the IHCP, supports were not 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.

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

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

- Individual #97 had a behavioral support plan to reduce the time that he spent restricted in a jumpsuit, that he was unable to remove, due to stripping behavior. His action plans only addressed programming outside the home for less than one hour per day. This hour was scheduled during the three hours a day that he was scheduled to be out of his jumpsuit. Staff reported that removal of the jumpsuit was delayed on days that he went to programming. The IDT needs to integrate these two plans so that both can be consistently implemented. Ensuring that he was engaged when his jumpsuit was removed might also reduce his stripping behavior. He also had communication support strategies that were not integrated into other action plans.
- Individual #36's communication assessment indicated that she was able to verbally state her preferences. She had a SAP for choosing her nail polish color by smiling when her preference was presented.

14. None of the ISPs included action plans to support meaningful integration into the community. Individual #78 was working in the community, which was positive to see. However, he did not have action plans to support his job in the community. Individuals made frequent trips into the community, but were rarely given opportunities to utilize community resources that might support them to be more independent and integrated into the community. Individuals generally 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. One ISP (Individual #132) documented the IDT's consideration of opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Individual #132's ISP did document work exploration trials to determine her preferences for work. Day and work opportunities were particularly limited for most individuals. Vocational training was not focused on building skills that might lead towards employment in a more integrated setting. Individual #78 was working in the community, however, vocational supports focused on contract work at the sheltered workshop instead of building skills that might expand his opportunities for community employment.

Across the SSLC, seven individuals were employed at seven different employers throughout the Lufkin community for one to two hours, for one to five days per week. Although still rather limited, it was good to see this occurring. In addition, about a dozen other individuals were employed via enclave groups at four other employers in the Lufkin community, also for one to hours, once or twice per week.

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. During observations, activities were rarely functional and did not provide opportunities to experience new things and learn new skills. IDTs need to expand the preference assessment to offer more opportunities to try new things and identify new interests.

- Individual #36's ISP indicated that she had two hours per day of scheduled programming. Her ISP offered little functional training. Her ISP indicated that a majority of her day was spent watching TV and catnapping. During observations, she was not functionally engaged.

- Individual #78's staff indicated that he typically was engaged in work activities much of his day. His ISP, however, reflected few opportunities for functional engagement and training.
- Individual #227's ISP indicated that she was scheduled to attend school 4.5 hours per day, but she often refused to go. During observations, she was not engaged in functional activity. Her ISP offered little guidance for training opportunities. She was scheduled to graduate in May 2019. The IDT had not considered assessing her work skills and developing training based on a functional work assessment.
- Individual #97 was scheduled for programming/training outside of his home for six hours per week. The IDT was focused on his refusals to leave the home, but had failed to identify his preferences related to day/work opportunities. His action plans did not provide opportunities for functional training that might lead towards meaningful engagement and greater independence.
- Per staff and observation, Individual #132 was engaged for a majority of her day in activities based on her preferences. The IDT, however, has not developed action plans to support functional training opportunities that might lead towards learning new skills.
- Individual #107's ISP indicated that she was attending school daily, however, observations did not support this. On three separate days, she was observed in bed during school hours. Staff reported that refusals to attend school were increasing. The ISP did not address barriers to participation in school.

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.

18. Action plans did not describe detail about data collection and review, in almost all cases. The one exception was Individual #107's action plans/skill acquisition plan to make her snack independently. 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.

Although IDTs had created 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 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: The ISPs for half of the individuals did not have a description of the individual's living preferences and how those preferences were determined (indicator 19). This was also the case during the ISP meeting observed by the Monitoring Team (indicator 20). Indicator 19 will remain in the category of requiring less oversight, but a return to high performance needs to be seen at the next review in order for it to remain in this category. The absence of thorough	Individuals:

discussions of living options is reflected in the low scores for the other indicators in this outcome, including those based on an ISP meeting observed by the Monitoring Team. That being said, ISPs included statements regarding the overall decision of the entire IDT for all, or for all but one, individual for this review and the previous three reviews, too. Therefore, the Monitor will move indicator 22 to the category of requiring less oversight. The other indicators will remain in active monitoring).

#	Indicator	Overall Score	36	78	227	97	132	107			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	0% 0/1									
21	The ISP included the opinions and recommendation of the IDT's staff members.	83% 5/6	1/1	1/1	1/1	1/1	1/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	83% 5/6	1/1	1/1	1/1	1/1	1/1	0/1			
23	The determination was based on a thorough examination of living options.	33% 2/6	0/1	0/1	1/1	0/1	0/1	1/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	67% 4/6	0/1	1/1	1/1	1/1	1/1	0/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	0% 0/1									
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 0/1									
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	0% 0/3		0/1	0/1			0/1			

Comments:

19. Three ISPs included a description of the individual's preference for where to live and how that preference was determined by the IDT. The other three did not:

- Individual #36 had lived at the Center since 1972. Her ISP noted that she was unable to indicate her preferences. Based on her known preferences, the IDT agreed that a group home near her family would meet her needs. Her living option action plans were continued from the previous year without exploration or discussion regarding specific living options that might provide her needed supports.
- Individual #97 had lived at the Center for almost 30 years. His ISP noted that he showed no interest in living anywhere other than his current placement. It was further noted that he had little exposure or understanding of living options. Based on his reaction to seeing his mother, the IDT determined that he might like to live in a group home closer to his mother. The ISP did not discuss what supports he would need to live in the community or his known environmental preferences.
- Individual #132 had lived in a state supported living facility since age nine. She expressed to the LIDDA that she liked her current placement, however, in the past, she expressed a desire to live with her sister. Since she had not explored community living options in the past two years, it was not clear that she was able to make an informed decision regarding living options.

20. Individual #85's ISP meeting was observed by the Monitoring Team. The IDT noted that he went on a group home tour in 2016 and cried during the entire tour. Based on the reaction to this single tour, the team deduced that he preferred to live in his current home. The IDT did not discuss living options that might support his needs and preferences based on what the IDT knows about him.

21. Five ISPs included the opinions and recommendation of the IDT's staff members. Individual #107's ISP indicated that all team members agreed that she could live in the community and recommended referral. Her summary statement, however, indicated that the IDT did not recommend referral due to psychiatric medication changes.

22. Five ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR. As noted above, Individual #107's ISP statement did not reflect the opinion of team members.

23. Two of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths.

- Individual #227's IDT agreed that past observation of Individual #227 in a smaller, less chaotic home on the SSLC campus was much more suitable for addressing her support needs. This was compared to her behavior while living in her current larger home.
- Per documentation by the LIDDA of discussion with Individual #107's LAR, the family was aware of various living options that might support Individual #107's support needs and preferences in the community.

24. Four 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. Individual #36 and Individual #107's ISPs did not clearly define obstacles to referral.

26. None of the individuals had individualized, measurable action plans to address obstacles to referral, or were referred if obstacles were not identified.

25 and 27. Individual #85's ISP meeting was observed. The IDT did not clearly define obstacles to referral or develop measurable action plans to address any obstacles.

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. All 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.

29. IDTs had not developed action plans to facilitate the referral if no significant obstacles were identified.

- Individual #78's IDT agreed to refer him for community placement but failed to develop action plans to facilitate the referral.
- Individual #227 and Individual #107's IDTs did not identify significant obstacles to referral, and neither was referred for community placement.

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

Summary: Performance remained about the same as at the last review. Ensuring relevant IDT members attend (and are invited to) annual ISP meetings needs to be assessed by the Center. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 36	78	227	97	132	107			
30	The ISP was revised at least annually.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A									
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	67% 4/6	0/1	1/1	1/1	1/1	1/1	0/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	33% 2/6	0/1	1/1	0/1	0/1	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.

33. Four individuals attended their ISP meetings. The exceptions were Individual #36 and Individual #107. Individual #36 was in the infirmary when her ISP meeting was held, and Individual #107's ISP meeting was scheduled when she was on an outing in Houston for the day.

34. Two of the individuals 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 #36's ISP meeting. She had significant mobility and positioning needs that were not integrated into her action plans. Her SLP attended the meeting to represent habilitation therapy, however, it was not evident that the team received specific recommendations from OT/PT when developing programming for Individual #36.
- Individual #227's SLP did not attend her meeting and communication recommendations were not integrated into her ISP. The team did not consider participation by vocational services, though Individual #227 will graduate from high school during this ISP year.
- Individual #97's nutritionist, SLP, and OT did not attend his meeting. He had a recent g-tube placement due to swallowing issues and was now NPO.
- Individual #107's LAR did not participate in her meeting and there was no evidence that her input was received.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: Both indicators improved from 0% scores at the last review. For about half of the individuals, IDTs identified and then sought out and obtained a set of relevant assessments prior to the annual ISP meeting. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	36	78	227	97	132	107			
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.	33% 2/6	1/1	0/1	0/1	0/1	1/1	0/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	50% 3/6	1/1	0/1	0/1	1/1	1/1	0/1			

Comments:

35. For two individuals, 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 #227 will be graduating from high school in the upcoming ISP year. The IDT did not consider her need for a vocational assessment.
- Individual #97 has not had a vocational assessment since 2011. The IDT has not discussed the need for an updated assessment.
- Individual #78 started a new job in the community, the IDT did not update his vocational assessment to determine what job supports or training he might need.
- Individual #107's IDT has not considered her need for a neurological assessment to address her worsening tremors.

36. Three IDTs did not arrange for and obtain all needed, relevant assessments prior to the IDT meeting.

- Individual #78's medical and nutritional assessments were submitted late.

- Individual #227's nutritional and OT/PT assessments were submitted late.
- Individual #107's OT/PT and communication assessments were submitted late.

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

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

Summary: Although identified as a priority area by the QIDP department at the last review, improvement in performance was not seen for either indicator. Both will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 36	78	227	97	132	107			
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 IDT reviewed supports, services, and serious incidents. This was good to see, however, IDTs did not routinely revise supports or goals or address barriers when progress was not evident. As noted in other sections of this report, data were rarely available to assist the IDT in decisions regarding revising the ISP.

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 routinely submitted on time and included a cursory review of all services. The consistent completion of the QIDP monthly reviews was good to see, however, they included little meaningful information regarding progress towards goals and efficacy of supports. When additional assessments were recommended throughout the ISP year, it was often not apparent that the IDT obtained those assessments, reviewed any resulting recommendations, and/or implemented changes to supports when recommended.

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

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

Outcome 1 – Individuals at-risk conditions are properly identified.											
Summary: In order to assign accurate risk ratings, IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings within no more than five days. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	The individual's risk rating is accurate.	6% 1/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	61% 11/18	2/2	0/2	2/2	1/2	2/2	2/2	0/2	N/A	2/2
Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #78 – diabetes, and constipation/bowel obstruction; Individual #36 – skin integrity, and infections; Individual #31 – circulatory, and gastrointestinal (GI) problems; Individual #10 – seizures, and respiratory compromise; Individual #1 – falls, and aspiration; Individual #107 – constipation/bowel obstruction, and dental; Individual #12 – respiratory compromise, and GI problems; Individual #468 – osteoporosis, and urinary tract infections (UTIs); and Individual #132 – choking, and weight]. a. The IDT that effectively used supporting clinical data, and used the risk guidelines when determining a risk level was for Individual #1 – falls. b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #78 – diabetes, and constipation/bowel obstruction; Individual #31 – circulatory, and GI problems; Individual #10 – seizures; Individual #1 – falls, and aspiration; Individual #107 – constipation/bowel obstruction, and dental; and Individual #132 – choking, and weight.											

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.												
Summary: The Lufkin SSLC psychiatry department made some progress in the development of psychiatric indicators as evidenced in the eight 1/2 scores in the table below. That is, the Center had created psychiatric indicators for decrease for all individuals and, for some individuals (less than half), the indicators were related to the individual's diagnoses and were written in observable terminology. This was not the case for the psychiatric indicators for increase. In general, the process of diagnosis->indicators->definitions->goals->to data system->ISP/IHCP documentation needs to occur. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	0% 0/9	0/2	1/2	0/2	0/2	0/2	1/2	1/2	1/2	0/2
5	The individual has goals related to psychiatric status.	0% 0/9	0/2	1/2	0/2	0/2	1/2	0/2	1/2	0/2	0/2
6	Psychiatry goals are documented correctly.	0% 0/9	0/2	0/2	0/2	0/2	1/2	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% 0/9	0/2	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 psychiatric condition and behavioral functioning.

In behavioral health services positive behavior support plans (PBSPs), the focus is upon what are called target behaviors and replacement behaviors. These are the observable, measurable behaviors for reduction and for increase, respectively. They are hypothesized to be, for the most part, under operant control. A functional assessment is conducted to determine the variables that set the occasion for, and maintain, target behaviors (i.e., their function). Replacement behaviors are chosen to provide a functionally equivalent, more socially appropriate alternative to the target behavior. Replacement behaviors sometimes need to be taught to the

individual. Many times, however, replacement behaviors are already in the individual's repertoire, in which case the task for the Center is to set the occasion for those replacement behaviors to occur, be reinforced, and maintained.

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

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

Lufkin SSLC showed some progress in this area as all individuals in the review group had one or more indicators related to the reduction of psychiatric symptoms. This was good to see (sub-indicator a). These indicators, however, were not described in observable terminology (sub-indicator c), and it was not possible to determine how the indicators related to the individual's psychiatric diagnosis or diagnoses (sub-indicator b). For example, Individual #410 had a diagnosis of autism spectrum disorder. The identified indicator for the reduction of psychiatric symptoms was to reduce the amount of time he spent in bed. The relationship of this to the diagnosis was not documented (and not obvious to the Monitoring Team). In another example, Individual #78 had a diagnosis of Schizoaffective Disorder. The identified indicators for the reduction of psychiatric symptoms were aggression and irritability. The relationship to the diagnosis was not documented. In this example, psychotic or mood symptoms related to the diagnosis may be more appropriate.

Five of the individuals in the review group also had psychiatric indicators for increase in positive/desirable actions identified (sub-indicator a). These indicators were not specifically defined (sub-indicator c) and there was no documentation of how the indicators for increase related to the individual's diagnosis (sub-indicator b). For example, Individual #227 has diagnoses of autism spectrum disorder, attention deficit disorder, and obsessive compulsive disorder. The indicator for increase was identified as engagement in leisure activities. This was not defined. In another example, regarding Individual #5, the indicator was identified as increasing cooperation. This was not operationally defined, and there was no documentation of how this related to the diagnosis of autism spectrum disorder. The Center psychiatrists will need to document their rationale of how the positive/desirable action relate to the diagnosis when the action is not immediately evident.

Thus, criteria were met for all three sub-indicators (a, b, c) for psychiatric indicators for reduction for four individuals in the review group 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.

At Lufkin SSLC, there were acceptable goals written regarding psychiatric indicators for reduction for three of the individuals in the review group, Individual #36, Individual #78, and Individual #85. Goals included the psychiatric indicator and a criterion (sub-indicator d). There were no acceptable goals written regarding psychiatric indicators for increase.

There were notations indicating that data would be collected via behavioral health services and while this seems reasonable, the indicators will need to be clearly described in observable terminology in order for them to be accurately identified. Because the purpose of the psychiatric indicator is to determine an individual's symptom experience, a mixture of individually-defined indicators and/or data from direct observations by staff of psychiatric indicators with goals and the collection of data utilizing rating scales normed for this population could be considered.

Thus, both sub-indicators were met for three of the individuals for goals for reduction and for none of the individuals for goals for increase.

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.

At Lufkin SSLC, psychiatric indicators/goals for reduction were not regularly incorporated into the Center's overall documentation system, the IHCP. In one example, regarding Individual #78, the goal for reduction was in the IHCP section of the ISP and included metrics and duration. The goal documented in the IHCP, while similar to the goal in the psychiatric documentation, was slightly different in that while the indicators were the same, the metrics of allowable occasions differed. In this example, the goal in the IHCP was noted as met, although psychiatric documentation did not support this statement. It seemed odd that a goal entered into the new year's ISP/IHCP would say it was already met. If so, then one would expect a different goal. It may be that the psychiatrist wanted to keep the same goal from the previous year. That is, an individual might have met a goal for no occurrences of psychiatric indicators (for reduction). The psychiatrist might feel it appropriate to keep the same goal and target for the upcoming year (not uncommon in psychiatry practice). If so, it might be better to indicate this logic rather than inserting statement that the goal was already met.

Goals for increase were not yet authored and, therefore, not incorporated into the IHCP.

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

by behavioral health services, residential, or psychiatry staff. In addition to using data regarding psychiatric goals/indicators, psychiatrists often utilize behavioral health services target/replacement behavior data as supplemental information when making treatment decisions.

At Lufkin SSLC, data were reported for behavioral challenges and identified target behaviors. There were no reliable data regarding psychiatric indicators for the nine individuals in the review group. One individual, Individual #78, had psychiatric indicators that were identical to the behavioral health target behaviors and, as such, data were collected and presented during psychiatry clinics. Unfortunately, the data regarding Individual #78 did not meet the reliability standard for the period of July 2018 through September 2018, the data collection reliability was 72%, which did not meet the reliability standard of 80%.

The collection and presentation of reliable data is an area of focus for the psychiatry department. Likely, maintaining this will require ongoing collaborative work between psychiatry, behavioral health, residential services, day/vocational services, and the Center's ADOP. This will be the case as Lufkin SSLC moves towards further individualizing psychiatric indicators for decrease and increase that may not be identical to what is already being measured by the PBSP as target behaviors/replacement behaviors.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: New admissions had a CPE completed in a timely manner as well as required admission notes. As a result of this sustained high performance, indicator 15 will be moved to the category of requiring less oversight. Content of CPEs, however, needs some attention to ensure that all of the required components are completed as per criteria. Indicators 14 and 16 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 18	36	5	97	78	410	85	227	38
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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
15	If admitted within two years prior to the onsite review, and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	100% 1/1			1/1						
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.	33% 3/9	0/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1

Comments:

14. The Monitoring Team looks for 14 components in the CPE. None of the CPEs included all of the required components. The evaluations were missing one to six elements. One evaluation was missing one element, three evaluations were missing two elements, two evaluations were missing three elements, one evaluation was missing four elements, and one evaluation was missing six elements. The most common deficient element was the bio-psycho-social formulation. This was incomplete in seven examples.

15. For Individual #5, who was admitted in the two years prior to the onsite review, a CPE was performed within 30 days of admission, and there was documentation from nursing and primary care completed within the first business day.

16. There were six individuals whose documentation revealed inconsistent diagnoses across disciplines, Individual #18, Individual #78, Individual #410, Individual #85, Individual #227, and Individual #38.

Outcome 5 – Individuals' status and treatment are reviewed annually.											
Summary: It was positive to see that the psychiatrist attended the annual ISP meeting for every individual. Documentation continued to be prepared for the annual ISP, but every one was missing some components. Similarly, the final ISP documents did not contain all the required content regarding psychiatry. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
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).	0% 0/8	0/1	0/1		0/1	0/1	0/1	0/1	0/1	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	100% 9/9	1/1	1/1	1/1	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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
18. The Monitoring Team scores 16 aspects of the annual evaluation document. None of the annual evaluations contained all of the required elements. The annual evaluations were missing four to eight of the required elements. Two evaluations were missing four elements, three evaluations were missing five elements, two evaluations were missing six elements, and one evaluation was missing eight elements. The most common missing elements were the risk of medication, risk of illness, and risk benefit discussion.

20. The psychiatrist attended the ISP meeting for all of the individuals in the review group. This was good to see.

As a reminder, if the psychiatrist does not participate in the ISP meeting, there needs to be some documentation that the psychiatrist participated in the decision to not be required to attend the ISP meeting; this can be by the psychiatrist attending the ISP preparation meeting, or by some other documentation/note that occurs prior to the annual ISP meeting. Even so, in the three-month period between the ISP preparation meeting and the annual ISP meeting, the status of the individual may have changed, as there may have been psychiatry related incidents, a change in medications, and so forth. The presence of the psychiatrist always allows for richer discussion during the ISP with regard to the required elements.

21. In all examples, there was a need for improvement with regard to the documentation of the ISP discussion to include the rationale for determining that the proposed psychiatric treatment represented the least intrusive and most positive interventions, the integration of behavioral and psychiatric approaches, the signs and symptoms monitored to ensure that the interventions are effective and the incorporation of data into the discussion that would support the conclusions of these discussions, and a discussion of both the potential and realized side effects of the medication in addition to the benefits.

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

Summary: This indicator was scored positively for all individuals for the first time at Lufkin SSLC. This was good to see. It will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	100% 2/2									

Comments:
22. PSP documents regarding Individual #116 and Individual #9 were reviewed. The PSPs were detailed and contained a description of the psychiatric symptoms for monitoring and recommendations for staff regarding how to respond to and support the individual.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.

Summary: All medications had a current consent form (indicator 28). The consent forms did not include proper risk-benefit discussion or references to alternate and/or non-pharmacological treatment strategies (indicators 30 and 31). Written information about benzodiazepines was not adequate for three individuals, such as regarding the risks of dependency and withdrawal. This is indicator 29 and will need to show improvement at the next review in order to remain in the category of requiring less oversight. HRC review, however, occurred as required. With sustained high performance, this indicator (32) might be moved to the category of requiring less oversight. These four indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
30	A risk versus benefit discussion is in the consent documentation.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
32	HRC review was obtained prior to implementation and annually.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
29. Three individuals, Individual #18, Individual #97, and Individual #410 were prescribed benzodiazepines. The consent forms in these examples were inadequate because the risks of dependency and withdrawal were not included.

30. The risk versus benefit discussion was not included in the consent forms.

31. The consent forms for the individuals in the review group did not include alternate, individualized, non-pharmacological interventions.

Psychology/behavioral health

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

Summary: It was good to see that Lufkin SSLC regularly assessed PBSP target and replacement behavior reliability (IOA and DCT). The assessments, however, showed that more than half of the individuals' data were not reliable (i.e., did not meet the reliability standard). This was about the same as at the last review. More follow-up on low reliability assessments would likely increase reliability scores, resulting in a higher scoring for indicator 5, too. Indicator 5 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
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	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									

	PBSP.										
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.										
3	The psychological/behavioral goals/objectives are measurable.										
4	The goals/objectives were based upon the individual's assessments.										
5	Reliable and valid data are available that report/summarize the individual's status and progress.	44% 4/9	0/1	0/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1

Comments:
3. Individual #18's target behavior of disruption was not clearly defined, therefore, it was not measurable.

5. All individuals had evidence of interobserver agreement (IOA) and data collection timeliness (DCT) assessments in the last six months. Individual #78, Individual #410, Individual #85, Individual #36, and Individual #18, however, had DCT levels below 80% indicating that their PBSP data were not reliable. The BHS staff reported that feedback was given to staff. Ensuring the reliability of PBSP data should be a priority of the behavioral health department.

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

Summary: All but one functional assessment was current and complete. Although this shows high performance, the individual for whom the assessment was not complete was an individual who demonstrated complex behavioral challenges. Indicator 11 will remain in active monitoring. A comment is provided below for indictor 12; indicator 12 will remain in the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 18	36	5	97	78	410	85	227	38
10	The individual has a current, and complete annual behavioral health update.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
11	The functional assessment is current (within the past 12 months).	88% 7/8	1/1	1/1	1/1		1/1	0/1	1/1	1/1	1/1
12	The functional assessment is complete.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
11. Individual #410's functional assessment was completed in the last year, however, it was scored as 0 because the indirect assessments were more than a year old and no rationale was provided as to why they were not conducted in the last year. If it is hypothesized that the functions have not changed in the last year, BHS staff can interview one or two DSPs that are familiar with the individual to verify indirect assessment results, and provide a statement of their observations in the last year.

12. Individual #410's functional assessment included some examples of antecedents and consequences associated with his target behaviors, however, the functional assessment did not include a clear summary statement identifying both the antecedent and consequent conditions hypothesized to affect his SIB and aggression.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
Summary: Many, but not all, PBSPs had complete and correct content. Indicator 15 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
14	The PBSP was current (within the past 12 months).										
15	The PBSP was complete, meeting all requirements for content and quality.	75% 6/8	0/1	1/1	1/1		1/1	1/1	1/1	1/1	0/1

Comments:
15. The Monitoring Team reviews 11 components in the evaluation of an effective behavior support plan. Six plans met the content requirements, two did not:

- Individual #38's PBSP identified her functional replacement behavior as communication of wants and needs. The PBSP, however, described the replacement behavior as Individual #38 pointing to areas that are in pain. The functional assessment indicated that Individual #38's target behaviors were also maintained by positive and negative reinforcement. The PBSP did not, however, specifically instruct staff to functionally reinforce replacement behaviors by specifically reinforcing her requests (e.g., providing a break when he indicated he did not want to engage in an activity.).
- Individual #18's target behavior (disruptive behavior) was not clearly differentiated from her replacement behavior.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
Summary: None of the individuals at Lufkin SSLC were receiving counseling services. These indicators will remain in active monitoring for possible scoring at the next review. The Monitoring Team observed a group session and was impressed with the quality of the session and the participation of the individuals.			Individuals:								
#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	N/A									
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	N/A									

Comments:

24-25. At the time of the onsite review, none of the individuals at Lufkin SSLC were receiving counseling.

Lufkin SSLC did, however, conduct behavioral skill training for five individuals. The Monitoring Team observed one of these sessions, which taught individuals progressive muscle relaxation skills, and was impressed by overall quality of the instruction and the level of cooperation and participation of the individuals.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Center staff 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	78	36	31	10	1	107	12	468	132
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.										
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: b. In the last report (i.e., for Round 13), the Monitor stated: "In the last report [i.e., for Round 12], the Monitor indicated: 'Although Indicator b was moved to the category requiring less oversight, in reviewing individuals' annual medical assessments for other purposes, the Monitoring Team noted that three of nine individuals' annual medical assessments were not timely. If such issues are not corrected, then Indicator b might move back to active monitoring at the time of the next review.' Similarly, for this review, the two newly-admitted individuals had timely initial medical assessments, but three out of the seven individuals did not have timely AMAs. One, though, was late by one day, one was late by two days, and the third was late by three days. Therefore, the Monitor chose to leave Indicator b in the category of less oversight, but again reminds Center staff that Indicator b could move back to active oversight, if issues with timeliness continue to be problematic."

Unfortunately, two of the nine individuals reviewed for this report (i.e., Round 14) had late annual medical assessments. One was late by one day, and the other was late by four days. The Monitor has chosen to leave the indicator in less oversight with the same reminder.

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 improve the quality of the medical assessments. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
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. Problems varied across the medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed, as appropriate, social/smoking histories, past medical histories, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, and updated active problem lists. Most, but not all included, as applicable, pre-natal histories, and complete physical exams with vital signs. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history, childhood illnesses, pertinent laboratory information, and thorough plans of care for each active medical problem, when appropriate.

According to one of the State Office quality improvement physicians, the changes in the AMAs were implemented in October 2018. Due to the legal parties' request that the Monitoring Team assess outcomes for individuals, individuals in the review group had AMAs that PCPs completed between March 2018 and October 2018. In order to provide the Center and State Office with comments on the newer AMAs, the physician member of the Monitoring Team reviewed four additional AMAs that four different providers completed after October 2018. These additional assessments, which Center staff selected, have not been used for scoring purposes, but rather the following comments are meant to offer feedback about the effectiveness of the changes:

- It is important to note that the Monitoring Team's assessment of the AMAs was limited by the lack of other documents that are normally reviewed. It is through review of other documents that the Monitoring Team can determine, for example, that the active problem list is complete or missing a critical diagnosis, or the hospital summary is accurate.
- Overall, there was some improvement in the quality of the AMAs. This was primarily observed in the assessment and plan for the active medical problems and the documentation of childhood illnesses.
- A State auditor's feedback was included in the copies provided. One concern was the commentary from the auditor related to the active medical problems. For example, several individuals were diagnosed with osteopenia and the auditor noted that osteopenia should not be included in the active problem list. The auditor further commented that the diagnosis of osteopenia should not be included in the assessment and plan section of the AMA. However, the individuals with osteopenia received multiple medications for treatment, including denosumab, calcium, and Vitamin D. Additionally, the individuals were monitored with bone mineral density (BMD) studies. Osteopenia was a problem for which the individuals received treatment

and monitoring. As such, it was an active problem that PCPs should include in the active problem list, and the Assessment and Plan section of the AMA.

- Most of the AMAs did not document the attempts to update the family history.
- Laboratory data was incomplete for most. The AMA, at a minimum, should document the basic laboratory data. Noting that a potassium or a chloride level is abnormal provided insufficient data for interpretation of the basic metabolic panel. Similarly, stating that the red cell distribution width (RDW) was abnormal had little clinical relevance if the PCP had not documented the basic values of the complete blood count (CBC).
- The AMAs were lengthy. Each document included four pages of data related to immunizations. A series of immunizations were listed and there was no data for many of the entries. If the immunizations were not applicable that should have been clearly noted. The results of the purified protein derivative (PPD), documented as millimeters (mm) of induration, was equally as important as the date of the test.

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 #78 – diabetes, and gastrointestinal (GI) problems; Individual #36 – osteoporosis, and respiratory compromise; Individual #31 – cardiac disease, and respiratory compromise; Individual #10 – seizures, and medication side effects; Individual #1 – constipation/bowel obstruction, and osteoporosis; Individual #107 – cardiac disease, and other: tremor; Individual #12 – cardiac disease, and aspiration; Individual #468 – infections, and medication side effects/interactions; and Individual #132 – cardiac disease, and diabetes].

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.

#	Indicator	Overall Score	Individuals: 78	36	31	10	1	107	12	468	132
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.	22% 4/18	1/2	0/2	0/2	0/2	2/2	0/2	0/2	1/2	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 #78 – diabetes, and GI problems; Individual #36 – osteoporosis, and respiratory compromise; Individual #31

– cardiac disease, and respiratory compromise; Individual #10 – seizures, and medication side effects; Individual #1 – constipation/bowel obstruction, and osteoporosis; Individual #107 – cardiac disease, and other: tremor; Individual #12 – cardiac disease, and aspiration; Individual #468 – infections, and medication side effects/interactions; and Individual #132 – cardiac disease, and diabetes). 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 #78 – diabetes, Individual #1 – GI problems, and osteoporosis; and Individual #468 – medication side effects/interactions. b. 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.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: The Center should continue its focus on completing timely annual dental exams, as well as improving the quality of dental exams and summaries. The assessments done in the past two to three months demonstrated improvement in quality, but additional improvement was still needed. In June 2018, the Center hired a new Dental Director, who had conducted a needs assessment for the clinic. This has allowed for the identification of gaps in practices and in the care provided to individuals. The clinic is working to correct these gaps. As noted in previous reports, dental services have declined over the past several years. Correcting the problems will take time and the continued efforts of the clinic staff.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	Individual receives timely dental examination and summary:	Due to the Center's sustained performance, these indicators remained in the category of requiring less oversight									
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.										
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.										
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.										
b.	Individual receives a comprehensive dental examination.	11%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1

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

Comments: a. At the time of the last monitoring visit, three individuals had annual dental exams that were late, putting the Center at risk of having this indicator return to active oversight. It was positive that the Center's performance had improved in this regard, with only one individual (i.e., Individual #468) having a late annual exam. This exam was more than a month late, though, so the Center should ensure it pays close attention to the annual timeframes. These indicators will remain in the category of less oversight.

b. It was positive that for two of the nine individuals reviewed, the dental exams included all of the required components. It was also good to see that all the remaining dental exams reviewed 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; and
- An odontogram;

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;
- A treatment plan; and,
- Periodontal charting: The dental audit tool explains: "For individuals with periodontitis, if the individual did not have periodontal probing completed, this indicator will be marked as '0.' Dental Progress Notes or the description of cooperation section of the dental exam is where auditors would find documentation of any challenges and decisions to recall the individual to complete periodontal charting." Based on the documentation submitted, the Dentist had not documented the reason, if any, for the decision not to complete at least annual periodontal probing. As has been agreed with the with the State Office Dental Discipline Lead, the standards used for periodontal disease are those of the American Academy of Periodontology. As their website (i.e., https://www.perio.org/consumer/perio-evaluation.htm) states: "In 2011, the American Academy of Periodontology published the Comprehensive Periodontal Therapy Statement, which recommends that all adults receive an annual comprehensive evaluation of their periodontal health." Of course, IDTs would need to weigh the risks-benefits if sedation were required to complete the procedure.

c. None of the dental summaries reviewed included all the required components. With the most recent dental summary, it was good to see some improvement from the previous review, however. All dental exams reviewed included the following:

- Effectiveness of pre-treatment sedation;

- A description of the treatment provided (i.e., treatment completed);
- The number of teeth present/missing; and
- Recommendations for the risk level for the IRRF.

Most, but not all, the dental summaries included the following:

- Dental care recommendations; and
- Provision of written oral hygiene instructions.

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

- Recommendation of need for desensitization or another plan;
- Dental conditions that could cause systemic health issues or are caused by systemic health issues; and
- Treatment plan, including the recall frequency.

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.											
Summary: For the nine individuals reviewed, nurses completed timely annual nursing reviews and physical assessments, as well as quarterly nursing record reviews and/or physical assessments. This was good to see. At this time, these indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
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.	N/A									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: a.i. and a.ii. It was positive that for all nine of the individuals reviewed, nurses completed timely annual comprehensive nursing reviews and physical assessments, as well as quarterly nursing record reviews and physical assessments.											

Outcome 4 – Individuals have quality nursing assessments to inform care planning.	
Summary: Work is needed to ensure that nurses complete annual and quarterly physical assessments that address the necessary components. Work is also needed	Individuals:

to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to individuals' at-risk conditions. It was good to see that in some instances, when individuals experienced changes of status, nurses completed assessments in accordance with current standards of practice, but this is also an area in which improvements are still needed. All of these indicators will continue in active oversight.											
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	Individual receives a quality annual nursing record review.	11% 1/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1
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.	33% 3/9	0/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1
c.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual receives a quality quarterly nursing record review.	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 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.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
f.	On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	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.	50% 3/6	N/A	0/2	N/A	1/1	N/A	N/A	1/2	N/A	1/1

Comments: a. It was positive that all of the annual nursing record reviews the Monitoring Team reviewed included the following, as applicable:

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

The components on which Center staff should focus include:

- Family history;
- Social/smoking/drug/alcohol history;
- Immunizations; and
- Allergies or severe side effects to medication.

b. Some of the problems with the annual physical assessments included missing fall risk scores, incomplete descriptions of mental status, and a lack of follow-up for abnormal physical findings.

c. and f. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #78 – diabetes, and constipation/bowel obstruction; Individual #36 – skin integrity, and infections; Individual #31 – circulatory, and GI problems; Individual #10 – seizures, and respiratory compromise; Individual #1 – falls, and aspiration; Individual #107 – constipation/bowel obstruction, and dental; Individual #12 – respiratory compromise, and GI problems; Individual #468 – osteoporosis, and UTIs; and Individual #132 – choking, and weight).

Overall, none of the annual comprehensive nursing or quarterly assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Nurses often had not included status updates in annual and quarterly assessments, including relevant clinical data; analyzed this information, including comparisons with the previous quarter or year; and/or made recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

d. It was positive that all of the quarterly nursing record reviews the Monitoring Team reviewed included the following, as applicable:

- Active problem and diagnoses list updated at time of the quarterly assessment;
- Procedure history;
- Consultation summary;
- Lab and diagnostic testing requiring review and/or intervention; and

- Tertiary care.

Most, but not all of the quarterly nursing record reviews the Monitoring Team reviewed included, as applicable:

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

The components on which Center staff should focus include:

- Family history;
- Social/smoking/drug/alcohol history; and
- Allergies or severe side effects to medication.

e. Some of the problems with the quarterly physical assessments included missing fall risk scores, incomplete descriptions of mental status, and a lack of follow-up for abnormal physical findings.

g. The following provide examples of positives as well as concerns related to nursing assessments in accordance with nursing protocols or current standards of practice in relation to individuals' changes of status:

- On 7/27/18, at 8:20 p.m., a nurse wrote an IPN related to a skin tear on Individual #36's left buttock. The initial nursing assessment stated: "an open lesion to left buttocks." Nursing standards for assessment of skin integrity were not followed for measuring the depth of the wound, documenting whether or not there was pain associated with touch to the area, and/or describing a review of the individual's Braden risk score. The plan section of the IPN stated in part: "Nurse to assess per guidelines," which did not meet standards of care. As discussed below, this wound became progressively worse.

  On 9/17/18, a medical IPN stated: "[Individual #36] placed on MAC [Medical Acute Care] for evacuation of wound with slough, accompanied by tunneling that was not present two days ago according to LVN." The assessment was: "Open wound of left buttock Stage IV pressure injury." On 10/2/18, a culture showed the wound was positive for Methicillin-resistant Staphylococcus aureus (MRSA) and Proteus. On 10/3/18, at 8:30 p.m., the PCP ordered antibiotic irrigation. On 10/4/18, at 7:55 a.m., an IView entry noted that a nurse applied gentamicin topical, and documented a nursing assessment, including wound measurements. The nurse defined the area using the clock method and provided a description of the wound to be irrigated. The nurse did not follow standards of care/nursing guidelines, including a pain assessment. Similarly, on 10/4/18, at 6:00 p.m., when the individual was medicated with acetaminophen-codeine, the nurse documented no assessment for pain prior to or one hour after the administration of pain medication, in accordance with nursing standards.
- On 6/22/18, at 12:30 p.m., a nursing IPN indicated that Individual #10 experienced respiratory distress. It was positive that the nurse assessed the individual in accordance with applicable nursing guidelines, and based on the individual's signs and symptoms completed suctioning, administered oxygen, and notified the PCP. The individual was transferred to the ED, where she was subsequently hospitalized, and diagnosed with aspiration pneumonitis.
- Similarly, on 10/29/18, at 8:19 a.m., based on Individual #12's signs and symptoms, the nurse conducted an assessment in accordance with applicable nursing guidelines. Based on vital sign findings, the nurse increased the individual's supplemental oxygen from 2 liters (L) to 3L, and notified the PCP. The PCP ordered transfer by EMS to the hospital, where the individual was diagnosed with aspiration pneumonia.
- On 10/25/18, Individual #12, who had a gastrostomy tube (G-tube), vomited. Although according to the nursing IPN, dated 10/25/18, at 6:01 a.m., and IView entries at 5:40 a.m., the nurse conducted a head-to-toe assessment, neither entry included

information related to his intake, or whether or not he was receiving formula at the time of the vomiting. The related Power Form did not include an analysis of intake and output.

- On 7/17/18, Individual #132 choked on medication and required staff to implement the abdominal thrust. Based on nursing IPNs and IView entries, the nurse conducted a head-to-toe assessment, and notified the PCP. The nursing IPN described assessments for choking, respiratory distress, and performance of the abdominal thrust that followed applicable standards of care. The individual was transferred to the Infirmary.

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

Summary: Given that over the last several review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. At this juncture of the implementation of the Settlement Agreement, the lack of relevant nursing care plans in individuals' IHCPs indicates that Nursing Department administrators are not supervising and/or holding RN Case Managers accountable. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 78	36	31	10	1	107	12	468	132
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. through f. For one of the risk areas reviewed, the IDT had not developed an IHCP (i.e., Individual #107 – dental). For four others, the IHCPs included no nursing interventions (i.e., Individual #10 – seizures, and respiratory compromise, Individual #468 – osteoporosis, and Individual #132 – cardiac disease). For other risk areas, IHCPs included some nursing interventions, but common problems included a lack of preventative interventions, interventions that did not comport with relevant nursing guidelines or

standards or practice, missing interventions, and a lack of measurable interventions.

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, it was good to see some improvement with regard to individuals being referred to the PNMT, when their needs required referral. However, often the referrals were late. The Center should also focus on timely completion of the PNMT initial reviews, completion of PNMT comprehensive assessments for individuals needing them, and significant improvements to the quality of the PNMT comprehensive assessments. These indicators have not shown improvement, and will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	25% 2/8	0/1	1/2	N/A	N/A	N/A	1/1	0/2	0/2	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	13% 1/8	0/1	0/2				1/1	0/2	0/2	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/7	N/A	0/2				0/1	0/2	0/2	
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	25% 2/8	0/1	1/2				1/1	0/2	0/2	
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	0% 0/2	N/A	N/A				N/A	0/1	0/1	
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/8	0/1	0/2				0/1	0/2	0/2	
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and	0% 0/1	0/1	N/A				N/A	N/A	N/A	

	• Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.										
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/7	N/A	0/2				0/1	0/2	0/2	

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

- Between December 2017 and December 2018, Individual #78's weight varied [December 2017: 191.4 pounds, 1/9/18: 170.9, 1/29/18: 166.4, 2/5/18: 166.0, 3/13/18: 178.6, April 2018: 184.2, May 2018: 185, 6/6/18: 182.8 (post hospital), July 2018: 184.4, August2018: 194.6, September 2018: 197.6, October 2018: 203, November 2018: 205, and December 2018: 201.8], but overall, he experienced weight gain. In June 2018, after a hospitalization, he lost a few pounds, and his IDT held an ISPA meeting, and identified the possible need for increased protein for healing, but they did not make a referral to the Registered Dietician. In reviewing his weights over the year, though, between the end of January 2018 and August 2018, he had a weight gain of 17% over six months, and between January 2018 and November 2018, he gained a total of 39 pounds, which represented a 23% increase in weight. In June 2018, his IDT discussed a possible referral to the PNMT, if his weight gain continued, but they never made a referral. The PNMT should have conducted at least a review.
- On 1/30/18, Individual #36 was discharged from the hospital with a diagnosis of left lower lobe pneumonia. It was not until 2/8/18, that her IDT made a referral to the PNMT as a result of a Pneumonia Event Root Cause Analysis (PERCA) review for aspiration pneumonia. In terms of her history of pneumonia, on 1/31/17, she was hospitalized for bacterial pneumonia; from 11/3/17 to 12/11/17, she was hospitalized for pneumonia; and from 12/12/17 to 1/30/18, she had left lower lobe pneumonia. It appeared that on 4/20/18, the PNMT initiated a review/assessment, and on 4/27/18, they completed it.
- On 9/18/18, Individual #36's IDT referred her to the PNMT for a Stage 4 pressure ulcer that staff documented/staged on 9/17/18. Specifically, on 9/17/18, a medical IPN stated: "[Individual #36] placed on MAC for evacuation of wound with slough, accompanied by tunneling that was not present two days ago according to LVN." However, as discussed elsewhere in this report, staff appeared to have identified this wound much earlier. For example, at time of the PNMT assessment for aspiration pneumonia in April 2018, the wound was mentioned. RN notes indicated that the wound was healing, and on 5/4/18, the acute care plan for a wound to the left buttock was discontinued. Then, on 7/27/18, an open wound to the left buttocks was reported, as well as on 8/2/18, an abrasion to the left ischial tuberosity (IT) or "sit bones" was noted. On 9/17/18, staff documented the diagnosis of the Stage 4 wound due to a previous Stage 4 pressure ulcer in same location in 2010. It was not until 10/17/18, according to the signatures, that the PNMT conducted a review. The PNMT should have completed a comprehensive assessment, but did not.
- From 10/11/17 to 1/6/18, Individual #107 had eight reported episodes of emesis (i.e., 10/11/17, 10/15/17, 10/17/17, 11/7/17, 12/3/17, 12/22/17, 12/26/17, and 1/6/18). Reportedly, three of these episodes were related to the individual sticking her finger down her throat and making herself vomit. Although on 2/28/18, her IDT referred her timely, it was not until 3/9/18, that the PNMT completed the assessment.
- On 4/24/18, Individual #12 had a right humeral fracture while hospitalized. Although the PNMT mentioned it in their review related to aspiration pneumonia, it did not appear that his IDT referred him to the PNMT or that the PNMT made a self-referral of this long bone fracture. They stated that there had been a thorough "root cause analysis" for both the fracture and aspiration pneumonia and that further assessment by the PNMT was not indicated.

In July 2018, he had aspiration pneumonia for which he was hospitalized (i.e., from 7/23/18 to 7/27/18), but it did not appear the PNMT conducted a review or assessment. He had at least two vomiting episodes on the date of admission, one when EMS was transferring him onto the stretcher.

On 10/18/18, his IDT made a referral to the PNMT for emesis. Based on documentation submitted, staff reported 22 episodes of emesis from 10/1/17 to 10/31/18. On 10/29/18, he was hospitalized for aspiration pneumonia. Although the referral occurred on 10/18/18, the PNMT did not initiate an assessment until 10/31/18. It was completed on 11/26/18.

- Individual #468 experienced unplanned weight loss from August 2017 to July 2018 (i.e., 184.8 pounds to 155.6 pounds). His estimated desired weight range (EDWR) was 136 to 178 pounds. On 6/20/18, the IDT made a referral to the PNMT related to weight loss. However, they should have referred him in March 2018, when the weight loss was 8.78% in one month (i.e., >5%), as well as in June 2018, when his weight loss was another 8.18%. It was not until 8/14/18, that the PNMT initiated the assessment, and completed it on 8/28/18.

  From 11/10/18 to 11/15/18, Individual #468 was hospitalized with confirmed aspiration pneumonia. The PNMT noted that an IDT "root cause analysis" was pending. This individual had a previous aspiration pneumonia from 5/12/18 to 5/16/18, for which the IDT did not make a referral to the PNMT. The IDT's completion of a "root cause analysis" did not substitute for the need of a PNMT assessment. For this individual with two recent episodes of aspiration pneumonia, the PNMT should have taken the lead in completing a thorough assessment, which could/should have included components of a "root cause analysis."

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).

e. For Individual #12, Center staff submitted an RN post-hospitalization review for his hospital discharge on 11/7/18, but it was not completed until 11/12/18. For his hospital discharge on 7/27/18, the RN assessment was dated 8/1/18. No evidence was found of PNMT discussion for the latter, although for the former, the PNMT discussed it in the assessment completed on 11/26/18.

For Individual #468's hospitalization, the Center did not submit evidence of an RN-post hospitalization review.

h. As noted above, two individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #36 for Stage 4 pressure ulcer, and Individual #468 for aspiration pneumonia). The following summarizes some of the findings for the assessments that the PNMT completed:

- For Individual #36, on 4/27/18, some of the positives with regard to the PNMT assessment for pneumonia were that it included:
  - A discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs;
  - A discussion of medications that might be pertinent to the problem, and discussion of relevance to PNM supports and services; and
  - Evidence of observation of the individual's supports at his/her program areas.

  However, overall, the assessment did not meet the individual's needs. For example:
  - The PNMT listed IRRF ratings from April 2017, and did not discuss whether these continued to be accurate;
  - The PNMT did not thoroughly assess her nutrition and residuals;
  - The PNMT did not offer recommendations for specific outcomes/goals;
  - The PNMT identified the discharge criteria only as the individual would have no episodes of pneumonia with effective control of mucous plugging with Mucomyst, for the next six months; and
  - The PNMT merely stated that the reassessment criterion was pneumonia, if she was referred from the PERCA review process.
- For Individual #107, the PNMT noted that peaks of emesis in October and December might have been related to increases in Risperdal and/or Lithium. Meal refusals numbered 16 in January 2018, and she had weight loss. The PNMT found no correlation with blood sugars or bowel movement patterns. They concluded that insufficient data or medical history was available to identify a "root cause" at that time. However, except for recommending discharge and reassessment criteria, the PNMT offered no recommendations.
- For Individual #12, the PNMT should have conducted an assessment in July 2018, after that episode of aspiration pneumonia, as well as in response to his numerous episodes of emesis.
- For Individual #468, some of the positives with regard to the PNMT assessment for weight were that it included:
  - A 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;
  - A discussion of medications that might be pertinent to the problem, and discussion of relevance to PNM supports and services;
  - Discussion of the individual's behaviors related to the provision of PNM supports and services; and
  - Evidence of observation of the individual's supports at his/her program areas.

  However, overall, the assessment did not meet the individual's needs. For example:
  - The PNMT did not complete a thorough assessment of the individual's physical status. One of the recommendations, for example, was a nutritional assessment, which should have been a part of the PNMT assessment, given that the assessment related to weight loss;
  - The PNMT did not use data to analyze the individual's current supports to determine their effectiveness;
  - The only discharge criterion the PNMT established was: "should he demonstrate the appropriate weight gain/maintenance for six months per RD," which was not measurable.
  - The PNMT recommended no other outcomes/goals.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. In some cases, IDTs had included many 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, many action steps were not measurable. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	6% 1/18	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/18	0/2	0/2	0/2	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.	17% 3/18	0/2	2/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/18	1/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: Individual #78 – weight, and falls; Individual #36 – aspiration, and skin integrity; Individual #31 – choking, and falls; Individual #10 – aspiration, and fractures; Individual #1 – choking, and fractures; Individual #107 – falls, and GI problems; Individual #12 – aspiration, and fractures; Individual #468 – aspiration, and weight; and Individual #132 – falls, and choking. a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP.											

b. IHCPs also often did not include preventative physical and nutritional management interventions to minimize the individuals' risks. The exception was the IHCP for Individual #36 – aspiration.

In some cases, IDTs had included many 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 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., "monitor routinely," "PNMT intervention for emesis," etc.).

c. Individual #78 only had a Dining Plan, but had physical and nutritional management needs for which a PNMP was warranted. For example, he appeared to require head-of-bed elevation (HOBE) due to a diagnosis of GERD, and the PCP ordered 30 to 35 degrees of elevation after surgery related to his shunt. (Documentation was somewhat unclear with regard to whether or not the HOBE remained necessary.) He also was at high risk of falls. Staff were supposed to provide a wheelchair for periods of fatigue or if he was unsteady. In terms of history:

- The OT/PT assessment, dated 10/15/18, indicated that if he continued to maintain his independence, the IDT might consider discontinuing the PNMP. At that time, changes to the PNMP reflected increased independence following a neurological event and direct therapy, which according to an ISPA, was discontinued on 7/25/18.
- On 11/19/18, the IDT held an ISPA meeting to discuss living options. At that time, the IDT identified the need for a shower chair to be available so he could use it if he wanted to, a grab bar and toilet, HOBE, and a hospital bed.
- At an ISPA meeting, held on 12/12/18, the OT/PT recommended discontinuation of the PNMP and the IDT agreed. The justification for doing so was unclear. HOBE not noted anywhere on the dining plan or in the IHCPs, although after the shunt placement, the PCP had ordered 30 to 45 degrees of elevation. In addition, there was a statement in the IHCP under GERD that the individual reported "chest pain," when GERD is not controlled.

Problems varied across the other PNMPs and/or Dining Plans reviewed.

- It was positive that for all of the remaining eight PNMPs, IDTs had reviewed and/or updated them within the last 12 months, and as applicable to the individuals' needs, the PNMPs included:
  - Descriptions of assistive/adaptive equipment;
  - Positioning instructions;
  - Transfer instructions;
  - Mobility instructions;
  - Bathing instructions; and
  - Oral hygiene instructions.
- As applicable to the individuals, most, but not all of the PNMPs reviewed:
  - Identified the full list of the individuals' PNM risks;
  - Included toileting/personal care instructions;
  - Provided handling precautions or moving instructions;
  - Included mealtime instructions;

- Included medication administration instructions; and
- Provided complete communication strategies.

- The components of the PNMPs on which the Center should focus on making improvements include:
  - The pictures of some individuals' seating in PNMPs/Dining Plans were small and dark and did not have enough contrast to provide staff with the detail needed.

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

f. The IHCPs that identified triggers and actions to take should they occur were those for: Individual #36 – aspiration, and skin integrity; and Individual #468 – aspiration.

g. Often, the IHCPs reviewed did not include monitoring and/or the frequency of monitoring. Those that did were for: Individual #78 – weight, and Individual #1 – choking.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	33% 1/3	N/A	0/1	N/A	N/A	N/A	N/A	0/1	1/1	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/2		0/1					0/1	N/A	
Comments: a. and b. Individual #36 and Individual #12's IRRFs did not include sufficient clinical justification for continued enteral nutrition.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.	
Summary: The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the	Individuals:

individuals' needs has varied, but demonstrated improvement since the last review. The quality of OT/PT assessments continues to be an area on which Center staff should focus. As part of the onsite review week, the Monitoring Team appreciated the Habilitation Therapy Director's willingness to conduct an objective review of one individual's OT/PT assessment and another individual's communication assessment, review the findings with the Center therapists, and then discuss her findings openly with the members of the Monitoring Team and State Office staff. This effort showed Center staff's ability to identify strengths, as well as weaknesses in the assessments, as well as to identify potential solutions to the significant improvements that are needed with regard to the assessments. The Monitoring Team is hopeful that the Habilitation Therapy Director's ongoing auditing of assessments with feedback provided to therapists will assist in improving the quality of the assessments. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
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.	56% 5/9	0/1	1/1	0/1	0/1	1/1	0/1	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:	N/A									

	▪ 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.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/5	0/1	0/1	0/1	N/A	N/A	N/A	N/A	0/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/4	N/A	N/A	N/A	0/1	0/1	0/1	0/1	N/A	N/A

Comments: a. and b. Six of the nine individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status.

- In June 2018, Individual #78 returned from a hospitalization for a craniotomy/placement of a peritoneal shunt. This represented a significant change in status, which should have triggered the completion of an OT/PT assessment. However, although the OT/PT wrote a note on 6/28/18, recommending skilled therapy, the therapists did not conduct a comprehensive assessment.
- For Individual #31, Individual #10 and Individual #107, habilitation staff did not complete the required ISP assessments at least ten days prior to the annual ISP meeting.

d. As discussed above, Individual #78 should have had a comprehensive assessment, but did not. None of the four comprehensive assessments reviewed met all criteria for a quality assessment. It was positive that all updates reviewed met criteria, as applicable, with regard to:

- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale.

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

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports.

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

- 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;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living;

- 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;
- 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.

e. It was positive that all updates reviewed met criteria, as applicable, with regard to:

- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);

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

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day; 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:

- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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: Improvement is needed with regard to all of these indicators. To move forward, QIDPs and OTs/PTs should work together to make sure IDTs discuss and include information related to individuals' OT/PT supports in ISPs and ISPAs. These indicators will continue in active oversight.	Individuals:

#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	44% 4/9	0/1	1/1	0/1	0/1	1/1	0/1	1/1	1/1	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.	11% 1/9	0/1	0/1	1/1	0/1	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.	0% 0/10	N/A	N/A	0/2	0/1	0/1	0/1	0/2	0/1	0/2
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	0% 0/5	0/2	N/A	N/A	N/A	N/A	N/A	0/2	N/A	0/1

Comments: a. The ISPs reviewed did not consistently include concise, but thorough, descriptions of individuals' OT/PT functional statuses, but some improvement was noted since the previous review. Therapists should continue to work with QIDPs to make improvements. Examples of continuing concerns included:

- For Individual #78, Individual #31, Individual #10, and Individual #132, the respective ISPs included a summary from the OT/PT assessment, but these provided a very limited description of functional abilities and skills.
- Individual #107 had experienced multiple falls, but the ISP included only limited discussion with regard to falls; rather, it stated she was independent with mobility with no discussion of any other gross motor or community mobility skills.

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

c and d. Examples of concerns included:

- Often, IDTs did not address individuals' OT/PT needs by including recommended interventions in ISP action plans, and/or include goals/objectives for direct therapy that OT/PT's recommended or implemented.
- IDTs also did not hold ISPA meetings to review and approve OT/PT assessment recommendations for the initiation of or modification to therapy services and supports.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.	
Summary: Significant work is needed to improve timeliness and quality of communication assessments and updates in order to ensure that SLPs provide IDTs	Individuals:

with clear understandings of individuals' functional communication status; AAC options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated. These indicators will remain in active oversight.											
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
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.	13% 1/8	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	N/A
b.	Individual receives assessment in accordance with their individualized needs related to communication.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	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
		N/A									

	Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/7	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A

Comments: a. and b. Individual #132 was a functional communicator and had a current screening based on her needs. Of the remaining eight individuals, seven did not have timely communication assessments that were in accordance with their individualized needs. The only exception for this group of eight was for Individual #12. Examples of problems noted included, but were not limited to:

- Between 5/21/18 and 6/27/18, Individual #78 was hospitalized twice due to excess fluid on his brain which required draining and an eventual shunt placement. After the initial hospitalization, the IDT met on 6/6/18, and documented possible head trauma, change in mobility status, and "difficulty getting words out at times." Following the shunt placement, the IDT did not request that the SLP complete a formal rescreening or assessment at that time, but rather, the SLP completed brief consults on 6/29/18 and 7/2/18. On 6/29/18, the SLP provided a brief overview and stated she would complete an assessment on that date when the individual was up and alert, but the Center did not provide evidence that further assessment occurred at that time. The only indication the IDT acted was to identify some additions to his PNMP, one to allow additional processing time and to note that he had trouble "getting words out" at times. This did not demonstrate the needed assessment was completed.
- Individual #10 did not communicate verbally and had no supports provided to address expanding communication. Her last communication evaluation was in 2016. The OT/PT update in 2018 indicated that she had reduced spasticity and was now reaching and grasping items, but the SLP did not conduct at least an update to re-evaluate for potential AAC use.
- The Center did not provide for review a comprehensive assessment for Individual #1, who had AAC and continued to participate in direct communication intervention at the time of this onsite review. The SLP submitted updates for 2016, 2017 and 2018, but provided no rationale for not providing a comprehensive assessment based on his needs. Per the update on 5/17/18, he might have received a comprehensive assessment in 2015, so a comprehensive should have been considered in 2018, in any event.
- The Center had not provided any assessment for Individual #468 since a 2016 update, despite his having AAC and communication supports at that time. Per his current ISP, he also continued to use a voice-output device (VOD) to listen to recorded stories or songs from his sisters.

d. For a number of individuals (i.e., Individual #78, Individual #36, Individual #31, Individual #1, Individual #107, and Individual #468), SLPs had not conducted updated comprehensive communication assessments. The comprehensive assessment for Individual #12 did not meet criteria for any of the following sub-indicators:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- The individual's preferences and strengths are used in the development of communication supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;

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

e. An update should have been completed for one individual (i.e. Individual #10), but was not. Moving forward, Center staff should ensure that updates meet the following sub-indicators:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- The individual's preferences and strengths are used in the development of communication supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;
- The 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: Overall, improvement is needed with regard to these indicators. To move forward, QIDPs and SLPs should work together to make sure IDTs discuss and include information related to individuals' communication supports in ISPs. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 78	36	31	10	1	107	12	468	132
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	33% 3/9	0/1	0/1	0/1	0/1	1/1	0/1	1/1	0/1	1/1

	used in relevant contexts and settings, and at relevant times.										
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/6	N/A	0/1	N/A	0/1	0/1	0/1	0/1	0/1	N/A
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	10% 1/10	N/A	0/1	0/1	0/1	1/4	0/1	0/1	0/1	N/A
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: a. The following provides information about problems noted:

- Individual #78's presented with significant behavioral challenges, some of which were noted to occur when he felt overwhelmed and the ISP indicated he had a history of physical aggression when he became upset. It further indicated he spoke softly and could be hard to understand. The ISP did not describe how staff should communicate with him, beyond a broad statement to be patient when he was speaking and to allow him time needed to communicate. For instance, it did not reference whether his PBSP included any replacement behaviors or strategies that focused on communication.
- Individual #36, Individual #31, and Individual #10 did not have the needed current assessments to provide updated information related to communication for use in their ISPs.
- Individual 107's ISP noted she was hard to understand and that she used her hands to help communicate, pointed or took people to show them what she was trying to say. The instruction for how staff should communicate with her was that they should be patient with her and let her talk at her own pace, but this provided no specific guidance with regard to how to provide directions, prompts, etc.
- Individual #468's ISP did not address AAC or how others should communicate with him.

b. Simply stating that the Communication Dictionary was updated annually and located in the home did not provide evidence of what the IDT reviewed, revised, and/or approved, and/or whether the current Communication Dictionary was effective at bridging the communication gap.

c. For Individual #1, the IDT did not include three of the four recommendations from the communication assessment, or provide justification for not including them. For the remaining individuals, the SLPs should have updated assessments and/or made recommendations that addressed all relevant 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 SAPs, though two-thirds of the individuals had but	Individuals:

two SAPs, even though they all had many skills deficits for which programming would have been beneficial to improving their independence, participation, and quality of life. Most SAPs were based on assessment results and with sustained high performance, this indicator (3) might be moved to the category of requiring less oversight after the next review. Two-thirds of SAPs remained not practical, functional, and/or meaningful. About half of the SAPs had data shown to be reliable. This was a good improvement from the last two reviews, when none were. Indicators 3, 4, and 5 will remain in active monitoring.											
#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
1	The individual has skill acquisition plans.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The SAPs are measurable.										
3	The individual's SAPs were based on assessment results.	90% 19/21	2/2	1/2	2/2	2/2	1/2	3/3	2/2	3/3	3/3
4	SAPs are practical, functional, and meaningful.	33% 7/21	2/2	0/2	0/2	0/2	0/2	1/3	0/2	3/3	1/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	48% 10/21	1/2	2/2	2/2	0/2	0/2	1/3	2/2	2/3	0/3

Comments:

1. All individuals had skill acquisition plans (SAPs). The Monitoring Team chooses three current SAPs for each individual for review. But, there were only two SAPs to review for Individual #85, Individual #78, Individual #97, Individual #5, Individual #36, and Individual #18 for a total of 21 SAPs for this review.

3. Two SAPs did not meet criteria with this indicator. Individual #78's FSA indicated that he can independently write his name, and Individual #36's FSA indicated that she can independently choose among three items.

4. Seven SAPs were judged to be practical, functional, and consistent with their ISP vision statement (e.g., Individual #227's point to letters SAP, which was consistent with her IEP objectives). The SAPs that were judged not to be practical or functional typically represented a compliance issue rather than a new skill (e.g., Individual #85's tolerate the wearing of his massage headband SAP), were not clearly related to the ISP vision statement (e.g., Individual #38's identify her body parts), or the individual already possessed the skill (e.g., Individual #78's write his name).

5. About half of the SAPs had interobserver agreement (IOA) demonstrating that the data were reliable. There was still room for improvement, however, this represented a dramatic improvement from the last review when none of the SAPs were demonstrated to have reliable data.

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: Performance improved for both indicators. With some additional attention to ensuring that all assessments are presented to the IDT timely, and that all assessments include recommendations for SAPs, these indicators can score even higher. They will remain in active monitoring.			Individuals:								
y	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
10	The individual has a current FSA, PSI, and vocational assessment.	Due to the Center's sustained performance, this indicator was 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.	78% 7/9	1/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	78% 7/9	1/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1

Comments:

11. Individual #410's vocational assessment and Individual #5's PSI were not available to the IDT at least 10 days prior to the ISP.

12. Individual #78's vocational assessment and Individual #5's FSA did not include recommendations for SAPs.

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

This domain contains 40 outcomes and 176 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the last review, 32 of these indicators were already in, or were moved to, the category of requiring less oversight. For this review, two other indicators were added to this category, in psychiatry and pharmacy.

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

<u>Goals/Objectives and Review of Progress</u>
Psychiatry quarterly clinics were occurring as scheduled and included the required standard components (as observed by the Monitoring Team during the onsite visit). Data reviewed at the clinics were primarily regarding PBSP target behaviors, not regarding psychiatric indicators or symptoms. The resultant documentation of the clinic was missing various components.

Regarding psychotropic polypharmacy, there was a need for improvement of the written justifications. In addition, there was no documentation of a plan to taper or a rationale as to why to not taper. Not all individuals who should have been reviewed, were reviewed, by polypharmacy.

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.

<u>Acute Illnesses/Occurrences</u>
Lufkin SSLC had a decreasing frequency of crisis intervention restraint usage (see domain 1 of this report). Even so, in those occasions when there were more than three in a rolling 30-day period, the Center was not meeting the discussion and planning requirements of indicators 20-23.

In psychiatry, once Lufkin SSLC routinely obtains reliable data for psychiatric indicators, then progress can be assessed by the Monitoring Team. That being said, the Monitoring Team acknowledges the efforts of the psychiatry staff in taking action for individuals.

With regard to acute illnesses/occurrences, in the months prior to the review, State Office provided training to all of the Centers on the development of acute nursing care plans. For this review, the Monitoring Team reviewed a small number of acute care

plans to provide feedback on the revised processes. Based on the few acute illnesses/occurrences reviewed, results varied with regard to nurses completing assessments at the onset of signs and symptoms of illness, and on an ongoing basis, as well as for nurses timely notifying the practitioner/physician of such signs and symptoms in accordance with the related nursing guidelines. Nursing staff were not developing acute care plans for all relevant acute care needs, and those that were developed needed significant improvement.

Based on the dental emergencies reviewed, the dentist provided the individuals with timely dental assessment. It was also positive that since the previous visit, the Center improved its performance for the provision of emergency dental care. Pain assessment and management, and documentation of it, are areas on which the Center should focus.

Implementation of Plans

At the time of the last review, the Monitoring Team summarized numerous problems with regard to the provision of medical care that had persisted at the Center for some time, and placed individuals at risk. Since the last review, State Office staff worked with Center staff to improve the systems in place with the goal to improve the care and treatment provided to individuals. Although during the onsite review, State Office and Center staff described some of the initiatives underway to improve medical care, based on the individuals reviewed, the described changes had not yet fully taken been realized:

- Although in comparison with the previous four reviews, some incremental progress was noted, significantly more work is needed to improve the care the Center provides to individuals with acute illnesses/occurrences. PCPs' assessment and follow-up of acute issues treated at the Center requires particular focus. For hospitalized individuals, PCP follow-up, as well as IDT follow-up with input from the PCP are also both areas in which work is needed to meet individuals' needs.
- For most of the individuals' chronic or at-risk conditions reviewed, medical assessment, tests, and evaluations consistent with current standards of care were not completed, and/or the PCP had not identified the necessary treatment(s), interventions, and strategies, as appropriate.
- The Center should focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.
- As indicated in the last several reports, overall, much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.
- Some examples of how these failures impacted individuals are discussed in detail with regard to the Medical Outcomes #6 and #8. In sum, though, for individuals with ongoing pain, pressure ulcers, fractures, changes in mental status, and aspiration pneumonia/respiratory issues, PCPs and other providers frequently had not documented assertive and timely medical evaluation treatment that followed current generally accepted standards.

On a positive note:

- In comparison with the previous two reviews, it was good to see improvement with regard to PCPs indicating agreement and/or disagreement with rationale for consultant recommendations and writing IPNs that generally met criteria, but timeliness of these reviews was still often an issue. Improvement also was noted with regard to practitioners writing orders for agreed-upon recommendations. The Center should continue to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

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

As noted in previous reports, dental services have declined over the past several years. In June 2018, the Center hired a new Dental Director, who had conducted a needs assessment for the clinic. This has allowed for the identification of gaps in practices and in the care provided to individuals. The clinic is working to correct these gaps. With the assistance of the new Dental Director, the Center should continue to focus on improving the provision and quality of dental treatment

Based on the individuals reviewed, the Clinical Pharmacist completed Quarterly Drug Regimen Reviews (QDRRs) timely. As a result of the Center's sustained progress in this area, the related indicator will be placed in the category requiring less oversight. Although since the last review, some improvement was noted with regard to the quality of the QDRRs, continued improvement is needed with regard to the Clinical Pharmacist's review of laboratory irregularities, and the provision of related recommendations.

Given the Center's ongoing issues with pressure ulcers, the following findings were concerning:

- Proper fit of adaptive equipment was often still an issue.
- Based on observations, there were still numerous instances (36% of 110 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.
    - Based on the Monitoring Team's observations, individuals were positioned correctly during 19 out of 41 observations (46%).
    - With regard to positioning, problems varied, but the most common problem was that staff did not use equipment correctly (i.e., about 50% of the observations).

- As discussed while the Monitoring Team was onsite, and in the exit comments, positioning, particularly in bed, needs significant improvement. On Monday of the onsite review week, the Monitoring Team member visited Home 549, in which many individuals with complex needs live, and several individuals were not in the correct position. The Monitoring Team appreciated the Center's efforts to immediately retrain staff. However, staff should continue to follow-up to ensure problems are corrected, particularly given the skin integrity issues that individuals at the Center continued to experience.

There was good coordination between psychiatry and behavioral health. Psychiatry continued to have a forum for collaboration with neurology. When needed, it occurred at least annually.

Throughout the week, the Monitoring Team observed or heard about the behavioral health services department staff working collaboratively with other departments, either upon request or upon the BHS department volunteering to participate. Examples were identified with communication, habilitation, and nursing/medical.

PBSP Data reliability measures were consistently assessed and reported for individuals with a PBSP. However, Lufkin SSLC was not consistently achieving its own data reliability and treatment integrity objectives, suggesting that their PBSP and replacement behavior data were not reliable and PBSPs were not being consistently implemented.

The BHS department recently began behavioral skill training for selected individuals with PBSPs. The Monitoring Team observed one of these group sessions, which taught individuals progressive muscle relaxation skills. There was a high overall quality of the instruction and the level of cooperation and participation of the individuals.

One of the four individuals who had good reliable data (indicator 5) was also making progress. Further, given that this individual also met criteria for indicators 1-9, a deeper review was not required for him. One of the other of these four individuals (i.e., one who was not making progress), however, did meet criteria for all of the other indicators in outcomes 1 and 2 (indicators 1-9) and for the remainder of psychology/behavioral health indicators. Thus, this individual, although not making progress, was deemed to be receiving psychology/behavioral services and supports as per the monitoring tool.

For half of the individuals, most of their staff was trained on their PBSPs.

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: Lufkin SSLC had a decreasing frequency of crisis intervention restraint usage (see domain 1 of this report). Even so, in those occasions when there were	Individuals:

more than three in a rolling 30-day period, the Center was not meeting the discussion and planning requirements of indicators 20-23. These indicators, as well as 26 and 29 will remain in active monitoring.

#	Indicator	Overall Score	410								
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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.										
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.	0% 0/1	0/1								
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/1	0/1								
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	0% 0/1	0/1								
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	0% 0/1	0/1								
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	Due to the Center's sustained performance, 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									

#	Indicator	Overall Score									
27	The crisis intervention plan was complete.	Due to the Center's sustained performance, these indicators were 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.										
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	100% 1/1	1/1								

Comments:
This outcome and its indicators applied to Individual #410. It is based on a 11/8/18 ISPA.

18. Individual #410 had his fourth restraint on 11/7/18, and the team met to discuss more than three restraints in 30 days on 11/8/18

20. The ISPA contained a discussion of Individual #410's adaptive skills, and biological, medical, and psychosocial issues. The discussion did not reflect, however, if these issues affected the behaviors that provoked his restraints.

21. Individual #410's ISPA following more than three restraints in 30 days did not reflect a discussion of the role of contributing environmental variables to his recent restraints.

22. Antecedents to the dangerous behaviors that provoked restraint were discussed, however, it was not clear those antecedents were hypothesized to affect Individual #410's most recent restraints.

23. Individual #410's ISPA did not reflect a discussion of the role of maintaining variables to his recent restraints

28. Individual #410's plan had integrity measures, however, the last measure was below 80% and, therefore, indicated that the PBSP was not being implemented as written.

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: Once Lufkin SSLC routinely obtains reliable data for psychiatric indicators, then indicators 8 and 9 can be assessed by the Monitoring Team. Similarly, indicators 10 and 11 can then be assessed, too. That being said, the Monitoring Team acknowledges the efforts of the psychiatry staff in taking action for individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
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:

8-9. Given the absence of appropriate indicators, goals, and data shown to be reliable (and perhaps valid) for psychiatric goals/indicators, progress could not be determined for goals for reduction or for increase. The Center reported that Individual #85 was psychiatrically stable, but this was not determined via a review of indicators. The data provided regarding the identified indicator for decrease, aggression, showed stability, but the data were not reliable. Overall, Individual #85 appeared stable, but given his current condition, it is questioned if he should be monitored for increasing cognitive deficits related to dementia.

10-11. It was apparent that in general, when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (e.g., medication adjustments) were developed and implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.	
Summary: Coordination between psychiatry and behavioral health continued. Documentation was evident and psychiatry participation was confirmed (though better documentation is needed). With sustained high performance, the Monitor will consider moving both indicators to the category of requiring less oversight. They will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
23. The psychiatric documentation referenced the behavioral health target behaviors. The functional assessment discussed the role of the psychiatric disorder upon the presentation of the behaviors in all examples.

The behavioral health documentation was detailed with regard to the review of the diagnoses and the role of the psychiatric disorder in the presentation of specific target behaviors. The psychiatric documentation, although less detailed, included basic information regarding target behaviors and graphs of data.

24. The documentation did not reveal evidence of psychiatric participation in the development of the PBSP. However, during the onsite monitoring visit, it was confirmed that the psychiatrist regularly attended behavioral therapy committee meetings and provided input into the development of the PBSP. This was good to hear. It is recommended that the psychiatrist specifically document this collaboration.

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: Psychiatry continued to have a forum for collaboration with neurology. When needed, it occurred annually for all individuals for this review and for the last two reviews, too. Therefore, indicator 26 will be moved to the category of requiring less oversight. The other two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 2/2						1/1		1/1	
26	Frequency was at least annual.	100% 1/1						1/1			
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 2/2						1/1		1/1	

Comments:
25 -27. These indicators applied to two of the individuals, Individual #227 and Individual #410. There was documentation of

consultation between psychiatry and neurology, specifically a review of documentation. As Individual #227 had a new onset of seizure activity beginning in late 2018, she was not seen annually yet. This facility had an ongoing neurology clinic on campus. The psychiatry clinical support staff members were responsible for coordinating this clinic. Currently, psychiatric providers did not attend the clinic; this is a potential missed opportunity for coordination of care.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: Quarterly clinics were occurring as scheduled and included the required standard components (as observed by the Monitoring Team during the onsite visit). The resultant documentation was missing various components. This might be a function of the sections/prompts in the electronic record. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
34. The Monitoring Team looks for nine components of the quarterly review. None of the examples included all the necessary components, with examples missing two to three components. The psychiatric providers at this facility were utilizing a word document in order to document quarterly and annual clinical encounters. In doing so, there were some elements that were not adequately addressed. It was considered that some of the information that is automatically included into the IRIS documents (e.g., laboratory results) were not included in the word documents. In addition, information regarding medication (e.g., specific medication risks or side effects) was not regularly included.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: Progress was made in that these assessments were being conducted and in a timely manner. Criteria for this indicator also includes prescriber timely review, which was not happening. Therefore, this indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	44% 4/9	1/1	1/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1

Comments: 36. In general, MOSES and AIMS assessments were performed in a timely manner. There were issues with the prescriber review of the assessments. For example, regarding Individual #97, the prescriber did not review the AIMS dated 12/14/18. The MOSES dated 12/22/17 was not reviewed by the prescriber until 2/8/18. In another example, regarding Individual #78, the MOSES dated 10/15/18 was not reviewed by the prescriber.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary: This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
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?	100% 6/6			1/1	1/1	1/1	1/1		1/1	1/1
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. The Center should make sure it implements PEMA labeling and actions when appropriate to do so.			Individuals:								
#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	0% 0/1					0/1				
Comments: 43. Although the document request indicated that there were no incidences of PEMA, there was a documented example of Individual #78 being prescribed medication in the absence of a clinical review. On 1/22/18, there was documentation that "placement of the patient in a psychiatric hospital is not an option...will restart the Depakote, use the Ativan on a temporary basis, and increase the											

Seroquel to 400 mg twice daily...the patient was not seen as this was a follow-up...the team is frantic about him...Depakote and Ativan will be used on a temporary basis." While the need to treat this individual with medication is not questioned, this episode should have been categorized as PEMA.

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

Summary: Justification for polypharmacy regimen did not meet criteria. In addition, there was no documentation of a plan to taper or a rationale as to why to not taper. Not all individuals who should have been reviewed, were reviewed, by polypharmacy. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 18	36	5	97	78	410	85	227	38
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	0% 0/4			0/1		0/1	0/1			0/1
45	There is a tapering plan, or rationale for why not.	0% 0/4			0/1		0/1	0/1			0/1
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.	50% 1/2					1/1	0/1			

Comments:
44. These indicators applied to four individuals. Polypharmacy justification was not appropriately documented in any examples.

45. There was no documentation for individuals who met criteria for polypharmacy showing a plan to taper various psychotropic medications or documentation as to why this was not being considered.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for one of the individuals meeting polypharmacy criteria. Two individuals, Individual #5 and Individual #38, met criteria for polypharmacy in late 2018, so the lack of review in these cases was understandable, and they were not included in the data for this indicator.

For the two other individuals, Individual #410 and Individual #78, a review was located for Individual #78. Although there were adjustments to Individual #410's medication regimen, he was not reviewed by the committee in the last six months.

The polypharmacy committee meeting was observed during the visit. This meeting was attended by multiple disciplines, including primary care, pharmacy, and nursing. The psychiatry department was responsible for organizing the meeting and the facility lead psychiatrist chaired the committee. There was a need for improvement with regard to the review and justification of the regimens. This meeting should be a brisk discussion of the regimens with the psychiatrist presenting the justification of polypharmacy for

critique. There was improvement in that the minutes of the meeting included a review of specific regimens and there was now a schedule for review. In order to ensure that all regimens meeting criteria for polypharmacy are reviewed in a timely manner, the psychiatry clinic staff could consider changes to the scheduling of polypharmacy review. Specifically, individuals should be scheduled for review annually, or quarterly if medication adjustments are made or if there is an active medication taper in progress.

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: One of the four individuals who had good reliable data (indicator 5) was also making progress. Further, given that this individual also met criteria for indicators 1-9, a deeper review is not required and, therefore, the remaining indicators in the psychology behavioral health sections of this report are not scored for him (Individual #97). One individual was reported to have met his goals/objectives, but no updates or new objectives were made (Individual #78, indicator 7). Of the individuals who were not rated as making progress, one (Individual #5) did meet criteria for all of the other indicators in outcomes 1 and 2 (indicators 1-9) <u>and</u> all indicators met criteria in the deeper review, too (see the remainder of this report's psychology/behavioral health sections). Thus, this individual, although not making progress, was deemed to be receiving psychology/behavioral services and supports as per the monitoring tool. Indicators 6 and 7 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
6	The individual is making expected progress	11% 1/9	0/1	0/1	0/1	1/1	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.	0% 0/1					0/1				
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
9	Activity and/or revisions to treatment were implemented.										
Comments: 6. Individual #97 was scored as making progress toward his target behavior objectives. Individual #85 and Individual #78's PBSP data											

indicated progress, however, because their data were not demonstrated as reliable (indicator 5), this indicator for them was scored as 0. Individual #18, Individual #36, Individual #5, Individual #227, Individual #38, and Individual #410 were judged to not be making progress.

7. Based upon the Center's reporting of Individual #78 as meeting his objectives for physical and verbal aggression, in February 2018 and May 2018, respectively, the Monitoring Team looked to see if goals were updated or if new ones were made. New or updated objectives were not documented.

8. Individual #227 and Individual #38 were reported by the Center as not making progress. Corrective actions were not documented in the progress note.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
Summary: Staff for half of the individuals had most of their staff trained on their PBSPs. Although an improvement from the last review, improvement is still needed. Indicator 16 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
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.	50% 4/8	1/1	0/1	1/1		1/1	0/1	0/1	0/1	1/1
17	There was a PBSP summary for float staff.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.										

Comments:
16. Individual #38, Individual #78, Individual #5, and Individual #18 had documentation that at least 80% of DSPs working in their residence were trained on their PBSPs. Although Lufkin SSLC still has room for improvement, this represents a substantial improvement from the last review when one individual had documentation that at least 80% of DSPs working in their residence being trained on their PBSPs.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
Summary:			Individuals:								
#	Indicator	Overall Score									
19	The individual's progress note comments on the progress of the individual.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	The graphs are useful for making data based treatment decisions.										

21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	
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.	
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.	

Comments:
Criteria were not met for one case for each of these two indicators. Even so, these indicators will remain in less oversight.

19. Individual #227 had a current progress note, however, it indicated that she wore a bodysuit that was, in fact, never initiated.

20. Individual #18's graph did not include an indication (e.g., phase lines, asterisk, etc.) of when the change in the definition of the target behavior was initiated.

Outcome 8 – Data are collected correctly and reliably.

Summary: Performance remained the same (low) on achieving data reliability and treatment integrity frequency checks and agreement levels. Indicator 30 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 18	36	5	97	78	410	85	227	38
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.										
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.										
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).										
30	If the individual has a PBSP, goal frequencies and levels are achieved.	25% 2/8	0/1	0/1	1/1		0/1	0/1	0/1	0/1	1/1

Comments:
30. Goal frequencies and levels of data collection timeliness, IOA, and treatment integrity were achieved for Individual #5 and Individual #38.

There were no treatment integrity measures reported for the last year for Individual #18, and Individual #227 and Individual #410's most recent treatment integrity assessments were below 80%. Individual #18, Individual #36, Individual #78, Individual #410, and Individual #85's DCT levels were below 80%.

If the most recent TI and/or DCT measures are below 80%, staff should be retrained and reassessed. Ensuring that the established frequency and levels of IOA, data collection timeliness, and treatment integrity are consistently achieved should be a priority for Lufkin SSLC.

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	78	36	31	10	1	107	12	468	132
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.	11% 2/18	1/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #78 – diabetes, and GI problems; Individual #36 – osteoporosis, and respiratory compromise; Individual #31 – cardiac disease, and respiratory compromise; Individual #10 – seizures, and medication side effects; Individual #1 – constipation/bowel obstruction, and osteoporosis; Individual #107 – cardiac disease, and other: tremor; Individual #12 – cardiac disease, and aspiration; Individual #468 – infections, and medication side effects/interactions; and Individual #132 – cardiac disease, and diabetes). None of goals/objectives reviewed were clinically relevant, achievable, and/or measurable.

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 #78 – diabetes; and Individual #10 – seizures.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports 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: Four 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	78	36	31	10	1	107	12	468	132
a.	Individual receives timely preventative care:										
	i. Immunizations	44% 4/9	0/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1	0/1
	ii. Colorectal cancer screening	100% 6/6	1/1	1/1	1/1	N/A	N/A	N/A	1/1	1/1	1/1
	iii. Breast cancer screening	100% 3/3	N/A	1/1	1/1	N/A	N/A	N/A	N/A	N/A	1/1
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	88% 7/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	0/1	1/1
	vii. Cervical cancer screening	75% 3/4	N/A	N/A	1/1	1/1	N/A	1/1	N/A	N/A	0/1
b.	The individual's prescribing medical practitioners have reviewed and	22%	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1	0/1

	addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	2/9									

Comments: a. The following problems were noted:

- Individual #78's varicella status was not documented.
- Individual #31's Hepatitis B status was not identified in the immunization records.
- Individual #10's varicella status was not documented.
- Individual #468's varicella status was not documented. In addition, his last BMD scan was in November 2016, and one was due again in 2018.
- Individual #132's Hepatitis B status was not identified in the immunization records. In its comments on the draft report, the State disputed this finding and stated that the titer information was included in the AMA, because IRIS does not have a space for it. As the Monitoring Team has discussed with the State Office Medical Discipline Lead, the audit tool identifies the data source for immunizations as the official immunization record. Other Centers have identified a methodology for entering titer information into IRIS.

  In addition, the pap smear completed on 4/5/18, was unsatisfactory for evaluation due to insufficient cellularity. In its comments on the draft report, the State disputed this finding and stated that on 4/17/18, the IDT met, and concluded that the individual did not need further pap smears. The State indicated that the IDT conducted a: "…Risk/Benefit analysis in which the provider stated the individual was not sexually active, she is at high risk for sedation, HPV negative on 4/5/2018 and vaginal smear was negative on 12/12/2017. For those reasons a repeat pap test was not pursued." This comment was from the Medical Compliance Nurse. The Center did not submit any documentation to substantiate this assertion and the AMA that the State referenced in its comments did not provide a detailed justification for the decision. Without further information from a medical provider, the Monitoring Team could not conclude that the decision was clinically justified.

b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. In other words, the PCP should review the QDRR, provide an interpretation of the results, indicate if he/she agrees or disagrees, and discuss what changes can be made to medications based on this information, or state if the individual is clinically stable and changes are not indicated. Such discussion was found in the AMAs of Individual #107 and Individual #468.

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	78	36	31	10	1	107	12	468	132
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A

	Office Guidelines.										
Comments: a. The Center submitted a DNR form, signed on 12/11/14, stating the DNR was due to intractable epilepsy. This did not provide a clinical justification consistent with State Office policy.											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Although in comparison with the previous four reviews, some incremental progress was noted with regard to the scores for these indicators, significantly more work is needed to improve the care the Center provides to individuals with acute illnesses/occurrences. PCPs' assessment and follow-up of acute issues at the Center requires particular focus. For hospitalized individuals, PCP follow-up, as well as IDT follow-up with input from the PCP are also both areas in which work is needed to meet individuals' needs. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
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.	30% 3/10	0/1	0/1	1/2	1/2	1/2	0/1	N/A	N/A	0/1
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	10% 1/10	0/1	0/1	0/2	0/2	1/2	0/1			0/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	55% 6/11	1/2	1/2	N/A	0/2	N/A	1/1	2/2	1/2	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	60% 3/5	0/1	N/A		0/1		1/1	2/2	N/A	
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	100% 11/11	2/2	2/2		2/2		1/1	2/2	2/2	

f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	0% 0/6	0/2	0/1		0/1		N/A	0/2	N/A	
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	55% 6/11	1/2	1/2		1/2		1/1	2/2	0/2	

Comments: a. For seven of the nine individuals reviewed, the Monitoring Team reviewed 10 acute illnesses addressed at the Center, including: Individual #78 (left foot pain on 10/9/18), Individual #36 (Stage 4 pressure ulcer on 6/26/18), Individual #31 (pressure ulcer on 10/18/18, and conjunctivitis on 12/7/18), Individual #10 (bilateral pitting edema on 6/7/18, and abdominal distension and wheezing on 9/23/18), Individual #1 (scrotal lesion on 7/31/18, and contact dermatitis on 10/9/18), Individual #107 (bilateral traumatic tympanic membrane perforations on 9/12/18), and Individual #132 (multiple rib fractures on 8/30/18).

PCPs assessed the following acute issues according to accepted clinical practice: Individual #31 (pressure ulcer on 10/18/18), Individual #10 (abdominal distension and wheezing on 9/23/18), and Individual #1 (contact dermatitis on 10/9/18).

b. For Individual #1 (scrotal lesion on 7/31/18), the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized.

The following provide examples of concerns noted:

- On 10/9/18, the PCP evaluated Individual #78 for left foot pain and discolored toenails. The exam was remarkable for a left middle toe with pain upon joint palpation and slight swelling. The assessment was possible gout. The plan was to check the uric acid and comprehensive metabolic panel (CMP) and give Tylenol. The PCP did not document a follow-up examination of the swollen joint, and in the IPNs, there was no documentation of the results of the CMP and uric acid.
- On 6/26/18, nursing staff documented that Individual #36 had a 1.5 centimeter (cm) "spot on her left bottom." The nurse placed her on the medical clinic list. On 6/27/18, the PCP wrote: "open area to left buttocks deferred by RN- scabbed over." From 7/5/18 to 7/11/18, nursing staff continued to document the presence of a wound. On 7/12/18, nursing staff noted that the wound was healed. On 7/20/18, nursing staff again noted an open area to the individual's left buttock. On 7/26/18, the PCP evaluated the individual's enteral tube stoma site, but made no comments on the left buttock wound. On 7/27/18, the PCP noted a skin tear to the left buttock, and prescribed local wound care with review in 30 days. On 7/27/18, nursing staff documented a left buttock abrasion in the site of a previous injury. On 8/6/18, nursing staff documented an open area with purulent drainage. On 8/9/18, the PCP did not examine the individual, but noted that x-rays would be ordered. On 8/15/18, nursing staff noted the "abrasion to left buttock: deteriorating." On 8/18/18, the individual was sent to the ED and on 8/19/18, the PCP saw the individual. The PCP did not document an assessment of the wound. On 8/20/18, 8/21/18, and 8/22/18, the PCP's assessments also did not include an assessment of the wound. Because Individual #36 was in the Infirmary, the PCP assessed her almost daily. However, although Habilitation Therapy staff and nursing staff documented wound assessments, it

was not until 9/17/18, that the PCP assessed the wound, and noted that the wound was a Stage 4 pressure ulcer, and the follow-up would occur with wound doctor. On 9/24/18, the PCP wrote that in two days, the individual would be seen in the Wound Care Clinic, and the PCP would follow-up weekly until resolved. In January 2019, at the time of the Monitoring Team's review, the wound remained open as a healing Stage 4 pressure ulcer. The Wound Care Clinic continued to follow the individual.

- On 10/18/18, the PCP evaluated Individual #31 due to abrasions on both ears. The assessment was abrasions to both earlobes caused by glasses. The plan was to provide local wound care, and follow up in two weeks. The PCP made no referral to the wound care nurse. On 11/1/18, the PCP did not conduct actual follow-up for the individual. However, the PCP cut and pasted the IPN entry from the nurse, dated 10/31/18, stating that the abrasions were healed.
- On 6/7/18, Individual #10's PCP wrote: "Per RN-CM [Registered Nurse Case Manager] assessment of patient: BLE [bilateral lower extremity] pitting edema LLL [left lower leg] 4+; RLE [right lower extremity] 3+." Based on this nursing assessment and without any documentation that the PCP conducted an assessment, the PCP ordered Lasix 20 mg daily. The PCP did not conduct and/or document a follow-up evaluation.
- On 9/23/18, Individual #10's PCP documented that the individual was being evaluated due to abdominal distention. The physical exam was remarkable for "gaseous distention of the abdomen" and bilateral expiratory wheezing. The plan was to insert a rectal tube, administer an enema, and provide nebulizer treatments. The PCP was to follow-up in 24 hours. On 9/24/18, the PCP did not complete and/or document follow-up. On 9/25/18, the PCP assessed the individual and documented improvement. The plan was for nursing staff to monitor the individual, and use the rectal tube, as needed. The PCP did not conduct and/or document additional follow-up. On 11/28/18, the individual was admitted to the hospital with a severe ileus.
- On 9/12/18, the PCP evaluated Individual #107 due to blood in the ear. The exam noted a foreign body in the left ear canal. The individual was referred to ENT for evaluation. The PCP signed an ENT consult IPN that the Licensed Vocational Nurse (LVN) transcribed. The ENT noted that no foreign body was found in the ear, but the individual had bilateral traumatic perforations. It was also recommended that the staff contact the ENT if drainage developed. The IPN note did not accurately summarize the findings of the consultant. Based on the documentation submitted, the PCP did not conduct any follow-up. On 10/25/18, the individual had her next ENT evaluation.
- On 8/30/18, nursing staff documented that Individual #132 fell around noon, hit her ribs on the arm of a chair, and complained of rib pain. The Medical Acute Care (MAC) PCP was notified and ordered a stat x-ray. At that time, it was documented that the individual had a rib facture, and the nurse administered Tylenol #3. The PCP who gave the orders did not document an assessment in the IPNs. However, a post-injury report included as assessment from the PCP stating that x-rays were pending. The PCP made an addendum stating that rib fractures were strongly suspected, but the radiology report was not received for several weeks. The PCP appeared to have signed this addendum on 10/18/18 (i.e., six weeks after the entry).

  On 8/31/18, another PCP assessed the individual and noted a 9-cm by 10-cm bruise to the left rib cage. X-rays were pending, according to the documentation. Given that other injuries may occur with rib fractures, it was not clear why the PCP did not attempt to obtain the results of the radiographs over a period of nearly two months. The plan was to continue pain medications and prevent atelectasis.

  On 9/11/18, a third PCP noted that no rib fractures were evident on the x-ray of 8/30/18. Page 226 of Document Request #12 included an x-ray report for 8/30/18. The very bottom of the report stated mildly displaced fractures of left lateral 7th, 8th,

9th, and 10th ribs. It was not clear if the PCP actually reviewed the report. Again, an LVN appeared to transcribe the findings in the IPN. The PCPs are responsible for reading the results of all diagnostics and not relying on an LVN's interpretation and transcription of results.

The PCP did not complete and/or document a follow-up physical examination for this individual with four rib fractures. The first documentation of follow-up for the rib fractures was on 10/23/18. The PCP documented that the pain had resolved, the lungs were clear, and a repeat x-ray was pending. The results of the follow-up x-rays were documented in the interval medical review.

c. For six of the nine individuals reviewed, the Monitoring Team reviewed 11 acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #78 (unresponsiveness on 6/20/18, and rhabdomyolysis on 12/14/18), Individual #36 (status epilepticus, and UTI on 6/1/18, and hypoxia on 8/18/18), Individual #10 (aspiration pneumonitis on 6/22/18, and UTI on 7/2/18), Individual #107 (chest pain on 8/22/18), Individual #12 (pneumonia on 7/23/18, and pneumonitis and gastritis on 8/1/18), Individual #468 (seizures on 6/24/18, and seizure on 10/31/18).

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

- It was positive to see that the following individuals displaying signs/symptoms of acute illness received timely acute medical care, and follow-up care: Individual #36 (hypoxia on 8/18/18), Individual #107 (chest pain on 8/22/18), and Individual #12 (pneumonia on 7/23/18, and pneumonitis and gastritis on 8/1/18).
- By way of history, based on the interval medical review, dated 7/26/18, from 5/26/18 to 5/30/18, Individual #78 was hospitalized for drainage of subdural hygromas. On 5/31/18, he was transferred back to his home. Over the next 18 days, the PCP did not document completion of an assessment.

  On 6/18/18, nursing staff documented that the individual had a change in mental status; he was disoriented. He was placed on sick call. On 6/19/18, nursing staff documented that the PCP was informed of the "AMS [altered mental status]," but responded that the individual "will need to be seen by Psych."

  On 6/20/18, nursing documented that the individual was found unresponsive, and at 9:20 a.m., the PCP gave the order to transfer the individual to the hospital. Even though the transfer occurred during normal business hours, the PCP did not document an assessment in the records. On 7/17/18, almost a month later, the PCP wrote a transfer note.

  The individual was admitted to the hospital with a right subdural hematoma with midline shift. On 6/21/18, a ventriculoperitoneal (VP) shunt was placed, and on 6/28/18, he returned to the Center. On 6/28/18, 6/29/18, and 6/30/18, a PCP evaluated him.

  On 6/28/18, the IDT held an ISPA meeting. No PCP or RN appeared to attend the meeting. The IDT should have discussed how to monitor an individual with a new VP shunt, but based on the documentation, they did not.
- On 12/14/18, Individual #78 was transferred to the ED for evaluation of chest pain. He was admitted to an observation bed with the diagnosis of rhabdomyolysis. On 12/15/18, the individual was discharged back to the Center, and on 12/15/18, and

12/16/18, the PCP saw him. However, there was no documentation of further assessment or the results of the follow-up creatine phosphokinase (CPK) levels. Two follow-up CPK levels were documented in the lab section of IRIS.

- On 6/1/18, nursing staff documented that Individual #36 was transferred to the ED due to multiple seizures that persisted after the administration of two Diastat 10 mg suppositories. This was an after-hours transfer, but the PCP did not write a transfer note.

  On 6/6/18, the individual returned to the Center and was admitted to the Infirmary. On 6/6/18, the PCP conducted follow-up, and noted that the seizures were under control. There was no discussion of the treatment plan or follow-up for management of an individual with a recent diagnosis of status epilepticus, and in the documentation submitted, no neurology consult was found. (In March 2018, the individual had experienced a seizure, but did not have an EEG and was not started on AEDs.)

  On 6/7/18 the PCP documented that the seizures were treated with Keppra and the individual would follow-up in the neurology clinic. On 6/12/18, a PCP conducted the next assessment in the Infirmary. The Center did not submit any neurology consult notes. On 6/13/18, the IDT met, but the PCP was not present to discuss the individual's status epilepticus and a new seizure diagnosis.
- On 6/22/18, the PCP documented that nursing staff called and stated that Individual #10 was in respiratory distress. There was no documentation that the PCP assessed the individual. She was treated in the ED and returned to the Center later that day. On 6/23/18, a PCP evaluated her in the Infirmary, and she was diagnosed with aspiration pneumonitis.
- On 7/2/18, nursing staff documented that Individual #10 was being transferred to the ED for evaluation of abdominal distention, respiratory distress, and fever. The transfer occurred around 8:00 a.m. There was no PCP note for the transfer. Upon her return, on 7/6/18, a PCP assessed her, but there was no additional follow-up and no documentation that the UTI was adequately treated.
- Despite two hospitalizations in short succession for aspiration pneumonia and hypoxemia presumed to be related to the aspiration pneumonia (i.e., on 7/23/18, and 8/1/18, respectively), Individual #12's IDT did not hold an ISPA meeting(s) to discuss the hospitalizations and needed modifications to his plans to prevent their recurrence to the extent possible.
- Per the IRRF, and by way of history, from 5/12/18 to 5/16/18, Individual #468 was hospitalized after having respiratory distress and multiple seizures on campus following sedation with Geodon 40 mg IM on 5/9/18. On 5/20/18, he was diagnosed with a subdual hematoma.

  On 6/22/18, he was administered Geodon 40 mg IM as pre-treatment sedation for a CT scan. The individual had a history of hypertension, but blood pressure readings were 98/58, and 96/68. On 6/24/18, at approximately 3:00 a.m., he had a seizure, and was transferred to the ED. Due to the recently diagnosed subdural hematoma, there was a standing order to transfer the individual to the ED for any seizure activity. This was an after-hours transfer, but the PCP note was signed on 6/25/18 at 11:58 p.m., which was after the close of the next business day.

  On 6/24/18, he returned to the Center. On 6/25/18, the PCP evaluated him. His blood pressure was 137/99. Per nursing documentation, on 6/25/18, Individual #468's two ED visits were discussed during morning meeting. The PCP notes did not mention any discussion regarding the problems documented following the use of IM Geodon for sedation. The document request stated that no pre-treatment sedation was done.

The next PCP assessment was dated 6/28/18. The PCP documented that on 6/26/18, and 6/27/18, the PCP saw the individual, but there were no PCP IPNs for these dates. On 6/28/18, the PCP noted that the neurosurgeon saw the individual and the report was pending. On 6/29/18, follow-up was documented again and the individual was noted to be doing well.

- On 10/31/18, the PCP documented that Individual #468 was sent to the ED due to a seizure. Again, there was a standing order to transfer the individual to the hospital for any seizure activity due to the history of a recent subdural hematoma. It was an after-hour transfer, and the PCP wrote a note the following business day. On 11/1/18, the PCP saw him. The CT of the head was reported as normal. There was no additional follow-up documented. On 11/5/18, the PCP documented labs that included a sodium of 133. Salt tablets were started. On 11/8/18, the individual was seen for a pustule that nursing staff reported, but the PCP could not substantiate. On 11/10/18, the PCP wrote that the individual was sent to the hospital again for hypoxia, tachycardia and tachypnea, and fever. He was admitted with acute respiratory failure due to aspiration pneumonia and ESBL E coli, and UTI.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: In comparison with the previous two reviews, it was good to see improvement with regard to PCPs indicating agreement and/or disagreement with rationale for consultant recommendations and writing IPNs that generally met criteria, but timeliness of these reviews was still often an issue. Improvement also was noted with regard to practitioners writing orders for agreed-upon recommendations. The Center should continue to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs. At this time, these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	100% 16/16	2/2	2/2	2/2	2/2	N/A	2/2	2/2	2/2	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	63% 10/16	0/2	0/2	0/2	2/2		2/2	2/2	2/2	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	88% 14/16	1/2	2/2	1/2	2/2		2/2	2/2	2/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	100% 16/16	2/2	2/2	2/2	2/2		2/2	2/2	2/2	2/2

e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	50% 1/2	N/A	N/A	1/1	N/A		0/1	N/A	N/A	N/A

Comments: For eight of the nine individuals reviewed, the Monitoring Team reviewed a total of 16 consultations. The consultations reviewed included those for Individual #78 for ophthalmology on 8/28/18, and neurology on 10/25/18; Individual #36 for ophthalmology on 7/24/18, and pulmonology on 9/26/18; Individual #31 for cardiology on 11/20/18, and neurology on 6/28/18; Individual #10 for renal on 12/5/18, and neurology on 10/25/18; Individual #107 for podiatry on 11/29/18, and Ear, Nose, and Throat (ENT) on 10/19/18; Individual #12 for pulmonary on 11/2/18, and ENT on 10/19/18; Individual #468 for pulmonary on 11/30/18, and renal on 10/15/18; and Individual #132 for endocrinology on 12/4/18, and ophthalmology on 9/19/18.

a. For all of the consultation reports reviewed, PCPs indicated agreement or disagreement with the recommendations, and provided rationales for disagreements.

b. The reviews that did not occur timely included: Individual #78 for ophthalmology on 8/28/18, and neurology on 10/25/18; Individual #36 for ophthalmology on 7/24/18, and pulmonology on 9/26/18; and Individual #31 for cardiology on 11/20/18, and neurology on 6/28/18.

c. Most of the PCP IPNs related to the consultations reviewed included all of the components State Office policy requires. The exceptions were for: Individual #78 for ophthalmology on 8/28/18; and Individual #31 for neurology on 6/28/18.

d. It was good to see that when PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments.

e. For Individual #107, the PCP should have made a referral to the IDT with regard to the ENT consultation, dated 10/19/18, but the PCP did not request the IDT's involvement. The consultant recommended water protection, which required supports from other disciplines, including Habilitation Therapy and direct support professionals.

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 reviewed, medical assessment, tests, and evaluations consistent with current standards of care were not completed, and/or the PCP had not identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.

Individuals:

#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
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.	28% 5/18	1/2	0/2	0/2	0/2	1/2	1/2	1/2	0/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #78 – diabetes,

and GI problems; Individual #36 – osteoporosis, and respiratory compromise; Individual #31 – cardiac disease, and respiratory compromise; Individual #10 – seizures, and medication side effects; Individual #1 – constipation/bowel obstruction, and osteoporosis; Individual #107 – cardiac disease, and other: tremor; Individual #12 – cardiac disease, and aspiration; Individual #468 – infections, and medication side effects/interactions; and Individual #132 – cardiac disease, and diabetes).

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 #78 – diabetes, Individual #1 – constipation/bowel obstruction, Individual #107 – cardiac disease, Individual #12 – cardiac disease, and Individual #132 – cardiac disease. The following provide examples of concerns noted:

- For Individual #78, the AMA did not discuss the individual's history of colon polyps as an active diagnosis. Therefore, there was no plan to address the need to repeat the colonoscopy in 2021. It was mentioned in the preventive care section.
- Individual #36's AMA did not provide a clear assessment and plan for the diagnosis of osteoporosis. Osteoporosis was mentioned briefly as part of a discussion of chronic hip pain, scoliosis, and spasticity. The assessment should include the results of the most recent BMD (and any change from previous BMD). The individual's calcium and Vitamin D levels should be documented. The PCP should include the current treatment regimen along with the plan for further medical management.
- Individual #36 had a history of recurrent aspiration and pneumonia. She received nothing by mouth (NPO) due to dysphagia. Per pulmonary, she had allergic rhinitis, chronic bronchitis, chronic respiratory failure, and was at risk for aspiration. The AMA and interval medical reviews did not sufficiently discuss these conditions. Much of this information was extracted from documents such as pulmonary consults. The PCP's medical plan of care did not reflect the full set of supports that were required to meet the individual's needs.
- According to Individual #31's AMA, she was diagnosed with atrial fibrillation, hypertension, and congestive heart failure (CHF). The three diagnoses were grouped together. The assessment and plan for each was inadequate. There was no documentation of the target blood pressure or if it had been achieved. The heart failure classification was not documented, and there was no assessment of stroke risk/CHADS2 score documented.
- In Individual #31's AMA, severe obstructive sleep apnea (OSA) was discussed with other pulmonary conditions. This is a serious diagnosis associated with significant morbidity. There should be a specific plan to address the diagnosis. A pulmonary specialist followed the individual, although it was not clear if this was a sleep disorders specialist. It was reported that her apnea was severe with an apnea hypopnea index (AHI) of 43.1. There was no documentation of how many events occurred with treatment. The PCP should document the response to treatment based on the number of apnea events and symptoms, such as daytime somnolence. The PCP also should provide information on other aspects of care, such as how often the equipment is cleaned and frequency for routine replacement of masks and tubing.
- According to Individual #10's AMA, she had intractable epilepsy and received four anti-epileptic drugs (AEDs). The individual also had hyponatremia that was attributed to the seizure medications. The hyponatremia required treatment with sodium chloride tablets. There was no discussion of the hyponatremia as an ADR, or the need to consider a change in medication or dose. Moreover, in the AMA, the PCP did not discuss the etiology and work-up for the long-term hyponatremia.
- For Individual #107, the PCP did not discuss the diagnosis of tremor in the AMA. Under the diagnoses of aggression/anxiety/akathisia/tremors, the PCP stated: "Refer to Psych Annual Assessment and Plan." This individual had a significant tremor (resting and intentional) that staff reported had worsened in the past year, and interfered with her activities of daily living (ADLs). However, the PCP did not discuss it, and no documentation was found of a recent neurological consult.

- According to Individual #12's AMA, he had three confirmed pneumonia diagnoses in the previous year. For an individual with recurrent aspiration pneumonia, the plan did not meet his needs.
- Individual #468's AMA documented that in 1993, the PPD was positive and the individual was treated. Latent tuberculosis infection (LTBI) was not listed as a diagnosis. Therefore, a plan was not documented. There should be a plan related to monitoring for signs of active TB and completion of the yearly TB questionnaire.
- Individual #468's AMA did not list his subdural hematoma as an active problem, and in the consults submitted, there was no documentation of follow-up with neurosurgery. The AMA was completed less than three months after the diagnosis of the subdural hematoma. There was still an order in place for staff to transfer the individual to the ED for any seizure activity due to the recent subdural hematoma. This was an active medical problem. The PCP should have outlined a comprehensive plan of care that included the timing of neurosurgery follow-up, the need for follow-up CT scans, and the parameters for blood pressure control. There should have also been a discussion about the use of contraindicated medications, such as non-steroidal anti-inflammatory drugs (NSAIDS) and all anticoagulants.
- Per Individual #132's AMA, in January 2018, the individual started metformin due to an A1c of 6.6. The AMA, dated 6/28/18, listed an inactive diagnosis of impaired glucose tolerance, but failed to provide a plan to address it. It further noted that the individual did not have metabolic syndrome. The individual met criteria for the diagnosis of metabolic syndrome. Moreover, an A1c of 6.6 met the criteria for diagnosis of Type 2 diabetes mellitus (T2DM). The interval medical review, dated 4/16/18, listed metabolic syndrome. At that time, she had a diagnosis of T2DM. Moreover, the interval medical review, dated 10/31/18, noted metabolic syndrome, while the IRRF noted that T2DM was newly diagnosed.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. However, for the IHCPs reviewed, documentation often was found to show implementation of those few action steps assigned to the PCPs. 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	78	36	31	10	1	107	12	468	132
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	80% 4/5	1/1	N/A	1/1	N/A	N/A	N/A	1/1	N/A	1/2
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, the few action steps assigned to the PCPs were implemented for the following: Individual #78 – diabetes, Individual #31 – cardiac disease, Individual #12 – respiratory compromise, and Individual #132 – cardiac disease.											

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	78	36	31	10	1	107	12	468	132
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: Given the timely completion of QDRRs for individuals reviewed during this review and the past two reviews (Round 12 – 100%, Round 13 – 100%, and Round 14 - 100%), indicator a will move to the category requiring less oversight. Although since the last review, some improvement was noted with regard to the quality of the QDRRs, continued improvement is needed with regard to the Clinical Pharmacist's review of laboratory irregularities, and the provision of related recommendations.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	QDRRs are completed quarterly by the pharmacist.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
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;	67% 12/18	0/2	0/2	2/2	2/2	0/2	2/2	2/2	2/2	2/2

	ii. Benzodiazepine use;	94% 17/18	2/2	2/2	2/2	2/2	2/2	1/2	2/2	2/2	2/2
	iii. Medication polypharmacy;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iv. New generation antipsychotic use; and	100% 6/6	2/2	N/A	2/2	N/A	N/A	2/2	N/A	N/A	N/A
	v. Anticholinergic burden.	89% 16/18	2/2	2/2	2/2	2/2	2/2	1/2	2/2	1/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	86% 6/7	1/1	N/A	1/1	0/1	1/1	1/1	N/A	1/1	1/1
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	N/R									

Comments: a. It was good to see timely completion of QDRRs for individuals reviewed.

b. The following provide examples of concerns noted:

- For Individual #78, the Clinical Pharmacist documented several abnormal lab values, but made no comments. For example, the individual's mean corpuscular volume (MCV) was 101.4, but the Clinical Pharmacist did not comment on whether this irregularity might be medication-related. The Clinical Pharmacist also noted that the individual's atherosclerotic vascular disease (ASCVD) risk score was 21% and recommended a high-intensity statin. The individual was prescribed a moderate intensity statin, but the Clinical Pharmacist made no formal recommendation related to this. The Clinical Pharmacist also noted increased iron and iron saturation. Although it was unclear if the PCP had followed up on this, the Clinical Pharmacist made no comments.
- In August 2018, Individual #36's liver enzymes were consistently elevated, but in the QDRR, dated 9/30/18, the Clinical Pharmacist did not comment on whether this could have been medication-related. The QDRR did not include the most recent lab values. In the QDRR, dated 12/6/18, the Clinical Pharmacist stated that the labs for lipids were within normal limits. The Pharmacist should indicate whether or not the target was met, or if the treatment was based on a risk score and the appropriate decrease occurred. The abnormal liver enzymes were documented, but the Clinical Pharmacist made no comments on them.

- For Individual #1, one or both of the QDRRs documented low ferritin, platelets, and total protein, and a borderline Vitamin D, but the Clinical Pharmacist made no comments. For example, since 2016, the individual had a very low ferritin of 20, but it was unclear if the test was repeated to ensure that the individual's iron stores were normal. The individual had osteoporosis, but it was unclear if repeat levels of Vitamin D were completed, or a change in dose was made.
- For Individual #107, the QDRR, dated 7/28/18, did not indicate whether or not benzodiazepines had been used, and did not mention the individual's anticholinergic burden.
- Individual #468's QDRR, dated 9/30/18, indicated that the individual did not have anticholinergic burden, but the individual was prescribed Trileptal.

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

- For Individual #10, no response was found for two recommendations the Clinical Pharmacist made in the QDRR, dated 9/29/18.

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	78	36	31	10	1	107	12	468	132
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/3	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% 0/3	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% 0/3	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% 0/3	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% 0/3	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 three individuals (i.e. Individual #78, Individual # 107 and Individual #12) with											

medium or high dental risk ratings. None of the three had clinically relevant, achievable and measurable goals/objectives related to dental outcomes.

In addition, although IDTs had rated some individuals at low risk for dental, their dental status should have resulted in medium or high risk ratings. This included: Individual #36 (i.e., missing 24 teeth, use of suction tooth brushing, and "undetermined" periodontal condition), Individual #31 (i.e., missing 10 teeth; no periodontal charting since 2014; change of status on 9/21/18, when she complained of pain in all teeth; and on 11/8/18, when the dentist referred her to an oral surgeon for removal of two teeth), Individual #10 (missing 10 teeth, uses suction tooth brushing, and no periodontal charting), Individual #1 (i.e., Type II periodontal disease, and in need of TIVA to complete deep cleaning), Individual #468 (i.e., Type III periodontal disease, and eight missing teeth), and Individual #132 (i.e., Type III periodontal disease, 12 missing teeth, and need for TIVA).

The Monitoring Team will be working with State Office on developing clinically relevant goals/objectives 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 lack of clinically relevant, achievable and measurable goals/objectives, 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	78	36	31	10	1	107	12	468	132
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	Not rated (N/R)									
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: With the new Dental Director, the Center should continue to focus on improving the provision and the quality of dental treatment.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
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.	44% 4/9	0/1	0/1	1/1	0/1	0/1	1/1	0/1	1/1	1/1
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	67% 6/9	1/1	0/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	33% 3/9	1/1	0/1	1/1	0/1	0/1	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.	100% 3/3	1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	1/1
e.	If the individual has need for restorative work, it is completed in a timely manner.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 2/2	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/1
Comments: a. through e. A number of individuals reviewed had not had needed dental care and treatment, including regular prophylactic care based on their individual needs, tooth brushing instruction and/or dental x-rays in accordance with accepted guidelines. It was positive, though, that individuals with medium or high caries risk routinely received at least two topical fluoride applications per year. f. It was positive that for both individuals who required extractions (i.e., Individual #107 and Individual #132), the record included sufficient justification for the extraction and informed consent was documented.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: Based on the dental emergencies reviewed, the dentist provided the individuals with timely dental assessment. If the Center sustains this performance, at the time of the next review, Indicator a might move to the category of less oversight. It was also positive the Center improved its performance for the provision of emergency dental care (i.e., Indicator b) since the previous visit. Pain assessment and management, and documentation of it, are areas on which the Center should focus.			Individuals:								
#	Indicator	Overall	78	36	31	10	1	107	12	468	132

		Score									
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 4/4	N/A	N/A	1/1	N/A	N/A	3/3	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 3/3			1/1			2/2			
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	33% 1/3			0/1			1/2			

Comments: a. through b. Individual #31 had a single dental emergency, while Individual #107 had three. In all four instances, the Center's dental staff provided timely assessment and dental treatment, but did not routinely document assessing or providing for pain management.

- On 11/8/18, nursing staff referred Individual #31 for pain to a tooth on the right side, which was tender to percussion. Dental staff determined that tooth, as well as the root of another previously root treated tooth, might need extraction and referred her to an oral surgeon. Documentation did not indicate an assessment for pain management needs or treatment for pain.
- On 6/29/18, dental staff saw Individual #107 for a complaint of tooth pain, provided her with antibiotic treatment for pericoronitis, and referred her to an oral surgeon for extraction of two teeth. Documentation did not reference an assessment for pain management needs or treatment for pain.
- On 8/2/18, dental staff saw Individual #107 again for pain in her left lower mouth, and diagnosed an aphthous ulcer. On that occasion, pain medication was prescribed as needed.
- On 12/6/18, dental staff performed a limited exam for Individual #107, after complaints of tooth pain beginning on 12/15/18. Dental staff took x-rays, which were negative, with no findings noted. The documentation again did not indicate an assessment for pain management needs or treatment for pain.

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
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	N/A	0/1	N/A	0/1	N/A	N/A	0/1	0/1	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/4		0/1		0/1			0/1	0/1	
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/4		0/1		0/1			0/1	0/1	
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/4		0/1		0/1			0/1	0/1	

Comments: a through d. IDTs did not include suction tooth brushing strategies/plans in the ISPs/IHCPs for any of the four applicable individuals. IDTs need to include measurable interventions related to suction tooth brushing, including the parameters for monitoring in individuals' ISPs/IHCPs, and then implement the strategies. QIDPs should then report on implementation.

Outcome 9 – Individuals who need them have dentures.											
Summary: The Center's dental staff often did not complete an assessment for individuals with missing teeth related to the appropriateness of dentures.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	50% 4/8	1/1	0/1	1/1	0/1	N/A	0/1	0/1	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. Individual #1 was only missing his third molars, so this indicator was not applicable for him. For the eight individuals reviewed who had missing teeth, the Dental Department did not provide clinically justified recommendations for four of them. The primary issue was the failure to complete the denture assessment (i.e., it was blank or said N/A for individuals with missing teeth). b. Individual #194 was pending dental impressions, and Individual #132 had impressions completed on 11/7/18.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Based on the few acute illnesses/occurrences reviewed, results varied with regard to nurses completing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis, as well as for nurses timely notifying the practitioner/physician of such signs and symptoms in accordance with the related nursing guidelines. Nursing staff were not developing acute care plans for all relevant acute care needs, and those that were developed needed significant improvement. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical	50% 2/4	N/A	N/A	1/1	N/A	N/A	1/1	N/A	0/2	N/A

	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.	50% 2/4			1/1			1/1		0/2	
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	33% 1/3			1/1			N/A		0/2	
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	100% 1/1			N/A			1/1		N/A	
e.	The individual has an acute care plan that meets his/her needs.	0% 0/4			0/1			0/1		0/2	
f.	The individual's acute care plan is implemented.	0% 0/4			0/1			0/1		0/2	

Comments: Given that State Office recently provided training and the Centers are at the beginning stages of developing and implementing acute care plans that reflect the training, the Monitoring Team reviewed a small group of acute care plans. Specifically, the Monitoring Team reviewed four acute illnesses and/or acute occurrences for three individuals, including those for Individual #31 - conjunctivitis of her left eye on 12/7/18, Individual #107 – chest pain on 8/22/18 that required an ED visit, and Individual #468 - blister on foot on 6/6/18, and blister on foot on 7/11/18.

a. The acute illnesses/occurrences for which nursing assessments (physical assessments) were performed were for Individual #31 - conjunctivitis of her left eye on 12/7/18, and Individual #107 – chest pain on 8/22/18 that required an ED visit.

b. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms in accordance with the SSLC nursing protocol entitled: "When contacting the PCP" were: Individual #31 - conjunctivitis of her left eye on 12/7/18, and Individual #107 – chest pain on 8/22/18 that required an ED visit.

e. For Individual #107 – chest pain on 8/22/18 that required an ED visit, and Individual #468 - blister on foot on 6/6/18, and blister on foot on 7/11/18, the Center did not submit acute care plans.

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

- For Individual #31's conjunctivitis, the acute care plan included the following nursing interventions: 1) Daily assessment of left eye and document finding; however, this action step was not specific regarding specifically what nurses were to assess; 2) Administer any treatment ordered by the PCP; however, the prescribed medications were not listed; and 3) Assessments interventions to be documented in IPNs/IView. The acute care plan also included infection control practices to prevent transmission that were only specific to the direct support professionals, and provided no indication of how the individual could participate in her care. Data were not present to show implementation of all of the interventions.
- An IView entry, dated 6/5/18, at 6:50 a.m., documented that Individual #468 had a blister on the plantar of his left foot.

Although the nurse provided measurements, the nurse did not document a pain assessment, or any plan to notify the PCP, and there was no reference to an IPN. On the same date, a medical IPN stated that nursing staff reported a blister on the individual's left foot. Based on documents submitted, nursing staff did not develop or implement an acute care plan.

On 7/11/18, at 9:24 a.m., for Individual #468, the Medical Progress Note denoted: "patient was seen today for follow-up to impaired skin integrity to left foot. LVN reports large blister has improved and is now closed and smaller lower blister covering has sloughed off and is now open." Because no prior nursing IPNs were found addressing this skin integrity issue, it was unclear if this was a new blister or the same one noted on 6/5/18. Based on the documentation submitted, nursing staff did not develop and/or implement an acute care plan to address the blister(s) noted on 7/11/18.

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

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

#	Indicator	Overall Score	Individuals: 78	36	31	10	1	107	12	468	132
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	33% 6/18	2/2	0/2	0/2	1/2	1/2	1/2	1/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #78 – diabetes, and constipation/bowel obstruction; Individual #36 – skin integrity, and infections; Individual #31 – circulatory, and GI problems; Individual #10 – seizures, and respiratory compromise; Individual #1 – falls, and aspiration; Individual #107 – constipation/bowel obstruction, and dental; Individual #12 – respiratory compromise, and GI problems; Individual #468 – osteoporosis, and UTIs; and Individual #132 – choking, and weight).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #78 – diabetes, and constipation/bowel obstruction; Individual #10 – seizures; Individual #1 – aspiration; Individual #107 – constipation/bowel obstruction; and Individual #12 – GI problems.

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports with data and analysis of the data 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 nursing supports and services to these nine individuals.

Outcome 6 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.											
Summary: Nurses often did not include interventions in IHCPs to address individuals' at-risk conditions, and even for those included in the IHCPs, documentation often was not present to show nurses implemented them. In addition, often IDTs did not collect and analyze information, and develop and implement plans to address the underlying etiology(ies) of individuals' risks. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	14% 1/7	N/A	0/2	N/A	0/1	0/1	N/A	1/2	N/A	0/1
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	6% 1/18	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

a. and c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, or that nursing interventions were implemented thoroughly. The lack of measurability for a number of interventions prevented the Monitoring Team from determining whether or not the interventions were implemented as intended. Based on review of a sample of documentation for Individual #78's one nursing intervention for constipation, nursing staff consistently implemented it.

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

risks:

- In January 2019, at the time of the Monitoring Team's onsite review, Individual #36 had a Stage 4 pressure ulcer. Although the pressure ulcer was at the site of a previous Stage 4 pressure ulcer, and the staging guidelines required that staff stage it as a Stage 4 pressure ulcer when it appeared again, based on documentation, on 9/17/18, a medical IPN stated: "[Individual #36] placed on MAC for evacuation of wound with slough, accompanied by tunneling that was not present two days ago according to LVN." The assessment was: "Open wound of left buttock Stage IV pressure injury." On 10/2/18, a culture showed the wound was positive for Methicillin-resistant Staphylococcus aureus (MRSA) and Proteus. In reviewing ISPAs related to the pressure ulcer, the IDT had not taken necessary action. For example:
  - On 7/27/18, at 8:20 p.m., a nurse wrote an IPN related to a skin tear on Individual #36's left buttock. The initial nursing assessment stated: "an open lesion to left buttocks." At that point, the nurse did not document the depth.
  - Her IHCP for skin integrity included 14 nursing interventions, many of which were measurable. Some positive interventions included, for example, head-to-toe assessments during bathing or other activities, and involved different nursing staff or other disciplines. However, some basic preventative interventions were missing, such as addressing her incontinence of bowel and bladder, use of skin barriers, etc.
  - On 8/8/18, Individual #36's IDT met to discuss the wound and the individual's weight loss. The IDT discussed that the wound on her left buttock was a reoccurring wound from a pressure sore in 2014, and that she had experienced a 15.6-pound weight loss. However, the IDT did not review her IRRF or IHCPs for skin or weight, or reference an acute care plan. Action steps included requesting labs and an x-ray.
  - On 8/15/18, the IDT held its next meeting, and again, according to documentation, the IDT did not review the IRRF, IHCPs, or an acute care plan, or data from the results of their implementation. The IDT noted Habilitation Therapies staff were working on obtaining a softer Roho cushion, but set no target date.
  - On 8/23/18, the IDT met about her wheelchair and her new cushion. Again, there was not review of the IRRF, IHCP, or acute care plan, or data from the results of their implementation.
  - On 9/5/18, the IDT held a meeting in follow up to the new cushion, and they discussed that attempts at custom molding were unsuccessful.
  - On 9/19/18, the ISPA documented the IDT's discussion that: "[Individual #36] has a reoccurring Stage 4 pressure wound." There was discussion that it had suddenly happened over the weekend, and the IDT would schedule a "root cause analysis." Again, the IDT did not document review of the IRRF, IHCP, or acute care plan, or data from the results of their implementation.
  - On 9/26/18, the IDT met, and the ISPA indicated the individual was seen in the Wound Clinic after a diagnosis of a Stage 4 wound with changes. The stated purpose of the meeting was to follow up on the wheelchair.
  - An ISPA, dated 10/3/18, indicated on 9/27/18, the IDT completed a "root cause analysis," and that the "root cause" was "Time constrains and complex position of [Individual #36] required by staff." It indicated that on 7/28/18, nursing staff initiated an acute care plan for skin impairment, but the IDT did not discuss or document discussion of whether or not it was meeting the individual's needs, or if nurses made any revisions since the Stage 4 pressure ulcer was identified. Again, the IDT did not document review of the IRRF, or IHCP related to the infection of the left hip wound with MRSA and Proteus that required antibiotic therapy.
  - On 10/10/18, the IDT held an ISPA meeting with the stated purpose to conduct a "root cause analysis" 10-day follow-up on the pressure injury and three injuries in 30 days. The documentation indicated that the RN Case Manager would

complete a Change of Statue (COS) IRRF and IHCP by the 10th. However, the IDT did not document agreement on what the changes would entail, nor did the IDT document review of whether her wound was responding to treatment, getting worse, or if any of the interventions in the current IRRF or IHCP were meeting the needs of the individual.
    - In January 2019, at the time of the Monitoring Team's onsite review, Individual #36 still had the wound, and still did not have an IHCP or acute care plan that met her needs.
- On 6/22/18, at 12:30 p.m., a nursing IPN indicated that Individual #10 experienced respiratory distress. The individual was transferred to the ED, where she was subsequently hospitalized, and diagnosed with aspiration pneumonitis. No ISPA was found to show that the IDT met and discussed whether or not her current plans met her needs.

  On 7/10/18, the IDT met to discuss hospitalizations over the past year, with two in past six months. The questions to which the IDT responded did not address her hospitalizations/Infirmary stays related to her respiratory system. The documentation showed no review of the IRRF or IHCP, and the action plans discussed were related to constipation, and UTIs.
- On 10/29/18, Individual #1 was hospitalized for aspiration pneumonia. Based on the records submitted, his IDT did not meet to review his hospitalization, and nursing staff did not develop and implement an acute care plan.
- According to an ISPA, dated 10/9/18, on 9/5/18, 9/13/18, and 9/28/18, Individual #12 vomited. The IDT recommended continued monitoring, and further recommendations, if he had additional vomiting. The IDT did not conduct a review of his total intake via his G-tube over a specified period of time, nor did they review his current medications. The record stated he had not had any increased residuals, but did not indicate what his baseline for residuals was. On 10/29/18, he was hospitalized with aspiration pneumonia secondary to E. coli and Pseudomonas infection, hypoxia, respiratory failure, and sepsis. After this hospitalization, the IDT conducted a more comprehensive analysis, and identified vomiting as the "root cause" of the aspiration pneumonia, with a relationship to GERD, dysphagia, and pain. Although at this meeting, the IDT did not document review of the IRRF and IHCP, they did develop a more comprehensive list of action steps to attempt to address the underlying etiology(ies) of his respiratory issues.
- On 7/17/18, Individual #132 choked on medication and required staff to implement the abdominal thrust. On 7/18/18, the IDT held an ISPA meeting. The Speech Language Pathologist (SLP) defined in understandable terms, the issue that likely caused the choking incident, specifically that the longer the calcium pill was in the applesauce, the pill began to dissolve, and created a bitter taste. Based on her history, the individual had hypersensitive taste buds. The IDT developed action plans, including: 1) the SLP and Behavioral Health Specialist were to observe medication pass on 7/19/18, and 7/20/18; 2) PNMP instruction would specify that the individual should self-administer her medication in her bedroom to reduce distractions; and 3) the individual would trial taking her calcium in applesauce/yogurt over the next two nights. The IDT did not review the IRRF or IHCP. Based on the documentation submitted, the IDT did not meet again to review the results of the observations or evaluate the effectiveness of the changes.

Outcome 7 – Individuals receive medications prescribed in a safe manner.	
Summary: For at least three reviews, as well as this review, the Center did well with the indicators related to: 1) nurses administering medications according to the nine rights; and 2) nurses adhering to individuals' PNMPs. However, given the importance of these indicators to individuals' health and safety, these indicators will	Individuals:

continue in active oversight until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement. An area of significant concern relates to the lack of action steps in applicable individuals' IHCPs for the completion of regular respiratory assessments to address their high risk for respiratory compromise. These indicators will remain in active oversight.											
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
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).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	N/A									
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	0% 0/4	N/A	0/1	N/A	N/A	0/1	N/A	0/1	0/1	N/A
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

		9/9									
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of the nine individuals.

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

d. With regard to respiratory assessments, the following concerns were noted:

- On 8/18/18, Individual #36, who had a G-tube, went to the ED for hypoxia. Upon her return, she went to the Infirmary, where she required oxygen up to 3L due to oxygen saturations as low as 88%. On 9/4/18, she was discharged from the Infirmary. Her IHCP did not include nursing interventions for respiratory assessments.
- On 10/28/18, Individual #1 had aspiration pneumonia. His IDT had not modified his risk rating from medium to high, and had not met to change his IHCP to include respiratory assessments.
- On 10/29/18, Individual #12 was hospitalized with aspiration pneumonia secondary to E. coli and Pseudomonas infection, hypoxia, respiratory failure, and sepsis. However, his IHCP only included reactive respiratory assessments to be implemented if he showed abnormal respiratory symptoms.
- Individual #468 was rated at high risk for aspiration/respiratory compromise, received enteral nutrition, and over the last year, had acute respiratory compromise and/or pneumonia/aspiration pneumonia a number of times (i.e., 2/17/18, aspiration pneumonia; 4/11/18, pneumonia; 7/23/18, pneumonia; 8/3/18, dyspnea; and 11/20/18, hypoxia and aspiration pneumonia). Although the medication nurse indicated he had an order for nurses to complete lung sounds, the order was not found in the documentation submitted.

f. It was positive that medication nurses implemented the individuals' PNMPs and checked the position of the individuals prior to medication administration.

g. With regard to adherence to infection control practices, the exceptions were:

- For Individual #10, the medication nurse did not sanitize the scissors prior to cutting open packets.
- For Individual #468, when administering medications, the nurse weaved the uncovered tip of the G-tube through his clothing, and it came into contact with his clothing.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Since the last review, it was good to see some improvement with regard to individuals being referred to the PNMT, when needed. Overall, though, IDTs and/or the PNMT did not have a way to measure clinically relevant outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
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% 0/10	0/1	N/A	0/2	0/2	0/2	0/1	N/A	N/A	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/10	0/1		0/2	0/2	0/2	0/1			0/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/10	0/1		0/2	0/2	0/2	0/1			0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/10	0/1		0/2	0/2	0/2	0/1			0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/10	0/1		0/2	0/2	0/2	0/1			0/2
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										

	i.	If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	75% 6/8	0/1	2/2	N/A	N/A	N/A	1/1	1/2	2/2	N/A
	ii.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/8	0/1	0/2				0/1	0/2	0/2	
	iii.	Individual has a measurable goal/objective, including timeframes for completion;	25% 2/8	1/1	0/2				1/1	0/2	0/2	
	iv.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/8	0/1	0/2				0/1	0/2	0/2	
	v.	Individual has made progress on his/her goal/objective; and	0% 0/8	0/1	0/2				0/1	0/2	0/2	
	vi.	When there is a lack of progress, the IDT takes necessary action.	0% 0/8	0/1	0/2				0/1	0/2	0/2	

Comments: The Monitoring Team reviewed 10 goals/objectives related to PNM issues that six individuals' IDTs were responsible for developing. These included goals/objectives related to: Individual #78 – falls; Individual #31 – choking, and falls; Individual #10 – aspiration, and fractures; Individual #1 – choking, and fractures; Individual #107 – falls; and Individual #132 – falls, and choking.

a.i. and a.ii. For Individual #31, the OT/PT recommended continuation of a direct therapy goal for her for to walk to/from 509 building with a rolling walker and stand-by assistance. However, the IDT had not included this goal in the IHCP.

b.i. The Monitoring Team reviewed eight 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 #78 – weight; Individual #36 – aspiration, and skin integrity; Individual #107 – GI problems; Individual #12 – aspiration, and fractures; and Individual #468 – aspiration, and weight.

These individuals should have been referred to the PNMT:

- Between December 2017 and December 2018, Individual #78's weight varied [December 2017: 191.4 pounds, 1/9/18: 170.9, 1/29/18: 166.4, 2/5/18: 166.0, 3/13/18: 178.6, April 2018: 184.2, May 2018: 185, 6/6/18: 182.8 (post hospital), July 2018: 184.4, August2018: 194.6, September 2018: 197.6, October 2018: 203, November 2018: 205, and December 2018: 201.8], but overall, he experienced weight gain. In June 2018, after a hospitalization, he lost a few pounds, and his IDT held an ISPA meeting, and identified the possible need for increased protein for healing, but they did not make a referral to the Registered Dietician. In reviewing his weights over the year, though, between the end of January 2018 and August 2018, he had a weight gain of 17% over six months, and between January 2018 and November 2018, he gained a total of 39 pounds, which represented a 23% increase in weight. In June 2018, his IDT discussed a possible referral to the PNMT, if his weight gain continued, but they never made a referral.
- Individual #12 had a right humeral fracture while hospitalized. Although the PNMT mentioned it in their review related to aspiration pneumonia, it did not appear that his IDT referred him to the PNMT or that the PNMT made a self-referral of this long bone fracture.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT did not develop clinically relevant, achievable, and measurable goals/objectives for these individuals. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #78 – weight, and Individual #107 – GI problems.

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: None of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Many of the PNM action steps that were included were not measurable, making it difficult to collect specific data. Substantially more work is needed to document that individuals receive the PNM supports they require. In addition, in numerous instances, IDTs did not take immediate action, when individuals' PNM risk increased or they experienced changes of status. At this time, these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	18% 2/11	1/2	0/2	N/A	N/A	N/A	0/2	0/1	0/2	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.	0% 0/2	N/A	N/A	N/A	N/A	N/A	0/1	0/1	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. Monthly integrated reviews often only included statements such as "ongoing," or "continues in place," without specific information or data about the status of the implementation of the action steps.

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

- According to Individual #78's IRRF, dated 11/27/18, he was 50 pounds over his EDWR, and during the previous year, his

weight had steadily increased. However, his IDT did not develop and implement a reasonable plan to address his diagnosis of obesity.

- For Individual #36's pressure wound that reopened on 3/23/18, no evidence was found that the IDT identified the cause(s), and/or implemented plans to address suspected causes. The pressure ulcer worsened. In January 2019, at the time of the Monitoring Team's onsite review, the individual had a Stage 4 pressure ulcer. Although the pressure ulcer was at the site of a previous Stage 4 pressure ulcer, and the staging guidelines required that staff stage it as a Stage 4 pressure ulcer when it appeared again, based on documentation, on 9/17/18, a medical IPN stated: "[Individual #36] placed on MAC for evacuation of wound with slough, accompanied by tunneling that was not present two days ago according to LVN." The assessment was: "Open wound of left buttock Stage IV pressure injury." On 10/2/18, a culture showed the wound was positive for Methicillin-resistant Staphylococcus aureus (MRSA) and Proteus. In reviewing ISPAs related to the pressure ulcer, the IDT had not taken necessary action. For example:
    - In March 2018, there was some discussion of the individual possibly sliding down on the shower wedge, and perhaps weight loss, but the PNMT did not identify these as potential causes in its April 2018 assessment. At this juncture, there was no evidence that staff staged the wound.
    - In April 2018, the PNMT offered no recommendations related to the wound.
    - On 7/27/18, an open wound to the left buttocks was noted perhaps due to friction during check and change. Also, the individual had an abrasion/wound (i.e., not clear in PNMT review) to the left IT.
    - On 8/7/18, based on pressure mapping, the individual was experiencing increased pressure.
    - On 8/8/18, the IDT met to discuss the wound to the individual's left buttock (other notes state left IT), as well as the individual's weight loss. Based on the ISPA, from 8/17/17 to 8/8/18, she lost 15.6 pounds, at which point, she weighed 108.6 pounds. The IDT discussed a dietary consult and labs for protein. The IDT did not make a referral to the PNMT (although she was already on the PNMT caseload). The consult, dated 9/25/18, stated the Dietician did not have any new recommendations. Based on the documentation submitted, the IDT did not have any subsequent discussion about the nutrition consult until 10/3/18.
    - Individual #36's air mattress was deflated, so on 8/21/18, Habilitation Therapies staff in-serviced staff and increased inflation to 150 pounds. According to a note, dated 8/29/18, she received a new air mattress.
    - The IDT also identified three injuries attributed to staff handling (i.e., a bruise that occurred during transfer, a thumb nail torn off and caught on the individual's shirt sleeve, and scratches to her right leg caused by staff during check and change). The action step was for the Home Manager to discuss injuries and how fragile the individual was with direct support professionals.
    - At a "root cause analysis' meeting, on 9/27/18, the IDT identified staff handling as the root cause of the injury, as well as increased pressure. More specifically, the IDT stated that staff had improperly turned her, pulling the brief instead of rolling her to remove it (i.e., on 8/7/18). She also had been in the ED for six hours on a gurney without her wheelchair (i.e., on 8/18/18). This was in addition to weight loss, a previous Stage 4 pressure injury, and staying in bed more frequently due to extreme pain from arthritis. The IDT stated she was allowed to stay in bed for long periods of time per her preference due to arthritis pain, and thus, staff were not following her PNMP. The IDT agreed upon recommendations to conduct 10-day follow up, and the home manager was to re-in-service staff on check and change. The PNMT also was to follow up, but the IDT provided no specifics, and nursing staff were to complete daily wound care treatment after the individual's bath. Nursing staff also were to administer Tylenol one hour before wound care.

This "root cause analysis" did not show a sufficient analysis of data, and did not generate a comprehensive set of recommendations to meet the individual's needs.
    - In January 2019, at the time of the Monitoring Team's onsite review, Individual #36 still had the wound, and still did not have a set of supports that met her needs.
- According to Individual #107's IRRF, completed in July 2018, her IDT rated her at low risk for falls, despite six falls in the previous ISP year. The OT/PT assessment, dated 7/5/18, recommended increasing her fall risk to medium, so it was unclear why the IDT chose to leave the risk rating at low. As a result of the low risk rating, the IDT did not develop an IHCP for falls. Since her ISP meeting, on 7/12/18, she fell at least three additional times (i.e., 8/11/18, 8/31/18, and 9/17/18). She also had an increase in tremors, which could impact her functioning and her safety. Even since the additional falls, the IDT did not meet to develop an IHCP.
- On 7/17/18, Individual #132 choked on medication and required staff to implement the abdominal thrust. On 7/18/18, the IDT held an ISPA meeting. The Speech Language Pathologist (SLP) defined in understandable terms, the issue that likely caused the choking incident, specifically that the longer the calcium pill was in the applesauce, the pill began to dissolve, and created a bitter taste. Based on her history, the individual had hypersensitive taste buds. The IDT developed action plans, including: 1) the SLP and Behavioral Health Specialist were to observe medication pass on 7/19/18, and 7/20/18; 2) PNMP instruction would specify that the individual should self-administer her medication in her bedroom to reduce distractions; and 3) the individual would trial taking her calcium in applesauce/yogurt over the next two nights. The IDT did not review the IRRF or IHCP. Based on the documentation submitted, the IDT did not meet again to review the results of the observations or evaluate the effectiveness of the changes.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.

Summary: Overall, PNMP/Dining Plan implementation at Lufkin SSLC continued to need improvement. Often, the errors that occurred (e.g., staff not intervening when individuals took large bites or ate at unsafe rates, staff utilizing incorrect food presentation techniques, and staff incorrectly using positioning equipment, resulting in individuals in positions that were not consistent with the PNMPs) placed individuals at significant risk of harm with regard to issues such as aspiration and skin breakdown. These indicators will continue in active oversight.

#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	64% 70/110
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.	25% 3/12

Comments: a. The Monitoring Team conducted 110 observations of the implementation of PNMPs. Based on these observations,

individuals were positioned correctly during 19 out of 41 observations (46%). Staff followed individuals' dining plans during 48 out of 63 mealtime observations (76%). Staff completed transfers correctly during three out of six observations (50%).

The following provide more specifics about the problems noted:

- With regard to Dining Plan implementation, the majority of the errors related to staff not using correct techniques (e.g., cues for slowing, presentation of food and drink, bite size, prompting, etc.). Individuals were at increased risk due to staff's failure, for example, to prompt individuals when they took large unsafe bites, or ate at too fast a rate, or in a number of cases, staff did not follow instructions for food presentation techniques. Some issues also were noted with food texture, and individuals' positioning during mealtime.
- With regard to positioning, problems varied, but the most common problem was that staff did not use equipment correctly (i.e., about 50% of the observations).

  As discussed while the Monitoring Team was on site, and in the exit comments, positioning, particularly in bed, needs significant improvement. On Monday of the onsite review week, the Monitoring Team member visited Home 549, in which many individuals with complex needs live, and several individuals were not in the correct position. The Monitoring Team appreciated the Center's efforts to immediately retrain staff. However, staff should continue to follow-up to ensure problems are corrected, particularly given the skin integrity issues that individuals at the Center continued to experience.
- For one of the transfers observed, staff did not follow the PNMP instructions to use the gait belt. In one, the individual's head was in hyperextension throughout the transfer. In another, staff failed to position the individual correctly in the chair at the conclusion of the transfer.

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	78	36	31	10	1	107	12	468	132
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: Individuals reviewed did not have clinically relevant and measurable	Individuals:

goals/objectives in their ISPs to address their needs for formal OT/PT services. In addition, QIDP interim reviews often did not include data related to existing goals/objectives. As a result, IDTs did not have information in an integrated format related to individuals' progress or lack thereof. These indicators will remain in active oversight.											
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/24	0/6	0/1	0/5	0/1	0/1	0/1	0/3	0/1	0/5
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/24	0/6	0/1	0/5	0/1	0/1	0/1	0/3	0/1	0/5
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/24	0/6	0/1	0/5	0/1	0/1	0/1	0/3	0/1	0/5
d.	Individual has made progress on his/her OT/PT goal.	0% 0/24	0/6	0/1	0/5	0/1	0/1	0/1	0/3	0/1	0/5
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/24	0/6	0/1	0/5	0/1	0/1	0/1	0/3	0/1	0/5

Comments: a. and b. Most individuals did not have goals/objectives that were clinically relevant. In several instances, OTs/PTs developed goals/objectives for which assessment information was not available to establish clinical relevance or to provide baseline measurements.

For the two goals that were clinically relevant, as described in the individuals' OT/PT assessments, the IDT failed to develop a measurable goal in the ISP. As a result, Indicator a could not be scored positively. Concerns included:

- Individual #31's assessment recommended a goal that was clinically relevant and achievable (i.e., ambulation with a walker to and from Building 509). This was discussed in the ISP narrative, but not identified as a specific goal in either the ISP or the IHCP, nor monitored in the QIDP monthly summary.
- For Individual # 132, the OT/PT assessment made a recommendation for leisure/recreation that she ambulate for 20 to 30 minutes around the housing circle where she lived at least three times a week with staff, using her rollator walker, weather permitting, or in the campus gym. This was clinically relevant in response to her increase in weight and recent diagnosis of diabetes mellitus, type 2. While this recommendation was also measurable, the IDT did not use this to develop a measurable goal; instead, the action plan stated only that she "will walk on campus twice per week,'" adding that could be to and from work. The IDT did not provide a clear rationale for making this change from the assessment recommendation.

For Individual #78, it was unclear if the goals/objectives the OT/PT developed were clinically relevant due to the lack of a comprehensive assessment to address his change of status. In addition, the IDT did not develop an ISPA to incorporate them into the ISP.

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. The Monitoring Team conducted full reviews for all nine individuals.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: For the individuals reviewed, evidence was not found in ISP integrated reviews to show that OT/PT supports were implemented. IDTs also did not yet consistently consider and approve changes to OT/PT supports that occurred outside of the annual ISP meeting, but some improvement was noted since the last review. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/6	N/A	N/A	0/2	0/1	N/A	N/A	0/2	N/A	0/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	50% 3/6	1/2	N/A	1/2	N/A	N/A	N/A	1/1	N/A	0/1

Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that supports were implemented. OTs and PTs should work with QIDPs to ensure data are included and analyzed in ISP integrated reviews.

b. The Center still did not consistently ensure that proposed terminations of OT/PT services or supports were discussed and approved by the individuals' IDTs. Concerns included that the IDT either did not meet (e.g. for Individual #78's OT), or met but did not document a thorough discussion of the PT goals that were being discontinued or of any recommendations for continued integration (e.g. for Individual #132.)

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.												
Summary: Proper fit of adaptive equipment was often still an issue. 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 – 50%, Round 13 – 78%, and Round 14 - 67%), Indicator c will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [Note: due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]			Individuals:									
#	Indicator	Overall Score	152	402	47	46	255	191	108	109	127
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance, these indicators remained in 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.	69% 24/35	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
		Individuals:									
#	Indicator		194	599	132	75	440	1	382	13	574
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	1/1	1/1	0/1	1/1	0/1	0/1
		Individuals:									
#	Indicator		85	351	466	360	468	504	147	117	310
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1
		Individuals:									
#	Indicator		27	68	124	530	354	519	422	22	
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	1/1	1/1	1/1	

Comments: c. Based on observations of individuals in their wheelchairs, the outcomes for the following 11 individuals were that they were not positioned correctly or supported adequately: Individual #152, Individual #127, Individual #194, Individual #599, Individual #1, Individual #13, Individual #574, Individual #85, Individual #310, Individual #504, and Individual #530. 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.

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 last review, three indicators were already in, or were moved to, the category of requiring less oversight. At this review, one other indicators will be moved to this category, in skill acquisition.

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

In ISPs, for the 11 personal goals that met criterion with indicators 1 and 2, action plans to support achievement of the goals were not consistently implemented. Reliable and valid data were not available for nine of the 11 goals. Therefore, progress could not be determined. For the two goals that had reliable data, one individual was making progress and one was not.

In skill acquisition programming, there was substantial improvement in quality of SAP plans, and the percentage of SAPs with integrity measures. The monitoring of SAP data, however, needed to improve because SAP data demonstrated that few individuals were actually acquiring skills, and there was little evidence of actions taken to address the lack of progress. To be specific, 10 SAPs had reliable data; one was making progress.

Regarding engagement, for two visits in row, none of the individuals in the review group were found to be consistently engaged (i.e., engaged during at least 70% of our direct observations).

That being said, staff were for the most part attempting to engage individuals. In some cases, staff ratios made it difficult for staff to attend to the engagement of all of the individuals. This was particularly evident during the 2-10 hours, a period that the Center already identified as having staff recruitment and retention problems.

During the mid-day hours, during a cold day when many individuals had to stay at home, the Lone Pine individuals were, for the most part, around tables with staff attempting to engage them with materials and social interactions. On the other hand, during the dinner hours at Castle Pine, individuals who were not in the dining room were not engaged in activities.

Recent increases in staffing resources to the 510-550 day programs now set the occasion for those two programs to move forward in improving activities. Given the supervision and staffing, the Center should consider conducting specific engagement probes, assessing attendance, and involving assigned DSP staff to a greater extent in programming. The Monitoring Team acknowledges the Center's commitment to these programs.

An increase in community employment was seen.

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

Although since the last few reviews, improvement was noted, the Center should continue to focus on ensuring individuals have their AAC devices with them and accessible. Most importantly, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: One of the two goals that met criteria with indicators 1-3 was showing progress. This was good to see. For the other goal that met criteria with indicators 1 and 2, there were insufficient data and/or implementation to be able to determine progress. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	36	78	227	97	132	107			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	1/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/5			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/5			

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

For the 11 personal goals that met criterion with indicators 1 and 2, there was no evidence that action plans to support those goals were consistently implemented because reliable and valid data were not available for nine of the 11 goals (i.e., indicator 3). Therefore, progress could not be determined.

For the two goals that had reliable data, Individual #227 had not made progress on SAPs related to her school/day goal over the past eight months. The IDT had not made revisions or addressed barriers to her progress. Individual #107 was making progress towards learning to make a snack.

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: The Monitoring Team observed many respectful and supportive interactions between DSPs and individuals. Many DSPs were knowledgeable about individuals' preferences and support needs. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	36	78	227	97	132	107			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	50% 3/6	0/1	1/1	1/1	0/1	1/1	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. For the most part, direct support professional staff interviewed and observed throughout the week were knowledgeable about individual's preferences and support needs and very respectful and supportive to each individual in their interactions.

The staff for three individuals, however, were not found to exhibit a level of competence to ensure implementation of the ISP. These were staff supporting Individual #36, Individual #97, and Individual #107. For the most part, this could be attributed to the lack of clear staff instructions for carrying out the supports included in the ISP. Staff were not fully implementing ISPs, so it was difficult to verify that they could exhibit competence in implementing support plans. ISPs rarely included detailed instructions to guide staff when implementing the ISP. 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.

40. Action steps were not regularly and correctly implemented for all goals and/or action plans, as noted throughout this report.

Going forward, IDTs need 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: Ten SAPs had reliable data (indicator 5), thus, progress could be determined. Of these 10 SAPs, one was making progress. One SAP was reported as being met (though criteria for indicator 5 was not met), and the IDT progressed her to the next step. For those SAPs identified as not progressing, actions were not being taken to address the lack of progress. These indicators will remain in active	Individuals:

monitoring.												
#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
6	The individual is progressing on his/her SAPs.	5% 1/20	0/2	0/2	1/2	0/2	0/2	0/3	0/2	0/3	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	100% 1/1									1/1
8	If the individual was not making progress, actions were taken.	0% 0/9	0/2	0/2	0/1		0/1			0/3	
9	(No longer scored)										

Comments:

6. Individual #5's pressing a button to indicate need to be changed SAP was rated as progressing (and there were reliable data). Some SAPs (e.g., Individual #85's wear a massage headband SAP) were not making progress. Individual #410's write his address SAP did not have sufficient data to determine progress and was not scored. Other SAPs with insufficient data were scored as 0 because their data were not demonstrated to be reliable (e.g., Individual #97's greet others SAP). Finally, some SAP data did indicate progress (e.g., Individual #38's put soap on a washcloth SAP), but were scored as not making progress because they did not have reliable data (see indicator 5).

7. Individual #38 moved from step 1 to step 4 on her put soap on her washcloth SAP.

8. Nine SAPs were judged to not be progressing (e.g., Individual #227's point to letters SAP), however, none had documentation of actions to address the lack of progress. Lufkin SSLC should ensure that SAP progress is closely monitored and that data-based decisions to continue, discontinue, or modify SAPs are consistently applied.

Outcome 4- All individuals have SAPs that contain the required components.											
Summary: Much progress was seen. That is, more than half of the SAPs met all of the content requirements. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
13	The individual's SAPs are complete.	62% 13/21	1/2 16/19	1/2 17/18	1/2 18/20	2/2 19/19	2/2 20/20	1/3 24/30	1/2 19/20	3/3 27/27	1/3 25/30

Comments:

13. In order to be scored as complete, a skill acquisition plan (SAP) must contain 10 components necessary for optimal learning. Thirteen SAPs were found to contain all of those elements (e.g., Individual #18's turn on music SAP). This represents a dramatic improvement from the last review when four SAPs were scored as complete.

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.

Although 62% of the SAPs were judged to be complete, most of the SAPs contained the majority of the components. For example, at least 85% of the SAPs had a plan that included:

- a task analysis (when appropriate)
- behavioral objectives
- operational definitions of target behaviors
- relevant discriminative stimuli
- teaching schedule
- specific consequences for incorrect responses
- plans for maintenance and generalization
- documentation methodology.

Regarding common missing components:

- The multiple step SAPs that represented skills that consisted of chains of behavior identified the training step, and instructed staff to assist the individual with the completion of the subsequent steps. Some SAP instructions, however, confused the steps and instead of instructing staff to document and or reinforce step 1 (i.e., the training step), the instructions included steps 1 and 2 (e.g., Individual #18's open the door SAP).
- Ensuring that individuals are motivated to complete SAPs is a critical training component and, therefore, it is important that efforts are made to ensure that potent reinforcers are provided following the successful completion of all SAPs. This individualization of reinforcement for correct SAP completion was apparent in some SAPs (e.g., Individual #85's wear his music pillow SAP where correct responses were to be followed by praise <u>and</u> the opportunity to listen to his music). Many SAPs, however, merely included saying "good job," which may not function as a potent reinforcer for every individual (e.g., Individual #38's identify body parts SAP).

A few SAPs (e.g., Individual #410's state three benefits of working SAP) did not have a complete generalization plan. Finally, a few SAPs targeted <u>describing</u> the desired behaviors, rather than targeting the <u>demonstration</u> of the skill. For example, Individual #410's state the benefits of work SAP consisting of him stating the benefits of work rather than actually experiencing the benefits of work (e.g., earning money). Being able to describe the steps of an activity does not necessarily result in performing the skill. Generally, it is most useful to directly teach individual's desired skills, rather than having them simply describe them.

Outcome 5- SAPs are implemented with integrity.	
Summary: Two of the three SAPs observed were implemented correctly. Four other SAPs could not be observed because the individual refused and/or the required materials were not available. Thus, these other SAPs would not have likely been implemented correctly, which would have resulted instead in a lower score for	Individuals:

indicator 14. That being said, the Center showed that it was checking on implementation integrity more so than it had in the past. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
14	SAPs are implemented as written.	67% 2/3	1/1			1/1					0/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	48% 10/21	1/2	2/2	2/2	0/2	0/2	1/3	2/2	2/3	0/3

Comments:
14. The Monitoring Team attempted to observe the implementation of seven SAPs. Due to refusals and unavailable SAP materials, three SAPs were observed. Individual #97's greet others, and Individual #18's turn on her music SAPs were judged to be implemented and documented as written. Individual #38's identify her body parts, SAP was not judged to be implemented as written. In order to maximize the learning of new skills, it is critical that all staff consistently implement SAPs in the same way. Ensuring that SAPs are consistently implemented as written should be a priority for Lufkin SSLC.

During the morning unit meeting at Woodland Crossing, the unit director made an announcement that the observation of Individual #18's SAP went very well. It was good to see this type of recognition of staff performance.

15. Forty-eight percent of the SAPs had integrity measures. Lufkin SSLC established that each SAP would have integrity measures at least every six months

Outcome 6 - SAP data are reviewed monthly, and data are graphed.											
Summary: Performance on indicator 16 remained about the same as at the previous two reviews, showing that some but not most SAPs were properly reviewed each month. SAPs had graphic summaries of performance for 90% or more of the SAPs for this and the last two reviews, 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	18	36	5	97	78	410	85	227	38
16	There is evidence that SAPs are reviewed monthly.	60% 12/20	2/2	2/2	2/2	0/2	0/2	0/3	1/2	3/3	2/2
17	SAP outcomes are graphed.	94% 16/17	2/2	2/2	2/2	2/2	1/1		2/2	3/3	2/3

Comments:
16. Some SAPs had a data-based review in the QIDP monthly report (e.g., Individual #36's identify colors SAP). Other SAP reviews,

however, did not occur monthly (e.g., Individual #97's SAPs), or were not included in the SAP monthly reviews (e.g., Individual #410's SAP).

17. SAP data were consistently graphed. Individual #38's put soap on her washcloth SAP was graphed, but not useful because multiple step progress was combined, which did not allow a clear presentation of progress.

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
Su Summary: Individuals observed by the Monitoring Team were not engaged in activities a majority of the time that they were observed throughout the onsite review week (indicator 18). Similarly, the Center did not achieve its own goals for engagement (indicator 21). Improvements continued at the 510 and 550 day programming buildings, including the provision of additional resources (e.g., supervisor overseeing both programs, DSPs assigned to the programs as their sole work site). Indicators 18 and 21 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	18	36	5	97	78	410	85	227	38
18	The individual is meaningfully engaged in residential and treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	The day and treatment sites of the individual have goal engagement level scores.										
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	56% 5/9	0/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1

Comments:
18. The Monitoring Team directly observed nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found none of the nine individuals to be consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

The Center reported dealing with numerous DSP vacancies, mostly on the afternoon/evening (2 pm to 10 pm) shifts. This was especially noticeable to the Monitoring Team during direct observations, especially for those staff and individuals not involved in mealtimes during the mealtime hours. For instance, at one point, two staff in a Woodland Cross home were supervising 12 individuals in a large open living room area while others were having dinner.

21. Lufkin SSLC tracked engagement in all residential and treatment sites. Their established engagement goal was individualized to each residence and day program site. The Center's engagement data indicated that Individual #85, Individual #410, Individual #78, Individual #97, and Individual #5's residences achieved their goal level of engagement.

In the last report, the Monitor commented on the then recently initiated specialized day programs in the 510 and 550 buildings. These programs had a lot of potential, but were hampered by staffing problems, including staff supervision, assigned staff, and staff who knew the individuals for whom they were responsible for teaching, engaging, and supervising. In the interim period since then, the Center had made a number of changes (and improvements). These were evident to the Monitoring Team. The improvements were the creation of a supervisor position to oversee and manage both programs, hiring staff who's sole assignment was to the day programs (i.e., they were not residential staff), and continuation of the two hands-on coordinators for each of the two sites. Both of these coordinators were very engaged with individuals and knowledgeable about their programs.

During the onsite week, however, exceptionally cold weather resulted in many individuals remaining in their homes because they were on cold-weather restrictions due to medical issues. Thus, for example, less than 20 individuals were present in the 550 program one afternoon when the attendance is usually more than 30 (according to the coordinator).

Even so, there was limited engagement in the activities presented for those individuals who were present. That being said, these two programs now had the resources to really move the program forward in terms of engagement, individuality, and experiences. For instance, more frequent engagement probes could be conducted, attendance could be improved, and staff input more readily obtained and included. The Monitoring Team looks forward to seeing the continued development of the 510 and 550 programs.

During the cold days, individuals were observed in the Lone Pine (549) homes A, B, and D. For the most part, individuals were up, in the living rooms areas, and gathered around tables in small groups. Staff were circulating attention and doing a good job trying to keep individuals engaged with various toys and arts/crafts materials.

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

Summary: Individuals had opportunities for community outings, which was good to see, however, there should be some goal frequencies for outings as well as for SAP training in the community. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 18	36	5	97	78	410	85	227	38
22	For the individual, goal frequencies of community recreational activities are established and achieved.	22% 2/9	1/1	0/1	0/1	1/1	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. Individual #18's QIDP monthly report indicated that she had a goal of at least one community outing a month. Additionally, Individual #97's QIDP monthly report indicated that he had a goal of at least one community outing a quarter. Available data indicated

that they both achieved their community outings goals in the last six months.

There was evidence that the remaining individuals participated in community outings, however, there were no established goals for this activity. The facility should establish a goal frequency of community outings for each individual, and demonstrate that the goal was achieved.

23. There was no documentation of SAP training in the community. SAP training data and goals for the frequency of SAP training in community should be established for each individual, and the facility needs to demonstrate that the goal was achieved.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
Summary:			Individuals:								
#	Indicator	Overall Score									
25	The student receives educational services that are integrated with the ISP.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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: N/A			Individuals:								
#	Indicator	Overall Score	78	36	31	10	1	107	12	468	132
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A									
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									
Comments: a. through d. None.											

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: Significant work is still needed to improve the clinical relevance of goals/objectives, and to ensure that the ISPs of individuals who have the need for formal communication supports include necessary goals/objectives and programs. 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	78	36	31	10	1	107	12	468	132
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/10	0/1	0/1	0/1	0/1	0/3	0/1	0/1	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/10	0/1	0/1	0/1	0/1	0/3	0/1	0/1	0/1	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/10	0/1	0/1	0/1	0/1	0/3	0/1	0/1	0/1	
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/10	0/1	0/1	0/1	0/1	0/3	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	0/1	0/3	0/1	0/1	0/1	
Comments: a. through e. Individual #132 had functional communication skills, but was part of the core group. None of the remaining eight individuals reviewed had clinically relevant or measurable goals. 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: Most individuals did not have measurable strategies and action plans included in the ISPs/ISPAs related to communication. 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	78	36	31	10	1	107	12	468	132
a.	There is evidence that the measurable strategies and action plans	0%	N/A	N/A	N/A	N/A	0/3	N/A	N/A	0/1	N/A

	included in the ISPs/ISPAs related to communication are implemented.	0/4									
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									
Comments: a and b. 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, although most ISPs did not include such strategies. While QIDP monthly reviews for Individual #1 provided some indication that communication strategies and action plans had been implemented, the reviews consisted primarily of cut and pasted Individual Progress Notes (IPNs) and lacked presentation of data, summaries of monthly progress, or evidence of progress review by the SLP.											

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: Although in comparison with the last few reviews, improvement was noted, 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."]			Individuals:								
#	Indicator	Overall Score	405	1	471	81	182	241	68	117	412
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	100% 11/11	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	8% 1/12	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
			Individuals:								
#	Indicator		117	369	402						
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		1/1	1/1	1/1						
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		0/1	0/1	0/1						
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings,	N/R									

	and at relevant times.	
Comments: a. and b. It was positive that individuals' AAC devices were present or readily accessible, but concerning that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them. Individual #81 did not have an AAC device, but rather he used signs as a language-based support. Staff did not prompt the individual to either sign or use speech to request more food. Rather, staff stated that he understood that when the individual was looking around that he wanted more food.		

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

This Domain contains five outcomes and 20 underlying indicators. At the last review, one of these indicators was moved to the category of requiring less oversight. For this review, one additional indicator will be moved to this category.

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

The transition department staff were responsive to all comments, asked good questions, and were very professional in their activities. The activities of the placement coordinator and post move monitor showed improvement since the last review. The APC was very experienced in the role and knowledgeable of transition activities, IDT workings, and community providers.

Overall, performance continued to improve, as reflected in improved scores for some indicators and/or comments describing improvements for other indicators even if performance had not yet met criteria. For instance, improvements were seen in community provider pre-move supports regarding training, lists of CLDP supports, and post move monitoring.

The Center also made progress in addressing the variety of transition activities in outcome 4, such as regarding clinician to clinician contact, assessment of settings prior to transition, and QDRR and IRRF reviews. CLDPs included thorough descriptions of the discussions that occurred for each section of the CLDP. That is, the CLDP presented the recommended supports, a detailed narrative of the deliberations and discussion, and the resultant set of final CLDP supports.

Once referred, individuals received regular and ongoing activity from the transition department.

One individual had no PDCT events. The other had a PDCT, which was moving to a group home from the family host home (he stayed with the same community provider agency).

During the onsite week, the Monitoring Team attended a team meeting for an individual for whom the IDT, with lots of support and assistance from the transition staff, developed an individualized transition plan. This was because she had a failed trial visit to a community provider. The staff surmised that a more structured, slower, transition/exposure experience would increase the likelihood of success. Thus, four days of successively increasing individual, SSLC staff, and provider staff activities were being scheduled for a Tuesday through Friday period, with a plan to culminate the week with a weekend visit (Individual #391). It was good to see this type of team, individualized, planning.

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: As expected, performance continued to improve, continuing to approach meeting criteria for these two indicators. Continued focus on pre-move training for community provider staff was needed, including specifying how competency of those staff would be assessed. The lists of post-move supports continued to improve. Each area had relevant supports, though supports were missing for some important areas for both individuals. These two indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	80	212								
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: Three individuals transitioned from the Center to the community since the last review. Two were included in this review (Individual #80, Individual #212). Individual #80 transitioned to a community group home operated under the State's HCS program. Individual #212 transitioned to an HCS host home, but moved to an HCS group home operated by the same provider within 90 days. The Monitoring Team reviewed these two transitions and discussed them in detail with the Lufkin SSLC Admissions and Placement staff.

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

- Pre-move supports: The respective IDTs developed 11 pre-move supports for Individual #80 and 11 pre-move supports for Individual #212.
  - At the time of the last monitoring visit, the Monitoring Team found that neither CLDP included pre-move training supports that clearly indicated what provider staff knowledge or competence was required to ensure the needed supports. While some improvement was noted since the previous visit, neither of these CLDPs yet met criterion. The Monitoring Team strongly encouraged transition staff to continue to focus on the development of thorough and measurable pre-move provider training supports as the foundation for overall success in the transition process. Rather than just listing out the training topics, these supports should include specific competency criteria that answer this question: "what are the important things provider staff need to know - and know how to do - to meet an individual's needs?" Once these important things are identified, the IDTs will need to ensure provider staff know and can do each one. Sometimes a written test may be sufficient, but some other support needs could require that provider

staff demonstrate the proper techniques. Findings included:

    - Pre-move training supports provided a list of topics as the content to be covered under each broad area of training, but only a few in that list of topics indicated the specific knowledge provider staff would be required to know by the time of the transition. Most did not provide specific criteria by which competency could be measured. The CLDP supports frequently indicated competency observation checklists would be used, but examples of these were not available to determine if they might have provided the needed criteria.
    - As described in the previous monitoring report, the IDTs still needed to consider whether didactic learning was appropriate for all needs, and whether other methodologies, such as demonstration or hands-on modeling might be better suited to some. As the IDTs continue to make improvements in identifying specific competency criteria, those should form the basis for determining how competency could best be measured.
    - As also described in the previous monitoring report, the written quizzes provided for review did not test competency in a comprehensive manner for either individual. Again, testing needed to be constructed to measure the specific criteria that would demonstrate staff were competent to provide supports as required. The written tests reviewed for these two CLDPs did not include questions for many of the topics and/or competencies under each support, so there was no corresponding measurable evidence of related staff knowledge.
  - The CLDPs for both Individual #80 and Individual #212 included other pre-move supports that addressed the availability of furnishings; environmental preparations; pre-arrangement for certain services, such day habilitation and/or school registration, and the completion of pre-move site reviews (PMSRs) by the Center and the LIDDA. Overall, these pre-move supports met criterion for measurability, with the exception of the supports for the PMSR. As reported at the last monitoring visit, the pre-move support for completion of the Center's PMSR still needed to clearly indicate that provider staff competence would be confirmed prior to transition. Pre-move training supports did not yet consistently specify the criteria for provider staff competence and/or result in evidence that provider staff could demonstrate competence in all required criteria.

- Post-Move: The respective IDTs developed 30 post-move supports for Individual #80 and 45 post-move supports for Individual #212. Many post-move supports were measurable, including those that described medical and health care appointments. Other post-move supports could be improved, in terms of measurability, by providing more precise criteria for how and when they needed to occur and/or defining a specific expectation or outcome. For example, IDTs should avoid using terminology such as "in a timely manner;" rather, they should provide a specific expectation that defines what timeliness means in that particular circumstance. Examples of post-move supports that did not meet criterion included:
  - For Individual #80:
    - A post-move support called for the provider registered nurse case manager (RNCM) to monitor for side effects every six months, but included two requirements to call the PCP right away in the event of certain reactions. The support did not indicate how these immediate needs would be identified if the RNCM was monitoring at six-month intervals. It was positive the PMM recognized this as an issue at the time of the seven-day PMM visit and agreed with the provider for its staff to have a daily checklist to carry out this support going forward. The comments still did not describe a requirement or a specific plan for how provider staff would be trained to recognize the signs and symptoms of these side effects.
  - For Individual #212:

- The CLDP called for the provider nurse to complete a Quarterly Drug Regimen Review (QDRR.) At the Center, this review was typically completed by pharmacy staff and included clinical assessments about medications and interactions that called for professional judgment a nurse may not have the background or education to make. The support did not make clear what the expectations would be for the purpose, scope, and/or content of a QDRR to be completed by nursing staff.
- The CLDP included a post-move support for the provider to monitor a lengthy list of medication side effects, along with an asterisked item stating caution with grapefruit, related citrus, and licorice and to ensure adequate fluid intake. A second asterisked item indicated Individual #212 would notify the provider or vocational staff of any of the bad feelings or observations that may or may not be related to food or drug interactions. It was not clear what level of caution should be applied with the aforementioned foods or how adequate fluid intake would be defined; it was even less clear whether Individual #212 could independently report any unspecified bad feelings that may or may not be related to food or drug interactions.

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. This represented substantial improvement. 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, including how the provider could recognize re-emerging concerns and address them pro-actively. Findings included:
    - For both individuals, the IDT did develop some detailed pre- and post-move supports related to current behavioral needs, which was positive.
    - Individual #80's ISP indicated he carried a pipe cleaner at all times, but that staff should be sure they were not thrown away, flushed down toilet or put down the sink. Several assessments also noted that he had a recent history of self-induced forceful belching and throwing his back head and holding his breath while drinking liquids. The CLDP did not address either of these elements of his behavioral history with staff knowledge supports.
    - Individual #212's IDT did not describe clear behavioral supports related to specific reinforcement techniques. The pre-move training supports indicated topics to be included as follows: social history, psychiatric diagnosis and medications, target behaviors, triggers, interventions, prevention techniques and reinforcers (Cheetos). The supports did not specify any competency criteria for these. The post-move behavioral supports provided more detailed strategies for target behaviors, triggers, interventions and prevention techniques, but provided little direction about reinforcement and did not reference how Cheetos should be incorporated.
    - Individual #212 also historically had problems with weight loss and frequent hunger leading to agitation and aggression if not able to eat at night, which would have been important for the provider to know. The CLDP did not include a support for provider knowledge of this need or for having a plan for a late-night snack if needed.

- 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 this area. Examples included:

- For Individual #80:
  - Per the medical and audiology assessments, his hearing needed to be checked annually until he reached the age of 21, but the IDT did not develop a related support.
  - Similarly, the psychiatry assessment indicated he should have an ophthalmology consult every two years, as this was recommended for someone on atypical antipsychotics under the age of 40. The Integrated Risk Rating Form (IRRF) also included this recommendation. Again, the IDT did not develop a related support.
  - Per the medical and nursing transition assessments, Individual #80 had been seen by an otolaryngologist (ENT) and further discussion was needed to evaluate the possible need for septal surgery. Per the CLDP discussion, Individual #80's mother indicated she would consider this and discuss it further with the provider after transition. The IDT did not develop a post-move support to address resolution of this.
  - The IDT did not fully address Individual #80's communication needs:
    - His habilitation assessment included a brief section that addressed communication, but a complete communication assessment update was not completed.
    - Per his ISP, he could use communication posters, but needed to be encouraged to do so. The IDT developed a support to follow the recommendations of the Center's habilitation staff to use his communication dictionary, short phrases, and one-step directions with visual and tactile prompts, but did not include any supports related to the use of the posters.
    - Per the CLDP narrative, his parents wanted him to have speech therapy in the community. The IDT agreed this would be communicated to the provider, but did not provide any staff knowledge support.
- For Individual #212:
  - Individual #212's CLDP included post-move support that described an enhanced level of supervision in the home for 30 days and further described how often he needed to be checked on after that. It was positive the IDT developed a specific supervision support, but could have improved upon it by integrating all supervision needs into one coherent approach. For example, CLDP documentation also indicated he would need to be monitored in the kitchen around unfamiliar food.
  - Individual #212 had experienced an unexplained weight loss of 13 pounds over last year, although he remained within his estimated desirable weight range (EDWR.) A post-move support indicated he would be weighed within 72 hours of transition and monthly thereafter to monitor any weight gain or loss of more than five pounds in one month. This support did not take into account that smaller weight loss amounts over a period of several months could also result in an undesirable weight loss and needed to be monitored

- What was important to the individual: The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. Neither CLDP assertively addressed these outcomes. Findings included:
  - For Individual #80, the IDT identified several important outcomes including to live closer to his family and spend quality time with them; to spend his leisure time shooting basketball, using his iPad and watching TV; and to continue attending public school until the age of 22. These were addressed with supports, which was positive, however, as

described further in this report, he had important communication needs that were addressed minimally.
  - For Individual #212, the CLDP did not address important outcomes assertively.
    - His outcomes included having gainful employment; remaining healthy by keeping his weight and blood pressure under control through diet and exercise; and, continue having the opportunity to watch television and play video games. Of these, the latter two were addressed assertively. As indicated below, the opportunity for having gainful employment was not.
    - The IDT noted, but did not address other outcomes that he had specifically articulated. Some of these were large and some small, but overall, they described a picture of what a good life looked like to Individual #212. They included: he would like to go to the library, travel the world, sit in a monster truck, learn to ride a bike, and enter a sweepstakes. Further, he indicated he wanted to pick and choose where he wanted to go and would like a pet dog. Learning to ride a bike was included as one opportunity for physical activity (and later discontinued per the LAR's request), but none of the others were reflected in his supports.

- Need/desire for employment, and/or other meaningful day activities: Neither CLDP met criterion. Neither fully addressed vocational needs. Both CLDPs included supports for the individual to attend day habilitation, but provided minimal supports for meaningful day activities in integrated community environments.
  - Individual #80's ISP indicated the IDT envisioned that he would work and earn money while living in the community; further, both his vocational and behavioral health assessments supported this goal. The vocational assessment included a recommendation to pursue part-time employment. The CLDP included a post-move support for attending school as well as day habilitation during the summer months when not attending school and school holidays. It also included a post-move support for the provider to assist him in making in application for eligibility for services through the Texas Workforce Commission (TWC). None of these supports had a clear outcome for obtaining employment or employment related supports. He was at an important stage for beginning to transition from school to work, so the IDT should have considered establishing more assertive supports.
  - The CLDP discussion referenced a recommendation from Individual #80's social assessment for volunteering at an animal shelter per his strong preference. The discussion indicated he would go to day program when not in school, but that volunteering at animal shelter would be re-evaluated once the provider could determine how he would react to that setting. The CLDP did not include any support related to such activity.
  - Individual #212's vocational assessment indicated he should be given the opportunity to pursue part-time janitorial work in the community, making at least minimum wage. In addition, that assessment recommended he be provided with training regarding appropriate work behaviors, to include knocking on doors and controlling the loudness of voice. The IDT developed a post-move supports to attend a day program that offered no money earning opportunities, but also to receive vocational training services within 90 days and a yearly assessment at TWC. While these latter strategies were positive, they did not define a specific opportunity to pursue his preferred janitorial work in the community, nor did they address his specific learning needs for work behaviors.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success:
  - For Individual #80, behavioral supports indicated training would be provided on preferred reinforcers and reinforcement schedule, but the Center did not provide any specific evidence this was accomplished. In addition, some assessment information indicated most of his behaviors were due to his inability to express wants and needs, but his communication supports were minimal.

- For Individual #212, the CLDP did not included a cohesive approach to positive reinforcement, but should have. A CLDP support indicated he should receive positive attention intermittently throughout the day, but this was overly broad and not individualized. His CLDP did not include a support that clearly described the use of Cheetos or other reinforcers, even though it was clear from other supports that Cheetos were an important factor in this area. For example, a day-of-move support included the delivery of 60 bags of Cheetos. Another support for nutrition stated he should receive Cheetos twice a day if he earned his reinforcers for both the morning and afternoon, but did not describe any requirements for earning the reinforcer. The behavioral supports did not address the use of Cheetos at all. In the absence of specific positive reinforcement techniques, the provider had also begun to make community activities contingent upon unspecified good behavior, making access to reinforcing activities even less likely.

- Teaching, maintenance, participation, and acquisition of specific skills: It was positive the CLDPs included supports related to teaching, maintenance, participation, and acquisition of specific skills.
  - For Individual #80, the IDT developed several related supports for formal and informal training programs in the areas of laundry, socialization, and identifying traffic signs. The CLDP also included a post-move support to provide verbal and physical prompts for a variety of skills and activities of daily living such as picking out his clothes, tying shoes, toileting, and staying a safe distance from moving traffic. Overall, this CLDP provided a positive emphasis on maintenance, participation, and acquisition of specific skills in areas other than communication. The IDT could have made some improvements in these supports, as well, such as specifying his current skill levels or needs and/or specifying an expectation for how often training programs would be implemented.
  - For Individual #212, post-move supports called for verbal support for maintaining good oral and physical hygiene on a daily basis, including reminders to brush his teeth, bathe thoroughly, apply deodorant and aftershave lotion, and wash his hands throughout the day; assistance to brush teeth at specified intervals; training to include tying shoes (later discontinued per his LAR); to learn his new address and phone number; and, to learn shave with new electric razor. This CLDP met criterion.

- All recommendations from assessments are included, or if not, there is a rationale provided: Lufkin SSLC had a process in place for documenting in the CLDP discussion of assessments and recommendations, including the IDT's rationale for any changes to, or additional, recommendations. The Center had made improvement in its process for reviewing the discipline assessments for thoroughness, beginning at the 14-day ISPA meeting. This was positive. For this review, the IDTs did not yet address all recommendations with supports or otherwise provide a justification. Examples are described above for both Individual #80 and Individual #212.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.	
Summary: Post move monitoring was occurring at required intervals and documented in the required format. Thus, with sustained high performance, indicator 3 might be moved to the category of less oversight after the next review. All of the indicators in this outcome will remain in active monitoring.	Individuals:

Overall, post move monitoring had improved, due in large part to the efforts of the post move monitor (PMM). For instance, detailed comments were provided for every support and she systematically tried to address all three prongs of post move monitoring (observation, documentation, interview) even if the CLDP did not call for it. Correct scoring and documentation of follow-through also improved, but needed some additional improvement.											
#	Indicator	Overall Score	80	212							
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 assessment 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, corrective action is implemented 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									
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	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. PMM Checklists did not yet consistently provide valid and reliable data, but improvement was noted. To continue to move toward compliance, the Center should continue to focus on improving overall clarity and measurability of supports that provide guidance to the PMM as to what criteria would constitute the presence of various supports and ensuring that PMM documentation addresses all requirements of supports and corresponding evidence. Findings included:

- The PMM made improvements toward providing comments with sufficient detail that evidenced provider staff were

knowledgeable of individuals' needs and/or that supports had been provided as required. In other instances, the evidence provided was not reliable. For example:

- Individual #212's PMSR documented a house telephone was available for him to use to call his guardian, but the seven-day PMM Checklist indicated the telephone was not available. Per interview with transition staff, the PMM stated this support was marked as in place at the time of the PMSR because the provider had a cell phone Individual #212 could use, but this did not fully meet the intent of the support.
- Also, for Individual #212, the seven-day PMM Checklist provided conflicting information that addressed his supervision needs. Comments for one post-move support indicated the provider stated she checked on him in his room every 15 minutes while another indicated checks were made every 30 minutes to an hour

- Most of the CLDP supports required several prongs of evidence, including interviews, observations, and review of documentation. It was positive the PMM had implemented an improved process for more consistently addressing each of these required prongs, but sometimes did not do so as required. Examples included:
  - For Individual #80, the CLDP included a post-move support for the provider to ensure that he brushed his teeth after every meal, before bedtime, and after evening medications if those were administered with food. The evidence required staff interview and a review of residential notes, but the PMM comments only documented staff interview and did not reference review of documentation. The interview comments reflected that he brushed after every meal, but did not address the other required times.
  - For Individual #80's support to monitor for side effects of psychotropic medications, the PMM comment stated the provider service coordinator confirmed none had been reported by staff, but did not indicate review of any documentation; instead the comment stated it was agreed provider staff would complete a daily checklist in the future. The PMM also did not interview any provider staff to confirm their knowledge of the specific side effects to monitor.
  - For Individual #212, the PMM sometimes relied only on interviews with the provider, even when the evidence required interviews with Individual #212 as well. For example:
    - The CLDP included a post-move support for the provider to ensure Individual #212 had the opportunity to participate in physical activities he enjoyed at least 30 minutes a day, three times a week. The IDT correctly indicated that required evidence should include documentation as well as interviews with provider staff and Individual #212. The PMM documented interviewing provider staff, but did not interview Individual #212 about whether he was being provided with these choices at any of the three PMM visits.
    - A similar post-move support called for him to have opportunity to participate in outings of his choice weekly, with required evidence to include interviewing Individual #212. The PMM did not document interviewing him for two of the three PMM visits.

5. Based on information the Post Move Monitor collected, both individuals had frequently received supports as listed and/or described in the CLDPs, but this was not yet consistent. As described above, the Monitoring Team sometimes could not evaluate or confirm whether individuals had 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 supports not in place as required included the following:

- For Individual #80, the following supports were not in place as required:

- Some of his personal belongings had not been delivered on the day of move.
- He was not yet registered for school at the time of the seven-day PMM visit.
- His psychiatrist to psychiatrist collaboration had not been completed by the time of his 45-day visit. This was originally a pre-move support, but had been included as a post-move support when not achieved prior to the move.

- For Individual #212 the following supports were not in place as required:
  - Provider staff were not implementing his behavioral supports consistently at any of the PMM periods.
  - At the time the 90-day PMM visit, the provider had not obtained the required audiology appointment or completed a needed dental visit or annual labs.

6. Based on the supports defined in the CLDP, the Post-Move Monitor's scoring was not consistently correct, but demonstrated improvement since the previous monitoring visit. In some instances, the PMM still marked supports as in place without having documented obtaining the required evidence that would confirm this evaluation. In addition to those examples described in Indicator #4 above:

- For Individual #80:
  - At the time of the seven-day PMM visit, the provider had not yet implemented skill training requirements for two supports at the home or day habilitation program. The PMM described their plans to do so and, based on that, scored both supports as being in place. The support for skill training in the home, to occur within 30 days of transition, was not yet due at the time of the seven-day PMM visit and should have been scored as not yet applicable. The day program support was also scored as in place, but the evidence provided indicated otherwise. While it was good the PMM probed the provider's knowledge of these supports, they should not have been scored as in place based on having a plan for implementation.
  - Another post-move support stated the provider would monitor the signs and symptoms for various health and safety risks including, for example, GERD and constipation. The evidence to be reviewed included review of a community transition checklist given to the provider by the Center, as well as interview with provider staff. The comments for the seven-day PMM Checklist indicated the PMM spoke with the provider Service Coordinator, who stated he had not shown any signs or symptoms. It was not clear whether this would have been the appropriate provider staff to interview or whether, for example, direct support staff should have been interviewed for their knowledge of signs and symptoms that needed to be reported. The comment further indicated it was decided the provider would monitor bowel movements on the MAR and that the PMM would list this support in a checklist that would be given to the provider. This comment reflected that the required evidence of the community transition checklist was not yet in place at the time of the seven-day PMM and, therefore, could not be reviewed. The PMM marked this support as in place, but should have been marked as not in place due to the lack of available evidence.
- For Individual #212:
  - Behavioral supports were marked as in place, but staff were not implementing them consistently as required.
  - Individual #212's 90-day PMM Checklist, which occurred after he changed homes, documented that not all of his belongings had yet been moved from the previous home. Instead, the comment reflected a plan had been developed to ensure the remaining items were moved and for the PMM to be notified once complete. The PMM marked this support as in place based on this plan, but should have marked it as not in place and, therefore, in need of follow-up to resolution.

7 through 8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed up through to resolution. 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. As described in the previous indicators, the PMM did not always document the evidence needed to confirm presence or absence of a support. Other findings included:

- For both individuals, documentation of follow-up frequently stopped short of resolution; instead, it referenced what remedial actions were planned for the future, but failed to close the loop to document if those planned actions occurred. The PMM should take care not to mark concerns as resolved until confirming the actions had been implemented.

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

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.											
Summary: One individual had no negative events occur. The other had a change in living option from a family host home to a group home. A review of the change, the CLDP, and the transition assessments showed that problems were identified with the appropriateness of the home prior to transition. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	80	212							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	50% 1/2	1/1	0/1							

Comments:

11. One of two individuals had experienced a PDCT event.

- Individual #80 had not had any reported PDCT events.
- Individual #212 had a change in residence within 90 days of his transition. He moved from the host home to a group home operated by the same provider, following the provider's termination of its contract with the host home operator. The IDT met to discuss the need for the move on 10/11/18 and again to formally review the PDCT on 10/16/18.
  - The ISPAs documented the host home contract was terminated due to multiple issues about competency and reliability. This included ongoing phone calls from the host home provider to ask questions about his behavioral supports. They also indicated the LAR wanted Individual #212 to move because the setting had not provided the home-like experience he had hoped for.
  - The PDCT ISPA indicated the IDT had not anticipated the problem prior to the move, however, pre-move documentation had indicated potential problems with reliability and stability, as the move was delayed on two

occasions when the host home provider brought other family members to the setting to live on either a temporary or permanent basis without notifying anyone.

- When considering whether anything could have been done differently, the IDT concluded it might have offered pre-move visits to both a group home and a host home for comparison's sake. This did not address the stated cause of the PDCT; rather, it addressed another pre-move concern that had not been fully articulated in the transition documentation. In interview, transition staff acknowledged they had pre-move reservations about whether the host home was an appropriate setting for Individual #212 because they didn't feel it would meet his social needs as well as a group home might. They reported they felt stymied to move in that direction because of the guardian's wishes for a host home setting. It was positive transition staff had shared their concerns with the LAR during the transition planning process, as indicated during interview, but the Center may wish to consider how it might address any similar situations that may occur in the future in a more formal manner.
- The IDT should also have considered whether anything could have been done differently to address the issues of competency and reliability that eventually caused the PDCT, but did not document it had done so. For example, the IDT should have considered whether its training for behavioral supports had been adequate to prepare the host home provider, rather than only remarking that she had received training. As noted in Indicator 2 and Indicator 5 above, there was not a clear and consistent reinforcement strategy for the home, and related training documentation did not evidence provider knowledge. For example, the Center provided three sets of provider staff quizzes related to behavioral supports, but the only one that probed staff knowledge of the use of Cheetos as a reinforcer was completed in November 2017, which was approximately eight months prior to transition.

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: Again, progress continued to be seen. The CLDPs specifically addressed more of the requirements of this outcome (e.g., indicators 15-17). The transition staff continued to work with SSLC disciplines on improving the transition assessments, and some progress was seen. The Center continued to involve IDTs, LARs, and individuals in the transition process. This has been the case for this review and the previous two reviews, too, for all individuals. Therefore, indicator 13 will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	80	212							
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	100% 2/2	1/1	1/1							

	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.										
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.	100% 2/2	1/1	1/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/1	0/1							
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	Due to the Center's sustained performance, this indicator was moved to the category of 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 yet consistently meet criterion for this indicator. Overall, improvement was noted, but this remained an area of need. It was positive transition staff had been working with several disciplines on the quality of transition assessments and recommendations. For example, transition staff reviewed the ISPs and assessments for each new referral before holding the 14-day meeting with the IDT so they could be prepared to assist them to think through the needed supports and considerations for what the disciplines would need to include in their discharge assessments. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated with 45 Days of transition: Most assessments provided for review met criterion for timeliness. Transition staff reported timeliness had significantly improved. Findings included:
    - The Center documented a review of the Quarterly Drug Regimen Review (QDRR) for both individuals in the CLDP narrative, which was positive.
    - At the time of the previous visit, the Monitoring Team recommended the Center might want to consider formally updating the IRRF document, which could be a useful reference tool for provider staff knowledge. The Center did not provide a copy of an updated Integrated Risk Rating Form (IRRF), but both CLDPs included a section in the narrative for this purpose.

- For both the QDRR and the IRRF, the narrative should include more detail than just what changed since last version, since, without an updated document, the provider would not be privy to the information that did not change. This did not consistently occur.
- Neither individual had a communication update. For example, the review of Individual #80's communication needs was included in an OT/PT/SLP discharge note and consisted of eight sentences; the sole recommendation was that he did not need speech therapy services. This was not adequate for his needs, particularly since he was still school-aged.

- Assessments provided a summary of relevant facts of the individual's stay at the facility: In some instances, the disciplines provided a summary of relevant facts in the available assessments. Comments are below:
  - The OT/PT discharge note indicated Individual #80 did not require a PNMP, but per the CLDP profile, he did have one.
  - As noted above, Individual #80 did not have a full communication update for the purposes of transition. The section in the habilitation assessment did not fully address his strengths and needs, such as his ability to use communication posters.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments often did not meet criterion. Transition staff should continue their efforts to assist the disciplines with improving their assessment content and recommendations. The latter should address all identified support needs that appear in the narrative content. This would also be a good place for each discipline to describe the pre-move training that needs to take place, including the competency criteria and how competency need to be measured.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not fully address/focus on the new community home and day/work settings. Currently, assessments did not consistently meet criterion in this area.

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

14. Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required: Training provided to community provider staff did not yet meet criterion for these two CLDPs, as described in detail in Indicator # 1 above. In summary, findings included:

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

document provider staff had knowledge of all essential supports based on each individual's needs.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The IDT should include in the CLDP a specific statement as whether any collaboration was needed, and if any completed, summarize findings and outcomes. Both CLDPs included this statement, but did not consistently meet criterion based on implementation.

- For Individual #80, the CLDP indicated a nurse-to-nurse collaboration would take place prior to transition and developed a pre-move support to address this. The Center provided good documentation of the extent of this collaboration. This was positive.
- Also for Individual #80, the CLDP stated a clinician-to-clinician consultation between the Center and community psychiatrists would take place prior to transition, but it did not. It was positive the IDT then developed a post-move support to address this requirement, but it did not provide a clear rationale that this postponement would be appropriate based on his needs, given their earlier judgment that it should occur pre-move. At the time of the 45-day PMM visit, which was the latest available documentation, the needed collaboration had not yet occurred.
- For Individual #212, the CLDP indicated psychiatry and nursing collaborations had been completed, which was positive, but it did not summarize the purpose, findings, or outcome.

16. SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs: The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. For both individuals, the IDT documented that neither individual had a need for a settings assessment to be completed by any clinician and this appeared to be correct based on their needs.

17. Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual: The CLDP should include a specific statement of IDT considerations of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results. Examples include provider direct support staff spending time at the 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. While neither CLDP provided a clear statement describing the IDT's consideration in this regard, it was positive that transition staff reported they were encouraging potential providers to come to the Center early in the transition process to shadow the individuals they were considering serving and meet with their IDTs.

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

19. The pre-move site reviews (PMSRs) for both individuals were completed prior to the transition date. 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.

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary: Transitions for individuals, once referred, received ongoing attention from the transition department. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	80	212								
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	100% 2/2	1/1	1/1								

Comments:

20. Both CLDPs met criterion for this indicator.

- Individual #80 was referred on 12/7/17 and transitioned on 11/8/18. This exceeded 180 days, but transition log documented ongoing community exploration and working with parents to locate appropriate setting.
- Individual #212 was referred on 9/13/16 and transitioned on 7/24/18. Documentation indicated good ongoing effort by the Center to locate and appropriate community host home setting, which included some unsuccessful trials. The transition process also encountered a delay when the agency LAR requested that the target location for transition be changed, due to the agency's desire to expand its service area. The Transition Specialist explained referral packets had already been sent to two different providers, per the original plan, but the LAR still required those referral packets to be rescinded. While this did not reflect negatively on the Center's timeliness or activities to support the transition process, it was nevertheless concerning. If accurately documented, it appeared the guardian's decisions on Individual #212's behalf were not clearly based on his needs, but rather on the agency's business plans.

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 <u>or</u> refused to allow completion of all or part of the dental exam or work once at the clinic);
    - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
    - In the past six months, individuals with dental emergencies;
    - Individuals with Do Not Resuscitate Orders, including qualifying condition; and
    - In the past six months, individuals with adverse drug reactions, including date of discovery.
- Lists of:
    - Crisis intervention restraints.
    - Medical restraints.
    - Protective devices.
    - Any injuries to individuals that occurred during restraint.
    - HHSC PI cases.
    - All serious injuries.
    - All injuries from individual-to-individual aggression.
    - All serious incidents other than ANE and serious injuries.
    - Non-serious Injury Investigations (NSIs).
    - Lists of individuals who:
        - Have a PBSP
        - Have a crisis intervention plan
        - Have had more than three restraints in a rolling 30 days
        - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
        - Were reviewed by 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 <u>and/or</u> 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 <u>and</u> FSA Summary
- PSI
- QIDP data regarding submission of assessments prior to annual ISP meeting
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)
- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up clinic notes)
- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN entries and any other related documentation.
- Listing of all medications and dosages.
- If any pretreatment sedation, date of administration, IPN notes, and any other relevant documentation.
- If admitted within past two years, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.
- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.
- Data that summarize the individual's community outings for the last six months.
- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- The individual's daily schedule of activities.
- Documentation for the selected restraints.
- Documentation for the selected HHSC PI investigations for which the individual was an alleged victim,
- Documentation for the selected facility investigations where an incident involving the individual was the subject of the investigation.

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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