United States v. State of Texas

Monitoring Team Report

Lufkin State Supported Living Center

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Background

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

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

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

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

Methodology

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

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

b. **Onsite review –** Due to the COVID-19 pandemic and resultant safety precautions and restrictions, the onsite review portion of this review was not conducted. Instead, the Monitoring Teams attended various meetings via telephone, such as Center-wide meetings [e.g., morning medical, unit morning, Incident Management Review Team (IMRT), Physical and Nutritional Management Team (PNMT)], and individual-related meetings [e.g., Individual Support Plan meetings (ISPs), Core teams, Individual Support Plan addenda meetings (ISPAs), psychiatry clinics]. In addition, the Monitoring Teams conducted interviews of various staff members via telephone (e.g., Center Director, Medical Director, Habilitation Therapies Director, Behavioral Health Services Director, Chief Nurse Executive, Lead Psychiatrist, QIDP Coordinator). Also, the Monitoring Teams met with some groups of staff via telephone (e.g., Psychiatry Department, Behavioral Health Services Department). This process is referred to as a remote review.
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 Center-wide documents. During the week of the remote review, the Monitoring Team requested and reviewed additional documents.
d. **Observations –** Due to the nature of the remote review, the Monitoring Team could not complete some observations (i.e., as discussed above, some observations of meetings were possible). As a result, some indicators could not be monitored or scored. This is noted in the report below.
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 move to the category of requiring less oversight. At the next review, indicators that move to this category will not be monitored, but may be monitored at future reviews if the Monitor has concerns about the Center's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the Center's plans for continued quality assurance and improvement. In this report, any indicators that were moved to the category of less oversight during previous reviews are shown as shaded and no scores are provided. The Monitor may, however, include comments regarding these indicators.

Organization of Report

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

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

Executive Summary

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

The Monitors and Monitoring Team members want to take this moment to recognize that the COVID-19 global pandemic has required Center staff to make some significant changes to their practices, and that the steps necessary to protect individuals and staff require substantial effort. The time since the pandemic began has undoubtedly been a challenging one at the SSLC and the other Centers, as it has been across the country. Throughout the course of the

week, we appreciated staff's willingness to share with us some of the ways that COVID-19 has impacted their work, and how life has changed for the individuals.

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

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

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

This Domain contains outcomes and underlying indicators in the areas of restraint management, pretreatment sedation/chemical restraint, mortality review, and quality assurance.

- The Center achieved substantial compliance with many of the requirements of Section C of the Settlement Agreement. The exceptions are Section C.5 related to licensed health care staff's (nurses' and/or physicians') roles in the monitoring of all types of restraints, and physicians' roles in defining monitoring schedules, as needed; and Section C.6 related to assessments for restraint-related injuries, as well as monitoring of individuals subjected to medical restraint. The Monitoring Teams will continue to monitor these remaining areas for which Center staff have not obtained substantial compliance using the outcomes and indicators related to these subjects. With the understanding that these topics are covered elsewhere in the Settlement Agreement, the SSLC exited from the other requirements of Section C of the Settlement Agreement.
  - As a result, the Center exited from these parts of Section C of the Settlement Agreement. This resulted in the removal of 10 outcomes, and 20 underlying indicators.
  - Three indicators were added to the nursing restraint audit tool.
- The Center also achieved substantial compliance with the requirements of Section D of the Settlement Agreement.
  - As a result, the Center exited from this section of the Settlement Agreement. This resulted in the removal of 10 outcomes and 19 indicators.
- The Center also achieved substantial compliance with most of the requirements of section N, pharmacy.
  - As a result, the Center exited from one outcome and two indicators in this domain.
- In sum, at the time of the next review, this Domain will include six outcomes and 25 underlying indicators. None of these are in the category of requiring less oversight.

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

<u>Restraint</u>

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

For two of the three physical restraints reviewed, nurses performed physical assessments, and documented whether there were any restraint-related injuries or other negative health effects. For the one protective mechanical restraint for self-injurious behavior (PMR-SIB) restraint reviewed, it was positive that an IHCP defined a specific nursing intervention to address the use of the helmet. However, nursing staff had not implemented it, and they also had not followed the nursing guidelines for checking the condition and use of the device, and/or assessing the individual's physical status during each shift.

Abuse, Neglect, and Incident Management
At a previous review, the Monitor found Lufkin SSLC to have met substantial compliance criteria with Settlement Agreement provision D regarding abuse, neglect, and incident management. Therefore, this provision and its outcomes and indicators were not monitored as part of this review. Aspects of incident management, occurrences of abuse/neglect, and investigations will remain and/or become part of the Center's quality improvement system and will be reviewed by the Monitoring Team as part of its monitoring of Quality Assurance/Improvement (i.e., section E of the Settlement Agreement).

Other
No individuals in the behavioral health review group had pretreatment sedation during the review period.

Pharmacy
In the report for Round 16, the Monitor reported that the Center achieved substantial compliance with most of the requirements of Section N of the Settlement Agreement. The exceptions are Section N.6 related to adverse drug reactions, and Section N.8 related to medication variances that the Monitoring Team will review as part of Section E.

Restraint

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

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

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

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.													
Summary: For two of the three physical restraints reviewed, nurses performed physical assessments, and documented whether there were any restraint-related injuries or other negative health effects. For the one PMR-SIB restraint reviewed, it was positive that an IHCP defined a specific nursing intervention to address the use of the helmet. However, nursing staff had not implemented it, and they also had not followed the nursing guidelines for checking the condition and use of the device, and/or assessing the individual's physical status during each shift. These indicators will remain in active monitoring.			Individuals:										
#	Indicator	Overall Score	410	143	178								
a.	If the individual is restrained using physical or chemical restraint, nursing assessments (physical assessments) are performed in alignment with applicable nursing guidelines and in accordance with the individual's needs.	67% 2/3	0/1	1/1	1/1								
b.	If the individual is restrained using PMR-SIB:												
	i. A PCP Order, updated within the last 30 days, requires the use of PMR due to imminent danger related to the individual's SIB.	100% 1/1	1/1	N/A	N/A								
	ii. An IHCP addressing the PMR-SIB identifies specific nursing interventions in alignment with the applicable nursing guideline, and the individual's needs.	100% 1/1	1/1										
	iii. Once per shift, a nursing staff completes a check of the device, and documents the information in IRIS, including: a. Condition of device; and b. Proper use of the device.	0% 0/1	0/1										
	iv. Once per shift, a nursing staff documents the individual's medical status in alignment with applicable nursing guidelines and the individual's needs, and documents the information in IRIS, including: a. A full set of vital signs, including SPO2; b. Assessment of pain; c. Assessment of behavior/mental status; d. Assessment for injury;	0% 0/1	0/1										

	e. Assessment of circulation; and f. Assessment of skin condition.										
c.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	50% 2/4	0/2	1/1	1/1						
d.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	75% 3/4	1/2	1/1	1/1						

Comments: The restraints reviewed included those for: Individual #410 from 5/19/21 to 5/26/21 (helmet for PMR-SIB), and on 12/30/20 at 12:14 p.m. (emergency escort); Individual #143 on 12/27/20 at 4:21 p.m. (horizontal side-lying basket hold); and Individual #178 on 4/30/21 at 2:35 p.m. (emergency escort).

a. through c. For Individual #143 on 12/27/20 at 4:21 p.m. (horizontal side-lying basket hold), and Individual #178 on 4/30/21 at 2:35 p.m. (emergency escort), the nurses performed physical assessments, documented whether there were any restraint-related injuries or other negative health effects, and took action as needed.

The following provide examples of findings for the other restraints reviewed:

- According to an Injury Report, dated 12/30/20, at 5:07 pm., at 11:55 a.m., Individual #410 pulled the fire alarm, ran outside, and began hitting a van with his fist. He hit the mirror on the drivers' side, causing it to shatter. He sustained injuries. A licensed vocational nurse (LVN) tried to assess him several times, but the individual refused these attempts. Another nurse documented that at 1:45 p.m., the individual allowed her to start cleaning and assessing the lacerations to his bilateral hands. Although the nurse documented the provision of treatment to multiple scratches and lacerations, and noted swelling and bruising of the individual's right hand, the nurse did not document the measurements that the skin integrity assessment nursing guidelines require. The nurse notified the PCP, who ordered an x-ray of the individual's right hand. At 3:25 p.m., a nurse documented the first set of vital signs, but no corresponding IView entries were found to show documentation of the individual's mental status.
- With regard to Individual #410's helmet that was used as PMR-SIB:
  - It was positive that an up-to-date PCP order was present for the use of the helmet.
  - In a skin integrity IHCP, developed in November 2020, the IDT included an intervention that read: "Nursing to assess q [each] shift scalp and skin under helmet for marks of pressure or abrasions." The inclusion of this intervention in the IHCP was consistent with requirements for the use of PMR-SIB. Unfortunately, based on review of the sample of IView entries and IPNs, nursing staff had not implemented this intervention.
  - Based on a review of the sample of IView and IPN documentation for the period from 5/19/21 to 5/26/21, nurses did not complete and/or document the results of many aspects of the assessments required by the restraint nursing guidelines.
  - Without these assessments, it was not possible to determine whether or not the individual sustained any restraint-related injuries or other negative health effects as a result of the use of the PMR-SIB, or whether nurses took necessary action to address them.

Abuse, Neglect, and Incident Management

At a previous review, the Monitor found Lufkin SSLC to have met substantial compliance criteria with Settlement Agreement provision D regarding abuse, neglect, and incident management. Therefore, this provision and its outcomes and indicators were not monitored as part of this review.

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

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	N/A									
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									
Comments: a. and b. Based on the documentation provided, during the six months prior to the review, none of the nine individuals in physical health review group received TIVA/general anesthesia or oral pre-treatment sedation for dental procedures.											

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A
Comments: a. On 1/20/21, Individual #441 received Benadryl 50 milligrams (mg) for an ophthalmology appointment. It was positive that on 7/28/20, the Pre-Treatment Sedation Committee reviewed and approved the administration of the 50 mg by mouth (PO). Informed consent was provided, and based on documents submitted nursing staff documented vital signs. The concern was that based											

on the IView entries submitted, nursing staff did not document the administration of Benadryl. In an IPN, at 9:42 a.m., a nurse stated for medication administration: "Benadryl 50mg 1/20/2021 at ? time." Without knowing the time of administration, the Monitoring Team could not determine whether or not a nurse completed pre-procedure vital signs.

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: No individuals in the review group had PTS during the review period.			Individuals:								
#	Indicator	Overall Score	98	332	221	93	330	78	125	392	176
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	N/A									
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.	N/A									
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:											

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	255	33	286	271					
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	100% 4/4	1/1	1/1	1/1	1/1					

	extension with justification, and the administrative death review is completed within 14 days of the clinical death review.										
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1					

Comments: a. Since the last document submission, 13 individuals died. The Monitoring Team reviewed four deaths. Causes of death were listed as:

- On 9/6/20, Individual #255 died at the age of 63 with cause of death listed as COVID-19 pneumonia.
- On 9/19/20, Individual #361 died at the age of 53 with causes of death listed as acute on chronic hypoxic respiratory failure, and congenital tracheomalacia.
- On 10/17/20, Individual #218 died at the age of 69 with causes of death listed as acute respiratory failure with acidosis, septic shock, and chronic obstructive pulmonary disease.
- On 10/19/20, Individual #33 died at the age of 68 with causes of death listed as hypotensive cardiovascular disease with congestive heart failure.
- On 2/10/21, Individual #574 died at the age of 76 with causes of death listed as aspiration pneumonia, ileus, and diastolic congestive heart failure.
- On 2/23/21, Individual #53 died at the age of 91 with causes of death listed as left lower lung pneumonia, and COVID-19.
- On 3/12/21, Individual #339 died at the age of 80 with cause of death listed as cardiac arrest.
- On 4/6/21, Individual #109 died at the age of 58 with causes of death listed as myocardial infarction, and tachycardia.
- On 4/18/21, Individual #286 died at the age of 60 with causes of death listed as cardio respiratory arrest, and acute coronary syndrome.
- On 4/22/21, Individual #468 died at the age of 63 with causes of death listed as acute hypoxic respiratory failure, and dysphagia.
- On 5/21/21, Individual #271 died at the age of 66 with causes of death listed as urinary tract infection (UTI), COVID-19 pneumonia, and cerebral palsy.
- On 5/31/21, Individual #122 died at the age of 63 with cause of death listed as sepsis.
- On 6/27/21, Individual #406 died at the age of 55 with causes of death listed as pending.

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

- It was positive that some of the discipline death reviews, and the clinical and administrative death reviews included some recommendations to address a variety of concerns identified. For example, recommendations across the four deaths related to topics such as nursing staff's completion of pre- and post-assessments after the completion of breathing treatments; nursing staff following the seizure guidelines; in-service training for all nurses on the updated policy pertaining to the use of pocket masks and ambu bags during cardiopulmonary resuscitation (CPR); and education of PCPs on the stages of sepsis, signs and symptoms of sepsis, and complications to assist PCPs in determining an appropriate diagnosis.
- It was good to see that nursing death reviews included a number of relevant recommendations, and that these often, but not always, were included in the administrative or clinical death reviews for follow-up.
- Overall, though, the disciplines' death reviews did not provide an objective review of the assessment, planning, treatment, care, and supports that Center staff provided to the individuals who died. Center staff should use mortality reviews as an opportunity to identify potential areas in need of improvement, including issues that might have impacted the individuals' deaths, but also issues that impacted the overall quality of care the individual received during at least the last several months of their lives. The reviews conducted did not achieve this objective. For example:
  - Although the medical clinical death review for Individual #33 listed only one dose of Shingrix, there was no related recommendation.
  - The Clinical Death Review noted that Individual #286 had elevated troponin levels, and cardiology determined he was not a candidate for intervention. It was also documented that he had severe aortic stenosis on the echocardiogram. Severe aortic stenosis is not an acute condition. The clinical death reviewer should have reviewed the records to determine if this condition was previously detected. Aortic stenosis is usually diagnosed when the physical exam suggests it, or when it is detected on echocardiogram. An individual with severe aortic stenosis would likely have a significant murmur on exam that should have been auscultated during routine examinations.
- Individual #255's clinical death review resulted in a recommendation that read: "All PCPs will read and educate about COVID-19 PNA [pneumonia]." The mortality committee did not discuss and/or document the reason that this was necessary. The Center should have had a process in place to ensure that the medical staff were kept updated on changing and emerging protocols for the management of COVID -19 disease, but the discussion documented did not state whether such processes were in place and effective.
- Similarly, Individual #271's death review resulted in a recommendation to educate the PCPs on Ogilvie's syndrome, ileus, megacolon, and chronic constipation. However, it was not clear why the mortality review committee determined that this action was necessary.
- For Individual #286, although the discipline reviews identified the following concerns, the clinical/administrative death review processes did not result in recommendations to address them:
  - Lack of sufficient scale types to adequately measure weights for the diverse population at the Center;
  - Documentation of caloric intake using the percentage of consumption; and/or
  - IDTs not thoroughly discussing individuals' weights during team meetings.

- For Individual #271:
  - The nursing clinical death review identified that Lippincott did not provide guidance related to the rectal stimulation technique that staff used with the individual, and additional nursing guidelines were recommended. However, the recommendation did not include involvement of the State Nursing Discipline Coordinator, given that nursing guidelines have generally been issued statewide. In addition, prior to carrying out an ordered nursing intervention such as this one that was not included in the Lippincott manual or another fundamentals of nursing book (e.g., Perry and Potter), the Chief Nurse Executive (CNE) should consult with State Nursing Discipline Coordinator for guidance on its use at Lufkin SSLC.
  - On 4/12/21, Individual #271 had a chest x-ray to evaluate hypoxia and a cough that started the previous night. The PCP documented that it showed a minimal right lower lobe infiltrate. The individual was treated with antibiotics, and on 5/12/21, a repeat chest x-ray was done. This x-ray showed "opacities in the lung bases that may be due to atelectasis or in proper clinical context pneumonia." On 5/14/21, at 11:26 a.m., the PCP documented the findings of the chest x-ray. The PCP did not examine the individual, but noted that the pneumonia/pneumonitis was resolved. Given that the radiologist made the recommendation to clinically correlate the chest x-ray findings with the clinical exam, it was not clear why the PCP elected to not conduct a face-to-face evaluation. At 7:40 p.m., the on-call PCP documented that the individual was being transferred to the ED for evaluation of respiratory distress and hypoxia. The reviewer should have been questioned this, but the medical clinical death review did not mention it.

    In general, a physician should have completed the clinical death reviews, as opposed to the Nurse Practitioner. Moreover, the Nurse Practitioner was in the position of reviewing the care that her supervisor provided, which presented a potential conflict of interest.

    In addition, on 5/14/21, pulmonary evaluated the individual. There was no indication of the time of the pulmonary assessment, but the PCP did not document any findings of the pulmonary assessment in the 5/14/21 PCP IPN entry. The pulmonologist noted the chest x-ray findings and stated: "the exact etiology is not clear to me." She further noted: "I have not reviewed the images myself but based on her description it could be atelectasis if the film was taken in the expiratory phase. Clinically she is doing well."

    On a positive note, the reviewer identified the deficiencies in preventive care. Breast cancer screening was overdue by two years, and cervical cancer was overdue by three years. At the time of her death, the individual was 66 years old and the PCV13 was due at age 65. Given that the reviewer identified three areas of preventive care that were problematic, a recommendation related to preventive services was indicated. Specifically, the Center should review its preventive care data to determine if these deficiencies were identified by the Center's internal audits and captured in the data presented to the quality assurance/quality improvement (QA/QI) Council.

e. Some improvement was noted with regard to the mortality committee writing recommendations in a way that ensured that Center practice improved. For example, a recommendation that read: "Consider ReEducation [sic] and training to the LVN [Licensed Vocational Nurse] who administered breathing treatment on 10-18-20 to document pre-post assessment in IVIEW" resulted in re-

training, but the clinical death review committee also appropriately required review of three individuals for whom the LVN administered breathing treatments to make sure the nurse conducted and documented the pre- and post-assessments.

However, other recommendations did not follow this format. For example, another recommendation was for: "All PCP [sic] will read and educate about COVID-19 PNA." The Monitoring Plan was: "In-service of all PCPs and provide literature about Covid-19 PNA." The evidence was a signed roster, and the expected outcome was: "All PCP [sic] have updated knowledge about COVID 19 PNA." As noted above, the reason for this recommendation was not clear. The recommendation and monitoring plan were not written in a way that allowed for a determination of whether or not PCPs had the necessary knowledge to, for example, assess and treat individuals with COVID-19 pneumonia. For example, if PCPs were missing specific knowledge or the need was to ensure that on an ongoing basis, PCPs updated their knowledge as treatment options evolved, then the monitoring plan should have been written in a way that allowed assessment of the identified goal of the education effort (e.g., pre- and post-tests once, or on an ongoing basis as practice guidelines changed).

In addition, Center staff often provided raw data as evidence of implementation. For example, staff training rosters were included in the documentation submitted, but Center staff did not include information about how many staff required training. As a result, this documentation could not be used to determine whether or not staff fully implemented the recommendation. Staff should summarize data, including, for example, the number of staff trained (n), and the number of staff who required training (N).

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	176	332	454	450	363	441	271	415	106
a.	ADRs are reported immediately.	N/A									
b.	Clinical follow-up action is completed, as necessary, with the individual.	N/A									
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A									
d.	Reportable ADRs are sent to MedWatch.	N/A									

Comments: a. through d. For the individuals in the review group, Center staff had not identified and/or reported adverse drug reactions.

In response to the Tier I document request #12.z, Center staff responded: "Pharmacy has had no adverse drug reactions reported in the past six months."

From the perspective of the Center's QA/QI system, it is essential Center implement reliability probes/checks to determine whether or not data are reliable. These would include mechanisms to ensure that potential ADRs are reported (e.g., comparing lists of medications

prescribed for allergic reactions to the list of ADRs reported, etc.). In addition, guidelines such as those that the American Society of Hospital Pharmacists (ASHP) publishes provide direction in terms of ensuring full reporting.

As indicated in the last report, based on the Center's scores for three monitoring cycles, the Center achieved substantial compliance with most of the requirements of Section N of the Settlement Agreement. The exceptions are Section N.6 related to adverse drug reactions, and Section N.8 related to medication variances that the Monitoring Team will review as part of Section E. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Lufkin SSLC exited from the other requirements of Section N of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the outcomes and indicators related to the exited provisions of the Settlement Agreement.

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, 28 of these indicators were moved to, or were already in, the category of requiring less oversight, and the four outcomes and 13 indicators in Psychology/Behavioral Health met sustained substantial compliance and were exited from monitoring.

Thus, at the start of this review, 28 indicators were in the category of requiring less oversight. For this review, an additional two indicators were moved to this category in the areas of ISPs and physical nutritional management.

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

Assessments

In the ISPs, the team arranged for and obtained the needed, relevant assessments prior to the IDT meeting for one-third of the individuals.

In psychiatry, the new lead psychiatrist described plans for the department's improvement, specifically that the clinical quality of services and the documentation will improve. To that end, the new psychiatrist is performing a detailed review of the individuals on his caseload, revising diagnoses as needed, reviewing the indicators/goals, and reviewing the pharmacology regimens to determine if simplification is possible. The plan is to do this over a period of time, performing a comprehensive review at the time of the scheduled annual ISP.

The psychiatry department had a plan to update the CPEs as well as to cross reference diagnoses in the documentation for each individual. A new format for the annual psychiatric evaluation was evident and a plan to improve documentation in the ISP was underway. The Center was embarking on using the consent forms and documents provided by State Office.

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 in the review group, the PCPs at Lufkin SSLC followed the State Office guidance related to the completion of quarterly interval medical reviews (IMRs) (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable").

Center staff should continue to improve the quality of the annual medical assessments, with particular focus on complete and accurate social/smoking histories that document if the individual has ever smoked, updated active problem lists, and thorough plans of care for each active medical problem, when appropriate. In addition, more work is needed to ensure that the IMRs follow the State Office template, and provide necessary updates related to individuals' chronic and at-risk conditions.

Annual dental exams typically included most of the required components, with the primary exception of periodontal charting. Moving forward, the Center should focus on ensuring all applicable individuals receive periodontal charting updated within the last year, or a justification for not completing it and a plan to do so, as well as information regarding the last x-rays, including the date. Seven of the annual dental summaries included all of the required components, and the remaining two included most of the required components.

It was positive that for about two-thirds of the risk areas reviewed, nurses included status updates in annual record reviews, and for more than half of the risks reviewed, the quarterly record reviews included relevant clinical data. Work is needed, though, for Registered Nurse Case Managers (RNCMs) to analyze this information, and offer relevant recommendations. Improvement continued with the content and thoroughness of other portions of the record reviews, as well as the annual and quarterly physical assessments. In fact, for the six individuals in the review group, their most recent quarterly physical assessments included all of the necessary assessment information. It also was positive that when individuals experienced exacerbations of their chronic conditions, nurses often completed assessments in accordance with current guidelines/standards of practice.

In comparison with previous reviews, improvement was noted with the timely referral of individuals to the PNMT. It also was positive that as needed, a Registered Nurse (RN) Post-Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results. As a result of the Center's sustained progress in this area, the related indicator will move to the category requiring less oversight. The Center should focus on the timely completion of the PNMT initial reviews, completion of PNMT comprehensive assessments for individuals needing them, and the quality of the PNMT reviews and comprehensive assessments.

Overall, significant improvement was needed with regard to the quality of the Occupational and Physical Therapy (OT/PT) assessments. The timeliness of OT/PT assessments continued to need improvement. It was positive that for individuals in the review group, OTs/PTs completed the correct type of assessment (e.g., assessment versus screening or focused assessment).

For several individuals in the review group, it appeared Speech Language Pathologists (SLPs) did not complete communication assessments during the last 12 months due to a lack of recommendations for services or supports in their last assessments. In

turn, this resulted in a plan to complete the individuals' next assessments in three to five years. However, the older assessments did not meet the criteria for quality assessments. Based on their needs, it appeared these six individuals required additional exploration of options, and might potentially benefit from augmentative and alternative communication (AAC) devices and/or direct therapy.

In skill acquisition, two thirds to three quarters of the individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP and included recommendations for skill acquisition.

Individualized Support Plans

In the ISPs, none of the individuals had goals that met criteria for indicator 1 in all ISP areas, however, all individuals had three or four goals that met criteria across the five personal goal areas. That is, most of the personal goals were individualized, aspirational, and based on the individual's preferences. The exception was day/work goals. IDTs were not identifying what kind of job/day program the individual would like to have. Similarly, more work is needed regarding health goals (i.e., the IHCP).

Overall, discussion was good regarding preferences for living options. Action plans to support living option goals, particularly related to educating individuals and their LARs and providing exposure to community living options were similar for all individuals.

None of the individuals had a full set of goals that were written in measurable terminology, but about half of all goals were written in measurable terminology. For goals that were not measurable, the goal was not written in observable, measurable terms (i.e., will host, will organize) or included multiply stated objectives (i.e., will write, read, and/or verbalize; will create model cars and organize car races).

IDTs were not yet developing a set of action plans that created a clear path to goal achievement and integrated all supports needed to overcome barriers to progress and ensure success.

Few of the goals had reliable data. There were sufficient reliable data to assess progress on two goals; neither were progressing. About half of the action steps that could be implemented, were implemented.

QIDPs were knowledgeable of the goals, strengths, and support needs of the individuals on their caseloads. QIDPs were doing a better job of reviewing all goals and including data in the QIDP monthly review when available. That being said, QIDPs did not generally include an analysis of data or summary of progress towards goals based on data submitted and action plans were not revised when individuals had met their action plans or were not making progress.

Staff were generally knowledgeable about the individuals they supported.

The psychiatry department was identifying psychiatric indicators for reduction and increase. The psychiatry clinicians need to ensure that the relationship of the indicator to the individual's diagnosis is clearly designated. The psychiatric clinicians were regularly defining the indicators and consistently writing goals associated with each indicator. The goals were not entered into the facility's overall treatment program, the IHCP.

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.

Eight out of nine PNMPs/Dining Plans reviewed met the requirements for quality. Given that during the previous review, the Center's score was 89%, and problems noted during that review as well as this review were minimal, if the Center continues to make needed improvements, and sustains its progress overall, then, after the next review, the related indicator might move to the category requiring less oversight.

In skill acquisition, three-quarters of the SAPs had reliable data.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.	
Summary: None of the individuals had goals that met criteria for indicator 1 in all six ISP areas, however, all individuals had three or four goals that met criteria across the five personal goal areas. Moreover, across the six individuals, personal goals met criteria for a total of 20 goals. Overall, this was about the same as at the last review. More work is needed regarding health goals (i.e., the IHCP). The Monitor has provided additional calculations to assist the Center in identifying progress as well as areas in need of improvement. For indicator 1, the data boxes below separate performance for the five personal goal areas from the health-IHCP goals. Both types of goals need to meet criteria, however, the State has reported that it is working towards improving both types of goals with two concurrent support and training programs. Indicator 2 shows performance regarding the writing of goals in measurable terminology. None of the individuals had a full set of goals that were written in measurable terminology, but about half of all goals were written in measurable	Individuals:

terminology. Further, of the 20 goals that met indicator 1, half were written in measurable terminology, less than at the last review. Indicator 3 shows that few of the goals had reliable data. These three indicators will remain in active monitoring.													
#	Indicator		Overall Score	332	93	78	176	106	415			
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.	Personal goals	0% 0/6 67% 20/30	4/5	3/5	3/5	4/5	3/5	3/5			
		Health goals	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
2	The personal goals are measurable.		0% 0/6 47% 14/30 33% 10/30	3/5 2/4	2/5 1/3	1/5 1/3	2/5 2/4	3/5 2/3	3/5 2/3			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.		0% 0/6	1/6	0/4	0/6	0/6	1/6	0/6			

Comments: The Monitoring Team reviewed the ISP process for six individuals at the Lufkin State Supported Living Center: Individual #332, Individual #176, Individual #415, Individual #106, Individual #78, and Individual #93. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed staff, including DSPs and QIDPs, and directly observed individuals on the Lufkin SSLC campus.

1. None of the individuals had a comprehensive score that met criterion for the indicator. During the last monitoring visit, the Monitoring Team found 22 goals that met criterion for being individualized, reflective of the individuals' preferences and strengths, and based on input from individuals on what was important to them. For this review, 20 goals met this criterion. The personal goals that met criterion were:

- the leisure goal for all six individuals.
- the relationship goal for Individual #332, Individual #176, and Individual #106.
- the work/day/school goal for Individual #93.
- the independence goal for Individual #332, Individual #176, Individual #415, Individual #78, and Individual #93.
- the living options goals for Individual #332, Individual #176, Individual #415, Individual #78, and Individual #106.

For those individuals, the goals were attainable, aspirational, and based on their preferences and support needs. For example:

- Individual #332's greater independence to brush her own hair.
- Individual #176's relationship goal to create artwork to share with her mother during facetime calls.

- Individual #415's living option goal to live in a community group home near his family.
- Individual #106's relationship goal to create model cars and organize car races with his peers.
- Individual #78's greater independence goal to research subjects on the computer.
- Individual #93's independence goal to use a computer to research recipes and make healthy snacks.

Some goals did not meet criterion for the indicator because they did not reflect the individual's specific preferences, strengths, and needs. For instance:
- Individual #176, Individual #415, and Individual #106 had similar work goals to increase work earnings. These goals were not individualized and did not identify the individual's work preferences. All three had indicated that they wanted to work in the community. Specific training needed to obtain/maintain jobs in the community had not been identified.
- Individual #93's living option goal was to live at Lufkin SSLC. This goal was not aspirational because he was living at Lufkin SSLC.
- Individual #78 had a relationship goal to repair his chicken coop with assistance from his preferred staff. This was unlikely to support relationship building.

When a goal is counted towards more than one goal area, the denominator remains the total number of goal areas for which there was a goal.

2. Of the 20 personal goals that met criterion for indicator 1, 10 also met criterion for measurability. Four others that did not meet criteria for indicator 1 were measurable. Those that were measurable:
- Recreation/Leisure: Individual #415 and Individual #106
- Relationship: Individual #176 and Individual #415
- Job/School/Day: Individual #332 and Individual #93
- Greater Independence: Individual #332 and Individual #106
- Living Option: all six.

For goals that were not measurable, the goal was not written in observable, measurable terms (i.e., will host, will organize), did not indicate what the individual was expected to do or how many times they were expected to complete tasks/activities, or included multiply stated objectives (i.e., will write, read, and/or verbalize; will create model cars and organize car races). Those included:
- Recreation/leisure: Individual #332, Individual #176, Individual #78, and Individual #93
- Relationship: Individual #332, Individual #106, Individual #78, and Individual #93. For Individual #332, it did not indicate what level of assistance she would need (hand over hand, verbal prompts?). It included multiple objectives (choose a peer, choose an animal or accessory, build an animal, in the community or in the home).
- Job/School/Day: Individual #176, Individual #415, Individual #106, and Individual #78. For Individual #176, Individual #106, and Individual 415, the goal did not include baseline or clear criteria for meeting the goal (increase by $5 one time? Monthly for how many months?). For Individual #78, per QIDP interview, the intent of his work goal was to turn off his personal alarm at home in the mornings to get to work on time.
- Greater Independence: Individual #176, Individual #415, Individual #78, and Individual #93

3. Of the 10 goals that met criteria with indicators 1 and 2, two had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals.

- There were data for Individual #332's skill acquisition plan related to her greater independence goal to brush her hair. She was not making progress, however, the SAP had only been implemented for two months.
- Individual #106 had not made progress on his leisure goal to decorate a t-shirt. He had not received the supplies needed to make his t-shirt.

Of the other goals, many of the action plans were on hold due to COVID-19 restrictions.

Even so, there were improvements in the collection of data and QIDPs were doing a better job of including data in their monthly reviews. On the other hand, they were not typically summarizing progress made towards goals based on that data. In many cases, implementation data were collected that did not reflect specific progress towards goals.

The QIDP Coordinator reported that the QIDP department had focused on the collection of data during the monthly review process and would be focusing on summarizing progress in the upcoming months.

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: There were sufficient reliable data to assess progress on two goals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	332	93	78	176	106	415			
4	The individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/5	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	N/A									
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/5	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	N/A									

Comments: A personal goal that meets criterion for indicators 1 through 3 is a pre-requisite for evaluating whether progress has been made. In other words, goals that do not meet criterion for indicators 1 through 3 receive a zero score for indicators 4 through 7.

4-7. Across the six individuals, there were 10 personal goals that met criterion for indicators 1 and 2. Two of the goals had corresponding data that were reliable or valid.

- There were data for Individual #332's skill acquisition plan related to her greater independence goal to brush her hair. She was not making progress, however, the SAP had only been implemented for two months.

- Individual #106 had not made progress on his leisure goal to decorate a t-shirt. He had not received the supplies needed to make his t-shirt and barriers to implementation were not addressed.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.

Summary: There was continued improvement in the indicators that are part of this outcome. With sustained high performance, indicators 9 and 11 might be moved to the category of requiring less oversight after the next review. Similarly, indicators 8, 10, 15, and 16 showed higher performance than in the past. These indicators will remain in active monitoring.

Individuals:

#	Indicator		Overall Score	332	93	78	176	106	415			
8	ISP action plans support the individual's personal goals.		17% 1/6 70% 14/20	2/4	2/3	3/3	3/4	2/3	2/3			
9	ISP action plans integrated individual preferences and opportunities for choice.	Individual preferences	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
		Opportunities for choice	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.		83% 5/6	1/1	1/1	0/1	1/1	1/1	1/1			
11	ISP action plans supported the individual's overall enhanced independence.		100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
12	ISP action plans integrated strategies to minimize risks.		50% 3/6	0/1	1/1	0/1	1/1	1/1	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.		33% 2/6	1/1	0/1	0/1	1/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.		17% 1/6	0/1	0/1	1/1	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.		83% 5/6	0/1	1/1	1/1	1/1	1/1	1/1			

16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	67% 4/6	0/1	1/1	1/1	1/1	0/1	1/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	1/6	0/6	2/6	0/6	0/6	0/6			

Comments:

8. For the 20 goals that met criterion for being personal and individualized, 14 had corresponding action plans that were supportive of goal-achievement. There was progress noted over the review period in developing action plans that supported goal achievement. The QIDP Coordinator reported that this had been a recent focus by the QIDP department. Goals that had action plans that were likely to lead to achievement of goals were:

- Individual #332's recreation/leisure and greater independence goal.
- Individual #176' s recreation/leisure, relationship, and greater independence goals.
- Individual #415's recreation/leisure and greater independence goal.
- Individual #106's recreation/leisure and relationship goals.
- Individual #78's recreation/leisure and greater independence goals.
- Individual #93's recreation/leisure, vocational, and greater independence goals.

Goals that did not have supportive action plans that might lead to goal-achievement included:

- Five individuals had a living option goal to live in the community. All had similar action plans to present living option information to the individual and/or LAR annually, attend provider fairs, and go on outings to increase community awareness. The action plans were not individualized and did not offer enough detail on how information would be presented, what supports were needed, or what information would be gathered to determine preferences.
- Individual #332's relationship goal had two broadly stated action plans that did not address barriers to implementation or supports needed to achieve her goal.

9. Six of the ISPs had action plans that integrated preferences and opportunities for choice.

10. Five of the six individuals had ISPs that met criterion for the indicator. In general, Capacity Assessments identified deficit areas and an individual's inability to make informed decisions. Individual #78's ISP action plans did not identify training or supports to mitigate those deficits.

11. Six ISPs had action plans that supported the individuals' overall independence. For each of those individuals, action steps taught functional skills, such as personal hygiene and domestic skills, For example:

- Individual #332 had action plans to use a pressure plate to activate an environmental device and to brush her hair.
- Individual #176 had action plans for notifying her line monitor before she leaves work using sign language, coordinating her clothing, and identifying the purpose of one of her medications.

- Individual #415 had action plans for money management, cleaning his room, and telling time.
- Individual #106 had action plans for money management and sanitizing his hands.
- Individual #78 had action plans for using a computer, cleaning his dentures, and managing his money.
- Individual #93 had action plans for shopping for healthy foods and making his own snack.

12. Three of the ISPs met criterion for the indicator (Individual #176, Individual #106, Individual #93). While some risks were addressed through the individuals' PBSPs, IRRFs, and IHCPs, supports were not always integrated into their ISP action plans to mitigate risks presented or to offer guidance to staff who were implementing action plans when relevant. For example:

- Individual #332 had significant medical risks including cardiac, skin, and GI issues. Health care plans and recommendations to minimize risks were not integrated into action plans to support her goals.
- Individual #415's nutrition evaluation recommended specific dietary guidelines and structured participation in physical activity for 30 to 60 minutes daily to address his risks related to obesity, metabolic syndrome, and hyperlipidemia. Individual #415 had a goal to document his food intake, however, specific recommendations were not integrated into action plans.
- Individual #78 was at high risk for diabetes, weight, and cardiac issues. He had a prescribed diet and a recommendation for physical activity daily. Support strategies to address risks were not integrated into action plans that supported his goals and the IDT had not considered training that targeted self-management of his health risks.

13. Two of the six ISPs met criterion for the indicator. Findings included:

- Individual #332's OT/PT recommendations to reach for objects and use environmental control switches were included in action plans to support her goals.
- Individual #176's ISP included action plans to support her in self-management of her health care supports through action plans to monitor her blood pressure, identify the purpose of her medications, and identify exercise options.

For the other four individuals, support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were not well-integrated, and they were not incorporated into action plans. For example:

- Individual #78's IDT had not considered training to support self-management of his health risks.
- Individual #106's positioning recommendations to minimize his risk for skin issues and edema were not integrated into his daily schedule or action plans to support his goals. Nutritional recommendations were not integrated into his action plans for preparing a snack.
- Specific dietary and exercise recommendations were not integrated into Individual #93's action plans to self-manage his diet.

14. The ISP should include individualized action plans that support community participation and integration. One of the ISPs included action plans to support meaningful integration into the community. Most individuals had broad statements in the ISP regarding opportunities for participation (shopping, going to parks, ballgames, etc.), but not for integration which usually requires membership or establishing relationships with people who do not have disabilities. (gym, banking, volunteering, playing on a local sports team) or receiving supports in the community (counseling, classes at community colleges, school). Rarely were action plans developed to address barriers or supports needed to allow the individual to fully participate in the community. Findings included:

- Individual #78 had action plans related to attending church in the community.

For the five other individuals, their action plans did not integrate encouragement of community integration. In general, action plans included steps for individuals to participate in community outings. Action plans did not include support for individuals to become active community members or address identified barriers to goal achievement. For example,

- The action plans corresponding to Individual #93's goal to work in the community were to be implemented at the facility. The action plans were not related to community access or participation, and they did not describe how he would be supported to seek a job in the community. The QIDP reported that the IDT was focused on supporting Individual #93 to obtain a job in the community. The IDT should develop action plans that assign responsible staff, set timelines, and addressed any barriers and needed supports to Individual #93 obtaining employment in the community to ensure that he is supported to find a job that would provide community integration opportunities. He had the following action plans related to his work goal:
    - Will attend work as scheduled.
    - Will be provided a reinforcer.
    - Will fill out his timesheet.
    - Will identify coins and their value while working in Rustic Corner.
- Individual #176 was employed in the community at AAA Trophy & T-Shirt Shop prior to Covid-19. She was no longer employed because the business closed. Her QIDP reported that the IDT would seek another community job, however, there were no related action plans or any other action plans for training in the community.
- Individual #415 did not have action plans that were likely to lead towards integration in the community.

15. Five ISPs included action plans to support opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Individual #332's ISP did not document consideration of day programming in a more integrated setting.

It was positive to see that several individuals had been working in the community prior to COVID-19 restrictions. Per QIDP interviews, IDTs were focused on getting those individuals back to work in the community, as soon as possible, however, the IDTs had not developed action plans specific to supporting individuals to work in the community.

16. Two 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. Many action plans were on hold due to Covid-19 restrictions. IDTs had not met to modify training that could be implemented at the home.

- Individual #332's ISP indicated that she would attend class for one hour daily at the activity center. The day program sites were closed until recently and 12 of 20 action plans were on hold due to COVID-19 restrictions. The IDT had not met to formally develop a plan for active treatment over the past year. All skill acquisition plans and service objectives were discontinued in July 2021 following a change in her health status and move to the infirmary. The IDT did not develop plans for supports or engagement opportunities while she was in the infirmary.
- Individual #106 had limited opportunities for functional training. His IDT did not identify training opportunities related to his recreation/leisure and relationship goals. His work goal did not identify training opportunities related to his job preferences. He did have a skill acquisition plan for filling out his timesheet. Implementation of the SAP was observed, and he could

complete the task independently. Additionally, he had SAPs to operate the microwave and record his earnings and expenditures.

For the other four individuals, action plans supported functional engagement with sufficient frequency to meet personal goals and needs.

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

18. Action plans provided sufficient detailed information for implementation, data collection and review to occur for three of the goals. For those goals, action plans had been developed that included specific implementation strategies and criteria for documenting and assessing progress.

- Action plans that supported Individual #332's goal to independently brush her hair met criteria. A skill acquisition plan was developed that included specific training instructions and described data to be collected.
- Action plans that supported Individual #78's recreation/leisure goal and greater independence goals met criteria. A skill acquisition plan was developed that included specific training instructions and described data to be collected.

Examples of action plans that did not meet criteria because they did not include detailed information on implementation, such as teaching strategies, when training should occur, or what supports were needed included:

- Individual #176's action plans to host a fashion show supported her goal. However, they did not include detailed information on implementation and/or documentation. Her action plans included:
    - will shop for fashion items, clothing, and decorations, funds will be requested,
    - will create invitations, and
    - will invite peers.
- Similarly, action plans to support Individual #176's relationship goal did not include enough detail to ensure consistent implementation. Action plans included:
    - create artwork/crafts monthly.
    - will video chat with her mother.

- The IDT developed action plans to support Individual #415's goal to decorate a food journal with drawings/sketches of choice and document/notate his recommended diet intake, daily, within the next year. Action plans did not include detailed information on implementation. Related action plans included:
    - Transportation/funding will be secured, and Individual #415 will purchase/obtain journals, arts & crafts, and supplies as needed.
    - Will write down his food intake.

- Action plans to support Individual #415's relationship goal to sketch a drawing of a favorite video game cover, to showcase during game nights, with preferred peers quarterly did not include detailed implementation instructions. Related action plans included:
    - Transportation/funding will be secured as needed for video games, food/snacks, and/or arts & crafts of choice, etc.
    - With assistance, will plan game nights with preferred peers.
    - Will showcase/display his drawing during game nights quarterly.

- Action plans to support Individual #106's recreation/leisure goal to create model cars of choice and organize car races with preferred peers, quarterly, within the next year did not include detailed implementation strategies. Related action plans included:
    - Funding will be requested as needed for model car kits, arts & craft supplies, admission costs/fees, snacks/meals, and/or any other purchases.
    - The Community Specialist will plan outings and shopping trips for and ensure transportation. Community Specialist will purchase items if Individual #106 is unable to go shopping due to Covid protocol.
    - Will invite a preferred peer to go shopping with him, as well as to the car races, including #1560 among others.
    - Will create model cars of choice with assistance as needed.
    - With assistance, will organize model car races with peers in the patio, in the Gazebo, gym, in outdoor areas, or in parks on/off campus.
    - Will display his model cars in his bedroom.

- Action plans to support Individual #93's relationship goal to plan a movie day/night out with a preferred peer, purchase snacks, and journal the events of the movie quarterly did not include detailed staff instructions for implementation or documentation. Action plans included:
    - CS will coordinate, schedules, staff, transportation, and funds as requested when restrictions are lifted.
    - Individual #93, preferred peer, and the CS will plan which movies to see in the community or host on the home.
    - Individual #93, preferred peer, and CS will pick a restaurant to eat at before or after seeing a movie in the community or plan snacks for movie viewing on the home.
    - Staff will assist Individual #93 with journaling and illustrating his movie experiences.
- Similarly, four action plans for his greater independence goal to use a computer/tablet to research recipes and make healthy snacks quarterly to create a personal recipe book did not include enough information for implementation and data collection to occur consistently. Related action plans included:
    - will shop for healthy food options and other necessities.
    - will research recipe options on a computer or tablet or at the Rustic Corner.
    - Familiar staff will assist with preparing foods/snack and create recipe book.
    - SO: Staff will assist with Individual #93 writing an ingredient list.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.	
Summary: Indicator 24 will be moved to the category of requiring less oversight due to sustained high performance. The same might occur for indicator 21 after the	Individuals:

next review, with sustained high performance. Performance on the other indicators was about the same as at the last review. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	332	93	78	176	106	415			
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, these indicators were 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.										
21	The ISP included the opinions and recommendation of the IDT's staff members.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
23	The determination was based on a thorough examination of living options.	17% 1/6	0/1	0/1	0/1	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).	100% 5/5	1/1	1/1	1/1	1/1	1/1				
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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		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% 0/1						0/1			

Comments:

21. Six ISPs included the opinions and recommendations of the IDT's staff members.

23. One of the individuals had a thorough examination of living options based upon preferences, needs, and strengths (Individual #415). The other individuals had limited exposure to community living options, and it was not evident that their IDTs thoroughly discussed potential placements in the community.

24. Five 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. No obstacles were identified for Individual #415, and he had been referred to the community.

26. The indicator was not met for any of the six individuals. None of their ISPs contained individualized, measurable action plans to address their obstacles to community referral. Individual #415 had been referred, however, the IDT did not develop measurable action plans to support his move to the community.

27. For Individual #415's annual ISP meetings, the IDT did not developed plans to address/overcome the identified obstacles to referral.

28. None of the individuals had individualized and measurable action plans to educate the individual and/or LAR on living options that might be available to support their needs.

29. Individual #415's IDT did not develop individualized actin plans to facilitate his referral.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.												
Summary: Indicators 32 and 33 showed progress/increased scoring. On the other hand, indicator 34 scored lower than at the last review. All three indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	332	93	78	176	106	415				
30	The ISP was revised at least annually.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.											
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	83% 5/6	1/1	1/1	1/1	0/1	1/1	1/1				
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	0/1	1/1	1/1				
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1				
Comments:												

32. Action steps that were on hold due to COVID-19 restrictions were not considered in the rating of this indicator. For this indicator, five of the individuals had ISPs that were fully implemented within 30 days of their ISP meeting. Findings included:

- Individual #176's annual ISP meeting was held on 2/11/21. Her skill acquisition plans were not implemented until April 2021.

33. Four individuals attended their ISP meetings. Individual #332 and Individual #176 did not attend their meetings and ISPs did not reflect the individuals' involvement in the process.

Individual #93's annual ISP meeting was observed. Individual #93 and his LAR did not attend his meeting. His LAR had a scheduling conflict. It was not evident that the IDT had considered rescheduling the meeting to a convenient time for his LAR to attend. Individual #93 declined to attend his meeting. The IDT did not discuss efforts made to encourage his participation.

34. One of the six individuals had appropriately constituted IDTs, based on their strengths, needs and preferences, who participated in the planning process. For the other five individuals, crucial members of the IDT did not attend the meeting. Findings included:

- For Individual #176, her SLP did not attend her meeting. Individual #176 was deaf and used a combination of formal sign and gestures to communicate. Communication supports were not well integrated into her plan.
- Dental staff did not attend Individual #415's annual meeting. He was at high risk for dental issues due to his refusals for dental care. His ISP included an action plan to monitor his toothbrushing, but did not address the thoroughness of brushing his teeth. His dietician did not attend his meeting. His diagnoses included obesity, vitamin deficiencies, metabolic syndrome, irritable bowel syndrome and hyperlipidemia.
- Individual #106's OT and PT did not attend his meeting. He was non-ambulatory and his diagnoses included osteoporosis, aspiration risk, dysphagia, chronic embolism and thrombosis, hemiplegia, and edema.
- For Individual #332, her OT, PT, and SLP did not attend her meeting. She had a PNMP in place. Her ISP indicated that she was non-weight bearing and non-ambulatory and totally dependent on staff for all aspects of positioning, transfers, mobility, and ADLs. She was high risk for fractures due to osteoporosis and a history of multiple fractures. She also had limited communication skills. Although, she had action plans to indicate her choice of items and to use a switch for environmental control, communication strategies were not well integrated into other action plans.
- Individual #93's dietician did not attend his meeting. His diagnoses included obesity, diabetes, constipation, and hyperlipidemia. He had a goal related to healthy eating, however, specific dietary recommendations were not integrated into action plans.

The Monitoring Team identifies missing attendance when the individual has very complex needs that need to be addressed throughout the majority of action plans. Action plans did not integrate strategies from disciplines noted as missing from the meeting.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	332	93	78	176	106	415			

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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.								
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	50% 3/6	0/1	1/1	1/1	0/1	1/1	0/1			

Comments:
36. The indicator was met for two of the six individuals. Findings included:
- Individual #332's PSI was not timely.
- Individual #176's nutritional assessment was not timely.
- Individual #415's behavioral, dental, and nutritional assessments were not timely.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	332	93	78	176	106	415			
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. None of the ISPs met criterion for the indicator. In general, IDTs did not meet to review ISP action plans or to develop strategies to revise action plans that were on-hold due to COVID-19. IDTs also did not meet to review data or to discuss an individual's lack of progress towards goal-achievement. IDTs typically met to discuss changes in health status, behavioral challenges, and incidents and injuries. This was good to see, however, supports were not always revised to address risks. When supports were revised, the IDTs rarely followed up to determine the efficacy of supports. For example,
- Individual #176's IDT met frequently to review health and behavioral issues. ISPAs generally included a review of data related to issues discussed. In April 2021, the IDT met to review five falls within 30 days, as required. She was not referred for an updated PT assessment and the IDT did not implement supports to minimize her risk for injury. In May 2021, the IDT met to discuss increased constipation, vomiting, and weight loss. The IDT agreed to change her risk level and revise her IHCP goal to she would have a daily BM. The IDT did not put additional supports in place to address bowel management.
- Individual #332's IDT met to discontinue all action plans when her health status changed, and she was admitted to the infirmary. The IDT did not develop action plans to address support needs while in the infirmary.
- Individual #415 had been referred for community placement over a year ago. The IDT met monthly and remained focused on supporting this goal, however, he was not making progress towards moving and the IDT had not developed action plans to address barriers. The IDT met on 3/26/21 and 4/22/21 to discuss progress towards his move. One action plan developed, for

the IDT to follow-up in 30 days. The IDT met again on 5/20/21 to discuss his referral. They wrote an action plan for Admissions and Placement staff to follow-up with identified providers, as needed. His QIDP monthly reviews did not specifically address progress or barriers to his referral.

- For all of Individual #106's goals, multiple action plans were on hold due to COVID-19 restrictions. The IDT had not discussed how plans could be modified and implemented to support progress towards his goals. Action plans related to his recreation/leisure and relationship goals that could have been implemented were not and no action was taken to address barriers to implementation. Four action plans related to his independence goal had implementation data, but no summary of progress.
- For Individual #78, many action plans were on-hold due to COVID-19 restrictions. Action plans that could be implemented were inconsistently implemented and it was difficult to determine if he was making progress or if there were barriers to implementation. His action plans to wash his hands, clean his dentures, and collect his eggs to sell appeared to be completed. No action had been taken to revise or discontinue completed action plans.
- Individual #93 had lost his job in the community when the business that he worked for closed permanently following COVID-19 closures. Individual #93 wanted to seek another job in the community and the QIDP reported that the IDT supported this goal. The IDT had not met to develop action plans to support him to find another job. He had not met his goal to use the computer/tablet to research recipes due to limited Wi-Fi availability. The IDT had not addressed this barrier.

38. QIDPs were knowledgeable of the goals, strengths, and support needs of the individuals on their caseloads. As noted for indicator 37, action plans were not revised when individuals had met their action plans or were not making progress. QIDPs were doing a better job of reviewing all goals and including data in the QIDP monthly review when available. QIDPs did not generally include an analysis of data or summary of progress towards goals based on data submitted. For example:

- Individual #415's QIDP was documenting how many times he had brushed his teeth monthly and how many times he had refused, but did not comment on the quality of his toothbrushing, what supports were needed, or indicated what progress he had made.
- Individual #332's QIDP recorded the number of times that she had used hand wipes to clean her hands, but did not document what supports were needed.
- Individual #176 had an action plan to video chat with her mother. Her monthly review indicated that she had talked to her month, but did not comment on the frequency or supports needed.
- Individual #93's monthly review for his SAP to make a snack noted how many trials had been completed and how many were completed independently. The monthly review did not indicate which step his was on, what supports were needed, or comment on his barriers to progress.

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: Staff were generally knowledgeable about the individuals they supported. About half of the action steps that could be implemented, were implemented. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	332	93	78	176	106	415			

39	Staff exhibited a level of competence to ensure implementation of the ISP.	100% 5/5		1/1	1/1	1/1	1/1	1/1			
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. Staff were generally knowledgeable regarding specific risks and supports needed and implementation of ISP action plans. This indicator was not scored for Individual #332. The Monitoring Team was unable to confirm that staff were able to implement her ISP because all action plans had been placed on hold while she was in the infirmary. The Monitoring Team observed Individual #332 for a few minutes in the infirmary. She and her QIDP interacted and Individual #332 responded positively, appearing comforted by the spoken words and physical touch of the QIDP.

40. Across all six individuals, there was a total of 133 action steps evaluated, 37 of which had been consistently implemented. Of the 96 remaining action steps that were not implemented, 64 could not be implemented due to COVID-19 community and gathering restrictions. Thus, of the 69 that could have been implemented, 37 were implemented (54%).

Individual	# of Action Steps in ISP	Action Steps Implemented	Action Steps Not Implemented Due to COVID-19	Action Steps Not Fully Implemented
Individual #332	20	7	12	1
Individual #176	18	5	9	4
Individual #415	24	10	9	5
Individual #106	30	8	14	8
Individual #78	20	6	10	3
Individual #93	21	1	10	2

Outcome 1 – Individuals at-risk conditions are properly identified.											
Summary: In order to assign accurate risk ratings, IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings and update the IRRFs within no more than five days. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
a.	The individual's risk rating is accurate.	17%	2/2	0/2	N/R	N/R	0/2	0/2	0/2	0/2	N/R

		2/12									
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.	25% 3/12	0/2	1/2			0/2	0/2	1/2	1/2	
Comments: For six individuals, the Monitoring Team reviewed a total of 12 IRRFs addressing specific risk areas [i.e., Individual #176 – constipation/bowel obstruction, and diabetes; Individual #332 – respiratory compromise, and gastrointestinal (GI) problems; Individual #363 – GI problems, and circulatory; Individual #441 – aspiration, and skin integrity; Individual #271 – respiratory compromise, and GI problems; and Individual #415 – falls, and infections]. a. The IDT that effectively used supporting clinical data, used the risk guidelines when determining a risk level, and as appropriate, provided clinical justification for exceptions to the guidelines was for Individual #176 – constipation/bowel obstruction, and diabetes. b. For the individuals in the review group, it was positive that the IDTs updated most of the IRRFs at least annually. The exception was for Individual #363 – circulatory, for whom no cardiac/circulatory IRRF was found for the ISP developed on 11/5/20. However, often when changes of status occurred that necessitated at least review of the risk ratings, IDTs did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #332 – GI problems, Individual #363 – circulatory, Individual #271 – GI problems, and Individual #415 – and infections.											

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: At Lufkin SSLC, there was progress in the sub-indicators of each of the indicators in this outcome (indicators 4, 5, and 7 scored higher than ever before). The psychiatry department was identifying psychiatric indicators for reduction and increase. The psychiatry clinicians need to ensure that the relationship of the indicator to the individual's diagnosis is clearly designated. The psychiatric clinicians were regularly defining the indicators and consistently writing goals associated with each indicator. The goals were not entered into the facility's overall treatment program, the IHCP. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	98	332	221	93	330	78	125	392	176
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	11% 1/9	1/2	1/2	2/2	1/2	1/2	0/2	1/2	0/2	1/2
5	The individual has goals related to psychiatric status.	89% 8/9	1/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
6	Psychiatry goals are documented correctly.	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

		0/9									
7	Reliable and valid data are available that report/summarize the individual's status and progress.	56% 5/9	1/2	0/2	2/2	2/2	2/2	1/2	2/2	0/2	2/2

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.

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

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

In psychiatry, the focus is upon what have come to be called psychiatric indicators. Psychiatric indicators can be measured via recordings of occurrences of indicators directly observed by SC 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 <u>and</u> 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 progress in this area as all individuals in the review group had a psychiatric indicator related to the reduction of psychiatric symptoms. The psychiatric indicators for reduction were also all identified as behavioral health target behaviors in each individual's PBSP. The psychiatry grid documented that the psychiatric indicator for reduction for Individual #392 was irritability and that this was a behavioral health target behavior, but there was no behavioral health PBSP target behavior identified as irritability with the same definition as that documented by psychiatry.

Overall, there was a need to document how the psychiatric indicators for reduction were related to a specific diagnosis. In four cases, criterion as met, where, for example, an indicator of aggression was associated with a diagnosis of an Autism Spectrum Disorder, or an indicator of psychosis was associated with a diagnosis of Schizophrenia, it was possible to determine the relationship intuitively. For the fifth case that met criterion, there was a recent change in the psychiatric indicator for reduction developed for Individual #93. Previously, the indicator was physical aggression. With a change to a new psychiatrist and a recent annual evaluation, the indicator was changed to psychotic symptoms, which is a psychiatric indicator clearly related to the diagnosis of Schizophrenia. This change of

indicator was pending IDT approval. In four other cases, for example regarding Individual #78, it was not possible to determine how the identified indicator of physical aggression related to a diagnosis of Schizophrenia, or for Individual #176, how an indicator of physical aggression was associated with a diagnosis of Schizoaffective Disorder, Bipolar Type.

All of the individuals in the review group had psychiatric indicators for increase in positive/desirable actions identified. In three examples, the indicators for increase were the same as a behavioral health PBSP replacement behavior. For two individuals, the indicator for increase was medication compliance. For two individuals, the indicator for increase was community exposure, where the indicator required the individual to go on scheduled outings in the community, wheelchair rides on campus, or family visits. One issue noted was the need to ensure that the indicator was sufficiently defined such that staff could determine if the individual met criteria. Further, the psychiatry clinic staff must document how the indicator for increase related to the individual's diagnosis.

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

The psychiatric goals regarding the psychiatric indicators for increase and decrease met monitoring criteria in that they included a measurement, the modality or scale that would be used to obtain the measurement, and a time metric. The psychiatry goals grid did not clearly note who was responsible for gathering data. For psychiatric indicators that were the same as behavioral health PBSP target behaviors or replacement behaviors, it was intuitive that behavioral health would be responsible for gathering data. For other indicators, there was documentation that the DSP was to mark a yes/no on a daily summary sheet in order to indicate if an individual had engaged in a specific behavior (e.g., going on a wheelchair ride). There were issues with data collection for these indicators. Recently, the psychiatry clinic had identified a staff member to assist with gathering these data. The identified staff member had experience working in the psychiatry clinic and was developing a system for data collection and reporting.

As 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 nine of the individuals for goals for reduction and for eight individuals for goals for increase. As the indicator for increase regarding Individual #98 was not yet defined, the goal for this indicator was pending.

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, goals for reduction and increase were written for the identified indicators and documented in the psychiatry goals grid. But, the goals were not incorporated into the Center's overall documentation system, 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.

At Lufkin SSLC, data were reported for psychiatric indicators for reduction for eight individuals. These data, while generally graphed for the presentation in psychiatry clinic, were then included in the psychiatry clinical notes. Data presented in clinical and review meetings were generally up-to-date and, as noted above, were graphed and trended. A review of the IOA reports for the data included in the psychiatry clinical documents revealed that data for seven of these eight individuals were reliable for psychiatric indicators for decrease. Data regarding Individual #332 were unreliable. This was reportedly due to her off campus hospitalization. For Individual #392, as noted above, the indicator for reduction and the definition of this indicator were not the same as the behavioral health target behaviors identified, so there were no data reported for irritability.

With regard to psychiatric indicators for increase, reliable data were presented for three individuals whose indicator for increase was the same as a behavioral health PBSP replacement behavior. For two individuals, Individual #176 and Individual #125, medication compliance was the identified indicator, so data would be as reliable as the information included in the Medication Administration Record. For three individuals, Individual #332, Individual #78 and Individual #392, there were no data reported regarding their identified indicator for increase and Individual #98's indicator for increase had not been finalized.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: Performance was about the same as at the last review. The psychiatry department had a plan to update the CPEs as well as to cross reference diagnoses in the documentation for each individual. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 98	332	221	93	330	78	125	392	176
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	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

	primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.											
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	44% 4/9	0/1	0/1	0/1	1/1	0/1	1/1	1/1	0/1	1/1

Comments:

14. The Monitoring Team looks for 14 components in the CPE. None of the CPEs included all of the required components. Two evaluations were missing one element, four evaluations were missing two elements, one evaluation was missing three elements, one evaluation was missing five elements, and one evaluation was missing 11 elements. The most common missing elements were an adequate bio-psycho-social formulation, missing in eight documents, and the results of the physical examination, missing in five documents.

- The evaluation regarding Individual #98 was missing the history of present illness, physical examination results, laboratory examinations, an adequate bio-psycho-social formulation, and treatment recommendations.
- The evaluation regarding Individual #332 was missing the history of present illness and an adequate bio-psycho-social formulation.
- The evaluation regarding Individual #221 was missing the physical examination results and an adequate bio-psycho-social formulation.
- The evaluation regarding Individual #93 was missing an adequate bio-psycho-social formulation and treatment recommendations.
- The evaluation regarding Individual #330 was missing the identifying information, history of present illness, past psychiatric history, family history, substance use history, medical history, developmental history, social history, physical examination results, an adequate bio-psycho-social formulation, and treatment recommendations.
- The evaluation regarding Individual #78 was missing an adequate bio-psycho-social formulation.
- The evaluation regarding Individual #125 was missing the physical examination results and an adequate bio-psycho-social formulation.
- The evaluation regarding Individual #392 was missing this history of present illness.
- The evaluation regarding Individual #176 was missing the physical examination results, laboratory examinations, and an adequate bio-psycho-social formulation.

16. There were five individuals whose records revealed inconsistent diagnoses, Individual #98, Individual #332, Individual #221, Individual #330, and Individual #392.

- For Individual #98, the AMA included a diagnosis of ADHD and the BHA included a diagnosis of ADHD and ICD that were inconsistent with the psychiatric diagnoses.
- For Individual #332, the BHA included a diagnosis of trichotillomania that was not indicated by psychiatry and the AMA indicated that the diagnosis of dysthymia, that was indicated by psychiatry, was inactive.
- For Individual #221, the AMA included a diagnosis of premenstrual dysphoric disorder that was not indicated by psychiatry.

- For Individual #330, the BHA included a diagnosis of tardive dyskinesia. The most recent psychiatry documentation noted that Individual #330 did not have tardive dyskinesia. The AMA included a diagnosis of impulse control disorder that was not indicated by psychiatry.
- For Individual #392, the AMA and the BHA included a diagnosis of dementia that was not indicated by psychiatry.

Outcome 5 – Individuals' status and treatment are reviewed annually.											
Summary: Performance scores were the same as at the last review. However, as noted in the comments below, a new format for the annual evaluation was evident and a plan to improve documentation in the ISP was underway. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	98	332	221	93	330	78	125	392	176
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).	38% 3/8	0/1	1/1	0/1	1/1	0/1	0/1		1/1	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.										
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/8	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. Three of the annual evaluations, regarding Individual #332, Individual #93, and Individual #392, contained all of the required elements. As two of these evaluations were using the new format developed to address requirements of both the CPE and the annual evaluation, this was positive to see and showed it likely that this will be applied to all individuals over the upcoming months. Of the remaining five evaluations, one was missing four elements, two were missing five elements and two were missing seven elements. The most common missing element was the risk versus benefit discussion.

- The annual evaluation regarding Individual #98 was missing the symptoms of the diagnosis, the derivation of symptoms, the psychological assessment or behavioral health assessment, the combined Behavioral Health review/formulation, the risk of medications, the risk of illness, and the risk versus benefit discussion.
- The annual evaluation regarding Individual #221 was missing the combined Behavioral Health review/formulation, the risk of medications, the risk of illness, non-pharmacological treatment and the risk versus benefit discussion.
- The annual evaluation regarding Individual #330 was missing the symptoms of the diagnosis, the combined Behavioral health review/formulation, the risk of medications, the risk of illness, non-pharmacological treatment, the risk versus benefit discussion, and future plans.

- The annual evaluation regarding Individual #78 was missing the combined Behavioral Health review/formulation, the risk of medication, the risk of illness, and the risk versus benefit discussion.
- The annual evaluation regarding Individual #176 was missing the symptoms of the diagnosis, the risk of medication, non-pharmacological treatment, the risk versus benefit discussion, and past pharmacology.

21. In eight 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. The documentation regarding Individual #93 was pending as his ISP was just completed 7/14/21 and the final documentation from that meeting was not yet available. As Individual #93 had a new psychiatrist who participated in this meeting, and given positive changes expected from the change of provider, it seemed prudent to wait to score this document in lieu of the one from 2020.

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

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
Summary: The Center was embarking on using the consent forms and documents provided by State Office. This likely will result in improved performance. Comments are also provided for the two indicators that are in the category of requiring less oversight. Indicators 29, 30, and 31 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	98	332	221	93	330	78	125	392	176
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	33% 3/9	1/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
30	A risk versus benefit discussion is in the consent documentation.	22% 2/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1

#	Indicator	Score									
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	67% 6/9	0/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1
32	HRC review was obtained prior to implementation and annually.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
28. Current medication consent forms were provided for all medications prescribed for seven of the individuals in the review group. The consent forms for Individual #221 expired 6/29/21 and per a supplemental document request, updated consent forms were not completed with a note from the facility that they were not due until 8/16/21. The consent forms for Individual #330 expired 6/15/21 and per a supplemental document request, updated consent forms were not submitted.

29. The consent forms included adequate medication side effect information in three examples. While the facility included some medication side effect information on the consent form inclusive of black box warnings, there was information missing. For example, consent forms for benzodiazepines did not include the risk of dependence, and consent forms for Seroquel did not include the risk of cataract development. The facility could consider the use of medication side effect information sheets from pharmacy to attach to their consent forms for comprehensive information.

30. A sufficient risk versus benefit discussion was included in the consent forms in two examples. The facility indicated that in August 2021 they will transition to the most recent version of the medication consent form promulgated by their state office. This should help with completion of the risk benefit section as it includes the requirement for cumulative risk, for example when two second generation antipsychotic medications or other medications with significant interactions are prescribed.

31. The consent forms for six individuals in the review group included alternate, non-pharmacological interventions in addition to the PBSP or PSP. In August 2021, the facility will transition to a new consent form that includes a list of alternative interventions that could be considered for an individual.

32. HRC review was documented with approvals for all medications for six individuals in the review group. Two individuals, Individual #221 and Individual #330 did not have current consent forms. The consent forms for Individual #392, dated 4/14/21, did not have HRC approval documented.

Psychology/behavioral health

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

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: For the individuals in the review group, the PCPs at Lufkin SSLC followed the State Office guidance related to the completion of interval medical reviews quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable"). If the Center sustains its progress in this area, then after the next review, Indicator c might move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
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	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: c. Per the instruction of State Office, and as memorialized in the State Office Medical Care policy #009.3, with an effective date of 2/29/20, PCPs now are expected to complete IMRs quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable"). For the individuals in the review group, the PCPs at Lufkin SSLC followed this guidance.											

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Center staff should continue to improve the quality of the annual medical assessments, with particular focus on complete and accurate social/smoking histories that document if the individual has ever smoked, updated active problem lists, and thorough plans of care for each active medical problem, when appropriate. In addition, more work is needed to ensure that the IMRs follow the State Office template, and provide necessary updates related to individuals' chronic and at-risk conditions. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
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.	50% 9/18	1/2	2/2	1/2	1/2	0/2	0/2	2/2	2/2	0/2

Comments: a. Problems varied across the medical assessments for individuals in the review group. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, childhood illnesses, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Most, but not all included family history, and past medical histories that provide accurate surgical histories. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, social/smoking histories that document if the individual has ever smoked, updated active problem lists, and thorough plans of care for each active medical problem, when appropriate.

c. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions [i.e., Individual #176 – iron-deficiency anemia, and hypertension; Individual #332 – obstructive sleep apnea, and abnormal liver function tests (LFTs)/chronic Hepatitis C/elevated carcinoembryonic antigen (CEA); Individual #454 – iron-deficiency anemia, and hypothyroidism; Individual #450 – seizures, and dependent edema; Individual #363 – macrocytic hyperchromic anemia, and seizures; Individual #441 – diabetes, and osteoporosis; Individual #271 – hyperlipidemia, and gastrointestinal (GI) problems; Individual #415 – GI problems, and macrocytic anemia due to B12 deficiency; and Individual #106 – hemochromatosis, and seizures].

The IMRs that followed the State Office template, and provided necessary updates related to the risks reviewed included those for: Individual #176 – hypertension; Individual #332 – obstructive sleep apnea, and abnormal LFTs/chronic Hepatitis C/elevated CEA; Individual #454 – hypothyroidism; Individual #450 – seizures; Individual #271 – hyperlipidemia, and GI problems; and Individual #415 – GI problems, and macrocytic anemia due to B12 deficiency.

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: 176	332	454	450	363	441	271	415	106
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

Comments: a. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions (i.e., Individual #176 – iron-deficiency anemia, and hypertension; Individual #332 – obstructive sleep apnea, and abnormal LFTs/chronic Hepatitis C/elevated CEA; Individual #454 – iron-deficiency anemia, and hypothyroidism; Individual #450 – seizures, and dependent edema; Individual #363 – macrocytic hyperchromic anemia, and seizures; Individual #441 – diabetes, and osteoporosis; Individual #271 – hyperlipidemia, and GI problems; Individual #415 – GI problems, and macrocytic anemia due to B12 deficiency; and Individual #106 – hemochromatosis, and seizures).

None of the IHCPs reviewed included action steps to sufficiently address the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.

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

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.

Summary: Annual dental exams typically included most of the required components, with the primary exception of periodontal charting. Moving forward, the Center should focus on ensuring all individuals receive periodontal charting updated within the last year, or a justification for not completing it and a plan to do so, as well as information regarding the last x-rays, including the date. Seven of the annual dental summaries included all of the required components, and the remaining two included most of the required components. These two indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	Due to the Center's sustained performance with these indicators, they moved to the category requiring less oversight.									
	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.	56% 5/9	1/1	0/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	78% 7/9	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1

Comments: b. For the nine individuals reviewed, many components of the annual dental exams were often thoroughly addressed. It was positive that for five of nine individuals reviewed, the dental exams included all of the required components. The remaining four dental exams reviewed also included all of 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;
- Number of teeth present/missing;
- Treatment provided (treatment completed);
- An odontogram; and,
- A treatment plan that addresses the individual's need.

The ADE submitted for Individual #271 indicated she did not have x-rays taken during the last year, and did not provide information to show the last time Center staff completed x-rays for her.

Center staff should also focus on ensuring the completion of periodontal charting. Based on the documentation, Individual #363 last had periodontal charting in December 2019. Individual #332, Individual #441 and Individual #271 did not have any documentation showing they received periodontal charting. Although Center staff indicated that, on 1/25/21, they completed Periodontal Screening and Recording (PSR) for Individual # 332. The Center's response to the document request stated the "PSR numbers/values could not be located in her chart." For Individual #441 and Individual #271, dental staff only noted that their behavior did not permit periodontal charting and did not discuss any plan to complete it.

For Individual #271, the State disputed the finding, and stated: "Individual # 271 Had PSR on 3/9/2021 noted on her hygiene visit for that day." Periodontal Screening and Recording allows documentation of a perio-exam without full charting. It does not provide a tooth-by-tooth assessment for later comparison. This is not consistent with the current dental audit tool, which references periodontal charting, or a plan to complete it.

c. It was positive that for five of the nine individuals reviewed, the dental summaries included all of the required components. The remaining four summaries reviewed also included all of the following:

- Effectiveness of pre-treatment sedation;

- Recommendation of need for desensitization or another plan;
- A description of the treatment provided (i.e., treatment completed);
- The number of teeth present/missing;
- Dental care recommendations;
- Treatment plan, including the recall frequency;
- Provision of written oral hygiene instructions; and
- Recommendations for the risk level for the IRRF.

Moving forward, the Center should focus on ensuring dental summaries address, as applicable, dental conditions that could cause systemic health issues or are caused by systemic health issues. The following described concerns noted:

- Individual #176 had a diagnosis of diabetes, but her annual dental summary did not describe its potential impact on oral health.

  In its comments on the draft report, the State disputed this finding, and stated: "Individual # 176 had two Dental Summaries submitted during the document request. The summary dated 1/30/2020 was before the center started to add "Conditions that affect or are affected by dental care to the annual exam" or "Relevant health history." However, the summary did discuss the number one medical condition preventing optimum care at that time; patient heart condition preventing TIVA supported care". The latest summary dated 1/28/2021 included diabetes, among other relevant medical conditions." In response to the Monitoring Team's document request #42, the Center provided one ADS, dated 1/28/21. The ADS included a section entitled *Relevant medical hx reviewed today*. It listed the following diagnoses: diabetes, cardiomyopathy, hearing impaired and hypertension. It provided no information on how these conditions were related to oral health. It simply listed four medical diagnoses.
- Individual #450 was prescribed Prolia, but the annual dental summary did not address the associated risk of medication-related osteonecrosis of the jaw. The American Dental Association published a Summary of Management Recommendations Based on Expert Opinion from the 2011 Expert Panel Report on Managing the Care of Patients Receiving Antiresorptive Therapy for Prevention and Treatment of Osteoporosis. These recommendations apply to patients treated with bisphosphonates as well as Prolia. They give specific guidance on dental practices and techniques. The first recommendation reads: "Have a discussion with patients regarding potential risks and benefits." It is important for the dentist to inform the individual/Legally Authorized Representative (LAR)/IDT about the risk of certain dental treatment, and this risk should be documented in this section of the annual dental summary.

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
a.	Individuals have timely nursing assessments:										

#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.				N/R	N/R					N/R
	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.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.										

Comments: a.i. and a.ii. None.

Outcome 4 – Individuals have quality nursing assessments to inform care planning.

Summary: It was positive that for about two-thirds of the risk areas reviewed, nurses included status updates in annual record reviews, and for more than half of the risks reviewed, the quarterly record reviews included relevant clinical data. Work is needed, though, for RNCMs to analyze this information, and offer relevant recommendations. Improvement continued with the content and thoroughness of other portions of the record reviews, as well as the annual and quarterly physical assessments. In fact, for the six individuals in the review group, their most recent quarterly physical assessments included all of the necessary assessment information. It also was positive that when individuals experienced exacerbations of their chronic conditions, nurses often completed assessments in accordance with current guidelines/standards of practice. After the next review, if the Center sustains its progress in this area, Indicator g might move to the category requiring less oversight. At this time, all of these indicators will continue in active oversight.

Individuals:

#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
a.	Individual receives a quality annual nursing record review.	33% 2/6	0/1	1/1	N/R	N/R	0/1	1/1	0/1	0/1	N/R
b.	Individual receives quality annual nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score;	50% 3/6	0/1	0/1			0/1	1/1	1/1	1/1	

	v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.										
c.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/12	0/2	0/2			0/2	0/2	0/2	0/2	
d.	Individual receives a quality quarterly nursing record review.	33% 2/6	0/1	1/1			0/1	1/1	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.	100% 6/6	1/1	1/1			1/1	1/1	1/1	1/1	
f.	On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk.	0% 0/12	0/2	0/2			0/2	0/2	0/2	0/2	
g.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	80% 8/10	1/2	2/2			0/1	2/2	1/1	2/2	

Comments: a. It was positive that two of the six annual nursing record reviews included all of the necessary components. Problems were noted with one or two components for each of the remaining assessments. All of the assessments thoroughly addressed:

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

One annual nursing record review (i.e., for Individual #176) did not include:

- Accurate information about family history.

The components on which Center staff should focus include:

- Social/smoking/drug/alcohol history (i.e., four of the assessments were missing information or included out-of-date information); and
- Immunizations (i.e., two of the assessments included incomplete information).

With minimal effort, nurses could make continued progress on the quality of the annual nursing record reviews.

b. It was positive that for three of the six individuals reviewed, nurses completed annual physical assessments that addressed the necessary components. Problems with the remaining assessments included a lack of follow-up for abnormal findings (i.e., for all three remaining individuals, including temperatures for Individual #176, and Individual #332; and pulse for Individual #363), and for one individual (i.e., Individual #363), no assessment of his gums, teeth, and mouth.

c. and f. For six individuals, the Monitoring Team reviewed a total of 12 IHCPs addressing specific risk areas (i.e., Individual #176 – constipation/bowel obstruction, and diabetes; Individual #332 – respiratory compromise, and GI problems; Individual #363 – GI problems, and circulatory; Individual #441 – aspiration, and skin integrity; Individual #271 – respiratory compromise, and GI problems; and Individual #415 – falls, and infections).

Overall, none of the annual comprehensive nursing or quarterly assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk.

- On a positive note, nurses included status updates, including relevant clinical data, for about two-thirds of the risk areas reviewed in the annual assessments (i.e., Individual #176 – constipation/bowel obstruction, and diabetes; Individual #363 – circulatory; Individual #441 – aspiration, and skin integrity; Individual #271 – respiratory compromise, and GI problems; and Individual #415 – falls), and for more than half of the risk areas reviewed in the quarterly assessments (i.e., Individual #332 – respiratory compromise, and GI problems; Individual #363 – circulatory; Individual #441 – aspiration, and skin integrity; and Individual #271 – respiratory compromise, and GI problems).
- Unfortunately, nurses often had not analyzed this information, including comparisons with the previous quarter or year (i.e., the exceptions were in the annual review for Individual #441 – aspiration, and skin integrity).
- Nurses frequently did not make necessary recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

d. It was positive that two of the six quarterly nursing record reviews included all of the necessary components. Problems were noted with one to three components for each of the remaining assessments. With minimal effort, nurses could make continued progress on the quality of the quarterly nursing record reviews. All of the assessments thoroughly addressed:

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

- Allergies or severe side effects to medication.

One quarterly nursing record review did not include:

- Accurate information about family history; and
- Up-to-date information about immunizations.

The component on which Center staff should focus includes:

- Social/smoking/drug/alcohol history (i.e., four of the assessments were missing information or included out-of-date information).

e. It was positive that for the six individuals in the review group, nurses completed quarterly physical assessments that addressed the necessary components.

g. When assessing exacerbations in individuals' chronic conditions (i.e., changes of status), nurses adhered to nursing guidelines in alignment with individuals' signs and symptoms for the following:

- On 2/27/21, when Individual #176's blood glucose level was below 70;
- On 3/23/21, when Individual #332 experienced respiratory distress and emesis;
- On 2/4/21, when Individual #332's G-tube became dislodged, and nursing staff replaced it;
- On 5/9/21, when Individual #441 had a residual greater than 100 milliliters (ml), necessitating notification of the PCP and implementation of the nursing guidelines for enteral feeding: tolerance/complications;
- On 4/5/21, when the Certified Wound Care Nurse assessed Individual #441's Stage 3 pressure injury;
- On 5/14/21, when Individual #271 experienced emesis and difficulty breathing, and subsequently was hospitalized for acute respiratory failure, hypercapnia, and pneumonitis due to inhalation of food and vomit;
- On 1/12/21, when Individual #415 fell in the shower, resulting in a loss of consciousness and lacerations, necessitating notification of the PCP and implementation of the nursing guidelines for a suspected moderate head injury, as well as skin impairment; and
- On 5/11/21, when Individual #415 complained of pain at his incision site, following gallbladder surgery.

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

- According to a nursing IPN, dated 3/9/21, at 8:15 p.m., a direct support professional (DSP) reported that Individual #176 had no bowel movement after a nurse administered a PRN Dulcolax rectal suppository at 4:00 p.m. The nurse notified the on-call PCP, who gave orders to administer 30 cubic centimeters (cc) of milk of magnesia. Based on the documentation submitted, the nurse did not follow the guidelines for constipation, because the nurse did not document the date of the individual's last documented bowel movement, or that the individual required the PRN rectal suppository. The nurse also did not conduct and/or document an assessment of the individual's intake, or whether or not she had any meal refusals. The documentation did not include results from the ordered medication. The nurse also did not document that the PCP ordered a KUB. However, on 3/10/21, in an IPN, a medical provider noted that a KUB revealed "Moderate to large colonic stool consistent with constipation>relative mechanical obstruction of more proximal colon, clinical correlation and follow-up recommended." The next nursing IPN was dated 3/10/21, at 10:56, noting that a nurse administered an ordered soap suds enema.

- On 5/13/21, at 10:30 a.m., in an IPN that described an initial assessment for constipation, a nurse stated that Individual #363 had not had a bowel movement since 5/10/21 at 10:46 a.m., despite two doses of milk of magnesia, and prune juice that morning. The nursing assessment did not include a pain assessment, abdominal assessment, or an assessment for hydration as outlined in the nursing guidelines for constipation.

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: For individuals in the review group, some improvement was noted with the inclusion of clinical indicators to be monitored, and the identification in IHCPs of the frequency of monitoring/review of progress. Overall, though, 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. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 176	332	454	450	363	441	271	415	106
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.	17% 2/12	0/2	1/2	N/R	N/R	0/2	0/2	1/2	0/2	N/R
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/12	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% 0/12	0/2	0/2			0/2	0/2	0/2	0/2	
d.	The IHCP action steps support the goal/objective.	0% 0/12	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).	42% 5/12	0/2	1/2			1/2	1/2	2/2	0/2	
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	50% 6/12	0/2	1/2			1/2	2/2	2/2	0/2	

Comments: a. through f. Most IHCPs reviewed included nursing interventions. The exception was the IHCP for falls for Individual #415, which included no nursing interventions. All were missing key nursing supports. For example, RN Case Managers and IDTs generally had not individualized interventions in relevant nursing guidelines and included in the action steps of IHCPs specific assessment criteria for regular nursing assessments at the frequency necessary to address conditions that placed individuals at risk [e.g., if an individual was at risk for skin breakdown/issues, then an action step(s) in the IHCP that defines the frequency for nursing staff to assess the color, temperature, moisture, and odor of the skin, as well as the drainage, location, borders, depth, and size of any skin integrity issues]. In

	addition, often, the IDTs had not included in the action steps nursing assessments/interventions to address the underlying cause(s) or etiology(ies) of the at-risk or chronic condition (e.g., if an individual had poor oral hygiene, a nursing intervention to evaluate the quality of the individual's tooth brushing, and/or assess the individual's oral cavity after tooth brushing to check for visible food; if an individual's positioning contributed to her aspiration risk, a schedule for nursing staff to check staff's adherence to the positioning instructions/schedule; if an individual's weight loss was due to insufficient intake, mealtime monitoring to assess the effectiveness of adaptive equipment, staff adherence to the Dining Plan, environmental factors, and/or the individual's food preferences, etc.). Significant work is needed to include nursing interventions that meet individuals' needs into IHCPs. a. The IHCPs that included interventions for ongoing nursing assessments that were in alignment with applicable nursing guidelines/standards of care were those for: Individual #332 – respiratory compromise, and Individual #271 – GI problems. b. IHCPs generally did not include preventative interventions. In other words, they did not include interventions for staff and individuals to proactively address the chronic/at-risk condition. Examples might include drinking a specific amount of fluid per day to prevent constipation, washing hands before and/or after completing certain tasks to prevent infection, etc. e. The IHCPs that included specific clinical indicators for measurement were for: Individual #332 – respiratory compromise, Individual #363 – circulatory, Individual #441 – aspiration, and Individual #271 – respiratory compromise, and GI problems. f. The IHCPs that identified the frequency of monitoring/review of progress were for: Individual #332 – respiratory compromise; Individual #363 – circulatory; Individual #441 – aspiration, and skin integrity; and Individual #271 – respiratory compromise, and GI problems.

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.	
Summary: In comparison with previous reviews, improvement was noted with the timely referral of individuals to the PNMT. It was positive that as needed, a Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results. As a result of the Center's sustained progress in this area (i.e., Round 15 – 100%, Round 16 – 88%, and Round 17 – 100%), Indicator e will move to the category requiring less oversight. The Center should focus on the timely completion of the PNMT initial reviews, completion of PNMT comprehensive assessments for individuals needing them, and the quality of the PNMT reviews and comprehensive assessments. The remaining indicators will continue in active oversight.	Individuals:

#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	100% 6/6	1/1	N/A	N/A	N/A	2/2	2/2	N/A	N/A	1/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	33% 2/6	0/1				1/2	0/2			1/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	33% 1/3	1/1				N/A	0/2			N/A
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	67% 4/6	1/1				2/2	0/2			1/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 5/5	1/1				2/2	1/1			1/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	67% 4/6	0/1				2/2	1/2			1/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/4	N/A				0/2	0/1			0/1
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/3	0/1				N/A	0/2			N/A

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

- On 2/16/21, and 2/19/21, staff reported that Individual #176 had poor intake. On 2/21/21, she vomited. On 2/22/21, she complained of not feeling well. She continued with poor intake and complained of significant abdominal pain, including on 2/23/21, lying on the floor in pain. She developed swallowing difficulties. Over time, she experienced weight loss [i.e., between 9/8/20, and 11/9/20, a weight loss of 12.2 pounds (143 to 130.8); and between 1/11/21, and 2/5/21, another 4.8 pounds]. On 2/23/21, the PCP sent her to the ED for acute onset swallowing difficulties and ileus per KUB (i.e., abdominal x-ray). She was admitted with a small bowel obstruction. On 2/26/21, she returned to the Center with diagnoses of chronic constipation, and dehydration.

On 3/2/21, the RN completed a post-hospitalization review. The recommendations were to continue the current plan, and for the PNMT to review the post-hospitalization review. On 3/9/21, the PNMT conducted a review. On 3/19/21, due to a lack of improvement in constipation, weight loss, and acute swallowing difficulties, the PNMT transitioned from a review to a comprehensive assessment. They noted that the current supports were not effective. On 3/22/21, she was sent again to the ED due to hypoglycemia. Staff found her on the floor drooling and lethargic, with a blood sugar of 40. Staff attempted to provide her with juice and glucose, but she was unable to swallow. On 4/19/21, the PNMT completed a comprehensive assessment. The sign-in sheet for the assessment included the RN's signature (i.e., on 4/16/19), and the APRN's signature (i.e., on 4/19/21). The remaining signatures were illegible. The quality of the assessment is discussed below.

- For Individual #363:
  - From 8/2/20 to 10/6/20, the individual was hospitalized for hypoxemia, and COVID-19. On 9/3/20, he had a gastrostomy-tub placed. On 10/9/20, he was diagnosed with viral pneumonia, secondary to COVID-19 with superimposed hospital-acquired bacterial pneumonia secondary to mechanical ventilation. During the hospitalization, he experienced a weight loss 12.39%. On 10/14/20, the PNMT completed a review, and found no indication to conduct a comprehensive assessment. They noted he was healing well, and the pneumonia, weight loss, and tube placement were all related to COVID-19. He was back to eating orally and tolerating this well. He was slowly gaining weight, and was within his estimated desired weight range (EDWR). He was enrolled in dysphagia therapy. The caseload SLP was also the PNMT SLP. Overall, the PNMT review included much of the necessary information. However, in order to address the individual's needs, the PNMT needed to address/recommend goals for dysphagia therapy, and specific strategies related to mealtimes to prevent aspiration.
  - On 4/6/21, the individual was diagnosed in the ED with a C1 and C2 cervical fracture. He tripped and fell during a transfer, which resulted in the cervical fracture. He was admitted and transferred to another hospital for a neurosurgery consult. On 4/12/21, he was discharged, and returned to the Center. On 4/15/21, the PNMT completed its review. The PNMT concluded that the IDT had supports in place to address his needs, and noted that he had had only two previous falls. Given the serious nature of the cervical fractures, the PNMT should have either completed a comprehensive assessment, or included a recommendation in the review to follow him for a period of time to make sure that the supports the IDT developed were in place, and that the IDT made the necessary changes to his related IHCPs.
- For Individual #441:
  - On 10/9/20, after the Pneumonia Committee confirmed aspiration pneumonia (i.e., on 10/6/20), the PNMT completed a review. A member of the PNMT was to attend a "root cause analysis" meeting that the IDT planned to hold. On 10/21/20, the PNMT RN attended the "root cause analysis" ISPA meeting. At that time, the IDT determined that he had received his enteral "feeding at a greater rate than tolerated secondary to not knowing the plan." According to the PCP, on 10/27/20, his pneumonia resolved. The IDT stated supports were effective, but staff had not followed the plan. The PNMT referred the individual back to the IDT with no further recommendations. The PNMT recommended/made no effort to monitor the implementation of his supports to determine if the issues related to following the plan were addressed satisfactorily over time.

    On 12/3/20, he had a second pneumonia, for which he was hospitalized from 12/3/20 to 12/14/20. According to the Pneumonia Committee, it was not aspiration pneumonia. The PNMT completed another review. He experienced

vomiting prior to the hospitalization, but the PNMT reported that he already had a cough with increased wet breath sounds, suggesting that he already had pneumonia and that cough was due to phlegm. While he was in the hospital, on 12/7/20, ileus was identified, which was after the pneumonia was diagnosed. He had a history of ileus resulting in aspiration pneumonia, which was previously linked to progressing Parkinson's Disease. He had excessive oral secretions, for which he was prescribed two medications. This was his second pneumonia in less than 12 months. The PNMT stated he had an elevated risk of aspiration, but this was a non-aspiration event, so a review was sufficient. They did find he had an increase in his inability to manage his oral secretions, and the PCP would follow-up regarding this finding. They made no changes or recommendations other than that they would follow up on 1/8/21.

From 5/2/21 to 5/7/21, the individual was hospitalized with sepsis, pneumonia, and hypoxia. On 5/10/21, the Committee determined it was not aspiration pneumonia. However, this was the third diagnosed pneumonia in just over six months. Especially because the PNMT did not complete a comprehensive assessment with the previous pneumonias, they should have completed one for this third pneumonia. On 5/19/21, which was seven working days after the referral, they completed a review.

- On 4/5/21, the PCP re-evaluated a pressure injury on the individual's right hand, which staff originally identified as a Stage 2 injury, and the PCP diagnosed it as a Stage 3 pressure injury. On 4/6/21, although not entirely clear, it appeared that the PNMT made a self-referral. The PNMT attended a "root cause analysis" ISPA meeting, at which the IDT identified no cause (i.e., it was unclear on what date the IDT conducted this meeting). The PNMT stated that on 4/15/21, they would reconvene and further discuss actions and the root cause of the injury. On 4/15/21, the PNMT completed a review. At that point, they provided no rationale for not completing a comprehensive assessment.

  There appeared to be discrepancies as to the actual cause of the wound. The APRN stated that the splint did not appear to cause pressure, but there was one rigid area that possibly could be the cause. On 4/5/21, the OT wrote a note stating that there was no evidence of the splint itself causing the open wound. Potential causes were staff leaving the splint on for too long, the covering having a fold in it, and/or staff using a rolled washcloth with a wrinkle instead of the splint. Also, according to video evidence, he was not wearing the splint on the morning of the day of discovery. Documentation was missing from the nurse who discovered the injury initially. No concerns were noted before discovery of the open wound. The individual's index finger did not rest on the webbing, and so, it would not be a cause, and the fingers were not tight and would not result in injury. The IDT documented: "Unable to determine a likely root cause. The hand splint is likely ruled out." On 4/25/21, the PNMT was to participate in a follow-up meeting at which time they would review post-root cause analysis follow-up to determine future level of PNMT involvement. It was not until 5/12/21, that the PNMT completed a post root cause analysis IPN. The PNMT stated the root cause was that the splint might have been on too long, but this could not be verified. The PCP discontinued the splint. On 4/30/21, the wound was considered healed.

- For Individual #106, the PNMT completed a review in relation to his femur fracture. Although the date of the referral was unclear, on 5/7/21, he returned to the Center from the hospital, and on 5/12/21, the PNMT completed a review. The PNMT stated that IDT had many supports in place and the cause of the fall/fracture was known. Specifically, he was living in a new home, and he might have misjudged the edge of the sidewalk in his power wheelchair.

The PNMT stated that the IHCP included that the nurse would consult with the PCP for variations in evaluations, and DSPs were to consult with the nurse in the event of any fall or suspected fall. DSPs also were to consult with the nurse for any swelling, bruises, discolorations, or for changes in baseline. None of these interventions were preventative or related to the accident that resulted in his femur fracture. The IDT made no revisions at the time of this event. The PNMT reviewed the PNMP, but the IDT had included none of the strategies in the IHCP. The PNMT/IDT made no reference to monitoring or evaluation of his mobility skills to navigate near his home once he was well enough to return to his wheelchair. Moreover, there was no evidence that the PNMT planned to follow his healing, and/or evaluate the effectiveness of his supports once he was able to begin using his wheelchair again. They made no recommendations.

h. As noted above, Individual #441 should have had comprehensive PNMT assessments for both pneumonia and his Stage 3 pressure injury. The following summarizes findings for the one PNMT comprehensive assessment completed for the review group:

- For Individual #176:
  - It was positive that the PNMT thoroughly addressed the following in the assessment:
    - Presenting problem;
    - Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs;
    - The individual's behaviors related to the provision of PNM supports and services;
    - Discussion of medications that might be pertinent to the problem, and discussion of relevance to PNM supports and services;
    - Evidence of observation of the individual's supports at his/her program areas; and
    - Assessment of current physical status.
  - The following describes some of the concerns noted:
    - The PNMT discussed her GI risk as medium, which it was as of the IRRF, dated 2/11/21. However, according to an addendum, dated 3/10/21, the IDT had elevated the GI risk level to high.
    - The PNMT assessment indicated that her bowel movement management strategies were not effective. However, by the time the PNMT completed the assessment, adjustments had been made, and improvements noted. It did not appear that the PNMT updated this information.
    - The small bowel obstruction was related to constipation, which was attributed to medication side effects, although the PNMT was not able to drill down to specific medications. Again, by the time the PNMT completed its assessment, the PCP had adjusted the individual's medications for bowel management, so her bowel movement pattern improved to effectively manage constipation. Her weight issue resolved, and the PNMT attributed the weight loss to GI issues, and a hospitalization during which she received nothing by mouth (NPO).
    - The assessment included a recommendation for PNMT monitoring, but did not state a timeframe (i.e., "routinely").
    - Given that the individual monitored her own bowel movements, but did not necessarily do so accurately, a recommendation for an ISP goal/objective to improve her skills in this area was warranted. However, the PNMT did not recommend such a goal/objective.

- The PNMT recommended a weight goal to “have weight management within 5% of her current weight for 3 months.” Without stating the baseline/current weight in the goal, it was difficult to measure her progress.
- In its recommendations, the PNMT made no mention of monitoring swallowing, changes to IHCP, etc.

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. The plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause(s) or etiology(ies) of the PNM issues in the action steps. In addition, many action steps were not measurable.

Eight out of nine PNMPs/Dining Plans reviewed met the requirements for quality. Given that during the previous review, the Center’s score was 89%, and problems noted during that review as well as this review were minimal, if the Center continues to make needed improvements, and sustains its progress overall, then, after the next review, Indicator c might move to the category requiring less oversight.

Individuals:

#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
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).	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2
b.	The individual’s plan includes preventative interventions to minimize the condition of risk.	17% 3/18	0/2	0/2	1/2	0/2	0/2	1/2	0/2	1/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual’s specific needs.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
d.	The individual’s ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual’s ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	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.	11% 2/18	0/2	2/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/18	0/2	0/2	0/2	1/2	0/2	0/2	1/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 risk areas, and the IHCPs, as available, to address them that nine individuals’ IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: Individual #176 – falls, and

constipation/bowel obstruction; Individual #332 – aspiration, and fractures; Individual #454 – choking, and falls; Individual #450 – choking, and fractures; Individual #363 – fractures, and aspiration/respiratory compromise; Individual #441 – skin integrity, and aspiration; Individual #271 – aspiration, and fractures; Individual #415 – weight (i.e., no IHCP), and falls; and Individual #106 – choking, and fractures.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP. The exceptions were for: Individual #415 – falls.

b. Overall, ISPs/IHCPs reviewed did not include preventative physical and nutritional management interventions to minimize the individuals' risks. The exceptions were for Individual #454 – falls, Individual #441 – aspiration, and Individual #415 – falls.

c. All individuals reviewed had PNMPs and/or Dining Plans. Eight of the PNMPs/Dining Plans reviewed fully met the individuals' needs. For Individual #106, the only component that did not meet criteria was related to communication. The PNMP provided no instructions for how staff should communicate with him. It stated that he communicated verbally, but had a mild vision impairment and borderline normal hearing in his right hear with possible mild hearing loss in the left ear.

Given that during the previous review, the Center's score was 89%, and problems noted during that review as well as this review were minimal, if the Center continues to make needed improvements, and sustains its progress overall, then, after the next review, Indicator c might move to the category of less oversight.

f. The IHCPs that identified triggers and actions to take should they occur were those for: Individual #332 – aspiration, and fractures.

g. Often, the IHCPs reviewed did not include PNMP monitoring and/or the frequency of review. Those that did was for: Individual #450 – choking, and Individual #271 – fractures.

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	176	332	454	450	363	441	271	415	106
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	50% 2/4	N/A	1/1	N/A	N/A	1/1	0/1	0/1	N/A	N/A

b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/2		N/A			N/A	0/1	0/1		
	Comments: a. and b. While return to oral intake might not be possible for Individual #441, his IDT did not provide clinical justification for the continued use of enteral nutrition or the lack of a plan to assist him along the continuum. On 8/31/99, he had a G-tube placed after a modified barium swallow study (MBSS) showed he was at high risk for aspiration and had a history of vomiting, pneumonia, and hypoxia. The 1999 MBSS was the most recent. The IDT just stated that there was no plan for him to return to oral intake at this time. They provided no new data to justify this conclusion. On 6/10/11, Individual #271 had a gastrostomy-jejunostomy tube (GJ-tube) placed due to respiratory failure and a hospitalization. She had diagnoses of dysphagia, gastroesophageal reflux disease (GERD), history of emesis, aspiration risk, hiatal hernia, and recurrent pneumonia. The IDT provided disjointed information in the summary about her continued need for enteral nutrition. For example, they cited previous hospitalizations for aspiration pneumonia, including on 10/3/17, and 5/23/19, as well as a hospitalization from 10/4/11 to 10/11/11, related to ileus and vomiting. They mentioned a "root cause analysis," on 11/18/19, at which the IDT determined that she had aspiration pneumonia due to gastric dysmotility, resulting in ileus; and acute pancreatitis, resulting in increased abdominal distension causing emesis leading to aspiration. However, then they cited an MBSS under plans to return to oral eating, dated 4/28/11. They reported at that time she was safe for Level 1 pureed foods, small bites, honey consistency fluids by spoon, and crushed pills. Positioning was a major factor in her safety. She had dysphagia level 6, meaning that her swallowing disorder did not prevent her from eating orally to meet nutritional needs, although general supervision was required to ensure use of compensatory techniques. No pooling or penetration or aspiration was noted during that study. If, at the time of the most recent ISP meeting, she had regressed and she was no longer a candidate for return to oral intake, the IDT did not provide a clear rationale for their conclusion.										

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center's maintained its progress with regard to providing the type of OT/PT assessment the individuals in the review groups needed (e.g., comprehensive versus screening or focused assessment). If the Center continues to maintain this performance, after the next review, Indicator b might move to the category requiring less oversight. The timeliness of OT/PT assessments continued to need improvement. Overall, significant improvement was needed with regard to the quality of the OT/PT assessments. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
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.	38% 3/8	0/1	1/1	0/1	1/1	0/1	1/1	0/1	N/A	0/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	N/A									
Comments: a. and b. The individuals reviewed did not consistently receive timely OT/PT assessments. The following describes concerns noted:											

- For Individual #176, Center staff completed the OT/PT assessment on 4/27/21, but this was after the annual ISP meeting held on 2/11/21.
- For Individual #454, Center staff completed the assessment on 12/10/20, but this was not at least ten working days prior to the annual ISP meeting on 12/17/21.
- For Individual #363, neither the OT and PT signed the comprehensive assessment. Only the SLP signed the assessment. The OT/PT appeared to make their last entries on 10/21/21, which was ten days before the individual's ISP annual meeting on 11/5/20, but without the needed signatures, it could not be determined when the assessment was completed and available to the IDT, and standard practice requires that OTs/PTs sign their assessments to show their approval of the information included.
- Similarly, for Individual #271, only the SLP signed/verified the assessment.

In its comments on the draft report, the State disputed these findings, and provided various reasons for the lack of signatures (e.g., "glitch in IRIS," need to change assessments after submission to the IDT). Based on the documentation submitted, the Monitoring Team could not confirm when therapists finalized the assessments.

d. None of the comprehensive assessments reviewed met all criteria for a quality assessment. Overall, significant improvement was needed with regard to the quality of the OT/PT assessments. It was positive, though, that all of the eight comprehensive assessments reviewed met criteria for providing 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. Most, but not all, also met criteria, as applicable, with regard to:

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports; and,
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale

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;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services; and,
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

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

Summary: 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	176	332	454	450	363	441	271	415	106
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	56% 5/9	1/1	0/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	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% 0/4	N/A	N/A	0/1	N/A	0/2	0/1	N/A	N/A	N/A
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	57% 4/7	N/A	N/A	0/2	N/A	4/4	0/1	N/A	N/A	N/A

Comments: a. The ISPs reviewed did not consistently include concise, but thorough descriptions of individuals' OT/PT functional statuses. Most assessments that did not score positively tended to rely on professional jargon rather than describing individuals' functional skills in a clear and concise manner that would be useful to other team members. In addition, for Individual #450 and Individual #363, the descriptions did not describe the required level of assistance for activities of daily living (ADLs). Therapists should work with QIDPs to make improvements.

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. For some individuals reviewed, excerpts from the assessments were included in the ISP with information about recommended changes. However, the ISPs did not include documentation to show the IDTs' deliberations/discussion regarding the information from the assessments. Therapists should work with QIDPs to make improvements.

c. As applicable, OT/PT assessments often did not make recommendations for OT/PT-related strategies, interventions and programs and when they did, individuals' ISPs/ISPAs did not include the strategies, interventions and programs as recommended in the assessment.

d. IDTs did not consistently meet to discuss and approve goals/objectives initiated outside of the annual ISP meeting. It was positive that the IDT for Individual #363 held ISPA meetings to discuss the implementation of goals/objectives, including on 3/9/21 (i.e., for transferring and ambulation), 2/22/21 (i.e., for standing balance), and on 2/24/21 (i.e., for sitting balance). However, the IDTs for Individual #454 and Individual #441 did not meet to discuss and approve their goals/objectives as needed.

In its comments on the draft report, the State disputed the findings for Individual #454, and Individual #441. More specifically:

- The State indicated: "For Individual #454, Direct PT services was initiated on (2/6/20) well before the document request review period (06/11/20-06/11/21). Her initial goals were discussed in ISPA from 02/06/20 with a total of 4 ISPA's completed before review period discussing therapy progress/goals, with the following ISPA's discussing her therapy with the IDT within the review period—

  07/30/20- IDT discussion regarding walking program
  08/06/20- IDT discussion regarding walking program
  08/13/20—IDT discussion re: PT services/walking program
  02/12/21—PT progress in therapy update with IDT
  03/18/21—PT Progress in therapy update with IDT
  04/22/21—PT Progress in therapy update with IDT
  07/07/21—PT discharge summary

  There is clear evidence that the IDT quite frequently reviewed and discussed goals for direct therapy services."

  The problem was that based on review of progress notes, the goals/objectives to which the IDT appeared to have agreed were not the ones that the therapist was implementing and/or providing documentation. More specifically, according to the ISPAs submitted, the individual's goals/objectives were: "Will complete sit to stand transfers and stand pivot transfers towards the right side with minimum assistance only. LTG [long-term goal] Will ambulate with Pacer Walker at least 50 feet with minimum assistance." In the notes provided, the therapist provided status updates with some measurable data for ambulation. The notes indicated that she generally required maximum assistance for transfers and sometimes refused; specific numbers related to this were not reported. The therapist's recommendations were to continue with these goals with treatment two to three times per week. However, in IPNs submitted, dated 12/7/20 through 6/9/21, the goals identified included a short-term goals (i.e., three months): Minimum assistance with stand step transfers using gait belt, and minimum assistance in ambulating at least 150 feet using Pacer Walker, and a long-term goal (i.e., six months): Minimum assistance in ambulating 300 feet using Pacer Walker. These discrepancies were not explained or reconciled in IPNs or ISPAs.
- The State indicated: "For individual #441- he never received any direct physical and occupational therapy services throughout the review period thus no indication for IDT discussion of goals. Multiple ISPA's [sic] noted regarding PNMP update/changes and Botox discussions."

  For this individual, the concern was related to the addition of the use of an elbow splint. According to IPNs, from 5/12/21 to 6/2/21, the OT and COTA applied the splint as a trial on at least five occasions. On 5/18/21, the OT stated that the purpose was to limit his elbow flexion. However, there was no documentation of an assessment or rationale for a trial by the OT prior to initiation of this treatment. There were references in various documents referring to limiting his elbow flexion, reference to elbow extension, and improvement of his range of motion to prevent future pressure injuries to his hand. The elbow separator was mentioned to maintain his range and that OT was "currently looking to see what other splint can be used." It was not clear that this other splint was explored. On 4/13/21, the "root cause analysis" attributed the Stage III pressure injury to his hand splint. Habilitation Therapy staff were to conduct further assesmsent of his current range of motion related to Botox injections to improve his range of motion and prevent furhter hand injuries. As of 6/17/21, this was listed as ongoing. Range-of-motion

measurements for his upper extremities was documented in the annual assesment dated 6/2/21. This was to be repeateed in six months but there was no reference to the status of Botox injections.

Communication

#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: For the applicable individuals reviewed, Center staff did not provide current assessments as needed. Going forward, it will be essential that SLPs provide timely and quality communication assessments in order to ensure they provide IDTs with clear understandings of individuals' functional communication status; AAC options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated. These indicators will remain in active oversight.			Individuals:								
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.	0% 0/6	0/1	N/A	0/1	0/1	N/A	0/1	0/1	0/1	N/A
b.	Individual receives assessment in accordance with their individualized needs related to communication.	0% 0/6	0/1	N/A	0/1	0/1	N/A	0/1	0/1	0/1	N/A
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following:	N/A									

	• Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.											
d.	Individual receives quality Comprehensive Assessment.	0% 0/7	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	N/A									

Comments: a through d. Individual #363 and Individual #106 had functional communication skills and Center staff completed assessments for them in 2019, which would be considered current consistent with the guidelines included in the communication audit tool.

For the other seven individuals reviewed, SLPs did not provide current assessments for review as needed. The following describes concerns noted:

- For Individual #415, who had functional communication skills, Center staff last completed a comprehensive assessment on 2/27/17. It did not document that his next assessment should be a screening, which the communication audit tool indicated would been to be completed within five years. In the absence of a recommendation for a screening, current guidelines indicate Center staff should complete an evaluation every three years.
- For the remaining five individuals, it appeared Center staff did not complete assessments during the last 12 months due to a lack of recommendations for services or supports in their last assessments. In turn, this resulted in a plan to complete the individuals' next assessments in three to five years. This was not consistent with the audit tool, which provided a maximum of three years in between assessments. In addition, the older assessments did not meet the criteria for quality assessments. Based on their needs, it appeared these six individuals required additional exploration of options, and might potentially benefit from augmentative and alternative communication (AAC) devices and/or direct therapy.

In its comments on the draft report, the State disputed these findings, and provided the dates of the assessments that the Monitoring Team reviewed. As indicated in the draft report, Center staff had not conducted quality assessments for these individuals. As a result, therapists had not provided sufficient clinical justification for delaying further assessments for three to five years.

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: For seven of the nine individuals reviewed, their ISPs provided complete functional descriptions of their communication skills. Improvement is needed with regard to the other indicators as well. 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.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/6	0/1	0/1	0/1	0/1	N/A	0/1	0/1	N/A	N/A
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	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. For seven of the nine individuals reviewed, their ISPs provided complete functional descriptions of their communication skills. The following describes exceptions noted:

- For Individual #441, the ISP did not describe how he communicated and how staff should communicate with him in a clear and concise manner that would be useful to and pertinent for, other team members, including direct support professionals (DSPs).
- For Individual #415, the ISP stated only that he communicated verbally in complete sentences. It did not state whether or not any special strategies were needed for communicating with him, nor did it outline any such strategies.

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

c. and d. Generally, individuals' assessments did not have current assessments to identify strategies to expand their communication skills, but should have. As a result, although these indicators were scored as not applicable, individuals still had unmet communication 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: Indicators 2 and 3 showed decreased performance. Both will remain in the category of requiring less oversight, but improvements are needed to return performance to the high levels seen in the past. Details are provided in the comments below for these two indicators. Performance on indicators 4 and 5 remained about the same as at the last review, which includes three-quarters of the SAPs have reliable data and all of the SAPs for two-thirds of the individuals. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	98	332	221	93	330	78	125	392	176
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.										
4	SAPs are practical, functional, and meaningful.	67% 16/24	3/3	3/3	2/3	1/3	2/2	1/2	2/3	1/2	1/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	75% 18/24	3/3	3/3	3/3	2/3	2/2	2/2	3/3	0/2	0/3

Comments:
All individuals had skill acquisition plans (SAPs). The Monitoring Team chooses three current SAPs for each individual for review. There were two SAPs to review for Individual #330, Individual #78, and Individual #392 for a total of 24 SAPs for this review.

2. The training objectives for Individual #221's wash her hair and brush her teeth SAPs, Individual #78's use a computer and recite a prayer SAPs, and Individual #392's knitting project SAP were not clear. Specifically, they did not clearly state how long the mastery criterion needed to be achieved in order to move to the next step or complete the SAP.

The training objectives for Individual #176's identify healthy activities SAP did not match the staff instructions. The objective indicated that Individual #176 would state and write the healthy activities. The staff instructions indicated that she should state **or** write the healthy activities.

3. Individual #221's FSA indicated that she could choose desired items independently. Individual #176's write why she takes her medication and identify healthy activities SAPs, Individual #392's clean her jewelry SAP, and Individual #78's recite a prayer SAP all had SAP baseline prompt levels that were identical to the training prompt level. For example, the SAP baseline indicated that Individual #78 could recite a prayer with gestural prompting and the training objective was for him to recite a prayer with gestural prompting. Therefore, these SAPs were judged to not be based on assessment results.

4. Sixteen SAPs were judged to be practical, functional, and consistent with their ISP vision statement (e.g., Individual #330's prepare Jell-O SAP). The SAPs that were judged not to be practical or functional typically represented a skill that individual already possessed (e.g., Individual #392's clean jewelry SAP), or were not clearly related to the individual's ISP vision statement (e.g., Individual #125's state his address SAP).

5. Individual #392's knitting project and clean her jewelry SAPs, Individual #176's identify why she takes a medication, making jewelry, and identifying healthy activities SAPs, and Individual #93's complete his time-sheet SAP did not have interobserver agreement (IOA) demonstrating that the data were reliable.

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: Criteria were met for two-thirds to three-fourths of the individuals, about the same performance as at the last review. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 98	332	221	93	330	78	125	392	176
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.	67% 6/9	0/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	78% 7/9	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1

Comments:
11. Individual #332 and Individual #98's PSIs and Individual #125's vocational assessment were not available to the IDT at least 10 days prior to the ISP.

12. Individual #93 and Individual #221's vocational assessments did not include recommendations for SAPs, or a rationale why vocational SAPs were not needed.

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 39 outcomes and 164 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. One outcome and 12 indicators in restraint met sustained substantial compliance and were exited from monitoring and four outcomes, 17 indicators in Psychology/Behavioral Health met sustained substantial compliance and were exited from monitoring, and two outcomes and 12 indicators in Pharmacy met sustained substantial compliance and were exited from monitoring. In addition, 23 other indicators were in the category of requiring less oversight. For this review, an additional six indicators were moved to this category, in the areas of psychiatry, dental, nursing, and physical nutritional management.

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

Goals/Objectives and Review of Progress
Because Lufkin SSLC is obtaining reliable data for some psychiatric indicators, progress can be assessed by the Monitoring Team. Most individuals were showing some progress in one of their two psychiatric goals. The Monitoring Team acknowledges the efforts of the psychiatry staff in taking action for individuals who were not meeting treatment goals.

The psychiatry providers continued to have individuals present for clinic via telehealth/video. Clinical encounters observed during the review week were comprehensive and detailed. The psychiatrist was prepared and had reviewed the case in detail prior to the clinic. There was curiosity about the individual, their life, and their progress. The psychiatrists asked questions of the team in an effort to elicit additional information.

The MOSES and AIMS assessments were completed in a timely manner, but the prescriber review of the assessments was delayed.

Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress with regard to individuals' physical and/or dental health. In other words, IDTs did not identify activities in which individuals needed to engage or skills that they needed to learn to improve their health (e.g., exercise to lose weight, improve cardiac health; learn to wash their hands or apply cream to dry skin to reduce the risk for skin infections; etc.), and then, develop goals/objectives/SAPs to measure individuals' progress with such activities or skill acquisition. In addition, integrated progress reports with data and analysis of the data generally were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

Acute Illnesses/Occurrences
The Center needs to ensure that individuals are reviewed by polypharmacy committee based on their regimen status (i.e., stable versus changes/tapers). There were inadequate justifications for polypharmacy.

For five of the six acute illnesses/occurrences reviewed, at the onset of signs and symptoms of illness, nurses conducted assessments that were in alignment with the relevant nursing guidelines. It also was positive that for the six acute illnesses/events reviewed, nursing staff timely notified the practitioner/physician of the individuals' signs and symptoms in accordance with the nursing guidelines for notification. As a result of the Center's sustained progress in this area a related indicator will move to the category requiring less oversight. One acute care plan included the necessary interventions, and met the individual's needs. Nursing staff did not address two of the six acute illnesses/occurrences with acute care plans. The remaining acute care plans were missing key interventions, and included interventions that were not measurable. Often, nurses did not implement the interventions included in the plans.

Similar to the last review, for acute illnesses/occurrences addressed at the Center, improvement was still needed with regard to PCPs' assessments. It was positive, though, that PCPs generally completed necessary follow-up for the illnesses/occurrences reviewed.

For the 11 acute events/illnesses requiring an ED visit or hospitalization that the Monitoring Team reviewed, it was positive that for six of them, the individuals received timely acute medical care, and follow-up care. For the remainder, PCPs did not provide the necessary follow-up.

Implementation of Plans
During the review period, psychiatrists participated in the development (and review) of all PBSPs.

In psychiatry, seven of the nine individuals' quarterly review documents contained all of the required components, the highest percentage yet seen at Lufkin SSLC.

In psychiatry, since the last monitoring review, the Center had taken a close look at all individuals who had medications indicated for dual usage. The Center's review resulted in all but two individuals being removed from this list. Some, however, should be re-assessed (as noted in the scoring and comments of this outcome). The Monitoring Team does not score based on the number of individuals who have medications for dual usage, but rather on whether the activities in these three monitoring indicators were occurring.

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 a 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.

Medical Department staff continue to need to make significant improvements with regard to the assessment and planning for individuals' chronic and at-risk conditions. For four of the 18 chronic or at-risk conditions reviewed, PCPs had conducted medical assessments, tests, and evaluations consistent with current standards of care, and/or identified the necessary treatment(s), interventions, and strategies, as appropriate.

For the 18 chronic or at-risk conditions reviewed for the nine individuals in the review group, IHCPs either did not address the condition at all, or did not include any medical interventions (i.e., assigned to the PCP), but all of them should have. The one intervention in the one IHCP that did assign a task to the PCP was not measurable. As a result, the Monitoring Team could not confirm completion of it.

In a couple of instances, PCPs did not review consultation reports timely. For consultation reports not received within two weeks, or sooner if clinically indicated, documentation needs to show Center staff's efforts to obtain them. It was good to see improvement with regard to PCPs writing IPNs that included the necessary content. Center staff needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

Five individuals had Type I periodontal disease, and one had Type IV. One individual was edentulous. One of the eight individuals with teeth received all of the dental care they needed.

While it was positive that Center auditors identified problems, medication administration nurses need to adhere to infection control standards of practice. Other areas that require focused efforts are the inclusion in IHCPs of respiratory assessments for individuals with high risk for respiratory compromise that are consistent with the individuals' level of need, and the implementation of such nursing supports.

Proper fit of adaptive equipment was sometimes still an issue.

Based on observations, there were still numerous instances (40% of 40 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. Often, the errors that occurred (e.g., staff not providing cues to slow individuals' eating pace, not presenting food correctly, not using methods to control bite-size, etc.) placed individuals at significant risk of harm. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Center staff, including Habilitation Therapies, as well as Residential and Day Program/Vocational staff, and Skill Acquisition/Behavioral Health staff should determine the issues preventing staff from implementing PNMPs correctly or effectively (e.g., competence, accountability, need for skill training for individuals, etc.), and address them.

Restraints

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

Psychiatry

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: Because Lufkin SSLC is obtaining reliable data for some psychiatric indicators, indicators 8 and 9 can be assessed by the Monitoring Team. Most individuals were showing some progress in one of their two psychiatric goals. The Monitoring Team acknowledges the efforts of the psychiatry staff in taking action for individuals who were not meeting treatment goals. This has been the case for a number of consecutive reviews and, therefore, indicators 10 and 11 will be moved to the category of requiring less oversight. Indicators 8 and 9 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	98	332	221	93	330	78	125	392	176
8	The individual is making progress and/or maintaining stability.	11%	1/2	1/2	0/2	1/2	2/2	1/2	2/2	1/2	1/2

#	Indicator	Overall Score	98	332	221	93	330	78	125	392	176
		1/9									
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	100% 6/6			1/1	1/1	1/1	1/1		1/1	1/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 7/7	1/1		1/1		1/1	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 7/7	1/1		1/1		1/1	1/1	1/1	1/1	1/1

Comments:
8-9. Per a review of the individual's goals and indicators as well as available data, there were individuals who were making progress toward their treatment goals. Specifically, Individual #98, Individual #330, Individual #78, and Individual #125 were progressing with regard to their indicators/goals for reduction. There were also individuals where it was apparent that goals needed adjustment or, as in the case of Individual #93, the goals were pending IDT approval. The psychiatry department did a good job of regularly reviewing the available data and the individual's progress toward their treatment goals as well as writing new/updated goals and including them in the psychiatry goals grid. The issue was that the original or updated goals were not included into the overall treatment program, the IHCP. In addition, with the recent change in a psychiatric clinician, the new psychiatrist was reviewing the case information during the annual evaluation and adjusting the psychiatric indicators and the psychiatric goals as needed.

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, environmental changes) were developed and implemented. There were individuals in the review group who were noted per their treating psychiatrist to be psychiatrically stable, however, some individuals with this designation were noted to have adjustments to their medication regimen or behavior management program. The only exceptions to this were Individual #332 and Individual #93. Both of these individuals were opined to be psychiatrically stable. Although the psychiatrist opined that there was a need to adjust Individual #93's medication regimen, Individual #93 was new to his caseload and the psychiatrist planned to check laboratory examinations/medication levels and meet with Individual #93's mother and the IDT regarding this.

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

Summary: During the review period, psychiatrists participated in the development (and review) of all PBSPs. This was an improvement compared with the last two reviews. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 98	332	221	93	330	78	125	392	176
23	Psychiatric documentation references the behavioral health target behaviors, <u>and</u> the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
24	The psychiatrist participated in the development of the PBSP.	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

		9/9									

Comments:
24. The psychiatric documentation for all nine individuals in the review group who had a PBSP included documentation regarding the individual's PBSP. Staff interviews and observation of psychiatry clinic during the monitoring visit revealed that the individual's PBSP was discussed during the psychiatric clinical encounters. In addition, attendance documentation, interviews, and observation revealed that psychiatric clinicians are regular participants in Behavioral Therapy Committee/Peer Review.

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: Since the last monitoring review, the Center had taken a close look at all individuals who had medications indicated for dual usage. The Center's review resulted in all but two individuals being removed from this list. Some, however, should be re-assessed (as noted in the scoring and comments of this outcome). The Monitoring Team does not score based on the number of individuals who have medications for dual usage, but rather on whether the activities in these three monitoring indicators were occurring. These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	98	332	221	93	330	78	125	392	176
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	0% 0/2			0/1			0/1			
26	Frequency was at least annual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	0% 0/2			0/1			0/1			

Comments:
25 and 27. These indicators applied to two individuals in the review group, Individual #78 and Individual #221. The facility reported reviewing the individuals at the facility to determine dual use designation and retaining this designation for only two individuals (neither of which were Individual #78 nor Individual #221).

- Individual #78 was previously identified as being prescribed a dual use medication. Per the last neurology consult in October 2020, he was prescribed VPA, and neurology recommended continuing this for a history of possible seizures, but then stated it was predominantly for behavioral issues. Then later in the same document, neurology stated, "from a possible seizure perspective, okay to continue Depakote..." He was later evaluated by neurology 2/5/21 with similar recommendations. The supplemental document request included the reviews of individuals removed from the dual use list stated that for Individual #78, the determination was "deferred to PCP and neurology for concerns Depakote only used for seizures pending response" when per neurology as noted above, the medication was mostly for behavioral issues.

- Although Individual #221, was not designated as having a dual use medication, it was apparent that she should be. When Klonopin was weaned in October 2019, Individual #221 experienced a grand mal seizure. She was seen by neurology in November 2020 and neurology noted that psychiatry was managing Klonopin, and the neurologist made recommendations that if psychiatry wanted to wean the medication, they could, but slowly. Given the history, this decision should be collaborative. Further, in the psychiatric documentation as of March 2021, the psychiatrist noted this medication was shared. When reviewing the list of individuals reviewed by psychiatry to determine if they needed to remain on the dual use list, this individual was not included. Even more confusing was that in the most recent psychiatric quarterly, psychiatry noted that neurology was managing Klonopin.

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

Summary: Seven of the nine individuals' quarterly review documents contained all of the required components, the highest percentage yet seen at Lufkin SSLC. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 98	332	221	93	330	78	125	392	176
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.	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	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. Seven of the examples included all the necessary components. This was good to see. The remaining two examples, regarding Individual #78 and Individual #176 were each missing one element. For Individual #78, pertinent labs were missing as the last EKG documented was from 2018. For Individual #176, the psychiatric diagnosis was documented along with the diagnostic criteria for the diagnosis. What was missing was what symptoms this individual exhibited in order to meet criteria for the diagnosis.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.

Summary: The MOSES and AIMS assessments were completed in a timely manner, but the prescriber review of the assessments was delayed. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 98	332	221	93	330	78	125	392	176
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	56% 5/9	0/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1	0/1

Comments:

36. The MOSES and AIMS assessments were completed in a timely manner, but the prescriber review of the assessments was delayed.

- For Individual #98, the AIMS dated 12/3/20 was not reviewed by the prescriber until 12/22/20.
- For Individual #221, the AIMS dated 10/5/20 was not reviewed by the prescriber until 11/2/20 and the MOSES dated 10/1/20 was not reviewed by the prescriber until 10/27/20.
- For Individual #93, the AIMS and MOSES dated 10/8/20 were not reviewed by the prescriber until 10/27/20. The AIMS dated 7/1/20 was not reviewed until 9/28/20.
- For Individual #176, the AIMS dated 7/2/20 was not reviewed by the prescriber until 8/6/20 and the AIMS 10/8/20 was not reviewed by the prescriber until 10/27/20.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary: Interim clinics were occurring, but documentation was insufficient. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	98	332	221	93	330	78	125	392	176
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?	25% 1/4						0/1	1/1	0/1	0/1

Comments:
39. There was documentation of emergency/interim clinical documentation regarding four of the individuals in the review group. The documentation from these emergency/interim clinical encounters, specifically when medication adjustments were made, were generally brief and insufficient. With the change of a psychiatric clinician at the facility, it is hoped that this will improve.

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary:			Individuals:								
#	Indicator	Overall Score									
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.										
42	There is a treatment program in the record of individual who receives psychiatric medication.										

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

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.											
Summary: Overall, performance had improved, especially over the last few months. The Center needs to ensure that individuals are reviewed by polypharmacy committee based on their regimen status (i.e., stable versus changes/tapers). These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	98	332	221	93	330	78	125	392	176
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	83% 5/6			1/1	1/1		1/1	1/1	1/1	0/1
45	There is a tapering plan, or rationale for why not.	83% 5/6			1/1	1/1		1/1	1/1	1/1	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.	67% 4/6			1/1	1/1		0/1	1/1	1/1	0/1

Comments:

44. Of the individuals participating in psychiatry clinic at the facility, 53 individuals were prescribed medication regimens that met the definition of polypharmacy.

These indicators applied to six individuals, Individual #221, Individual #93, Individual #78, Individual #125, Individual #392, and Individual #176. The polypharmacy justification for Individual #176 was insufficient. It was notable that prior to the recent psychiatric clinical staff change, most polypharmacy justifications were insufficient. The new clinician was working to remedy documentation and justification issues. This was good to see.

45. There was a documentation for the six individuals who met criteria for polypharmacy showing a plan to taper a psychotropic medication or a rationale as to why this was not considered. For Individual #176, it was noted that there was no plan to taper the regimen, but there was no documentation as to why this was not considered.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of regular meetings from June 2020 through July 2021. Although there was documentation of annual reviews of regimens meeting criteria for polypharmacy, there was no documentation of quarterly reviews when regimens were changed.

- Individual #78 was most recently reviewed 2/24/21. There was a medication adjustment to the polypharmacy regimen 6/20/20 and following this, he should have been reviewed in committee on a quarterly basis, but he was next reviewed 2/24/21.
- Individual #176 was last reviewed by polypharmacy committee in December 2020. She had multiple medication adjustments and should be on a quarterly review schedule, yet the plan per polypharmacy was to review her regimen annually.

The polypharmacy committee meeting was observed during the remote monitoring visit. The prescribing psychiatric clinician presented the medication regimens for individuals during the meeting with other information including laboratory examinations and data discussed. Overall, the meeting was comprehensive, but lacked any challenge to the current prescribed regimen. Generally, this meeting should be a brisk discussion of the regimens with the psychiatrist presenting the justification of polypharmacy for critique. 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

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

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 develop goals/objectives that reflected clinically relevant actions that the individuals could take to reduce their at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
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.	0% 0/18	0/2	0/2	0/2	0/2	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%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

		0/18									
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 #176 – iron-deficiency anemia, and hypertension; Individual #332 – obstructive sleep apnea, and abnormal LFTs/chronic Hepatitis C/elevated CEA; Individual #454 – iron-deficiency anemia, and hypothyroidism; Individual #450 – seizures, and dependent edema; Individual #363 – macrocytic hyperchromic anemia, and seizures; Individual #441 – diabetes, and osteoporosis; Individual #271 – hyperlipidemia, and GI problems; Individual #415 – GI problems, and macrocytic anemia due to B12 deficiency; and Individual #106 – hemochromatosis, and seizures).

IDTs developed clinically relevant, achievable, and measurable goals for none of these risk areas. In other words, IDTs did not identify activities in which individuals needed to engage or skills that they needed to learn to improve their health (e.g., exercise to lose weight, or improve cardiac health; engage in specific activities to stop smoking; make specific diet modifications to reduce GERD; drink a specific amount of fluid per day to prevent constipation; etc.), and then, develop goals/objectives/SAPs to measure individuals' progress with such activities or skill acquisition.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. As a result, it was difficult to determine whether or not individuals were making progress with regard to taking steps to improve their chronic or at-risk conditions, 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: It was positive that the eight individuals in the review group who needed screening for osteoporosis received it. Eight of the nine individuals in the review group had up-to-date hearing screenings. Seven of eight individuals had timely colorectal cancer screenings. Four of the nine individuals reviewed received the preventative care they needed. Although COVID-19 precautions might have impacted the provision of some preventative care, this was not consistently the reason for delays. In addition, based on interview and review of documents, Center staff did not follow the State Office directive entitled: "IDT Decision-making Related to Medical and Dental Appointments during COVID-19." For six of the nine individuals in the review group, medical practitioners reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines,	Individuals:

anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. However, this is an area that still needs improvement.											
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
a.	Individual receives timely preventative care:										
	i. Immunizations	44% 4/9	1/1	0/1	0/1	1/1	0/1	1/1	0/1	1/1	0/1
	ii. Colorectal cancer screening	86% 6/7	1/1	N/A	0/1	1/1	1/1	1/1	1/1	N/A	1/1
	iii. Breast cancer screening	67% 2/3	1/1	1/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A
	iv. Vision screen	57% 4/7	1/1	0/1	1/1	N/A	1/1	1/1	0/1	N/R	0/1
	v. Hearing screen	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
	vi. Osteoporosis	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
	vii. Cervical cancer screening	67% 2/3	1/1	1/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	67% 6/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1	0/1

Comments: a. According to the chart State Office submitted to the Monitors entitled: "Activities on Hold by Lufkin SSLC 6-30-21," on 3/16/20, Lufkin SSLC stopped consultations and preventative care, and off-campus appointments unless emergent, and then re-opened them on 3/22/21. The chart further indicated that: "The Medical Compliance Nurse maintains and generates lists of individuals who are due for preventative care testing and provides them to the providers so they can review them for medical necessity. Orders are entered for the testing to be completed after reviewed by the Provider. A drop in overall preventative care screening compliance was noted as a result of COVID restrictions on both a state office level and also locally at the hospitals. Since removal of the restrictions by state office on 03/22/2021 compliance has improved dramatically. Breast Cancer Screenings are currently the only category being tracked by the facility that is not at or above the facilities [sic] 85% compliance goal. Females ages 45-54 had dropped as low as 14% but is currently at 68% compliance as of 06/14/2021. The medical scheduler has scheduled most of those who are still delinquent as the hospital has allowed her to schedule in advance…"

The re-initiation date for off-campus appointments that the Center/State Office included on this chart appeared to be inconsistent with guidance State Office provided regarding off-campus appointments for medical and dental care. More specifically, at the Monitor's request, the Center provided a copy of the State Office directive, dated 5/27/20, entitled: "IDT Decision-making Related to Medical and

Dental Appointments during COVID-19." This directive instructed IDTs to "use a deliberate decision-making process to determine whether an individual should be scheduled to attend an off-site medical or dental appointment. The risk of exposure to COVID-19 and the Individual's level of risk should they contract the virus must be balanced with the level of urgency to the scheduled consult or procedure and the risk to the individual if treatment is delayed. The IDT should prioritize appointments based on the risk of delaying the appointment and should postpone the scheduling of any routine or non-urgent appointments, as appropriate. The Primary Care Provider and/or dental professional must be in attendance to the ISPA…" The directive identified factors for consideration when no options were available to provide the needed medical or dental service on campus, including, but not limited to: "The potential impact on the individual's overall health should an existing condition worsen, or a new condition go undetected due to delaying a screening… Whether the risks related to completion of the screening or procedure outweigh the risk of delay." Based on this directive, beginning on 5/27/20, off-campus appointments could occur, and IDTs had the responsibility to weigh the risks/benefits of delaying or moving forward with necessary preventive care and screenings (as well as other medical care and treatment). Moreover, based on review of individuals' records, a number of off-campus appointments occurred between May 2020 and March 2021. As a result, the Center's/State's use of the date of 3/22/21 as the "re-opening" date in the chart was unclear/confusing.

Based on interview and review of documents, Center staff did not follow the State Office directive referenced above. In a document request, the Monitoring Team specifically asked: "For any preventative care not completed due to COVID-19 precautions, please provide the ISPA showing the IDT risk-benefit discussion." For the nine individuals in the review group, Center staff provided no documents in response to this request. With regard to off-campus appointments, based on interview, PCPs/Medical Department staff made decisions about which appointments could be put on hold due to pandemic precautions. This was done without input from the IDTs. The PCPs requested IDT approval/input only after the PCP made the decision to reschedule the appointment.

It will be essential moving forward that staff follow the State Office procedure, and reschedule individuals for these services as soon as it is possible to do so safely.

The following provide examples of findings:

- It was positive that the eight individuals in the review group who needed screening for osteoporosis received it.
- Eight of the nine individuals in the review group had up-to-date hearing screenings.
- Seven of eight individuals had timely colorectal cancer screenings.
- For Individual #332:
    - In May 2021, she received a PPSV 23 vaccine. On 3/22/14, she received the previous dose. During the interview with her PCP, medical staff indicated that this individual likely received a second dose because she was considered immunocompromised. However, she did not receive the PCV13 vaccine. According to Centers for Disease Control (CDC) guidelines, adults with immunocompromising conditions who have already received one or more doses of PPSV23 should have one dose of PCV13 at least one year after the most recent pneumococcal vaccine dose. A second dose of PPSV23 should be administered at least eight weeks after the PCV13, and at least five years after the previous dose of PPSV23. Therefore, if this 48-year-old individual was immunocompromised, as reported by the medical staff, the CDC guidelines recommend administration of the PCV13 prior to receiving the second dose of the PPSV23. The CDC provides specific guidance on pneumococcal vaccine timing for adults at https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf.

- On 2/12/20, she had her last eye exam, which noted a cataract. The recommendation was to return in one year. Center staff did not submit an ISPA to show team deliberation about the risk-benefit of delaying or moving forward with the annual eye exam.
- For Individual #454:
  - The official immunization record did not include adequate documentation of Hepatitis B vaccination. It recorded one dose (the 3rd) of the TWINRIX vaccine. The first two doses were not recorded. The PCP stated during interview that the RNCM was responsible for updating the official immunization records. However, even the AMA did not record three doses of the TWINRIX vaccine.
  - According to the AMA, the individual's father died with colon cancer. The guardian refused consent to allow the individual to complete a colonoscopy. The IRRF stated that the guardian requested a Cologuard. Reportedly, in January 2019, a fecal immunochemical test (FIT) was negative. The PCP reported that FITs were done yearly for those eligible individuals who did not have colonoscopies. There was no documentation submitted for testing done after 2019.
- For Individual #363, the immunization record included no documentation of the tetanus, diphtheria, and pertussis (Tdap) vaccine. On 3/6/18, staff documented that consent was not obtained, and, so it was not given.
- For Individual #271:
  - According to the immunization record, she had not received the PCV13 vaccination. According to the PCP, there was also no order to obtain consent.
  - On 3/17/19, she had her last mammogram. In March 2020, she was due for a repeat. Although this was during the time that off-campus appointments were on hold, evidence was not found to show efforts to reschedule after the restrictions were lifted, or an ISPA to show team deliberation about the risk-benefit of delaying or moving forward with this preventative screening.
  - Although no report was submitted, on 5/3/19, she had her last vision exam. According to the AMA, her appointment on 4/28/20 was cancelled due to COVID-19 restrictions. However, no evidence was found to show efforts to reschedule after the restrictions were lifted, or an ISPA to show team deliberation about the risk-benefit of delaying or moving forward with this preventative screening.
  - On 6/14/18, she had her last audiology appointment, with a recommendation to return in three years. Her AMA also did not include sufficient information to show that the PCP conducted the necessary screening in the interim (i.e., "laughs or smiles when spoken to" was not specific enough).
  - On 3/29/18, her last cervical cancer screening report stated: "UNSATISFACTORY FOR EVALUATION; Insufficient cellularity. (Charges deleted, please resubmit.)" According to the AMA, on 8/3/18, the IDT completed a risk versus benefit discussion, and determined that the next pap test was due in March 2021. The IDT's rationale/justification was unclear for its determination that she should continue cervical cancer screening, but it was acceptable to delay it until 2021.
- On 12/16/19, Individual #415 had his last vision screening. When he was due for his next one, on 12/16/20, he was in isolation. It was rescheduled until 4/28/21, but he exhibited behavioral issues. He was then sick, and required surgery. As a result of these extenuating circumstances, the Monitoring Team did not rate Indicator a.iv for him.
- For Individual #106:

- He had not received the PCV 13 vaccination. On 1/17/12, and 12/21/20, this 57-year-old received the PPSV23 vaccination. During interview, the PCP was not able to state what the indication was for the revaccination. The lead NP stated it was possibly due to being immunocompromised. As explained above, according to the CDC guidelines, if the individual had an immunocompromising condition, the PCV 13 should have been administered first.
- On 4/15/19, he had his last vision exam with a recommendation to return in one year. Although in April 2020, such appointments were on hold due to COVID-19 restrictions, no evidence was found to show efforts to reschedule after the restrictions were lifted, or an ISPA to show team deliberation about the risk-benefit of delaying or moving forward with this preventative screening.

b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. In other words, the PCP should review the QDRR, provide an interpretation of the results, and discuss what changes can be made to medications based on this information, or state if the individual is clinically stable and changes are not indicated. For six of the nine individuals, PCPs had none this.

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.

Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A

Comments: a. On 2/10/14, a DNR was implemented for Individual #450 due to the diagnosis of a possible renal cell carcinoma (RCC). The documentation of the initial justification for the DNR was not provided. On 8/13/20, documentation in IRIS provided the most recent justification for the DNR. On 6/5/17, a CT showed an increase in the mass. On 12/18/17, the nephrologist recommended a biopsy of the kidney. On 1/4/18, the IDT met and made the decision to monitor the mass for three months and then repeat the CT. In April 2018, the CT was completed and showed the mass was stable. In June 2019, a CT showed a stable appearance of the mass consistent with RCC. On 10/2/19, the CT showed an increase in the size of the mass. At that time urology was consulted. The IPN summary did not provide any evidence of prior consultation with urology. On 10/2/19, the PCP noted that the recommendation of the urologist was that there should be no intervention. Reportedly, the urologist discussed this with the family. The rational for making the decision to forgo treatment in 2014 was not provided. In 2014, the individual had no evidence of metastatic disease. The PCP's final statement in the DNR note was that this condition was irreversible, and currently there was no plan to actively seek treatment. However, it should be noted that when patients present with RCC with localized disease, surgical resection can be curative. There was no rational for the decision not to proceed with further evaluation and biopsy in 2014. The documentation submitted did not provide adequate justification for the lack of evaluation and implementation of the DNR at that time.

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Similar to the last review, for acute illnesses/occurrences addressed at the Center, improvement was still needed with regard to PCPs' assessments. It was positive, though, that PCPs generally completed necessary follow-up for the illnesses/occurrences reviewed. For the 11 acute events/illnesses requiring an ED visit or hospitalization that the Monitoring Team reviewed, it was positive that for six of them, the individuals received timely acute medical care, and follow-up care. For the remainder, PCPs did not provide the necessary follow-up. If the Center sustains its progress with regard to the provision of necessary interventions prior to individuals' transfers to the ED or hospital, after the next review, Indicator e might move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
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.	40% 2/5	1/1	N/A	N/A	N/A	0/1	N/A	0/1	0/1	1/1
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	67% 2/3	1/1				N/A		0/1	1/1	N/A
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, <u>or</u> if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	100% 11/11	2/2	2/2	N/A	N/A	1/1	2/2	1/1	2/2	1/1
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	100% 9/9	2/2	2/2			1/1	2/2	N/A	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.	91% 10/11	1/2	2/2			1/1	2/2	1/1	2/2	1/1

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, this indicator 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.	100% 8/8	1/1	2/2			1/1	2/2	N/A	1/1	1/1
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.	50% 5/10	0/2	2/2			1/1	1/2	N/A	1/2	0/1

Comments: a. For five of the nine individuals reviewed, the Monitoring Team reviewed five acute illnesses addressed at the Center, including: Individual #176 (constipation on 3/9/21), Individual #363 (hip abnormality on 4/2/21), Individual #271 (pneumonitis on 4/12/21), Individual #415 (human bite injury on 4/22/21), and Individual #106 (laceration on 5/17/21).

PCPs assessed the following acute issues according to accepted clinical practice: Individual #176 (constipation on 3/9/21), and Individual #106 (laceration on 5/17/21).

b. For Individual #176 (constipation on 3/9/21), and Individual #415 (human bite injury on 4/22/21), the PCPs conducted follow-up assessments and documentation at a frequency consistent with the individuals' status and the presenting problem until the acute problem resolved or stabilized.

The following provide examples of related findings:

- On 4/6/21, at 12:16 p.m., the PCP documented an evaluation of Individual #363 for follow-up of a possible cyst to the right hip and hematoma to the right forearm. According to the PCP note, on 3/23/21, nursing staff first documented a hematoma to the right forearm. On 4/1/21, staff noted a bruise on the individual's hip, which the medical acute care (MAC) PCP assessed and believed was a possible cyst. On 4/2/21, x-rays of the right hip, femur, and forearm were completed "all with conclusion of no acute findings." On exam, the PCP noted a prominent deformity to the right posterior hip/buttocks, "appears trochanter is displaced as area is firm, immobile." The PCP further noted that the individual ambulated to the bedroom with no change in gait. However, the PCP noted: "ROM [range of motion] not otherwise assessed d/t [due to] visual indication of possible displacement." Stat x-rays of the hip femur and pelvis were pending. The plan included notification of the PT for assessment and use of a wheelchair for ambulation. Less than one later, the PCP was notified that the individual was injured during a transfer. In the records submitted, no IPN documentation was found of a PCP assessment of the individual on 4/1/21, related to a hip abnormality.

- On 4/12/21, at 4:21 p.m., the PCP documented an evaluation of Individual #271 due to hypoxia and a non-productive cough that started during the night. Nursing staff notified the on-call PCP of an oxygen saturation of 89%, and the PCP gave orders for labs and x-rays. The PCP documented a normal exam. However, there was no exam of the head, eyes, ears, nose, and throat (HEENT) other than stating the individual was normocephalic. The PCP also did not document examination of the individual's

extremities, such as the pulses or presence or absence of edema. The neurologic exam was stated to be non-focal, but pupillary responses were not documented. The chest x-ray showed minimal right lower lobe infiltrate, and labs were pending.

The assessment was pneumonia versus pneumonitis and resolved hypoxia. The PCP's plan was to start antibiotics and review the labs when received. On 4/14/21, the PCP did not examine the individual, but documented that the McGeer criteria for pneumonia were not met. The PCP considered the individual to have an illness significant enough to warrant lab work and broad spectrum antibiotics, but did not conduct a follow-up exam in 24 to 48 hours to assess her clinical status. The plan was to continue antibiotics. On 4/19/21, the PCP conducted follow-up and noted that the pneumonia/pneumonitis was resolved.

- On 4/22/21, Individual #415 was involved in a peer-to-peer altercation and sustained several bruises and abrasions. He also sustained a bite wound to the left 5th digit. Nursing staff documented cleaning the wounds, and contacting the PCP, who gave no new orders. The PCP ordered no specific interventions for the human bite wound and made no request to place the individual on list for MAC.

  On 4/23/21, nursing staff documented that the individual complained of "pain to right side." He was placed on the MAC list for further evaluation.

  On 4/23/21, the PCP evaluated the individual for complaints of pain in the right ribs and abdomen. The PCP documented that the abdominal exam was pertinent for tenderness in the right upper quadrant. The PCP also documented that the individual had a three-millimeter (mm) puncture wound of the left 5th digit. The PCP did not describe the exact location of the wound or the depth. The PCP also should have documented the motor and neurovascular status of the digit, but did not. Nursing staff did not document the degree of blood exposure, but the PCP also should have reviewed the human immunodeficiency virus (HIV), Hepatitis B, and Hepatitis C status of both individuals involved. Additionally, the PCP did not document the tetanus status of the individual. The plan for the human bite was to prescribe Augmentin for five days in addition to Bactroban. Follow-up was to occur on 4/27/21. X-rays of the ribs and a liver ultrasound were pending.

  During interview, the PCP reported that on 6/2/21, a tetanus-diphtheria (Td) booster was administered, because it had been more than five years since the administration of the Tdap vaccine, and the individual sustained a wound that was at risk for tetanus exposure. It was not clear why the risk of tetanus exposure was addressed in June 2021, and not at the time of the injury in April.

c. For seven of the nine individuals reviewed, the Monitoring Team reviewed 11 acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #176 (hospitalization for small bowel obstruction and altered mental status on 2/21/21, and ED visit for ileus and dysphagia on 3/19/21), Individual #332 (hospitalization for lower respiratory tract infection, heart failure, and sepsis on 3/23/21, and hospitalization for acute hypoxic respiratory failure secondary to aspiration pneumonia, and chronic diastolic congestive heart failure on 5/29/21), Individual #363 (hospitalization for C1-C2 fracture, and nasal fracture on 4/6/21), Individual #441 (hospitalization for pneumonia and sepsis on 5/2/21, and hospitalization for pneumonia and sepsis on 5/18/21), Individual #271 (hospitalization for aspiration pneumonia, urinary tract infection, and COVID-19 pneumonia on 5/14/21),

Individual #415 (ED visit for cholelithiasis, and abdominal pain on 4/25/21, and hospitalization for acute cholecystitis on 4/29/21), and Individual #106 (femur fracture on 5/5/21).

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

- It was positive to see that the following individuals displaying signs/symptoms of acute illness received timely acute medical care, and follow-up care: Individual #332 (hospitalization for lower respiratory tract infection, heart failure, and sepsis on 3/23/21, and hospitalization for acute hypoxic respiratory failure secondary to aspiration pneumonia, and chronic diastolic congestive heart failure on 5/29/21), Individual #363 (hospitalization for C1-C2 fracture, and nasal fracture on 4/6/21), Individual #441 (hospitalization for pneumonia and sepsis on 5/2/21), Individual #271 (hospitalization for aspiration pneumonia, urinary tract infection, and COVID-19 pneumonia, on 5/14/21), and Individual #415 (ED visit for cholelithiasis.

- On 2/21/21, nursing staff documented that a direct support professional (DSP) reported Individual #176 vomited. Nursing staff documented completion of an assessment, and initiation of the vomiting guidelines. On 2/23/21, nursing staff documented that at 3:25 p.m., the nurse and a DSP found the individual on the bathroom floor holding her stomach. According to nursing documentation, the DSP reported that the individual refused her 2 p.m. snack, and staggered from the couch into the bathroom "not too long before she was found on the floor." At 3:30 p.m., an LVN requested that the RN assess the individual because "she was not acting like herself." At 3:35 p.m., the RN inquired about giving the individual her pro re nata (PRN, or as needed) gas medication. The LVN reported that "the problem was noted to be more than gas at this time." At 4 p.m., the nurse contacted the PCP to place the individual on the MAC list for the next morning. At 4:45 p.m., the nurse found the individual on the floor next to her bed with signs and symptoms of distress. The RN arrived and completed her assessment. "Individual was lethargic at this time. RN went to call the on call doctor."

  At 5:20 p.m., the PCP evaluated the individual and documented that the individual was in bed, lethargic, and difficult to arouse. She was also "somewhat hypotensive." The plan was to transfer her to the ED via emergency medical services (EMS) for evaluation. According to nursing documentation, at 5:20 p.m., the PCP requested transfer by van, but at 5:46 p.m., the PCP called back and requested transfer by EMS.

  The individual was admitted to the hospital, and on 2/26/21, at 3:20 p.m., returned to the Center. The PCP saw her. The diagnoses were resolved small bowel obstruction, altered mental status, and chronic constipation. The note documented the admit and return dates, the diagnoses, and the physical exam. Ancillary testing, including hospital labs and radiographic studies, were listed. The PCP also documented the hospital discharge recommendations. The PCP then listed the diagnoses and the corresponding plans. The PCP did not provide a summary of the hospital events. Per State Office Medical Care policy #009.3, the PCP must summarize the events of the ED visit or hospitalization, surgeries, and any special procedures (e.g., scans, lab tests, etc.). Listing the labs and x-rays is a component of the post-hospital assessment, but does not satisfy the requirement to provide a brief summary of the hospital events. More importantly, the post-hospital note did not provide sufficient information for the IDT to understand what occurred during the hospitalization.

  The PCP's plan was to increase the individual's constipation medications. The plan did not address the abnormal labs from 2/24/21, such as the low albumin and significant anemia. The PCP also offered no discussion or plan to address the abdominal

computed tomography (CT) findings of the nodular opacities in the right upper lobe of the lung. Radiology made the recommendation to determine follow-up based on a risk assessment. On 2/26/21, and 2/27/21, the PCP saw the individual again, and reported she was doing well.

- On 3/6/21, a nurse documented that the "Nurse had to help hold [Individual #176] up for her to be able to drink the prune juice." On 3/7/21, nursing staff also documented increased drowsiness during medication administration. Nursing staff documented that on 3/14/21, the individual appeared to have trouble swallowing her pills during medication administration. On 3/16/21, the nurse found the individual on the floor on her hands and knees holding her stomach. A nurse administered a Dulcolax suppository.

  On 3/17/21, nursing staff documented "increased drowsiness while trying to give medications noted as well. It was hard for [Individual #176] to swallow the Depakote pills, and we tried one at a time with a generous amount of fluids to help get the pills down." On 3/17/21, the PCP documented a review of weights and bowel management, but did not evaluate the individual even though there was documentation of swallowing problems and drowsiness.

  On 3/19/21, nursing staff documented that a DSP reported the individual vomited while in the dining room. Per PCP documentation, at 2:44 p.m., the individual was assessed and transferred to the ED for evaluation of ileus and dysphagia. On 3/19/21, she returned to the Center. Based on the records submitted, the PCP did not conduct follow-up within 24 hours.

  Per State Office Medical Care policy #009.3: "A PCP must examine the individual within 24 hours, summarize the events of the ER visit or hospitalization, surgeries, and any special procedures (e.g., scans, lab tests, etc.). Any medication regimen changes are described and documented…. 24-hour ER return exception: If the patient returns from an ER visit (<24 hour stay) for an uncomplicated enteral tube replacement/unclogging, the PCP does NOT have to examine this patient within 24 hours. The PCP still needs to make a brief note about the ER visit."

  On 3/22/21, the PCP did not conduct a face-to-face assessment of the individual, but made an IPN entry that documented that a DSP reported the individual had been drowsy in the early evenings, and nursing staff reported difficulty with swallowing medications. The PCP documented that per speech language pathology (SLP) reports, there was no difficulty with medication administration, but significant difficulty was observed with the noon meal. The recommendation was a change in diet texture. The PCP's assessment was constipation, and the plan was to refer the individual to pharmacy for review of medications that may contribute to constipation, abdominal pain, drowsiness, dysphagia, and weight loss. The altered texture, daily bisacodyl and MiraLAX twice a day (BID) were to continue. Given the reports of drowsiness and possible new onset dysphagia, it was not clear why the PCP did not conduct an in-person evaluation.

  At 2:30 p.m., the individual was found "lying faced [sic]down on the floor next to her bed." At 3:30 p.m., she was transferred to the ED due to altered mental status.

- On 5/18/21, the PCP assessed Individual #441 who was admitted to the infirmary on 5/7/21, following a hospitalization for pneumonia. The assessment was sepsis, bacterial pneumonia versus viral pneumonia, and resolved hypoxia. Orders were

written to transfer the individual to his home. The plan included ordering a complete blood count (CBC) and albumin in two weeks.

On 5/21/21, the MAC PCP documented that the individual was being transferred to the ED for evaluation of tachycardia, fever, labored breathing, and hypoxia. The transfer occurred at 9:30 a.m.

According to the ED records, the individual arrived to the ED with a history of a gastrointestinal (GI) bleed. Staff reported removing approximately 60 ml of blood from the individual's G-tube. The individual was admitted for management of sepsis, pneumonia, and hypoxemia. According to the discharge summary, the individual had an episode of emesis prior to arrival at the hospital, and developed leukocytosis and sepsis. A single blood culture was positive, which was likely a contaminant, and the sputum culture did not grow bacteria. The individual's oxygen (O2) was weaned to 2 liters (L) by nasal cannula (NC), and enteral feedings were restarted. The individual was discharged back to the Center to continue antibiotics.

On 5/24/21, the individual returned to the Center, and the PCP saw him. The PCP documented the diagnoses of sepsis, pneumonia, and hypoxia, and listed the labs, radiographic studies, and medications from the hospitalization. The Monitoring Team learned about the hospital events from the hospital records, since the PCP did not include this information in the post-hospital note.

According to documentation for the physical exam, the individual had a productive cough. His lung sounds were diminished, but clear. The plan was to admit him to the Infirmary, start antibiotics, provide respiratory treatments, titrate oxygen, and repeat labs/chest x-ray. While he was admitted to the Infirmary, medical staff were to see the individual daily (i.e., Monday through Friday and as needed on the weekends).

On 5/25/21, the PCP documented medication changes that were made on 5/18/21, to reduce volume. In a separate note on 5/25/21, the PCP documented hospital follow-up. The individual remained on oxygen at 2L NC. The physical exam was pertinent for coarse lung sounds. The PCP added stool for fecal occult blood (FOB) times three to the plan, which otherwise remained unchanged. On 5/26/21, the PCP evaluated the individual. Volume intolerance was added as a problem, and the measures documented in the 5/25/21 IPN were listed. Medical staff followed the individual daily in the Infirmary. On 5/27/21, vomiting and possible GI bleed were added to the problem list. The diagnosis of possible GI bleed appeared to be based on the history of coffee ground residuals. Stools for occult blood times three were ordered. On 5/28/21, the provider added obtaining an upper gastrointestinal series (UGI) to the plan. The PCP documented the results of the stool testing in this note. On 6/1/21, the PCP documented the individual was off oxygen, and that one FOB was obtained and was negative. The next PCP documentation was not until 6/4/21. This was not a face-to-face evaluation, even though the individual remained in the Infirmary. The IPN addressed disturbances in salivary function, and the plan was to continue atropine.

On 6/8/21, the PCP completed the 14-day post-hospital assessment. The physical exam was normal. The individual's hemoglobin (Hb) was 12.5, albumin 3.3, and two of two FOBs were negative. The PCP's assessment was resolved hypoxia, resolved sepsis, pneumonia, GI bleeding ruled out, and volume intolerance. The PCP documented in multiple IPNs that the individual had a history of coffee ground emesis. The PCP did not document any findings related to the stool, such as melena or

a history of hematochezia. Therefore, it appeared that the concern was that the individual had an episode of upper GI bleeding. The three negative stool samples resulted in the conclusion that GI bleeding was ruled out. Negative stool tests do not rule out upper GI blood loss. The plan was to order an UGI to evaluate volume tolerance. This was the last submission (i.e., the document request went through 6/11/21).

- On 4/23/21, an ultrasound showed that Individual #415 had gallstones. On 4/25/21, due to reports of abdominal pain, cough, back pain, and black tarry stools, the PCP evaluated and referred the individual to the ED for evaluation.

  On 4/26/21, at around 2 p.m., the individual returned to the Center. The PCP saw him, and documented that the individual had "pain with slight palpation of RUQ [right upper quadrant]." The assessment was cholelithiasis. The plan was to continue Augmentin, PRN Zofran, and start Tylenol #3 for pain.

  On 4/27/21, the PCP documented that nursing staff reported the individual had an episode of severe pain the previous night and was found in the shower crying. Nursing staff gave him pain medication, and he was able to sleep. There was no change in the documentation of the physical exam. The plan was to start ibuprofen 800 milligrams (mg), and check labs on Monday. It was not clear why the PCP made the decision to prescribe 800 mg of ibuprofen to an individual with abdominal pain who had a history of gastritis and was also taking lithium.

  On 4/28/21, the PCP documented no change in the physical exam or the plan. The general surgeon saw the individual, and did not recommend a cholecystectomy. The surgeon recommended follow-up with GI for an esophagogastroduodenoscopy (EGD) and colonoscopy. The PCP indicated that there would be an attempt to get a second opinion. The ibuprofen was continued.

  On 4/29/21, nursing staff documented that the individual reported "bad pain" and requested medication. At around 3:00 p.m., the individual reported that he vomited and stated Tylenol #3 did not help. He was seen in MAC, and the PCP referred him to the ED for evaluation of acute cholecystitis. At 4:30 p.m., he was transferred.

  According to the ED notes and hospital discharge summary, the individual presented to the ED with RUQ abdominal pain. There was moderate tenderness in the RUQ on exam. The individual was admitted with the diagnoses of RUQ pain and an elevated white blood cell count. The admitting history and physical also documented RUQ tenderness. The CT scan showed no signs of cholecystitis, but the attending physician noted the individual was "significantly tender to right upper quadrant." The plan was to repeat the ultrasound in the morning and obtain a hepatobiliary iminodiacetic acid (HIDA) scan, if the ultrasound was equivocal. The ultrasound showed cholelithiasis, and the HIDA scan showed cholecystitis. Therefore, the individual underwent a laparoscopic cholecystectomy and was discharged the following day.

  On 5/4/21, at 1:23 p.m., the individual returned to the Center, and the PCP saw him. The PCP listed the diagnosis as cholecystitis with cholelithiasis. The PCP listed the various sets of data, but did not summarize the hospital course. Given that this individual had a long history of abdominal pain, it would be important to note the sequence of hospital events that led to the cholecystectomy. As noted above, the State Office Medical Care policy requires that the PCP "summarize the events of the ER visit or hospitalization, surgeries, and any special procedures (e.g., scans, lab tests, etc.)." Simply listing lab data and tests

did not summarize the hospital course, because it provided no context for the lists of information. Additionally, the PCP needs to document a plan to follow-up on the abnormal results from the hospitalization.

The plan included admitting the individual to the Infirmary, providing analgesia, as well as local wound care, and repeating the CBC. The PCP did not address the elevated liver enzymes or document a plan to repeat them to ensure that the values normalized following the cholecystectomy. At the time of the document request, the liver enzymes had not been repeated. On 5/5/21, the PCP documented that the individual complained of pain, but no other issues were documented. The plan was to await the CBC and start antibiotics if the white blood cells (WBCs) remained elevated.

On 5/6/21, the PCP documented that the individual's only complaint was incisional pain. On 5/17/21, the surgeon evaluated the individual and documented a fluid collection in the right lateral incision. Augmentin was prescribed.

- On 5/5/21, the PCP documented that nursing staff reported that Individual #106 drove his wheelchair off the end of the sidewalk. The individual fell from the wheelchair and complained of neck pain. EMS transferred him to the ED. According to the ED documentation, the individual complained of neck and hip pain. The left hip was externally rotated, and the individual experienced pain with any rotation. The individual's knee and ankle were nontender. He was diagnosed with an intertrochanteric femur fracture. Orthopedics recommended conservative treatment. On 5/7/21, the individual returned to the Center, and the PCP saw him.

  The PCP documented that the individual was diagnosed with a femur fracture. The PCP documented the procedures, labs, and radiographic studies. The plan was to admit the individual to the Infirmary, provide analgesia, and continue medications. At no point in the documentation did the PCP document the hospital evaluation and treatment. In other words, the PCP did not document that orthopedics evaluated the individual during the hospitalization determined that the individual was not a good surgical candidate, and recommended conservative management with analgesia, physical therapy, and non-weight bearing. This was important information that should have been included in the post-hospital note.

  The PCP documented multiple abnormal labs during the hospitalization, but there was no plan for follow-up to address these findings. The radiologist also reported an esophageal abnormality and recommended clinical correlation of the findings, noting that a CT of chest may be indicated based on clinical correlation. The PCP did not address this in the plan.

  On 5/8/21, the PCP evaluated the individual again. The following statement was the entire hospital summary: "[Individual #106] was transferred to ER on 5/5/21 after fall from electric WC due to reports of falling on/off curb. After evaluation in ER, it was discovered it had fx [fracture] of left femur neck. He was admitted to on [sic] 5/5/21 and was discharged back to the facility and admitted to infirmary on 5/7/21." This was not a thorough summary of the hospital events/course. Medical staff saw the individual daily while he was admitted to the Infirmary.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.	
Summary: In a couple of instances, PCPs did not review consultation reports timely. For consultation reports not received within two weeks, or sooner if clinically	Individuals:

indicated, documentation needs to show Center staff's efforts to obtain them. It was good to see improvement with regard to PCPs writing IPNs that included the necessary content. Center staff needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.											
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
b.	PCP completes review within five business days, or sooner if clinically indicated.	88% 15/17	2/2	2/2	1/1	1/2	2/2	2/2	1/2	2/2	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	88% 15/17	2/2	2/2	1/1	2/2	2/2	2/2	1/2	2/2	1/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A

Comments: For the nine individuals in the review group, the Monitoring Team reviewed a total of 17 consultations. The consultations reviewed included those for Individual #176 for cardiology on 4/23/21, and ophthalmology on 3/17/21; Individual #332 for gastroenterology (GI) on 4/14/21, and cardiology on 4/19/21; Individual #454 for pulmonology on 6/11/21; Individual #450 for renal on 12/1/20, and neurology on 4/2/21; Individual #363 for ophthalmology on 6/2/21, and pulmonary on 4/2/21; Individual #441 for ophthalmology on 1/20/21, and pulmonary on 5/4/21; Individual #271 for pulmonary on 5/14/21, and pulmonary on 4/16/21; Individual #415 for surgery on 5/17/21, and surgery on 4/28/21; and Individual #106 for hematology on 3/25/21, and pulmonary on 2/12/21.

b. The reviews that did not occur timely were for: Individual #450 for neurology on 4/2/21, and Individual #271 for pulmonary on 4/16/21.

One concern that impacted timeliness of reviews was the delay with which the reports were received. As the medical audit tool interpretive guidelines indicate: "If consultant reports are not received within two weeks, or sooner if clinically indicated, documentation should show the Facility's efforts to obtain them."

c. All but two of the PCP IPNs related to the consultations reviewed included all of the components State Office policy requires. The exceptions were for Individual #271 for pulmonary on 5/14/21, and Individual #106 for hematology on 3/25/21. Both excluded important comments from the consultants.

e. The ophthalmology consult for Individual #363, dated 6/2/21, identified dense cataracts and stated that when the individual began having trouble seeing, staff should refer him to Houston for cataract surgery under general anesthesia. The PCP should have referred this consultation to the IDT to make sure they were aware of the presence of dense cataracts that might start to impair his vision.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
Summary: Medical Department staff continue to need to make significant improvements with regard to the assessment and planning for individuals' chronic and at-risk conditions. For four of the 18 chronic or at-risk conditions reviewed, PCPs had conducted medical assessments, tests, and evaluations consistent with current standards of care, and/or identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
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.	22% 4/18	1/2	0/2	1/2	0/2	1/2	0/2	1/2	0/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #176 – iron-deficiency anemia, and hypertension; Individual #332 – obstructive sleep apnea, and abnormal LFTs/chronic Hepatitis C/elevated CEA; Individual #454 – iron-deficiency anemia, and hypothyroidism; Individual #450 – seizures, and dependent edema; Individual #363 – macrocytic hyperchromic anemia, and seizures; Individual #441 – diabetes, and osteoporosis; Individual #271 – hyperlipidemia, and GI problems; Individual #415 – GI problems, and macrocytic anemia due to B12 deficiency; and Individual #106 – hemochromatosis, and seizures).

a. For the following individuals' chronic or at-risk conditions, PCPs conducted medical assessments, tests, and evaluations consistent with current standards of care, and the PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #176 – hypertension, Individual #454 – hypothyroidism, Individual #363 – seizures, and Individual #271 – hyperlipidemia.

The following provide examples of concerns noted:

- Th AMA documented a sick-call note, done on 1/23/20, that stated Individual #176 had a mild anemia and a ferritin level of 17. The plan was to start ferrous sulfate and monitor every two to three months.

  The discussion of the assessment and plan in the AMA noted that the individual had a history of iron-deficiency anemia (IDA) that resolved with treatment. The plan was to continue ferrous sulfate, and ascorbic acid and monitor with periodic labs. The

AMA and sick-call IPN did not provide any documentation of a work-up to determine the etiology of the iron deficiency in this non-menstruating female. The PCP acknowledged during interview that the cause of the IDA was unknown, and there had been no evaluation to determine the etiology.

A number of organizations have published consensus guidelines regarding the evaluation of IDA. These guidelines note that there are a number of potential causes of IDA. The most common cause in men and postmenopausal women is blood loss from the GI tract. Organizations, such as the American Gastrological Association, provide guidelines for evaluation of patients with IDA in whom no obvious cause of the IDA has been identified.

This PCP's assessment and plan did not meet the criteria outlined in State Office Medical Care policy #009.3 that states: "A Plan of Care in the Annual assessment needs to be completed for every Active Problem. The Plan of Care needs to mention: all current medications for each diagnosis, if applicable (dosages do not need to be mentioned), current treatments, any future consultations/treatment options for the diagnosis, and if the condition is stable, worsening or improving." The policy further states that each problem should be summarized in detail, include past and current relevant information, and provide a plan of care specific to the problem.

- According to the AMA, Individual#332 was diagnosed with obstructive sleep apnea (OSA) and was treated with bilevel positive airway pressure (BiPAP) that was to be used at night and for nap times. The PCP's plan only noted that the individual was followed by pulmonary. The PCP provided no discussion of her current status. The PCP should have documented the individual's adherence to and the efficacy of the treatment, but the AMA included no information on either. Adherence is assessed based on the number of hours the therapy was used. Efficacy is measured through desired treatment outcomes, such as resolution of signs and symptoms of OSA, the apnea-hypo apnea index, and pulse oximetry. Additionally, the PCP should have included some information related to the maintenance of the device, such as how often the mask and tubing should be cleaned and/or replaced.

- The PCP documented that Individual #332 had a history of "chronic viral hepatitis C," and received treatment several years ago. The PCP documented that a GI referral was "established for elevated liver enzymes since 2018 that are worsening." The "liver fibrosis panel showed little activity, minimal fibrosis with no recommendations." At the time of the AMA, a GI appointment was pending on 2/10/21. The plan included obtaining new liver enzymes, discontinuing Tylenol, and educating DSPs on signs and symptoms of liver failure.

  The AMA did not document the dates of treatment for Hepatitis C, the type of treatment, or if the individual had achieved a sustained virologic response. Follow-up for Hepatitis C is largely based on whether the individual achieved a sustained virologic response (i.e., undetectable viral level). This information should have been included in the discussion of relevant information.

  The records included a consult IPN, dated 2/10/21. The IPN addressed a consult, done on 12/9/20. The PCP documented that the consultant stated "[Individual #332] has very little fibrosis or activity of her liver tests. At this point, we do not need to do anything further." The actual consult (dated 12/9/20) stated that the individual had elevated LFTs especially alkaline

phosphatase. The consultant noted a physical exam with no hepatomegaly and flexion contractures. The consultant indicated that further labs would be obtained.

The AMA documented that the CEA was elevated. During interview, medical staff did not have an explanation or indication for obtaining a CEA level.

On 2/10/21, the GI consultant documented that the labs showed no evidence of iron overload or Hepatitis C. The presumptive diagnosis based on the elevated antinuclear antibodies (ANA) was autoimmune hepatitis.

- According to the AMA, Individual #454 was diagnosed with iron-deficiency anemia that was treated with ferrous sulfate and ascorbic acid, which were started on 11/24/19.

  The ferritin level documented in the AMA was 6.3. The AMA provided no documentation of an evaluation to determine the etiology of the IDA. In January 2019, the individual completed a FIT that was negative. During interview, the PCP acknowledged there was no documentation of an evaluation to determine the etiology of the IDA. The lead Nurse Practitioner (NP) reported that FIT testing was done annually for those eligible individuals who did not have a colonoscopy done. However, reportedly, the most recent FIT for this individual was done in January 2019. As noted above, a number of organizations have published consensus guidelines regarding the evaluation of IDA. The most common cause of IDA in men and postmenopausal women is blood loss from the GI tract. The individual's father died with colon cancer.

  The plan for this individual was training for DSPs on identifying the signs and symptoms of anemia, and to monitor the CBC every six months.

- In the AMA completed on 8/20/20, the PCP documented that Individual #450: "was diagnosed with seizure disorder by history of witnessed seizure events, abnormal EEG [electroencephalogram] or a history of congenital causes such as brain malformation/head trauma, CNS infection." Based on this statement, it was not clear how the individual was diagnosed with a seizure disorder. There was no documentation in the records of a congenital brain malformation or central nervous system (CNS) infection. The PCP also did not document the seizure classification.

  The PCP went on to state that the individual experienced one seizure in the past year and did not have a vagus nerve stimulator (VNS). However, the PCP noted that: "He is seen by neurologist and VNS has been discussed." Again, it was not clear why there was discussion of a VNS for an individual with one seizure in the past year. Additionally, the PCP noted: "[Individual #450's] seizures have worsened over the past year in that he did experience 1 seizure; whereas, the previous year he did not experience any." The neurologist made the recommendation to wean the individual off Keppra and follow-up with neurology as needed. The PCP did not document any disagreement with the recommendation to discontinue the anti-epileptic drug (AED). Overall, this discussion was fragmented, and the Monitoring Team could not determine when the recommendation to taper the Keppra was made, implemented, or completed relative to the date of the AMA.

On 9/6/20, the individual experienced a seizure. In the IMR, dated 11/19/20, the PCP documented that on 9/10/20, a neurology consult was completed for "Evaluation for break through seizures was weaned off Keppra." The recommendation was to continue Keppra indefinitely.

- According to the AMA, Individual #450 was diagnosed with dependent edema for which he was prescribed daily furosemide. The PCP did not document the extent of the edema or identify the etiology of the dependent edema. The physical exam noted that there was no edema present, and there was no documentation of the hallmark signs of venous insufficiency. Medications such as amlodipine, which he was prescribed, can cause edema of the lower extremities, as well as a number of other medical conditions. Understanding the etiology of the edema is necessary to ensure that proper treatment is provided. The PCP's plan was for nursing staff to monitor for increased edema, and notify medical staff if it did not resolve with elevation of the legs. Electrolytes were to be monitored.

- According to the AMA, Individual #363 was diagnosed with a macrocytic hyperchromic anemia. His hemoglobin (Hb) and hematocrit (Hct) were 8.8 and 27.4, respectively. The PCP documented iron studies required to evaluate a microcytic anemia, but did not document the red blood cell (RBC) indices or lab values, such as B12 and folate levels, that are needed to further evaluate a macrocytic anemia. The plan was to repeat the CBC and review the peripheral smear.

  On 10/8/20, the labs done documented normal B12 and folate levels. On 10/19/20, the labs documented a Hb/Hct of 9.3/27.7 with a mean corpuscular volume (MCV) of 98.3. On 10/14/20, the pathologist reviewed a peripheral smear, and reported a "Macrocytic anemia as in liver disease vs B12/folate deficiency. Eosinophilia as in infection drug effect vs allergy." The PCP documented this in the IMR, dated 1/20/21. The PCP did not document a plan to address these findings.

  On 4/20/21, the most recent labs documented a Hb/Hct of 10.4/33 with normal red blood cell indices. In an IPN, on 4/22/21, the PCP documented that the anemia was stable. There was no discussion of the etiology or a plan to determine the cause of the anemia.

- The PCP stated in the AMA, dated 5/31/21, that Individual #441 was maintained on metformin 500 mg BID for prediabetes with the most recent A1c of 6.2 on 5/17/21. The PCP subsequently documented that "recent A1c is elevated, moving him from prediabetes to diabetes." The plan was to repeat the A1c to determine if illness was affecting his blood sugar, and "If the level remains PCP will increase his metformin dosing as well as changing his diagnosis." In the records reviewed, the most recent A1c was 6.2. An A1c of 6.2 did not meet the definition of diabetes. The PCP should review the A1c criteria for prediabetes and diabetes.

- The PCP documented in the AMA that Individual #441 was diagnosed with osteopenia based on a T-score of -0.4. The T-score was obtained from an ultrasound (US) bone mineral density (BMD) performed on 9/10/19. The individual was treated with Prolia, and calcium. He also received Vitamin D 50,000 international units (IU) monthly. However, the PCP did not document the individual's calcium and Vitamin D levels in the assessment. There was no plan of care specific to the problem as required by the State Office Medical Care policy. The plan should have documented if the medications would be continued, as well as the plan for future testing/diagnostics and consults.

The Prolia package insert recommends 400 IU of Vitamin D daily. On 5/17/21, and 11/30/20, the individual's Vitamin D level was 86. This was significantly higher than the target of 30 to 50 recommended in the State Office osteoporosis guidelines. The guidelines require that PCPs provide a justification when recommending a higher level.

As discussed with the PCP during interview, a T-score of -0.4 is a normal score and is not consistent with the diagnosis of osteopenia. The PCP reported during interview that on 7/19/17, a DEXA was done and the left femoral neck T-score was -3.7, and the right femoral neck T-score was -4.2. The significant difference in BMD measured by US and DEXA (i.e., two years apart) underscores the lack of reliability in using US to follow BMD.

- Per PCP documentation in the AMA, Individual #271 was diagnosed with GERD for which she was prescribed a proton pump inhibitor (PPI) to be administered every 24 hours. The PCP documented that there was a reduction in emesis and hypersalivation. The PCP did not document how often the emesis occurred. During the previous year, the individual was diagnosed once with aspiration pneumonia after emesis. The PCP noted that management of GERD included weight loss (if overweight), and raising the head of the bed by six to eight inches or by the GERD precautions from the PNMT. These represented generalized principles for the management of GERD. The PCP should have included in the plan the specific measures that this individual required. Those were not documented in the plan of care.

  Many aspects of GERD management require a physician's order. For example, PPIs are most effective when administered on an empty stomach, 30 to 45 minutes prior to the first meal. If this was appropriate for this individual, the PCP should have clearly noted this in the plan of care and medication order.

- According to the AMA, Individual #415 was diagnosed with mixed irritable bowel syndrome/unspecified abdominal pain. The AMA documented the individual's complaints of abdominal pain, nausea, vomiting, and diarrhea starting in March 2020.

  Numerous diagnostics were performed, and in 2020, the individual was evaluated in the ED multiple times. The PCP did not provide a summary by discussing the individual's symptoms, the diagnostics performed, or the results of the diagnostics. Rather, the PCP simply cut and pasted the recommendations from the GI consult, completed on 12/1/20. The recommendations included avoiding narcotics, starting a probiotic, providing a lactose-free diet, and checking stool studies. The plan also included referring the individual to an internal medicine physician. Per the IRRF, the individual was awaiting an appointment with an internal medicine doctor. Pasting the plan from the most recent GI consult did not provide the necessary clinically relevant information, and did not sufficiently document the breadth of the work-up that was done over the previous year. For example, it would be important to document in the summary that this individual with recurrent abdominal pain had undergone an upper endoscopy that demonstrated gastritis, had a CT of the abdomen, and was diagnosed with cholelithiasis. This assessment and plan did not meet the criteria as outlined in the State Office Medical Care policy. During interview, the PCP acknowledged that the individual had complaints of abdominal pain since early 2020. He underwent a cholecystectomy on 5/3/21.

- In the AMA, the PCP documented that Individual #415 was diagnosed with a macrocytic anemia due to B12 deficiency. The AMA assessment did not provide any evidence that the cause of the B12 deficiency was investigated in this very young man.

  There are numerous causes of B12 deficiency, such as inadequate dietary intake, pernicious anemia, and malabsorption. Once the diagnosis was established, there should have been additional testing to determine the cause. The PCP's plan was to start vitamin B12 supplementation, and recheck the CBC and B12 levels in six months. There was no plan to evaluate the cause of the B12 deficiency.

  On 2/11/21, the individual had a hematology evaluation for follow-up of leukocytosis. The consultant noted that the individual had a low B12 level. Due to the low B12 level, history of diarrhea, and abdominal pain, the consultant ordered additional studies to evaluate the individual for pernicious anemia and celiac disease. During interview, the PCP reported that the work-up was negative.

- Individual #106's AMA listed hemochromatosis as an active and stable diagnosis. The discussion and plan section included the diagnoses of "anemia/hemochromatosis." There was no discussion of the diagnosis of hemochromatosis, the treatment that was provided, or a plan of care for the diagnosis.

  On 3/25/21, a hematology consult was completed. The consultant noted that the individual was diagnosed with hereditary hemochromatosis based on being homozygous for the HFE C282Y mutation. This is an inherited disorder that causes increased intestinal iron absorption that can eventually lead to serious organ damage. Individuals with hereditary hemochromatosis remain at risk for iron overload throughout their lives. This is an active diagnosis due to the need for lifelong monitoring.

  The PCP provided no plan of care related to hemochromatosis. Typical management includes attention to dietary changes, and avoiding the use of multivitamins, Vitamin C supplements, and iron supplements. Periodic monitoring of the individual's iron level is required.

  On 3/25/21, the consultant noted that the last iron level in 2019 was normal. He further noted that the individual would not be seen at the next appointment if results were not available. It appeared that Center staff had not provided the results of the December 2020 iron studies to the consultant. The State Office Medical Care policy details the expectations of the PCP with regard to requesting consultations. One requirement is for the PCP to "provide any pertinent lab data or information from other clinical disciplines."

- In the AMA, dated 12/17/20, the PCP documented that Individual #106 "was diagnosed with seizure disorder by history of witnessed seizure events." The PCP did not document the seizure classification. Moreover, based on the PCP's statement of how the diagnosis was made, it appeared that the individual had not had an EEG. With regard to seizure frequency, the PCP noted that from 12/9/19 to 12/4/20, the individual had four seizures with the last seizure occurring on 12/25/19. According to documentation, the PCP reviewed the seizure logs and "he has had an increase since last year."

On 12/17/20, the neurologist evaluated the individual and documented the last seizure was in November 2019. The recommendations were to continue current medication, monitor labs, and follow-up in one year.

All of the IMRs reviewed documented that the last seizure occurred on 7/10/16. During interviews, Center staff reported that Medical Department LVNs assisted with data entry into the IMRs. The PCPs should ensure that the information is accurate and make corrections as necessary.

As noted above, per the current State Office Medical Care policy, each active problem should be summarized in detail, and include past and current relevant information, as well as a plan of care specific to the problem. Historical information, such as the results of the EEG, if performed, accurate data on seizure frequency, and the seizure classification (e.g., generalized, partial) would be considered relevant information. It would also be relevant to document why an EEG was not performed, if that were the case.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
Summary: For the 18 chronic or at-risk conditions reviewed for the nine individuals in the review group, IHCPs either did not address the condition at all, or did not include any medical interventions (i.e., assigned to the PCP), but all of them should have. The one intervention in the one IHCP that did assign a task to the PCP was not measurable. As a result, the Monitoring Team could not confirm completion of it. 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	176	332	454	450	363	441	271	415	106
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A
Comments: a. For the 18 chronic or at-risk conditions reviewed for the nine individuals in the review group, IHCPs either did not address the condition at all, or did not include any medical interventions (i.e., assigned to the PCP), but all of them should have. In the one IHCP that did assign a task to the PCP, the one intervention was not measurable. More specifically, Individual #415's IHCP for GI problems included an intervention that read: "Medical tests/procedures as indicated." As a result, the Monitoring Team could not confirm completion of it.											

Pharmacy

As indicated in the last report, based on the Center's scores for three monitoring cycles, the Center achieved substantial compliance with most of the requirements of Section N of the Settlement Agreement. The exceptions are Section N.6 related to

adverse drug reactions, and Section N.8 related to medication variances that the Monitoring Team will review as part of Section E. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Lufkin SSLC exited from the other requirements of Section N of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the outcomes and indicators related to the exited provisions of the Settlement Agreement.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental goals/objectives. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/8	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% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	

Comments: a. and b. Individual #106 was edentulous and did not require a dental goal/objective. For the remaining eight individuals reviewed, all had elevated dental risks due to periodontal disease (i.e., five had Type I, and one had Type IV), poor to fair oral hygiene, and/or multiple teeth lost in the past year (i.e., for Individual #415). None of the eight individuals had clinically relevant, achievable, and measurable goals/objectives related to these dental risks.

In order for IDTs to demonstrate that a goal/objective is clinically relevant, the IDT needs to document baseline data in the IRRF, ISP, or ISPA, and the goal/objective would need to reflect the reason why the individual is at risk with regard to their dental health. For example, if the individual is not brushing his/her teeth at the recommended frequency or for the recommended duration, is it due to a skill deficit? If so, then the IDT needs to develop a skill acquisition plan (SAP) to address the individual's specific skill deficit. Or rather, is it an issue related to the individual's ability to tolerate staff brushing his/her teeth? If so, then the IDT needs to develop a goal/objective to increase the individual's tolerance for tooth brushing. Does the individual need to brush a certain part of their mouth better (e.g., back teeth)? If so, the IDT needs to develop a goal to address this specific need, and specify whether staff will do the

brushing, or the individual will improve their skill or completion of this task. Does the individual brush his/her teeth well, but they never floss? If so, then baseline data should show this, and the IDT should develop an objective related to flossing, and again look at whether or not it is a skill deficit, or that the individual does not follow a routine that incorporates flossing. For the individuals for whom IDTs developed goals/objectives, IDTs had not identified the underlying cause of the dental problem.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, integrated progress reports on existing goals with data and analysis of the data generally were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For all nine individuals, the Monitoring Team conducted full reviews of the processes related to the provision of dental supports and services. Individual #106 was edentulous (i.e., had not achieved positive dental outcomes), so a full review was also conducted for him.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	N/R									
	c. As indicated in the dental audit tool, the Monitoring Team will only score this indicator 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: Seven of eight individuals reviewed did not receive one or more components of needed dental treatment. However, due to sustained performance with regard to the provision of tooth brushing instruction (i.e., Round 15 - 89%, Round 16 -100% and Round 17 – 100%), Indicator b will move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
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.	63% 5/8	1/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1	N/A
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A

c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	50% 4/8	0/1	0/1	1/1	1/1	1/1	0/1	0/1	1/1	N/A
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	50% 1/2	1/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A
e.	If the individual has need for restorative work, it is completed in a timely manner.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.										

Comments: a. through d. It was positive that all applicable individuals reviewed and/or their staff received twice-yearly tooth brushing instruction from Dental Department staff. However, otherwise applicable individuals reviewed did not receive one or more of the other components of needed dental treatment. The following provide examples of concerns noted:

- Individual #332, Individual #450, and Individual #441 did not have twice-yearly prophylactic care.

  The State disputed these findings in its comments on the draft report. The following provide comments on each of the State's assertions:
  - The State indicated: "Individual # 332 had 2 prophylactic visits; on 10/13/2020 & 3/19/2021." According to the Dental Director, the individual had no clinic appointments from July 2020 to October 2020. It was noted that on 10/13/21, treatment was provided which consisted of brushing with suction tooth brushing, and application of Biotene and fluoride. The individual had G-tube deposits, and it was documented that it was not safe to perform scaling. On 3/19/21, the visit also involved tooth brushing, but no scaling.
  - The State indicated: "Individual # 450 had a combined appointment (Exam and hygiene visit) on 8/12/2020. See the notes for 'Hygiene visit: brushing with Colgate paste; irrigation with chlorhexidine; fluoride application - all done by RDH with appropriate suction,' and a 2nd hygiene visit on 2/9/2021." The documentation for the 8/12/21 visit noted that brushing was done. A note stated: "CAVITRON would have been indicated and would have been the instrument of choice and very useful and would have allowed me to remove a great deal of the calculus… When he returns in 4 months, Cavitron scaling will be completed if ultrasonic use is being allowed." During the 2/9/21 appointment, there was an attempt to scale the teeth, but it was not completed.
  - The State indicated: "Individual # 441 Multiple attempts were made but were unsuccessful due to multiple reasons varying from care refusal, home restriction, hospital, and infirmary stay. However, patient health remains to be the main barrier to care at this time." On 6/10/20, the individual was seen in the clinic and had brushing with Spry. On 6/2/21, he was also seen in clinic and had brushing only.
- Individual #176, Individual #332, Individual #363, Individual #441, and Individual #271, did not receive needed x-rays.

  The State disputed some of these findings in its comments on the draft report. The following provide comments on each of the State's assertions:
  - The State indicated: "Individual # 332 is a recall adult partially edentulous patient with no clinical caries and has a low risk of developing caries; ADA recommendations are Posterior bitewing exam at 24-36 month intervals. Her last

radiographic exam was during her annual on 1/30/2020, and by ADA recommendation, her next due date should be on or before 1/30/2023. However, her treatment plan indicates a due date of 1/2022 at the 24-month interval, a strategy we have for most of our patients to obtain their x-rays within the recommended ADA time and not wait for the cutoff date of 36 months." This individual had 28 teeth, and was missing three 3rd molars. During interview, the Dental Director was unable to provide any evidence that full mouth x-rays were ever completed.

  - The State indicated: "**Individual # 363** is a recall adult partially edentulous patient with no clinical caries and has a low risk of developing caries; ADA recommendations are Posterior bitewing exam at 24-36 month intervals. His last radiographic exam was on 12/11/2019. His previous fillings were to repair fractured old restorations, and his previous new cavity was on 8/18/2016. He is caries-free and was rated low for dental caries on his previous annual exam. Based on ADA recommendation, his next due date should be **on or before 12/10/2022**." Per the annual dental summary, there was a watch placed on tooth #14. The ADS documented that x-rays were due in December 2021, which is not consistent with the comments that x-rays are due in 12/2022. The Monitoring Team revised the score, but the discrepancy between the plan and the comments should be reconciled.
  - The State indicated: "**Individual # 271** is a recall adult partially edentulous patient with no clinical caries and has a low risk of developing caries; ADA recommendations are Posterior bitewing exam at 24-36 month intervals. Individual 271 had a posterior bitewing exam and lower anterior PA (missing upper anterior teeth) on 3/9/2021." The IPN, dated 3/9/21, did not document that x-rays were completed. Moreover, the Dental Director stated during interview that the last x-rays were three bitewings, completed on 6/28/18, and the individual was due for x-rays with her July 2021 ADE. It was also reported that there was no documentation of full mouth x-rays. The annual dental summary, completed on 7/20/20, documented in the treatment plan that "radiographs will be attempted at her next appointment." The annual dental exam, completed on 7/2/20, documented in the treatment plan that radiographs were "Due now."

- Based on his annual dental summary, Individual #415 had a high risk for caries, with multiple caries in the past 36 months. He did not receive at least two topical fluoride applications per year. The individual brushed daily with a prescription fluoride toothpaste, but his treatment plan also required the application of fluoride varnish. His last documented fluoride treatment occurred in June 2020.

  The State disputed this finding, and stated: "**Individual # 415 Technically did receives two topical fluoride applications per year on <u>6/17/2020.</u>** However, that was not by design; patient's refusal and multiple broken appointments and at times, homes were under restriction during the pandemic, which did not allow more appropriate intervals." The State did not explain what the dentist meant by technically he received two topical fluoride applications per year on 6/17/2020, but it was "not by design." If he received two applications on 6/17/20 by error, then this should be reviewed as a medication error.

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106

a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A									
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A									
Comments: b. and c. Based on the documentation provided, during the six months prior to the review, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed experienced a dental emergency.											

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	176	332	454	450	363	441	271	415	106
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% 0/3	N/A	0/1	N/A	N/A	N/A	0/1	0/1	N/A	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/3		0/1				0/1	0/1		
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/3		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% 0/3		0/1				0/1	0/1		
Comments: a. and b. For the three applicable individuals, IDTs did not include suction tooth brushing strategies/plans in their ISPs/IHCPs. Although it appeared that each of the individuals received suction tooth brushing, in the absence of action plans that defined the needed schedule, the Monitoring Team could not evaluate whether Center staff provided this service with the appropriate frequency or duration. c. While it appeared each of the applicable individuals reviewed received at least one monitoring for suction toothbrushing, as indicated above, they did not have ISP action plans that defined the frequency of monitoring expected to meet the individuals' needs. Since the inception of the Dental Audit Tool, in January 2015, the interpretive guidelines for this indicator have read: "Frequency of monitoring should be identified in the individual's ISP/IHCP, and should reflect the clinical intensity necessary to reduce the individual's risk to the extent possible." Moving forward, IDTs should ensure that individuals with suction tooth brushing have IHCPs that define the frequency of monitoring and it is implemented according to the schedule.											

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

Outcome 9 – Individuals who need them have dentures.											
Summary: For the individuals reviewed with missing teeth, the Dental Department generally provided clinical justification for not recommending dentures. Due to the Center's sustained progress (i.e., Round 15 – 100%, Round 16 – 100%, and Round 17 – 89%), Indicator a will move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. It was positive that most individuals reviewed who were missing teeth received an assessment for dentures, and that those assessments included a clinical justification when the decision was to not provide them. The exception was for Individual #363, who was missing his upper left central incisor. The annual dental examination indicated only that the assessment to determine the appropriateness of dentures was not applicable. It did not provide any evidence that Dental staff consulted the individual, who had functional communication, or the IDT, to determine if he might desire to have a replacement for this visibly-missing tooth.											

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: For five of the six acute illnesses/occurrences reviewed, nurses conducted assessments at the onset of signs and symptoms of illness that were in alignment with the relevant nursing guidelines. It also was positive that for the six acute illnesses/events reviewed, nursing staff timely notified the practitioner/physician of the individuals' signs and symptoms in accordance with the nursing guidelines for notification. As a result of the Center's sustained progress in this area [i.e., Round 15 – 100%, Round 16 – 67% (i.e., 4/6), and Round 17 –	Individuals:

100%], Indicator a will move to the category requiring less oversight. One acute care plan included the necessary interventions, and met the individual's needs. Nursing staff did not address two of the six acute illnesses/occurrences with acute care plans. The remaining acute care plans were missing key interventions, and included interventions that were not measurable. Often, nurses did not implement the interventions included in the plans.											
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	83% 5/6	1/1	0/1	N/R	N/R	1/1	1/1	1/1	1/1	N/R
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	100% 6/6	1/1	1/1			1/1	1/1	1/1	1/1	
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	25% 1/4	N/A	0/1			N/A	0/1	1/1	0/1	
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	50% 1/2	1/1	N/A			0/1	N/A	N/A	N/A	
e.	The individual has an acute care plan that meets his/her needs.	17% 1/6	0/1	0/1			0/1	0/1	1/1	0/1	
f.	The individual's acute care plan is implemented.	17% 1/6	0/1	0/1			0/1	0/1	1/1	0/1	

Comments: The Monitoring Team reviewed six acute illnesses and/or acute occurrences for six individuals, including Individual #176 – ED visit for hypoglycemia on 3/22/21; Individual #332 - excoriation of right axillae on 12/6/20; Individual #363 – hospitalization for fall with fractures of C1-C2 vertebrae and nose on 4/6/21; Individual #441 – Stage 2 pressure injury to webspace of right thumb and index finger on 4/2/21; Individual #271 – respiratory distress with diagnosis of pneumonitis on 4/12/21; and Individual #415 – human bite wound resulting from peer-to-peer aggression on 4/22/21.

a. It was positive that for most of the acute illnesses/occurrences reviewed, nurses performed the initial nursing assessments (physical assessments) in accordance with applicable nursing guidelines. As discussed further below, the exception was for Individual #332 - excoriation of right axillae on 12/6/20.

b. It was also positive that for the six acute illnesses/occurrences, licensed nursing staff timely informed the practitioner/physician of signs/symptoms in accordance with the SSLC nursing protocol entitled: "When contacting the PCP."

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

- On 3/22/21, a DSP asked the nurse to assess Individual #176, because they found her face-down on the floor beside her bed. The LVN notified the RN, who assisted with the assessment, which they conducted according to related nursing guidelines. The assessment showed that the individual's blood sugar was 40, her blood pressure was 100/62, and she was drooling and lethargic. Nursing staff attempted to provide juice and glucose gel, but the individual was not able to swallow. Nursing staff notified the PCP, who arrived at the home. Staff contacted EMS, who transported the individual to the ED. On 3/23/21, at 8:15 a.m., she returned to the Center, and was admitted to the Infirmary. A nurse followed the guidelines in conducting the initial assessment upon her return.

  Nursing staff did not develop and/or implement an acute care plan for the problems of altered mental status, and hypoglycemia. As the Monitoring Team member discussed with Center and State Office staff, an acute care plan was warranted. Prior to this occurrence, the individual had a number of instances of hypoglycemia (e.g., 12/3/20, 12/6/20, 2/27/21, 3/11/21), and her IHCP did not include sufficient interventions to address the problem. As a result, an acute care plan was needed, and as discussed further below, the IDT needed to review and revise her IHCP to address the individual's chronic condition in the long-term.
- According to an IPN, dated 12/6/20, at 8:05 a.m., the Respiratory Therapist told the nurse that Individual #332's right axilla "looked really red and raw and needed to be looked at." The nurse documented cleansing the area with antimicrobial cleanser and putting an abdominal (ABD) pad in place. The nurse notified the RN, and placed the individual on the MAC list for 12/6/20. The initial nursing assessment did not include measurements of the skin integrity issue. In a nursing note that included an addendum, dated 12/6/20, at 4:20 p.m., a nurse documented that one RN informed another RN that the individual was put on the MAC list for excoriation of the right axillae, and that a provider saw the individual and ordered treatment. The IPN documented: "Excoriation is located on anterior crease of right axillae. 3.5cm [centimeters]x 1.5cm; about 1cm open without depth, no other areas noted in right axillae." In the medical progress note, dated 12/6/20, at 11:09 a.m., the provider noted that no RN assessment was available for review at the time.

  In its comments on the draft report, the State disputed the last sentence of the paragraph above, and stated: "An LVN was notified, assessed, and did a last minute addition to MAC for this to be seen, the fact that an RN assessment was unavailable shouldn't count against nursing, as this is during medication administration time and there are only so many nurses on campus who are off a cart, there may not have been an available RN right at that time for a non-urgent excoriation. An RN did assess and implement an ACP, just not before the PCP assessed it." Assessment of this skin integrity issue was outside of the scope of practice of an LVN, and as noted in the draft report, the LVN's "initial nursing assessment did not include measurements of the skin integrity issue, which was inconsistent with the nursing guidelines.

  On 12/6/20, nursing staff initiated an acute care plan. The plan was not consistent with the skin integrity guidelines, because it did not include pain assessments, and it did not require measurements of the skin integrity issue to allow determination of progress or changes to the wound. However, the acute care plan did require daily assessments of the individual's right axilla, including documentation in a progress note. From 12/9/20 to 12/17/20, nursing staff made no entries in IView to show the completion of the required assessments. In addition, from 12/9/20, to 12/14/20, nursing staff wrote no IPNs. On 12/17/20, a

nurse wrote in an IPN that: "I went to assess [Individual #332's] right axilla, this morning and her Right axilla was free of any skin impairment."

- According to IView entries, and an IPN, dated 4/6/21, at 1:00 p.m., and 1:45 p.m., respectively, an LVN notified the RN that Individual #363 fell and sustained a head injury. The DSP, who witnessed the individual's transfer from his wheelchair to the bed, stated that he tripped over his feet and fell forward striking his forehead and the bridge of his nose on the metal bed frame. The nurse followed standards of care for the control of bleeding, as well as the nursing assessment guidelines for falls, skin impairments, including measurements, and a suspected fracture. The nurse notified the PCP, who ordered the individual's transfer to the ED. The individual was admitted to the hospital.

  On 4/12/21, he returned to the Center. Based on review of IView entries, at 12:45 p.m., and an IPN, at 1:00 p.m., the nurse did not assess his vital signs (or document that he refused). The first documented vital signs were at 8:00 p.m., on 4/12/21. As part of the initial assessment, the nurse also did not complete a Braden assessment.

  On 4/13/21, at 7:15 p.m., nursing staff initiated an acute care plan. Although it included some necessary interventions, such as pain assessments, and the use of standard precautions, most of the interventions were not measurable. For example, the pain scale was not identified, and some interventions used terms that were not measurable, such as "encourage." In addition, key interventions were missing. For example, the PCP ordered daily nursing assessments of the individual's skin and neck at the contact points of the stabilizing collar. However, the acute care plan did not include a corresponding intervention.

  In disputing one of the findings in the paragraph above, the State identified a problem with its electronic record-keeping system that needs to be corrected. Specifically, the State indicated that nursing staff included the pain scale in the goal instead of the intervention, because of character limitations. As discussed on a number of occasions with State Office staff, corrections to the IRIS system are necessary to allow nursing staff to follow current standards of practice. Another example of problems with the system that the State highlighted in its comments is discussed below with regard to Individual #441.

  Based on a review of a sample of documentation, nurses did not fully implement the interventions. For example, although during the sampled time period, nurses assessed the individual's pain each shift, when they administered pain medication, they did not consistently follow-up to determine its effectiveness.
- In an IPN, dated 4/2/21, at 8:00 a.m., an RN documented that the LVN reported that Individual #441 had an injury on his right hand between his thumb and first finger. It was not bleeding, but the skin was broken with exposed tissue from possible pressure to the area. The RN noted the individual had been wearing a hand splint, but it was unclear for how long staff had applied it. The RN notified the PCP that the individual needed to be seen in the MAC clinic, but no one answered when the RN called. The PCP said a provider would see the individual. The nurse included measurements in the assessment data: length of 5 cm, width of 1.5 cm, and depth of 0.2 cm.

  On 4/2/21, at 12:46 p.m., nursing staff initiated an acute care plan. Although the plan included some necessary interventions, most were not measurable. For example, the plan did not include frequencies for assessing the wound, or the individual's pain, and did not provide criteria for the administration of pain medication (e.g., pain level of 4 or more). The intervention to change the dressing was inconsistent with the medical order to leave the wound open to air.

In its comments on the draft report, the State disputed the final sentence in the paragraph above, and stated: "The intervention to change dressing was added on 4/5/21 (the system does not include the date interventions were added/discontinued on the printed version), is consistent with the PCP order on 4/5/21." As referenced above with regard to the State's comments related to Individual #363, based on the State's comments changes need to be made to the IRIS system. The failure of the system to document when interventions are modified has the potential to impact the quality of services. In order to rely on the plans included in the system, nurses need a clear indication of when an intervention is added/discontinued on both electronic and printed versions, including the date and time that changes are made.

According to a medical IPN, dated 4/3/21, at 10:10 a.m., the individual had a Stage 2 pressure injury to the webspace of his right thumb and index finger. The provider ordered discontinuation of the splint, and use of a rolled washcloth instead, as well as daily assessments by nursing staff with notification of any changes. Based on documentation reviewed, nursing staff did not conduct assessments at the ordered frequency, and did not provide ongoing descriptions of the wound.

According to an IPN, dated 4/5/21, at 10:05 a.m., the wound care nurse assessed the area as a Stage 3 pressure injury to the right hand between the first and second fingers, and documented the size of the injury as 1.8 cm by 1 cm by 0.1 cm. The wound care nurse described the pressure injury as a full-thickness wound, with serosanguineous drainage noted on the peri-wound (area that surrounds the wound). The wound care nurse notified the PCP of the change in wound status.

- On 4/12/21, at 12:30 a.m., when staff found Individual #271 in respiratory distress (i.e., oxygen saturation of 88% to 89%), it was positive that nursing staff followed the nursing guidelines for assessment, and notified the PCP. On 4/12/21, at 2:46 a.m., nursing staff initiated an acute care plan that included the necessary interventions, and met the individual's needs. With one exception, nursing staff implemented the interventions included in the acute care plan, which was good to see. The one exception was that when nursing staff administered the first does of Levofloxacin, they did not follow the nursing guidelines for administration of a new medication.
- On 4/22/21, at 9:24 a.m., Individual #415 was involved in a peer-to-peer altercation, resulting in multiple abrasions to his upper body and a bite wound. More specifically, staff stated that while in the dining hall Individual #415 and another individual had a verbal altercation. Staff attempted to defuse the situation. The individuals returned to the home and the altercation became physical. The other individual had a stick approximately six inches long and stabbed Individual #415, who then "football tackled" the other individual to the ground. A third individual became involved, trying to separate the two individuals from each other. According to the post-injury report, dated 4/22/21, at 6:15 p.m., nursing staff measured the abrasions to his left upper arm, upper chest/clavicle, left forehead, and under his left eye, as well as on the left side of his face/cheek. The nurse noted a bite mark approximately 0.3 cm to his left pinky finger with opened skin. The nurse cleaned all of his wounds with antimicrobial cleanser, and notified the PCP with no new orders given.

  According to a medical IPN, dated 4/23/21, at 2:33 p.m., a provider saw the individual and noted pain in the individual's right lower ribs and pain in the right upper quadrant. The plan was for PCP follow-up and review of x-ray and ultrasound reports. PCP follow-up with regard to the bite wound was noted on 4/27/21, and included antibiotic treatment.

	Although on 4/23/21, nursing staff initiated an acute care plan, it did not address the problem of the human bite wound, and nurses did not update the plan after the PCP addressed the bite wound (i.e., four days after it occurred). In addition, in the days that followed this peer-to-peer altercation, nurses did not follow the nursing guidelines for skin impairments with regard to the frequency of assessments, as well as the measurements of the skin integrity issues. In addition, after administering the first doses of the antibiotics to address the bite wound, nursing staff did not follow the new medication nursing guidelines.

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 develop goals/objectives that reflected clinically relevant actions that the individuals could take to reduce their at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/12	0/2	0/2	N/R	N/R	0/2	0/2	0/2	0/2	N/R
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	8% 1/12	0/2	1/2			0/2	0/2	0/2	0/2	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/12	0/2	0/2			0/2	0/2	0/2	0/2	
d.	Individual has made progress on his/her goal/objective.	0% 0/12	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% 0/12	0/2	0/2			0/2	0/2	0/2	0/2	

Comments: For six individuals, the Monitoring Team reviewed a total of 12 IHCPs addressing specific risk areas (i.e., Individual #176 – constipation/bowel obstruction, and diabetes; Individual #332 – respiratory compromise, and GI problems; Individual #363 – GI problems, and circulatory; Individual #441 – aspiration, and skin integrity; Individual #271 – respiratory compromise, and GI problems; and Individual #415 – falls, and infections).

IDTs developed clinically relevant, achievable, and measurable goals for none of these risk areas. In other words, IDTs did not identify activities in which individuals needed to engage or skills that they needed to learn to improve their health (e.g., exercise to lose weight and/or improve cardiac health, learn to wash their hands or apply cream to dry skin to reduce the risk for skin infections, elevate their legs at specific intervals throughout the day to reduce edema, make specific diet modifications to reduce GERD, drink a specific amount of fluid per day to prevent constipation, etc.), and then, develop goals/objectives/SAPs to measure individuals' progress with such activities or skill acquisition.

Although the following goal/objective was measurable, because it did not reflect a clinically relevant action the individual could take to reduce the risk, the related data could not be used to measure the individual's progress or lack thereof: Individual #332 – GI problems.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. As a result, it was difficult to determine whether or not individuals were making progress with regard to taking steps to improve their chronic or at-risk conditions, 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 six 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 a full set of 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. At times, nurse implemented or partially implemented some of interventions included in the IHCPs reviewed. However, without IHCPs that comprehensively addressed individuals' needs, documentation was not present to show that nurses provided individuals with the supports they needed.

In addition, often IDTs did not collect and analyze information, and develop and implement plans to address the underlying etiology(ies) of individuals' risks. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 176	332	454	450	363	441	271	415	106
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.	9% 1/11	0/2	0/2	N/R	N/R	1/2	0/2	0/2	0/1	N/R
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/7	0/2	0/1			0/1	0/2	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).	9% 1/11	0/2	0/2			1/2	0/2	0/2	0/1	

Comments: As noted above, the Monitoring Team reviewed a total of 12 specific risk areas for six 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 exception was for: Individual #363's IHCP for cardiac/circulatory, which only included one applicable intervention. It required the RNCM to assess the individual for edema quarterly and PRN, which the RNCM did.

Given the ongoing nature of Individual #415's falls and the serious injuries he sustained, nursing interventions should have been included in a falls IHCP, but were not.

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

b. As illustrated below, a continuing 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:

- From 2/23/21 to 2/26/21, Individual #176 was hospitalized for a small bowel obstruction. On 3/19/21, she experienced another episode of small bowel obstruction possible ileus/constipation. She had multiple episodes of constipation, requiring PRN medications (i.e., on 2/28/21, 3/4/21, 3/6/21, 3/9/21, 3/10/21, 3/10/21, 3/11/21, 3/16/21, 3/19/21, 3/24/21, 4/20/21, and 5/12/21). On 3/3/21, her IDT held an ISPA meeting to discuss her recent hospitalization, from 2/23/21 to 2/26/21, and her admission diagnosis of bowel obstruction. The IDT identified the probable causes as meal refusals, sleeping a lot, not moving around as much, and not drinking enough fluids. However, the IDT did not review and revise the IHCP, which included only one nursing intervention, which was not discernable (i.e., "N-BM plan/med/PRN aids/fluid, asmt PRN GI s/s; notify PCP abn/ineffect/^s/s. CM rev GI trend qtrly.").

  From 3/4/21 to 3/10/21, she received five rectal suppositories, one dose of milk of magnesia, and a soap suds enema. On 3/18/21, the IDT held an ISPA meeting, and noted a weight loss of 18.20 pounds in the past 180 days. On 3/24/21, the SLP made a recommendation for a diet texture change due to recent increased emesis and dysphagia events. Based on the individual's constipation requiring rectal suppositories, oral medication, and an enema, the nursing interventions in her current IHCP were not meeting her needs, and the IDT did not change them. They included no preventive measures, including preventive measure in which the individual could participate.
- Similarly, Individual #176's IHCP for diabetes included one intervention assigned to nursing staff, and it was not discernable or consistent with standards of practice (i.e., "N-Med/insulin/BS; asmt PRN s/s glycemic rx; notify PCP abn/^ s/s. CM rev metabolic status qtrly"). After a hospitalization from 2/23/21 to 2/26/21, she had a hypoglycemic event on 2/27/21, requiring interventions to correct it. On 3/23/21, after staff found her lying face-down on the floor by her bed, she was sent to the ED for hypoglycemia, and altered mental status. Based on review of the listing of hyper- and hypoglycemic events that Center staff provided, she had significant swings in her blood sugar levels. However, in the ISPAs submitted, there was no indication that the IDT engaged in ongoing review/analysis of the potential causal factors of these changes, and/or their impact on her day-to-day life (e.g., programming, involvement in activities of daily living, etc.). Her IHCP for diabetes did not meet her needs, including preventive interventions in which she could participate, but the IDT did not review and/or revise it, as needed.

- From 3/23/21 to 4/1/21, Individual #332 was hospitalized for respiratory distress, a lower respiratory tract infection, and heart failure. From 5/29/21 to 6/3/21, she was hospitalized for hypoxia, and shortness of breath. On 4/5/21, the IDT held an ISPA meeting to discuss her hospitalization from 3/23/21 to 4/1/21. The IDT reviewed her clinical hospital data and determined she did not meet criteria for pneumonia, but did meet criteria for a lower respiratory infection. In the discussion, the IDT stated that no change-of-status (CoS) meeting would be conducted at this time, because she would remain in the Infirmary for seven days until stable or until a PCR test was negative. On 6/9/21, the IDT held the next ISPA meeting for the second hospitalization. Based on the documentation submitted, the IDT did not review acute care plans or the IHCPs as part of either post-hospitalization review. As noted elsewhere in this report, the IHCP did not include interventions consistent with the individual's needs. In addition, during the 4/5/21 ISPA meeting, even with the new diagnosis of heart failure, and the addition of Lasix as a new medication for her heart failure, as well as the PCP's plan to obtain a cardiac consultation, the IDT did not add any nursing interventions for monitoring her diagnosis of heart failure, such as assessments of lower extremity edema.
- On 4/12/21, Individual #363 fell and sustained a neck injury (i.e., fracture of C1-C2 vertebrae), requiring use of a cervical collar, with decreased mobility. In an IPN, dated 4/15/21, at 10:40 a.m., the PCP outlined his plan for pain management and GI problems. The individual was to receive Tylenol 650 mg one hour prior to PT/OT treatment. Nursing staff were to monitor to ensure daily bowel movements, and administer PRN milk of magnesia if he had no bowel movement in 24 hours; administer a second dose, if no results after eight hours; and if no bowel movements in 48 hours, administer an enema. On 4/15/21, his IDT held an ISPA meeting, but they did not review his potential GI risks given his recent fracture, and did not conduct a review of the acute care plan or IHCP to ensure that they included the nursing interventions necessary to meet his needs.
- On 10/20/20, Individual #441's IDT held an ISPA meeting to complete a "root cause analysis" for his aspiration pneumonia. The revised action plan included an intervention for the RNCM to talk with the case manager about the findings related to increased feeding rates that nursing staff implemented on 10/5/20, and 10/6/20. Based on the documentation submitted, the IDT did not review the record of the individual's residuals. On 11/4/20, the IDT met to conduct a 10-day follow-up for the "root cause analysis." They noted monitoring of the individual's feeding rate, but provided no data as to what the feeding rate should be to allow a determination of when/if nursing staff reached the outside parameters. The next ISPA meeting was for his IDT to discuss his hospitalization from 12/3/20 to 12/14/20. During this meeting, the IDT repeated the same "root cause analysis" interventions. Based on the documentation submitted, the IDT did not review an acute care plan, the IHCP, or the status of each of the 10 actions steps. During the 12/22/20 ISPA meeting, which was the 45-day "root cause analysis" follow-up meeting, the IDT changed the goal from less than five emesis to less than three emesis related to increased G-tube residuals. The IDT provided no dates or numbers for the five dates of emesis, nor did they discuss corresponding residual data with analysis of whether or not they were within the set parameters. Again, the IDT included the same 10 action steps, but did not provide current data on the action plan, or updates on the status of the implementation of the action steps, including supporting data for any completed steps. On 5/28/21, the IDT held a post-hospitalization ISPA meeting to discuss the individual's hospitalization from 5/21/21 to 5/24/21, for hypoxia, sepsis, and pneumonia. During this meeting, the IDT did not conduct a review of the acute care plan, or the IHCP and/or staff's implementation of it. Again, the IDT did not review his residuals over 100 ml, following his hospital discharge on 5/7/21 (i.e., for hypoxia and shortness of breath). The IDT did not appear to use a data-based process and a clinically-relevant goal to track his progress or regression, and they did not conduct the analysis necessary to correlate events or interventions that impacted his health positively or negatively, particularly his respiratory illnesses/pneumonia diagnoses.

- On 4/2/21, Individual #441 was diagnosed with a Stage 2 pressure injury on his right hand between the first and second fingers. On 4/5/21, the wound care nurse assessed the wound, and upgraded it to a Stage 3 pressure injury. He wore a splint and had a palm support for his right hand. This pressure injury was discovered at Stage 2, and progressed to Stage 3. It was not until, 4/15/21, 10 days after the diagnosis of the Stage 3 pressure injury, that his IDT met to discuss it. The ISPA indicated that the IDT should review the current IHCP and interventions. However, within the ISPA, the IDT did not state what the new interventions were, and there was no evidence that the IDT reviewed the IHCP or staff's implementation of it.
- On 12/12/20, Individual #415 fell and sustained a laceration, requiring sutures/staples. On 1/12/21, staff discovered him on the bathroom floor. When the nurse first arrived, he was unresponsive. He sustained a laceration measuring 3 cm x 0.25 cm x 0.25 cm to the right side of his forehead with moderate bleeding. He also had scattered razor burns covering the top of his head extending from the front to the back and sides of the crown of the head. He was diagnosed with a moderate head injury, and required a visit to the ED with Dermabond to close the laceration Based on the documentation submitted, at this time, he had no IHCP to address falls. His IRRF, developed for his ISP meeting on 3/1/21, noted that his IDT increased his risk rating for falls from low to high, and stated: "he has had 3 serious injuries from falls within 6 months of each other." The related IHCP included no nursing interventions. The interventions the IHCP included were largely not measurable (e.g., "R-Intervene for unsafe behaviors effecting [sic] fall risk," and "B-Evaluate for behavioral/social factors"), and did not identify preventive measure(s) in which the individual could participate to reduce his risk to the extent possible. For example, although the IRRF included recommendations for the individual to wear shoes in the shower, and for enhanced supervision while showering, these interventions were not included in his IHCP, and no justification was included in the IRRF for not including them.

Outcome 7 – Individuals receive medications prescribed in a safe manner.

Summary: While it was positive that Center auditors identified problems, medication administration nurses need to adhere to infection control standards of practice. Other areas that require focused efforts are the inclusion in IHCPs of respiratory assessments for individuals with high risk for respiratory compromise that are consistent with the individuals' level of need, and the implementation of such nursing supports. At this time, all of the remaining indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 176	332	454	450	363	441	271	415	106	410
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R						N/R	N/A			
b.	Medications that are not administered or the individual does not accept are explained.	N/R										
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.										

	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).											
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.											
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.	67% 2/3	N/A	0/1	N/A	N/A	N/A	1/1	1/1	N/A	N/A	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.	25% 1/4	N/A	1/2	N/A	N/A	N/A	0/1	0/1	N/A	N/A	N/A
	a. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	b. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.										
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).											
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.											

g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	63% 5/8	1/1	0/1	0/1	1/1	0/1			1/1	1/1	1/1
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	100% 3/3	N/A	1/1	1/1	N/A	1/1			N/A	N/A	N/A
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	100% 3/3	N/A	1/1	1/1	N/A	1/1			N/A	N/A	N/A
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R										
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R										
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R										
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R										
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R										
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R										

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of eight individuals, including Individual #176, Individual #332, Individual #454, Individual #450, Individual #363, Individual #415, Individual #106, and Individual #410. Prior to the Monitoring Team's remote review, Individual #217 died. During the review, Individual #441 was in the hospital.

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

- Individual #332 was at high risk for respiratory compromise, and was diagnosed with obstructive chronic bronchitis with a recent exacerbation, on 3/23/21, of acute tracheobronchitis. Her IHCP included interventions to auscultate and document lung sounds, anterior only, before and after each medication administration. During the medication administration observation, it was positive that the medication nurse completed the assessment. However, based on a review of a sample of documentation, nurses often did not implement the lung sound assessments before and after each medication administration that the IHCP required. This showed over time that nurses did not follow the safety requirements for this individual during medication administration times.
- Individual #441 was at high risk for aspiration/respiratory compromise. Recently, he was hospitalized from 5/21/21 to 5/24/21, with diagnoses of acute hypoxia respiratory failure secondary to aspiration pneumonia, and sepsis secondary to aspiration pneumonia. On 5/26/21, his IDT modified his IHCP to include an intervention to assess lung sounds, respiratory

rate, and oxygen saturation every shift until the pneumonia resolved. Based on a sample of documentation, nursing staff completed these assessments at least every shift. However, the individual's IHCP did not include an ongoing intervention (i.e., past the pneumonia diagnosis), which was necessary in order to mitigate his risk to the extent possible. • Individual #271 was at high risk for aspiration, and respiratory compromise. Her IHCP, dated 8/24/20. did not include an intervention for ongoing lung sound/respiratory assessments, which was necessary to mitigate her risk to the extent possible. An acute care plan, dated 4/14/21, for pneumonitis, and hypoxia, included an intervention to assess lung sounds every shift, and report any abnormalities to the PCP. Based on a sample of documentation, nursing staff completed these assessments. On 5/21/21, she died with causes of death listed as aspiration pneumonia, UTI, COVID-19 pneumonia, and cerebral palsy. g. For the individuals observed, some problems were noted with regard to medication nurses following infection control practices. It was positive that when problems did occur, the Center's nurse auditor identified them, and took corrective action as needed. The following concerns were noted: • The Center's nurse auditor identified that the medication nurse for Individual #332 did not follow standards of practice for handwashing, and the auditor provided reminders about the correct process. • During Individual #454's medication pass, the administering nurse potentially contaminated the drinking cup with her hand. The Center's nurse auditor identified the problem, and provided on-the-spot re-training. • For Individual #363, the Center's nurse auditor identified two issues for which the auditor provided on-the-spot feedback and corrective action. These issues included: 1) the medication nurse did not follow standards of practice for handwashing; and 2) the medication nurse did not use hand sanitizer after checking the individual's position with her bare hands, and before, then administering medications.	

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Given that over the last two review periods and during this review, when necessary, the individuals in the review group were generally referred to the PNMT (Round 15 – 88%, Round 16 – 100%, and Round 17 - 100%), Indicator b.i will move to the category requiring less oversight. IDTs and/or the PNMT did not develop goals/objectives that reflected clinically relevant actions that the individuals could take to reduce their PNM risks. As a result, it was difficult to determine whether or not individuals were making progress with regard to taking steps to improve their chronic or at-risk conditions, or when progress was not occurring, that the IDTs took necessary action. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106

a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/12	0/1	0/2	0/2	0/2	N/A	N/A	0/2	0/2	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/12	0/1	0/2	0/2	0/2			0/2	0/2	0/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/12	0/1	0/2	0/2	0/2			0/2	0/2	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/12	0/1	0/2	0/2	0/2			0/2	0/2	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/12	0/1	0/2	0/2	0/2			0/2	0/2	0/1
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	100% 6/6	1/1	N/A	N/A	N/A	2/2	2/2	N/A	N/A	1/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	0/1				0/2	0/2			0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/6	0/1				0/2	0/2			0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/6	0/1				0/2	0/2			0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/6	0/1				0/2	0/2			0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/1				0/2				

Comments: The Monitoring Team reviewed 12 goals/objectives related to PNM issues that seven individuals' IDTs were responsible for developing. These included goals/objectives related to: Individual #176 - falls; Individual #332 – aspiration, and fractures; Individual #454 – choking, and falls; Individual #450 – choking, and fractures; Individual #271 – aspiration, and fractures; Individual #415 – weight, and falls; and Individual #106 - choking.

a.i. and a.ii. IDTs developed clinically relevant, achievable, and measurable goals for none of these risk areas. In other words, IDTs did not identify activities in which individuals needed to engage or skills that they needed to learn to improve their health (e.g., exercise to lose weight, make specific diet modifications to reduce GERD or emesis, adhere to specific dining techniques to slow their eating pace, learn to navigate around obstacles in their path or slow their walking pace to reduce falls, etc.), and then, develop goals/objectives/SAPs to measure individuals' progress with such activities or skill acquisition.

For a few individuals, IDTs included goals objectives for choking that read something to the effect of: "Individual will safely eat a modified diet texture." Although this showed some improved thinking about the potential causes of the individuals' risks related to choking and the strategies to address them, the IDTs had not individualized the goals/objectives or provided data to support the need for a SAP or strategies in a specific area(s). For example, based on monitoring results, was the individual or staff not cutting the food to the proper diet texture, and/or did the individual not adhere to his/her prescribed diet texture? Depending on the findings, the IDT could then individualize the goal/objective to work on improvements in the specific prioritized area(s) in order to mitigate the risk to the extent possible. Analysis of such data should be included in the IRRF to support the goals/objectives that the IDT considered and agreed upon.

b.i. The Monitoring Team reviewed six areas of need for four 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 those for: Individual #176 – constipation/bowel obstruction; Individual #363 – fractures, and aspiration; Individual #441 – skin integrity, and aspiration; and Individual #106 - fractures.

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.

a.iii. through a.v, and b.iv. through b.vi. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. As a result, it was difficult to determine whether or not individuals were making progress with regard to taking steps to improve their chronic or at-risk conditions, 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	176	332	454	450	363	441	271	415	106
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% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	0% 0/8	0/2	N/A	N/A	N/A	0/2	0/2	N/A	0/1	0/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/3	0/1	N/A	N/A	N/A	0/1	0/1	N/A	N/A	N/A

Comments: a. As noted above, none of the IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Individual #415 did not have an IHCP for weight, but should have. Monthly integrated reviews generally provided no specific information or data about the status of the implementation of the action steps. One of the problems that contributed to the inability to determine whether or not staff implemented supports was the lack of measurability of many of the action steps.

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

- On 4/15/21, Individual #176's IDT met to discuss five falls in 30 days. However, the ISPA only stated to see a note dated 4/15/21. No note was submitted from the QIDP on this date. The individual had falls recorded on 4/10/21, when she reported she fell on her left knee, after losing her balance getting up from recliner in her home. On 3/25/21, she was running in the day room and slipped and fell on her right side. On 3/24/21, she squatted down to pick up something, leaned forward, and landed on her knees. On 3/16/21, a nurse walked out of the medication room and saw her on her hands and knees on the floor holding her stomach. The IDT identified the predominant cause of the falls as that she "just lost her balance." On 3/15/21, the individual tried to intervene when two other individuals engaged in peer-to-peer aggression, and she fell when the other person grabbed her. All of these falls occurred on the 2 p.m. to 10 p.m. shift. She took five medications that might contribute to her fall risk (i.e., Klonopin, Depakote, Haldol, Lamictal, and Seroquel). The IDT took or documented no actions or recommendations related to these falls.
- Between 9/8/20, and 11/9/20, Individual #176 lost 12.2 pounds (143 to 130.8); and between 1/11/21, and 2/5/21, she lost another 4.8 pounds. On 2/16/21, and 2/19/21, staff reported that the individual had poor intake. On 2/21/21, she vomited. On 2/22/21, she complained of not feeling well. She continued with poor intake and complained of significant abdominal pain, including on 2/23/21, lying on the floor in pain. She developed swallowing difficulties. On 2/23/21, the PCP sent her to the ED for acute onset swallowing difficulties and ileus per KUB (i.e., abdominal x-ray). She was admitted with a small bowel obstruction. On 2/26/21, she returned to the Center with diagnoses of chronic constipation, and dehydration. On 3/9/21, the PNMT conducted a review. On 3/19/21, due to a lack of improvement in constipation, weight loss, and acute swallowing difficulties, the PNMT transitioned from a review to a comprehensive assessment. They noted that the current supports were not effective. Neither the IDT, nor the PNMT assessed her fluid intake to determine whether it was sufficient.
- Individual #363 was enrolled in dysphagia therapy, but the assessment was not sufficient to establish the foundation for the therapy. His IHCP made no reference to direct dysphagia therapy. It also did not include specific strategies from the PNMP to

prevent aspiration, such as alternating sips and bites, not talking while eating, eating slowly, and head elevation to 30 degrees at all times.

- On 4/6/21, Individual #363 was diagnosed in the ED with a C1 and C2 cervical fracture. He tripped and fell during a transfer, which resulted in the cervical fracture. On 4/15/21, the PNMT completed its review. The PNMT concluded that the IDT had supports in place to address his needs, and noted that he had had only two previous falls. However, his IHCP did not include the interventions necessary to meet his needs, and his IDT did not modify it. For example, his IHCP for falls/fractures made no reference to the use of the gait belt; the need for a two-person assist for transfers, as well as when he was sitting on edge of bed; his bed alarm; the need for him to wear shoes or non-skid socks for transfers; the specific roles for the two staff during transfers, and when he used the bedside commode; the use of bed baths; the need for him to have foot rests in place during mobility; and/or the use of bed rails. The IHCP also included no reference to PNMP monitoring.
- On 10/9/20, after the Pneumonia Committee confirmed that Individual #441 had aspiration pneumonia (i.e., on 10/6/20), the PNMT completed a review, but not a comprehensive assessment. On 12/3/20, he had a second pneumonia, for which he was hospitalized from 12/3/20 to 12/14/20. According to the Pneumonia Committee, it was not aspiration pneumonia. The PNMT completed another review. From 5/2/21 to 5/7/21, the individual was hospitalized with sepsis, pneumonia, and hypoxia. On 5/10/21, the Committee determined it was not aspiration pneumonia. However, this was the third diagnosed pneumonia in just over six months. The PNMT again completed a review as opposed to a comprehensive assessment. His IHCP did not meet his needs, but the IDT did not make needed changes, and the PNMT did not recommend review of it or changes. For example, it did not include the PNMP interventions, and did not identify triggers and the actions staff should take when they occurred. The IHCP also included no reference to PNMP monitoring to assist in ensuring that staff were following the prescribed interventions.
- On 4/5/21, the PCP re-evaluated a pressure injury on Individual 441's right hand, which nursing staff originally identified as a Stage 2 injury, and the PCP diagnosed it as a Stage 3 pressure injury. Although the IDT held a "root cause analysis" ISPA meeting, both the reason why staff did not identify the pressure injury earlier, and the cause of the injury remained unclear. As a result, the IHCP for skin integrity continued to be insufficient to meet the individual's needs. For example, the IDT did not update the IHCP after assessments were completed with regard to the use of the splints and other adaptive equipment. Although the IHCP included a number of interventions for multiple disciplines to monitor his skin, it did not provide an organized plan for doing so, and a some of the related interventions were not measurable.
- Individual #415's IDT did not develop an IHCP related to weight, even though he was in the 95th percentile for his age group. His EDWR was 142 to 199. On 2/4/21, according to the IRRF, his weight was 84 pounds above his EDWR (i.e., 283 pounds).
- On 5/5/21, Individual #106 fractured his femur when he fell on the sidewalk after his motorized wheelchair tipped. From 5/5/21 to 5/7/21, he was hospitalized. The PNMT conducted a review, but made no recommendations. The IDT did not revise his IHCP, which did not meet his needs. As noted elsewhere in this report, his IHCP was missing key components. For example, it did not include preventive strategies, such as those included in the PNMP. It had no interventions related to monitoring.

c. For the individuals reviewed whom the PNMT discharged:

- According to an ISPA, dated 5/27/21, on 5/21/21, the PNMT discharged Individual #176. The ISPA did not reflect actions other than implementing a chart for her to use to report her bowel movements. The IDT and PNMT discussed no recommendations for modifications to her IHCP, or monitoring, despite, as noted elsewhere in this report, the IHCP not including key interventions. The IDT stated that the interventions met the PNMT criteria, but the report did not state them or

present data to support this conclusion. It was not clear that the IDT actually reviewed what it needed to in order to confirm that discharge was the correct decision. For example, the ISPA documented no review of criteria for discharge or a goal/objective to assess the individual's progress.

- According to an ISPA, dated 5/25/21, on 5/13/21, the PNMT discharged Individual #363 in relation to fractures. The PNMT made no new findings or recommendations. No evidence was found of a review of the current plan, and/or a determination of the criteria for re-referral.
- On 4/30/21, the PNMT discharged Individual #441 related to the pressure injury on his right hand, and on 5/18/21, they met with the IDT. The PNMT stated that the cause of the pressure injury was the splint, although previous documentation never confirmed that this was the cause. As of 4/30/21, the wound was healed. The PNMT offered no recommendations or discussion about his current IHCP to ensure that it met his needs related to the prevention of further pressure injuries. The PNMT made no reference to monitoring of the splint, or other adaptive equipment used in their place. At the ISPA meeting, the IDT/PNMT should have clarified the changes made and the need for monitoring.

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

Summary: Based on observations, staff completed two out of three transfers correctly. Efforts are needed to continue to improve Dining Plan implementation, as well as positioning. Often, the errors that occurred (e.g., staff not providing cues to slow individuals' eating pace, not presenting food correctly, not using methods to control bite-size, etc.) placed individuals at significant risk of harm. Center staff, including Habilitation Therapies, as well as Residential and Day Program/Vocational staff, and Skill Acquisition/Behavioral Health staff should determine the issues preventing staff from implementing PNMPs correctly or effectively (e.g., competence, accountability, need for skill training for individuals, etc.), and address them. These indicators will continue in active oversight.

#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	60% 24/40
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	N/R

Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs/Dining Plans. Based on these observations, individuals were positioned correctly during 14 out of 25 observations (56%). Staff followed individuals' dining plans during eight out of 12 mealtime observations (67%). Staff completed transfers correctly during two out of three observations (67%).

The following provides more specifics about the problems noted:

• With regard to Dining Plan implementation, all of the errors related to staff not using correct techniques (e.g., cues for slowing, presentation of food, prompting independent eating, use of methods to control bite-size, etc.). It was good to see that texture/consistency was correct, adaptive equipment was correct, and staff and the individuals observed were positioned correctly during mealtimes. • With regard to positioning, during 40% of the observations, individuals were not positioned correctly. For three individuals, staff did not use equipment correctly. • For one of the three transfers observed, staff did not set up the transfer correctly. Specifically, for Individual #374, when the individual moved from his wheelchair to the dining table chair, the gait belt was too loose for the transfer and ambulation.

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	176	332	454	450	363	441	271	415	106
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A		N/A			N/A	N/A	N/A		
Comments: a. None.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Most individuals reviewed did not have clinically relevant and/or measurable goals/objectives to address their needs for formal OT/PT services. In addition, IDTs did not integrate the clinically relevant goals/objectives into individuals' ISPs, which remains a key requirement, and QIDP interim reviews did not include data related to applicable goals/objectives. As a result, IDTs did not have information in an integrated format related to individuals' progress or lack thereof. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	18% 2/11	0/1	N/A	2/2	0/1	0/4	0/1	0/1	N/A	0/1

b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/11	0/1		0/2	0/1	0/4	0/1	0/1		0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/11	0/1		0/2	0/1	0/4	0/1	0/1		0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/11	0/1		0/2	0/1	0/4	0/1	0/1		0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/11	0/1		0/2	0/1	0/4	0/1	0/1		0/1

Comments: a. and b. Individual #332 did not require formal OT/PT goals, but did have OT/PT related supports (e.g., a PNMP). Individual #415 had functional motor skills and did not require any formal or informal OT/PT supports. The remaining six individuals had needs that required formal OT/PT services and supports, but most did not have clinically relevant and/or measurable OT/PT goals/objectives.

The two goals/objectives that were clinically relevant and achievable were for Individual #454 (i.e., transferring, and ambulation). However, they were not measurable because they did not provide clear mastery criteria (e.g., for five consecutive sessions, etc.). Generally speaking, completing a task only one time is insufficient to measure mastery.

It was positive that the IDTs developed some goals/objectives were clinically relevant. However, IDTs did not consistently integrate the goals/objectives reviewed into the individuals' ISPs/ISPAs. This was an important missing piece to ensure that an individual's IDT approved the OT/PT goals/objectives, and was aware of the progress with regard to their implementation, and could build upon and integrate those goals/objectives into a cohesive overall plan. Integration of goals/objectives into the ISP/ISPA remains a key requirement overall.

c. through e. For existing goals/objectives, although therapists sometimes submitted IPNs with data to show they were implemented, no evidence was found to show the OTs/PTs worked with the QIDPs to analyze the data and include it in the monthly integrated reviews for the IDTs' consideration.

The Monitoring Team conducted full reviews for all nine individuals. This included Individual #332, who did not require formal OT/PT goals, but did have OT/PT-related supports. Individual #415 did not require any OT/PT supports, but was part of the core group, so a full review was conducted for him.

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. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106

#	Indicator	Overall Score									
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	N/A									
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	N/A									
	Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to OT/PT needs were implemented. As noted above with regard to Outcome 1 and Outcome 3, most individuals reviewed did not have measurable goals/objectives included in their ISPs/ISPAs. In addition, regardless of measurability or incorporation into the ISP/ISPA, evidence of implementation was lacking. Therapists sometimes included data related to the implementation of goals/objectives in IPNs, but this information was not adequately summarized and analyzed in the monthly reviews. OTs and PTs should work with IDTs to ensure that goals/objectives, including formal therapy plans, meet criteria for measurability and are integrated in individuals' ISPs through a specific action plan.										

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.

Summary: Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators.

[**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]

Individuals:

#	Indicator	Overall Score	241	1	405	117	571	549	106	47	422
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they moved to the category requiring less oversight.									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	76% 29/38	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		88	225	454	450	599	376	294	104	131

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	1/1	0/1
		Individuals:									
#	Indicator		584	513	287	363	337	469	149	124	466
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
		Individuals:									
#	Indicator		561	402	112	127	319	458	502	190	264
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		79	84							
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1							

Comments: c. The Monitoring Team conducted observations of 38 pieces of adaptive equipment. Based on observation of Individual #1, Individual #549, Individual #88, Individual #225, Individual #376, Individual #131, Individual #561, and Individual #112 in their wheelchairs, the outcome was that they were not positioned correctly in accordance with their PNMPs. 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.

For Individual #149, it was not clear whether the lap tray attached to her wheelchair was a protective device or restraint. Center direct support professional staff reported that the purpose of the lap tray on her wheelchair was to prevent her from leaning forward, while clinical staff stated it was to keep her from reaching for things on the ground and risk falling. Based on review of her PNMP, it provided no rationale for the use of the lap tray. For positioning, the PNMP stated "N/A," and the lap tray was not listed as needed for mobility. Center staff should ensure that there is a clearly understood purpose for the lap tray.

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, four indicators were moved to the category of requiring less oversight. At this review, no additional indicators were 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.

In skill acquisition, more SAPs had more required components than at the last review. About two-thirds, had all of the required components.

SAP integrity checks were done for all SAPs for six individuals and for no SAPs for two individuals. The Monitoring Team observed eight SAPs (one for each individual) and all were implemented as written, the highest percentage seen at Lufkin SSLC.

Almost all SAPs were reviewed monthly. This was the highest performance yet seen at Lufkin SSLC on this indicator.

Many SAPs were not progressing, perhaps in part due to the many challenges due to COVID.

Observations were done remotely via video, however, during most observations, most individuals were engaged in activities, more so than ever observed previously. For about half of the individuals, the Center's own data showed that engagement goals were met.

For the one applicable individual reviewed, the IDT did not have a way to measure a clinically relevant outcome related to dental refusals.

During observations, it was positive that most individuals reviewed had their individualized and home-based AAC devices/supports present, or accessible to them. Based on observations, individuals did not consistently use their devices in a functional manner and Center staff did not always prompt them to do so.

ISPs

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

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Performance was about the same as at the last review. Many SAPs were not progressing, perhaps in part due to the many challenges due to COVID. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	98	332	221	93	330	78	125	392	176
6	The individual is progressing on his/her SAPs.	29% 6/21	0/3		3/3	0/3	1/2	2/2	0/3	0/2	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	14% 1/7			0/3		1/1	0/2			0/1
8	If the individual was not making progress, actions were taken.	9% 1/11	0/3			0/2	0/1		0/3	1/2	
9	(No longer scored)										

Comments:

6. Six SAPs (e.g., Individual #221's brush her teeth SAP) were rated as progressing. Individual #93's complete his timesheet, and Individual #176's make jewelry SAPs were progressing, however, they were scored as 0 because the data were not demonstrated to be reliable (see indicator 5). Additionally, Individual #392's clean jewelry SAP, and Individual #176's identify why she takes medication and identify healthy activities SAPs had insufficient data to score progress, however, were scored as 0 because the data were not demonstrated to be reliable. Finally, Individual #332's brush her teeth, choose an item, and activate music SAPs were not scored because there were insufficient data to determine progress.

7. Individual #330's prepare Jell-O SAP moved to the next step when the SAP objective was achieved. Individual #176's make jewelry SAP, Individual #78's operate a computer and recite a prayer SAPs, and Individual #221's choose an item, wash her hair, and brush her teeth SAPs also had objectives that were achieved, but their SAPs did not immediately move to the next training step.

8. Individual #392's clean jewelry SAP was not progressing; however, the prompt level was modified in response to the lack of progress. Ten other SAPs, however, were judged to not be progressing (e.g., Individual #93's prepare a snack SAP) and did not have 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: Progress was seen in that more SAPs had more required components than at the last review. About two-thirds, had all of the required components. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	98	332	221	93	330	78	125	392	176
13	The individual's SAPs are complete.	58% 14/24	2/3 29/30	3/3 28/28	0/3 23/30	3/3 30/30	2/2 20/20	0/2 18/20	3/3 30/30	0/2 16/20	1/3 25/28

Comments:

13. In order to be scored as complete, a skill acquisition plan (SAP) must contain 10 components necessary for optimal learning. Fourteen SAPs were found to contain all of those elements (e.g., Individual #332's brush her hair SAP).

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 58% of the SAPs were judged to be complete, most of the SAPs contained the majority of the components. For example, 100% of the SAPs had a plan that included:

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

Regarding common missing components:

- For several SAPs, the training objective was not clear. For example, Individual #78's operate a computer SAP stated he will ….operate a computer…..for one month for three consecutive months. It was not clear from this behavioral objective if he was to maintain the skill for one month or for three months. Additionally, Individual #392's knitting project SAP's behavioral objective did not include a length of time that the skill was expected to be achieved.
- In some SAPs, the staff instructions were unclear. For example, the training sheet for Individual #176's identify healthy activities SAP indicated in some places on the SAP training sheet that Individual #176 should <u>state</u> healthy activities. In other areas the SAP training sheet indicates that Individual #176 should <u>write</u> the healthy activities. Similarly, Individual #98's identify coins and bills SAP did not clearly indicate if he should both point to and state the value of bills.
- Several otherwise complete SAPs were scored as incomplete because an individualized potent reinforcer was not utilized contingent upon correct responding (e.g., Individual #221's choose an item SAP). This individualization of reinforcement for correct SAP completion was apparent in some SAPs (e.g., Individual #98's identify coins and bills SAP where correct responses

	were to be followed by praise <u>and</u> the opportunity to spend his money on a desired object). Some SAPs, however, merely included saying "good job," which may not function as a potent reinforcer for every individual (e.g., Individual #392's cleaning jewelry 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.

Outcome 5- SAPs are implemented with integrity.											
Summary: SAP integrity checks were done for all SAPs for six individuals and for no SAPs for two individuals. The Monitoring Team observed eight SAPs (one for each individual) and all were implemented as written, the highest percentage seen at Lufkin SSLC. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	98	332	221	93	330	78	125	392	176
14	SAPs are implemented as written.	100% 8/8	1/1		1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	75% 18/24	3/3	3/3	3/3	2/3	2/2	2/2	3/3	0/2	0/3

Comments:

14. The Monitoring Team observed the implementation of eight SAPs. No SAPS were observed for Individual #332 because she was in the infirmary during the remote review week.

The implementation of Individual #98's tell time SAP, Individual #221's choose an item SAP, Individual #93's complete his time-sheet SAP, Individual #330's prepare Jell-O SAP, Individual #78's use a computer SAP, Individual #125's wash his clothes SAP, Individual #392's clean her jewelry SAP, and Individual #176's make jewelry SAP were observed by the Monitoring Team. All SAPs were implemented and scored as written. This represents a dramatic improvement from the last review when 57% of the SAPs were found to be implemented and scored as written.

15. Seventy-five percent of the SAPs had integrity measures. Individual #176's identifying her medications, making jewelry, and identifying healthy activities SAPs, Individual #392's knitting project and cleaning her jewelry SAPs, and Individual #93's completing his time-sheet SAP did not have interobserver agreement (IOA). Lufkin SSLC established that each SAP would have integrity measures within the first three months of implementation and at least every six months after that.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.	
Summary: Almost all SAPs were reviewed monthly. This was the highest performance yet seen at Lufkin SSLC on this indicator. It will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	98	332	221	93	330	78	125	392	176
16	There is evidence that SAPs are reviewed monthly.	92% 22/24	3/3	2/3	3/3	3/3	1/2	2/2	3/3	2/2	3/3
17	SAP outcomes are graphed.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
16. Most SAPs had a data-based review in the QIDP monthly report (e.g., Individual #78's use the computer SAP). Individual #330's wash her clothes SAP, however, was not included in the SAP monthly reviews, and Individual #332's choose an item SAP data were not consistent with the SAP graph.

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

Summary: Observations were done remotely via video, however, during most observations, most individuals were engaged in activities, more so than ever observed previously. For about half of the individuals, the Center's own data showed that engagement goals were met. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	98	332	221	93	330	78	125	392	176
18	The individual is meaningfully engaged in residential and treatment sites.	75% 6/8	1/1		0/1	1/1	1/1	1/1	1/1	1/1	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	0/1	0/1	1/1	1/1	1/1

Comments:
18. The Monitoring Team directly observed eight individuals (Individual #332 was in the infirmary) multiple times on campus during the review week. The Monitoring Team found Individual #98, Individual #93, Individual #330, Individual #78, Individual #125, and Individual #392 to be consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations). This represents a substantial increase in engagement from the last review when 33% of individuals were observed to be engaged.

21. Due to COVID-19 precautions, day treatment sites were suspended since March 2020, and just beginning to be opened within the last month. Lufkin SSLC tracked engagement in all residences. Their established engagement goal was individualized to each residence. The Center's engagement data indicated that Individual #221's, Individual #93's, Individual #125's, Individual #392's, and Individual

#176's residences achieved their goal level of engagement over the last six months. This represents another improvement from the last review when 33% of residences achieved their engagement goals.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: Community outings/activities were suspended due to COVID-19 precautions since March 2020.			Individuals:								
#	Indicator	Overall Score	98	332	221	93	330	78	125	392	176
22	For the individual, goal frequencies of community recreational activities are established and achieved.	Not scored CV19									
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	Not scored CV19									
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	Not scored CV19									
Comments:											

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: For the one applicable individual reviewed, the IDT did not have a way to measure clinically relevant goals/objectives related to dental refusals. These indicators will remain in active oversight			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106

a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/1								0/1	
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/1								0/1	
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/1								0/1	
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/1								0/1	

Comments: a. through e. On 1/11/21, Individual #415 had an appointment at the Dental Clinic. The dental hygienist's notes for that appointment indicated that the individual verbally refused most of the planned treatment. The Center did not provide evidence that the IDT met to discuss the refusal, or that they developed a related goal/objective to address it. It appeared that the individual also frequently refused routine oral hygiene care, putting him further at risk for poor dental outcomes. For example, with regard to his tooth brushing service objective (SO), the QIDP monthly integrated progress notes indicated that in March 2021, he refused tooth brushing 18 of 42 opportunities, in April 2021, 26 of 33 opportunities, and in May 2021, 17 of 36 opportunities. The monthly integrated progress notes did not document the IDT took action to address these refusals.

Communication

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

Summary: Individuals with communication needs did not have goals/objectives to address those needs. Going forward, communication assessments should include recommendations for specific clinically relevant and measurable goals/objectives for IDTs to consider. It will also 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	176	332	454	450	363	441	271	415	106
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/6	0/1	0/1	0/1	0/1	N/A	0/1	0/1	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/6	0/1	0/1	0/1	0/1		0/1	0/1		
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/6	0/1	0/1	0/1	0/1		0/1	0/1		

d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/6	0/1	0/1	0/1	0/1		0/1	0/1		
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/6	0/1	0/1	0/1	0/1		0/1	0/1		

Comments: a. through e. Individual #363, Individual #415, and Individual #106 had functional communication skills and did not have any communication supports. All of the remaining six individuals had communication needs, but none had clinically relevant or measurable goals to address those needs.

The Monitoring Team conducted full reviews for all nine individuals. As noted above, Individual #415 and Individual #106 had functional communication skills, but both were part of the core review group, so full reviews were conducted for them. Individual #363 was part of the outcome group, but he did not have a current assessment or screening (i.e., the last assessment occurred in 2017) to describe his communication needs and identify any communication supports he might require, so a full review was conducted for him. For the remaining six individuals, the Monitoring Team completed full reviews due to a lack of needed clinically relevant, achievable, and measurable goals.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	176	332	454	450	363	441	271	415	106
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	N/A									
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									

Comments: a. As described above with regard to Outcome 1 and Outcome 3, despite having unmet communication needs, none of the applicable individuals reviewed had measurable goals/objectives related to communication included in their ISPs/ISPAs. The following describes examples of concerns noted:

- For Individual #176, Center staff completed the most recent assessment on 2/5/19, but it did not fully address her needs. For example, the assessment reported she had a visual impairment that could impact her ability to use AAC and participate in testing, but did not further elaborate on her functional vision (e.g., did not mention the impairment might also impact her ability to read sign language from her communication partners). The assessment also stated she did not need AAC, but the SLP based this opinion on previous documentation only and did not conduct a specific assessment. In addition, it was unclear why the assessment did not evaluate the opportunity to expand the individual's current sign vocabulary and/or work with staff so that more of them could communicate with her through sign language. While the assessment stated that her skills remained the same since her previous assessment in 2012, this may have been because she did not receive any communication supports to expand her skills since that time.

- For Individual #450, Center staff completed the most recent assessment on 8/26/19. It did not fully address the individual's needs. The assessment described a number of motor skills (e.g., shaking hands, squeezing hands, reach for objects when oriented, picks up his cup, holds manipulatives such as balls, paper, cups) and cognitive skills (e.g., follows simple instructions, turns head to sound, reaches for objects he wants, responds to touch, looks up when his name is called, will open his hand and accept an object, etc.) that could be built upon for AAC use. However, the assessment did not provide any recommendations for trialing AAC use.
- Individual #271 had not received a comprehensive evaluation since 11/30/18, which did not fully address her needs. For example, the assessment stated that she would not likely benefit from AAC due to lack of interest, but did not clearly describe the evaluation process that led to that conclusion. While it indicated the individual did not participate in the evaluation despite immediate and consistent reinforcement, it did not provide any specific information about how, when, or what the SLP tried in the evaluation process (e.g., the reinforcers used). The assessment also stated the individual had a lack of interest in pictures or objects, but did not document any specific responses. The assessment recommended that because the individual made some progress on a SAP for activating a pressure plate (i.e., to turn on a fan), she should continue to work on it. However, the Center did not submit any evidence to show that the SLP observed this SAP or provided any follow-up to evaluate the potential for expansion of communication skills.

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

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

[**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "Overall Score."]

#	Indicator	Overall Score	Individuals: 241	1	405	117	549	571	422	294	104
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	93% 14/15	2/2	1/1	1/1	2/2	1/1	1/1	1/1	0/1	1/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	64% 7/11	2/2	0/1	1/1	1/1	0/1	1/1	0/1	0/1	1/1
			Individuals:								
#	Indicator		17	176	392	222					
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	1/1					

b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		N/A	N/A	1/1	N/A					
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	Not rated									

Comments: a. and b. During observations, it was positive that most individuals reviewed had their individual and home-based AAC devices/supports present, or accessible to them. The exception was for Individual #294, for whom her Communication Builder device was not present at her table, but was instead on another table. Center staff indicated they kept it at the other table because, while she might use it, she might also throw it.

Although otherwise the devices/supports were present, based on observations, individuals did not consistently use their devices in a functional manner and Center staff did not always prompt them to do so. For example, based on Center staff's description, Individual #294 used her device only intermittently and not in a functional manner. The device did not have a button for the activities Center staff indicated she most liked to do (i.e., play cards, and go to bed). Instead, she more commonly used direct action to indicate her wants and needs (e.g., she will propel herself toward her bedroom) and Center staff interpreted what they thought she wanted. In another example, during the observation, Individual #1 repeatedly pressed the button on his device requesting to go outside, but instead, Center staff brought him his favorite item (i.e., the maracas). While it was unclear what he might have actually wanted, to promote development of functional use of the device, it will be important for Center staff to pair the appropriate action with each request. The Monitoring Team suggested that Center staff consult with the SLP to determine if modifications were needed.

Of note, it was positive was that SLPs distributed a number of core vocabulary books and posters across campus for use by all individuals and staff to assist with communication. However, based on the needs of individuals living at the Center, there were only a limited number of individualized AAC devices/supports.

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 time of the last review, four indicators were in the category of requiring less oversight. As of this review, three additional indicators were added 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.

Lufkin SSLC's long-tenured APC recently transferred to a position at State Office, but it was fortunate the Center retained experienced transition staff in the other positions, including the Placement Coordinator who was serving as the acting APC.

As usual, the transition staff were very well-informed about the needs and current status for all the individual referrals we discussed.

Since the previous review, the Center transitioned one individual, in May 2021, and the current referral list included 13 individuals. It was an active list, with one CLDP held a few weeks ago and several more pending in the near future.

It was good to see that the transition staff continued to develop new strategies for ensuring successful transitions. One notable example was the development of a pre-move support that described the requirements of the REMS protocol for individuals receiving Clozaril and further required the provider to submit a signed acknowledgement that identified the health care practitioners who would be responsible for the protocol's implementation.

While much work continued to be needed in the area of transition assessments, transition staff continued to focus efforts on assisting IDT members to understand what they needed to include to facilitate a successful transition. It was particularly good to see the nursing assessment provided many specific expectations about the competencies provider staff would need to demonstrate to show they were prepared to meet the individual's needs.

The IDTs continued to need improvement in developing a comprehensive set of measurable post-move supports. Transition staff do have a process in place for reviewing the CLDP and supporting documents (e.g., the 14-day ISPA, the ISP, the IRRF, the discharge assessments and the CLDP narrative) to identify supports that need to be included in the CLDP, so they might just need to refresh their practice in this regard.

Overall, the Center needed to focus on ensuring that, prior to transition, provider staff can demonstrate they have all needed competencies to meet individuals' needs. Once an IDT has identified a comprehensive set of measurable post-move supports, they need to determine what kinds of training provider staff might need to implement each of those supports.

Based on review of the seven and 45-day PMM Checklists, the PMM had an organized and thoughtful process in place. For each post-move support, the PMM used three headings (i.e., observations, interviews, and documentation) to clearly document the findings from each of her activities. The PMM sometimes noted that documentation was not available to confirm the presence of supports, but still marked them as in place.

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: There were many positive aspects in the set of supports in this individual's CLDP, including in all of the sub-indicators of indicator 2. That being said, there were also some supports that were not included that should have been (or a rationale as to why not). These are detailed in the comments below. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	57								
1	The individual's CLDP contains supports that are measurable.	0% 0/1	0/1								
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/1	0/1								

Comments: One individual (Individual #57) transitioned from the Center to the community since the last review. He transitioned to a community group home under the state's HCS host home program. The Monitoring Team reviewed his transition and discussed it in detail with the Lufkin SSLC Admissions and Placement staff. Lufkin SSLC's long-tenured Admissions and Placement Coordinator (APC) recently transferred to a position at State Office, but it was fortunate that the Center retained experienced transition staff in the other positions. This included the Placement Coordinator, who was serving as the acting APC. Overall, transition staff continued to have a very good understanding of the improvements the Center still needs to make to move toward compliance. The current referral list had 13 individuals. It was an active list, with one CLDP held the week before the review week, and several more pending in the near future. As usual, the transition staff were very well-informed about the needs and current status for all the individual referrals.

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. Overall, for this review, the Center needed to continue focusing on developing comprehensive and measurable supports, with the primary emphasis on ensuring that, prior to transition, provider staff can demonstrate they have all needed competencies to meet

individuals' needs. The following provides examples of pre-move and post-move supports that met criteria and that did not meet criteria.

Pre-Move Supports:

- Individual #57's IDT developed 16 pre-move supports for him. It was positive that a number of pre-move supports were measurable. Those supports addressed various staff activities, such as completing the pre-move site review (PMSR), designating the provider staff who would act as trainers, purchasing furnishings, implementing pre-move health care related activities, etc.
- It was especially good to note that Center staff had developed a measurable pre-move support to ensure that provider staff had a clear understanding of the protocols required for the administration of Clozapine, a medication Individual #57 received to address his behavioral needs. The support identified the components of the protocol [i.e., the Clozapine Risk Evaluation and Mitigation Strategy (REMS)]. Further, the support required the provider to sign an acknowledgement, including the identification of the psychiatrist and pharmacy enrolled in the REMS program that they would use to ensure all the components of the program were implemented as required.
- However, as reported for previous reviews, the Monitoring Team again 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. To be specific, rather than solely listing out the training topics, these supports should include specific competency criteria that answer the question "what are the important things provider staff need to know -and know how to do- to meet an individual's needs." For this review, Center staff still needed to continue to focus on ensuring that pre-move training supports were measurable and defined the specific competency criteria provider staff would need to meet. Overall, the pre-move supports did not provide competency criteria that specifically described what provider staff needed to know and know how to do. Instead, those supports simply outlined broad categories for which they would provide training. In addition, competency quizzes did not cover all important needs. As a result, the Center could not confirm that provider staff had needed skills and knowledge prior to this transition.
    - Seven pre-move supports related to ensuring provider knowledge and competence. Two of the supports called for the provider to designate a staff person to be responsible for training and re-training new and existing employees on the individual's needs, while another five supports addressed provider pre-move training or competency checks for medical/nursing, behavioral, vocational, and habilitation therapy support needs. Each of the supports listed topics for which training would be required, but did not specify the required competencies by which Center would measure provider staff knowledge or competence. The pre-move support that came closest to specifying the needed competency criteria was the one for habilitation needs, which noted the specific adaptive equipment Individual #57 required. However, it still needed to provide the degree of elevation required for the bed wedge and list the specific eating/nutritional instructions provider staff needed to know (i.e., instead of just listing the topic of eating/nutritional instructions). Going forward, it will be essential for pre-move supports to define the specific competency criteria. Center staff should make this a priority.
    - In some instances (i.e., for behavioral, vocational and habilitation therapy support needs), the pre-move supports called for competency checks, but did not specify how or when the original pre-move training was completed. Based on additional training documentation provided at the end the CLDP narrative, it appeared that for those categories of support needs, Center staff only provided training as a part of the pre-move provider visit (PPV) preparation. The documentation indicated that, on 3/4/21, Center staff delivered this initial training to the provider's identified trainers

and to residential and day habilitation program staff and provided a video copy of the in-services for the provider's use in future training. Then, on 5/14/21, at the time of the PMSR, the PMM completed competency checks to ensure provider staff retained the required knowledge. Going forward, if Center staff intend to employ this methodology, prior to the PPV, the Center should develop clear pre-move training supports that that meet all the criteria for measurability, including who will be trained, who will provide the training, the training methodologies, the competency criteria, and how competency will be tested. The CLDP, which is a living document, should include these pre-move supports. In addition, given that two months elapsed from the original training to the PMSR, the competency checks needed to be more thorough. For example, no direct support staff were present for the PMSR, so the only competency check completed was for the provider's Area Supervisor. This was a significant concern because it did not allow for confirming (i.e., measuring) competency of the direct support staff providing direct services. In summary, the competency check pre-move supports did not sufficiently describe how the Center would measure the competency of provider staff.

- In the future, the IDTs should also consider whether didactic learning is appropriate for all needs, and whether other methodologies, such as demonstration or hands-on modeling might be better suited as the measurement methodology for some. In addition, the pre-move training supports should specify the training methodologies. For this transition, Center staff reported they provided virtual training. On a positive note, the training was completed on a platform with video capabilities, which would allow for demonstration and even some forms of return demonstration. The Monitoring Team was unable to view the video training, and neither the pre-move supports or available training documentation specified the training methodologies, so it was unclear whether Center staff employed any methodology other than didactic learning.
- Written quizzes remained the primary method for pre-move competency testing and the quizzes still did not test competency in a comprehensive manner. As discussed with transition staff, testing needed to be constructed to measure the specific criteria that would demonstrate provider staff were competent to provide supports as required. In addition, pre-move training supports needed to be clearly state those criteria. The written tests reviewed for Individual #57's CLDP did not include questions for many of the topics and/or competencies listed for each support, so there was no corresponding measurable evidence of related staff knowledge. For example:
  - The medical/nursing pre-move training support included 20 topics, but did not define any competency criteria. The CLDP included extensive pre-move training information at the end of the document, including more than 12 pages of detailed material. While it was positive that Center staff appeared to be providing in-depth training in this area, it was unclear what provider staff, especially direct support staff, would be expected to know. The accompanying pre-move competency quiz consisted of 12 questions, in multiple choice, fill in the blank, or true/false formats. These did not cover all of the training material, and, without specific competency criteria, it was not possible to determine if the tested material was sufficient to demonstrate provider staff were competent. In some instances, it seemed clear that some of the needed competencies were not tested. For example, the nursing training materials included a section entitled "Instructions for staff to know what to look for" and "Criteria for Notification of a Nurse." It was reasonable to assume that these were important staff competencies. While it was positive that some of the instructions and criteria were covered in the testing, others were not (e.g., notification of falls, cardiac symptoms, weight gain

or loss of five pounds, increased blood pressure or pulse rate, signs of choking, aspiration or respiratory illness, etc.).

- The behavioral in-service also included extensive material, as depicted in the CLDP document. The accompanying quiz consisted of 10 questions. Some of the material not covered in the quiz included the full instructions for his plan to teach replacement behavior (i.e., it was limited to greeting others with a fist bump and was missing instructions for appropriate communication), most of the prevention techniques, his approved reinforcers, and the schedule of reinforcement. In addition, the quiz asked provider staff to demonstrate knowledge of only one of the many intervention techniques (i.e., use a firm voice) for his identified target behaviors of physical aggression, disruptive behavior, and inappropriate sexual behavior.
- The habilitation therapy quiz appeared to cover most of the specific criteria identified in the pre-move support, but it still lacked testing of most of the dining instructions covered in the training material provided for review.

Post-Move Supports: The respective IDTs developed 37 post-move supports for Individual #57. Many post-move supports were measurable, including those that described medical and health care appointments. However, this was not consistent. The following describes examples of post-move supports that were not fully measurable:

- The CLDP included supports for the post-move provider staff competency checks, consistent with the pre-move training provided by Center staff. This would have consistent deficiencies as well.
- The CLDP included a post-move support that called for the provider staff to monitor and chart on approximately 14 medical/ nursing needs and to notify the provider nurse if any were outside of the parameters. While this was a positive approach overall, the support did not provide the needed parameters for several of the daily requirements (i.e., respirations, oxygen level, and emesis log.)
- Another post-move support stated that it was "requested that Individual #57 stay physically active to aid in GI health and promote weight loss." It was not clear what would constitute staying physically active (i.e., frequency, duration, type of activity.)
- A support called for provider staff to implement his Positive Behavior Support Plan (PBSP) daily "as outlined." The outline only listed broad categories (e.g., target behaviors and symptoms, prevention techniques, interventions, etc.) and did not provide a measurable way, such as specific probes, to test provider knowledge. The support indicated the provider would keep the PBSP in the Special Needs Book and the PMM would ensure it was present and current, but this was not sufficient to measure staff knowledge/competency.

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 Individual #57 and it was positive they had made a diligent effort to address his needs. Still, the CLDP did not fully and comprehensively addressed support needs and did not meet criterion, as described below.

- Past history, and recent and current behavioral and psychiatric problems: This sub-indicator did not meet criterion. Going forward, 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 then pro-actively. Findings included:

- As described above with regard to Indicator 1, it was positive that the Center developed a pre-move support to ensure both provider staff knowledge of the REMS protocol related to the administration of Clozaril and the access to the resources (i.e., enrolled practitioners) needed for its implementation. Center staff should also have provided a clear post-move support for the continuation of the protocol, by which the PMM could confirm implementation and ongoing access to the required resources. While a post-move support indicated that the provider would assist the individual to obtain needed labs, including a monthly CBC, it did not lay out clear steps and/or expectations for the CBC results to be provided to the psychiatrist for review. Based on the CLDP narrative, the IDT agreed to several final post-move supports for Individual #57 relevant to the continuation of REMs requirements (i.e., to be seen by the community psychiatrist by 6/20/21, and for the psychiatrist and pharmacy to remain enrolled in the REMS registry). However, the CLDP only included the psychiatry appointment in the list of supports.
- Individual #57's behavioral health assessment (BHA) detailed a significant behavioral history that had resulted in several psychiatric hospitalizations prior to his admission to the Center. This history included behaviors about which provider staff needed to have knowledge in the event they began to re-emerge in the less structured community environments. In addition to physical aggression, these included suicidal gestures and having attempted to burn down a house. The CLDP did not include supports for staff knowledge with regard to these historical needs. He also had a relatively recent history of making false allegations that was removed from his PBSP in 2018 due to low frequency, and had required a crisis intervention plan (CIP) as recently as 2019. The CLDP did not address knowledge of this history, nor did Center staff provide evidence they had provided comprehensive training with regard to these issues or the behavioral strategies that had been successful in the past to reduce and/or eliminate them.
- As discussed above with regard to Indicator 1, this CLDP did not include pre-or post-move supports that provided clear behavior support expectations for provider staff to implement. Instead, the supports listed broad topics, with no specific information relating to the individual's unique needs.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: This sub-indicator did not meet criterion. The IDT developed supports in many areas related to safety, medical, healthcare, therapeutic, and risk needs, such as for scheduling of health care appointments. However, the IDT still needed to develop clear and comprehensive supports. Findings included:
  - As described above, for this review, the competency quizzes for these areas did not comprehensively test provider knowledge of many criteria included in the pre-move training supports.
  - The IDT did not develop a clear support to describe the individual's needs for supervision. The CLDP included two related supports. One indicated that he received routine supervision, but qualified that by also stating provider staff should always know his whereabouts. Other documentation, including the 14-day ISPA, indicated he also required hourly checks from 10:00 PM to 5:00 AM, but the IDT did not provide a rationale for omitting this requirement. Another support stated he should receive supervision on community outings, but did not include any parameters for the level of supervision.
  - Of note, in a number of instances, the IDT discussed important support needs in these areas and agreed to final supports to address them, but did not include them in the final set of post-move supports. Examples included:
    - The CLDP narrative indicated that the IDT agreed to a final support calling for the provider nurse to complete quarterly nursing assessments in eight areas (e.g., vital signs, weight, infections, skin integrity, seizures, etc.), but this was not included in the final set of post-move supports.

- The CLDP medical assessment narrative indicated the post-move supports should include an AIMS at admission and every three months thereafter, as well as a MOSES at admission and every six months thereafter. The final set of post-move supports did not include these.
- The IDT also agreed to a post move support for an influenza vaccination, due in October 2021, and specified it should be the egg-free variety. While the post-move supports did include obtaining the vaccination, the support did not specify that it needed to be egg-free.

- 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. Individual #57's CLDP did not fully address these outcomes and did not meet criterion. The CLDP listed the following as important outcomes: living in the community close to his family, meeting new friends, participating in community and leisure activities of his choice, and earning money at a vocational workshop. For the most part, these were broadly stated and relatively vague outcome statements, even though his ISP and assessments identified personal goals in more specific terms. For example, his ISP indicated he wanted to learn to play golf and participate in tournaments, while his ISP, PSI, and several assessments documented his desire for community employment. The CLDP did have supports for community and leisure activities, including but not limited to, a lengthy list of activities. This list included golfing, but the support could have been met without his having an opportunity to golf. In addition, the CLDP did not include any specific supports for making new friends. This appeared to be a statement of a hoped-for outcome, but did not suggest any specific strategies making friends.

- Need/desire for employment, and/or other meaningful day activities: Individual #57's ISP, PSI, and several assessments noted his desire for community employment, specifically to work stocking shelves. However, transition staff indicated he stated he preferred a workshop setting initially to help him prepare for community employment. The CLDP included a support for the individual to attend day habilitation. In addition to describing expectations for day program activities and training, the support includes an asterisked footnote that "recommended that when (he) can receive Vocational Services in the community; that the vocational services provider support and assist (him) in maintaining services with Texas Work Force Commission, for assistance in pursuing supported employment." It also noted that his next evaluation with the Texas Workforce Commission (TWC) should be completed by 2/11/22. It was unclear that a recommendation carried the weight of an agreement in the same way that the rest of the support did, and it was also somewhat equivocal in the language. While it was good that Center staff provided some guidance to the provider, this recommendation (i.e., rather than a clear support) did not appear to be reflective of his documented employment aspirations. This sub-indicator did not meet criterion.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success: Overall, this sub-indicator did not meet criterion. A support for day habilitation indicated provider staff should receive a diet soda three days a week for attending the day program. However, the PBSP included a much more detailed description of Individual #57's approved reinforcers and the schedule and procedures for positive reinforcement. The CLDP did not include a clear support requiring provider staff knowledge of these requirements, or for the PMM to use as a basis for confirming that provider staff were implementing them. Instead, the CLDP included only a broad support calling for staff to implement the PBSP, with no clear criteria. (Also, the PMM Checklists did not provide any comments with regard to the implementation of the reinforcement schedule.)

- Teaching, maintenance, participation, and acquisition of specific skills: It was positive the CLDP included some supports related to teaching, maintenance, participation, and acquisition of specific skills. The CLDP met criterion in this area.

- All recommendations from assessments are included, or if not, there is a rationale provided: This sub-indicator did not meet criterion. Overall, for this review, the IDTs did not yet address all recommendations with supports or otherwise provide a justification, as described throughout this section. Even when assessments and CLDP discussion and recommendations identified important support needs, the post-move supports did not always include them. Lufkin SSLC had a process in place for reviewing the CLDP and supporting documents (e.g., the 14-day ISPA, the ISP, the IRRF, the discharge assessments, and the CLDP narrative) to identify supports that need to be included in the CLDP, so Center staff might just need to refresh their practice in this regard. The Monitoring Team recommended that transition staff review this CLDP in detail to identify where improvements were needed.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.											
Summary: Similar to outcome 1 above, there were a number of positive aspects to the Center's post move monitoring, but there also remained some aspects that needed to be done more completely. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	57								
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 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% 0/1	0/1								
6	The PMM's assessment is correct based on the evidence.	0% 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% 0/1	0/1								
8	Every problem was followed through to resolution.	0% 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:
4. PMM Checklists did not yet consistently provide valid and reliable data to report the status regarding the individual's receipt of supports. The Center should continue to focus on 1) 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 2) ensuring that PMM documentation addresses all requirements of supports and corresponding evidence.

- Most of the CLDP supports required several prongs of evidence, including interviews, observations, and review of documentation.
  - It was very positive to see that the PMM had developed an organized and thoughtful process for documenting the evidence reviewed for each support, using three headings (i.e., observations, interviews and documentation) to clearly delineate the findings from each of her activities.
- The Monitoring Team again discussed with transition staff how difficult it may be for the Post-Move Monitor to fully document the presence of a support when it includes many, and sometimes disparate, components. The Center may want to consider whether this structure of supports is conducive to the ability of the Post-Move Monitor to fully and accurately monitor and document the implementation of supports. For example:
  - A post-move support called for provider staff to monitor and chart on approximately 14 different nursing needs. At the time of the seven-day and 45-day PMM visits, the PMM provided a comment that addressed some (e.g., weight, vital signs, seizures, bowel movements and emesis), but not others (e.g., jaw self-dislocation, temperature checks, oxygen level). The PMM marked the support as in place.
  - A post-move support for the implementation of the PBSP included a list of 14 broad requirements (e.g., fundamental outcomes, plan to teach replacement behaviors, triggers, prevention techniques, interventions for target behaviors), but, as described previously, did not provide any clear criteria for those topics that the PMM could use to confirm staff knowledge or implementation. For both the seven-day and 14-day PMM visits, the PMM offered brief comments indicating Individual #57 had not experienced any behavioral issues, but did not provide any comments to show she probed the knowledge of provider staff about the 14 topics. The PMM marked the support as in place.
  - A post-move support for medication administration included requirements for the individual to take his medication as prescribed, for provider staff to report refusals and/or side effects, and for medication administration instructions. The PMM commented that provider staff reported the individual took his prescribed medications and had not had refusals or side effects, but did not document confirming staff knowledge of the medication instructions. In addition, the support included a requirement for the provider to make no changes in prescribed medications until the prescribing physician contacted the Center's PCP or psychiatrist to discuss the individual's medication history. The PMM comment did not reference these criteria at either the seven-day or 45-day PMM visits, but marked the support as in place.
- The PMM did not consistently obtain required documentation to confirm that information obtained in interviews was correct. For example:

- At the time of the seven-day PMM visit, for the nursing post-move support described above, the PMM noted that she requested copies of the service delivery logs to confirm the required monitoring, but did not update the documentation to show this was completed. However, the PMM marked the support as in place.
- Also, at the time of the seven-day PMM visit, the PMM documented she requested copies of the service delivery logs and medication administration record (MAR) to confirm he received his medications as prescribed, as attested to by provider staff in interview. No additional documentation indicated the needed documents were provided, but the PMM marked the support as in place.

5. Based on information the PMM collected, Individual #57 often, but not always, received supports as listed and/or described in the CLDP. The most notable exceptions documented by the PMM were supports for the psychiatrist-to-psychiatrist collaboration and the appointment with a community Board-Certified Behavior Analyst (BCBA), along with the attendant monthly monitoring of behavioral data. However, as described in Indicator 4 above and with regard to Indicator 1, the Monitoring Team frequently could not evaluate or confirm whether he 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.

6. Based on the supports defined in the CLDP, the Monitoring Team could not confirm that the Post-Move Monitor's scoring was consistently correct. In many instances, the PMM still marked supports as in place without having documented obtaining all the required evidence for all components of supports that would confirm the evaluation. Examples are described with regard to Indicator 4 above.

7-8. 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 and, therefore, the need to take follow-up action. For example, as described above, the PMM sometimes marked supports as in place even though she did not have all of the needed documentation. Although she requested the documentation, which was positive, she did not mark these as areas of concern that required follow-up or routinely document if or when the required materials were provided. Going forward, whenever the PMM finds it necessary to ask for additional documentation to confirm a support, that support should not be marked as in place until the required documentation is received. In addition, in order to ensure follow-up, the PMM should list the missing documentation in the Area of Concern/Unmet Support section of the PMM Checklist and monitor until resolved.

Even so, there were positive examples of follow-up by transition staff when they recognized needs existed. One example, documented at the 45-day PMM visit, was the ongoing efforts to facilitate the psychiatrist to psychiatrist consultation. It was positive to see that the PMM had documented this and one other incomplete support (i.e., for the BCBA appointment) in the in the Area of Concern/Unmet Support section of the PMM Checklist. The documentation indicated that these were very recent findings and resolution had not yet been achieved, but had a due date of "as soon as possible." A better practice would be to project a specific date, which could then be used to trigger additional follow-up.

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: It was positive to see that the individual had not had any PDCT events. This is the third consecutive monitoring review with a 100% score for this indicator. This indicator will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	57								
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	100% 1/1	1/1								
Comments: 11. It was positive that Individual #57 had not experienced a PDCT event.											

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.											
Summary: The Center continued to work on improving transition assessments and some good progress was seen from some departments. More work was still needed. Indicators 15 and 17 showed sustained high performance and will be moved to the category of requiring less oversight. The others will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	57								
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/1	0/1								
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/1	0/1								
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	100% 1/1	1/1								
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	100% 1/1	1/1								
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% 0/1	0/1								

Comments:

12. Assessments did not yet consistently meet criterion for this indicator and remained an area for improvement. Transition staff were reviewing assessments prior to the CLDP, using a Transition Assessment Component Checklist. This held promise for further improvement in the content of assessments. The Monitoring Team considers the following four sub-indicators when evaluating compliance with this indicator:

- Assessments updated with 45 Days of transition: Based on the dates of the assessments provided for review, they all met criterion for timeliness. However, some assessments still included some outdated information or had not been updated based on recent developments. For example:
  - The dental assessment, dated 4/22/21, was not updated to reflect that Individual #57 received a new partial denture on 4/29/21. Center staff discussed this during the CLDP and further indicated that he would return to dental clinic on 4/30/21 for a follow-up to ensure the dentures fit well and noted he might require several additional visits for adjustments. In addition to a lack of updated information in the dental assessment, the CLDP did not include any additional information about the fit of the dentures or whether additional fittings might be needed.
  - The psychiatry and physical therapy assessments indicated the individual had a diagnosis of bradycardia, even though the medical assessment documented that the diagnosis had been discontinued and replaced by sinus tachycardia as of 2/1/21. Of note, the pre-move training quiz for nursing/medical needs included an item that indicated he had bradycardia and asked staff about possible symptoms. This helps to emphasize why it is important for assessments to be updated for discharge purposes.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: In some instances, but not all, the disciplines provided a summary of relevant facts in the available assessments. Areas of concern included the issues described above with regard to various assessments. In addition, the Center documented a review of the Quarterly Drug Regimen Review

(QDRR) in the CLDP narrative, which was positive. However, it indicated that the IDT reviewed the QDRR at the 14-day meeting, the annual ISP meeting, and at CLDP, but did not provide a summary of the content.

- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community; and, Assessments specifically address/focus on the new community home and day/work settings: 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. At the time of the previous review, Center transition staff had undertaken a Quality Improvement Plan (QIP) in this area, which was a positive step. For this review, they reported they continued to provide assessment training for IDTs, beginning upon referral and with a focus on assisting IDT members to understand what they needed to include to facilitate a successful transition. Overall, however, the CLDP assessments reviewed for this transition often did not clearly describe provider training needs.
    - Still, while much work continued to be needed, it was particularly good to see the nursing assessment provided many specific expectations about the competencies provider staff would need to demonstrate to show they were prepared to meet the individual's needs, including the sections (i.e., what staff should monitor and report) described with regard to Indicator 1 above.

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 this CLDP, as described in detail in Indicator # 1 above. In summary, findings included:

- 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 consider the method of training needed based on the nature of the support and document that in the pre-move training supports.
- 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. Individual #57's CLDP included this statement. The CLDP indicated a nurse-to-nurse collaboration had taken place prior to transition and included a pre-move support to this effect. The Center also provided good documentation of the extent of this collaboration in the form of the materials used in the consultation and a completed competency checklist. This was positive. The IDT also recommended a psychiatrist-to-psychiatrist collaboration. This collaboration did not take place within the expected timeframe. However, it was positive that Center staff documented ongoing and continued efforts until the collaboration was achieved. This CLDP met criterion.

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. The IDT agreed that a Home Safety Evaluation/Assessment would not be required, due to the individual's independence with regard to ambulation and mobility. This appeared to be correct and this sub-indicator met criterion. However,

when appropriate, the Monitoring Team again encourages Center staff to also consider other aspects of a setting that might be significant for an individual.

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. As reported previously, Center staff continued to use a modified CLDP template that included a section for this topic with sub-headings for possible activities (i.e., provider presentations completed with DSP participation, Center DSP spending time with the individual in the community, Center DSP staff meeting to discuss the individual's needs and provider DSP participation in the development of an Individual Transition Plan and other pre-placement visit activities). The documentation indicated the Center's Home Manager was able to accompany Individual #57 on the initial tour of the home, but that other participation of DSP was not feasible due to COVID-19 restrictions. This CLDP met criterion.

19. The pre-move site review (PMSR) was 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 the PMSR did not accomplish this. The documentation did not show that the competency checks the PMM completed at the time of the PMSR allowed her to directly confirm or measure the provider staff had the knowledge or competencies to meet individuals' needs before transition took place. For example, based on the pre-move training documentation, at the time of the PMSR, the PMM did not directly confirm testing the competencies of the provider staff who would be directly providing the individual's supports. Instead, these documents indicated that the PMM interviewed and reviewed the competency quizzes for the provider's Area Supervisor. In addition, as described above regarding Indicator 1 and Indicator 14, while the CLDP included numerous pre-move supports for pre-move training, those did not yet fully meet criterion for ensuring that provider staff were competent to meet the individual's needs and could not be relied upon as an adequate measure. Going forward, Center staff should continue to focus on efforts to develop pre-move training and competency testing consistent with the requirements of Indicator 1 above. Once that is accomplished, the Center should also be able to achieve compliance with this indicator as well.

Otherwise, it appeared Center staff often evaluated the remaining pre-move supports accurately. However, in one exception, the documentation related to the status of items to be purchased for the individual's room was not clear. Although the PMM marked the support as in place, the documentation only indicated that the transition assistance (TAS) funds had been approved, but did not clearly show that the items were in place.

Outcome 5 – Individuals have timely transition planning and implementation.											
Summary:			Individuals:								
#	Indicator	Overall Score									
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments:											

APPENDIX A – Interviews and Documents Reviewed

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

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

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

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

d. Nursing
e. Pharmacy
f. Dental

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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