United States v. State of Texas

Monitoring Team Report

Austin State Supported Living Center

Dates of Onsite Review: October 31st through November 4th 2016

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Background

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

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

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

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

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

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

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

Methodology

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

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a facility's compliance with all provisions of the Settlement Agreement.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, Positive Behavior Support Plan (PBSP) and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Monitoring Report** – The monitoring report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. A summary paragraph is also provided for each outcome. In this paragraph, the Monitor provides some details about the indicators that comprise the outcome, including a determination of whether any indicators will be moved to the category of requiring less oversight. Indicators that are moved to this category will not be monitored at the next review, but may be monitored at future reviews if the Monitor has concerns about the facility's maintenance of performance at criterion. The Monitor makes the determination to

move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the facility's plans for continued quality assurance and improvement.

Organization of Report

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

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

Executive Summary

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

Status of Compliance with the Settlement Agreement

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

This Domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, mortality review, and quality assurance. Twenty-one of these indicators had sustained high performance scores and will be moved to the category of requiring less oversight. This included five outcomes: Outcome 5 related to restraint; Outcomes 3, 5, and 9 related to abuse, neglect, and incident management; and Outcome 4 related to pharmacy/quality improvement.

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

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

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

<u>Restraint</u>
Austin SSLC had very low usage of crisis intervention restraint (one occurrence in the past nine months) as well as protective mechanical restraint for self-injurious behavior and restraint for medical-dental procedures. Moreover, the facility paid a lot of attention to restraint usage at the facility. As a result, eight indicators were moved to the category of requiring less oversight, many other indicators were scored at 100%, and the three indicators regarding crisis intervention chemical restraint were not rated because there were zero occurrences.

<u>Abuse, Neglect, and Incident Management</u>
Overall, the facility demonstrated a very high level of performance, with 11 indicators (and three outcomes) moving to the category of requiring less oversight. Of particular note was the improved performance on many indicators. That is, many indicators scored at 100% or near 100% for this review, including indicator 1, which is about whether there were protections in place to have reduced the likelihood of the occurrence of the event that led to the investigation.

There was a very important area for improvement. DFPS investigations were not completed within 10 days and the rationale for extensions was not clear, but might have been related to resources and staffing. For instance, in some cases, the first staff interview did not even occur within the first 10-day window. Delayed initiation of an investigation as well as delayed completion of an investigation can seriously compromise the quality and findings of an investigation.

Other

It was good to see that IDTs were talking about pretreatment chemical restraint and developing plans. Plans were implemented for some individuals, though teams were not determining whether the plans were effective and if any changes should be made.

It was also good to see that the Center completed clinically significant DUEs and followed up to closure on recommendations. Given that the Center's performance on the related indicators was at 100% during this review and the last two reviews, this entire Outcome will move the category requiring less oversight.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.											
Summary: Restraint usage was extremely low at Austin SSLC, reflected in the 100% scores for both of these indicators for this review and the previous review. Given the importance of these facility and individual indicators, both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	100% 12/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (January 2016 through September 2016) were reviewed. Due to the changeover to the electronic record (called IRIS), state office was unable to provide these data and graphs. Instead, the facility provided the graphs for the nine-month period. The Monitoring Team calculated the 1000-bed-day number using the facility-provided average daily census.

The frequency of crisis intervention restraint at Austin SSLC was the lowest of the 13 facilities. There was one crisis intervention physical restraint for two minutes for one individual in April 2016 (and none since). There were no occurrences of crisis intervention chemical or mechanical restraint. There were no injuries that occurred as a result of restraint. The number of individuals with protective mechanical restraint for self-injurious behavior (PMR-SIB) decreased from two to one, and the behavioral health services staff, along with the medical staff and IDT, were working to reduce (and eventually eliminate) that, too (mittens).

The number of non-chemical restraints for medical procedures was at zero for the past six months, reduced to that level after training sessions with nurses was conducted by the behavioral health services department. Non-chemical restraints for dental procedures was at zero. Chemical restraints for medical and dental procedures was at zero or low levels across the nine-month period.

Thus, facility data showed low/zero usage and/or decreases in all 12 of these 12 facility-wide measures (i.e., use of crisis intervention restraint; use of crisis intervention physical, chemical, and mechanical restraint; the duration of physical restraints; injuries during restraint; the number of individuals who were restrained and the number with PMR-SIB; and the use of non-chemical restraints for medical and dental procedures.

2. One of the individuals reviewed by the Monitoring Team was subject to crisis intervention restraint, one was subject to PMR-SIB subject to restraint, and one to medical restraint for healing. Data from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for all three (Individual #406, Individual #341, Individual #32). The other six individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period.

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.

Summary: Restraint occurred infrequently at Austin SSLC. When it did, it was implemented according to most of the criteria in this outcome. For instance, six of the indicators have had high scores for multiple reviews (3, 4, 5, 7, 8, and 10). These indicators will move to the category of requiring less oversight. The other three will remain in active monitoring. Indicators 6 and 11 require that the proper documentation be done; the facility should be able to accomplish that. Indicator 9 was not rated for this review and the last review. It will remain in active monitoring for review next time. With improved performance, all three of these indicators might move to the category of requiring less oversight after the next review.

Individuals:

#	Indicator	Overall Score	406	341	32						
3	There was no evidence of prone restraint used.	100% 1/1	1/1	N/A	N/A						
4	The restraint was a method approved in facility policy.	100% 3/3	1/1	1/1	1/1						
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 2/2	1/1	1/1	N/A						
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	50% 1/2	0/1	1/1	N/A						
7	There was no injury to the individual as a result of implementation of	100%	1/1	1/1	1/1						

	the restraint.	3/3									
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 3/3	1/1	1/1	1/1						
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	N/A	Not rated	Not rated	Not rated						
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 2/2	1/1	N/A	1/1						
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	67% 2/3	1/1	0/1	1/1						

Comments:
The Monitoring Team chose to review three restraint incidents that occurred for three different individuals (Individual #406, Individual #341, Individual #32). Of these, one was a crisis intervention physical restraint, one was use of protective mechanical restraint for self-injurious behavior, and one was use of non-chemical restraint for medical healing. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

6. One restraint checklist showed a release code Y (release completed) instead of code S (Individual #406 4/28/16).

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

11. For Individual #341, the IRRF section of the ISP was not correctly completed regarding considerations in the use of crisis intervention restraint.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
Summary: With sustained high performance, this indicator may move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	406	341	32						
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 2/2	1/1	1/1	Not rated						

Comments:
12. Because indicators 2-11 were met criteria for Individual #32, this indicator was not scored for him.

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.													
Summary: Performance improved to 100% for both indicators compared with the two previous reviews. With sustained high performance, both indicators may move to the category of requiring less oversight after the next review. They will remain in active monitoring.			Individuals:										
#	Indicator	Overall Score	406	341	32								
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 1/1	1/1	N/A	N/A								
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	100% 2/2	N/A	1/1	1/1								
Comments:													

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.													
Summary: In addition to improving the timeliness of restraint monitoring, nursing staff need to provide more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline. Working with State Office, the Center should review and revise, as needed, the IRIS/IView documentation for restraints. These indicators will remain in active oversight.			Individuals:										
#	Indicator	Overall Score	406	341	32								
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	33% 1/3	0/1	0/1	1/1								
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	67% 2/3	1/1	0/1	1/1								
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	33% 1/3	0/1	0/1	1/1								
Comments: The restraints reviewed included those for: Individual #406 on 4/28/16 at 8:15 p.m., Individual #341 from 9/6/16 to 9/12/16 (i.e., this appeared to be for mittens), and Individual #32 on 3/7/16 (medical). a. through c. For Individual #406, the restraint began at 8:15 p.m., but the nurse did not conduct the initial check until 8:55 p.m. The mental status only noted "awake/alert."													

For Individual #341, it appeared the restraint involved the use of mittens for a seven-day period, but the IRIS/IView documentation could not be interpreted.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary: Facility performance for this indicator was at 100% for this review and the last review. It will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	406	341	32							
15	Restraint was documented in compliance with Appendix A.	100% 3/3	1/1	1/1	1/1							
Comments:												

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.												
Summary: These indicators showed good performance for this review. Indicator 16 maintained performance from the last review, which was an improvement from the review before that. Indicator 17 was rated at 100% for this review and the past two reviews, too. It will be moved to the category of requiring less oversight. Indicator 16 will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	406	341	32							
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 1/1	1/1	N/A	N/A							
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 1/1	1/1	N/A	N/A							
Comments:												

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)												
Summary: There were no occurrences of crisis intervention chemical restraint, therefore, this outcome and its indicators was not applied. It will remain in active monitoring for review at the next onsite review. At that time, if there again were no occurrences, it may be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score										

47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	N/A									
48	Multiple medications were not used during chemical restraint.	N/A									
49	Psychiatry follow-up occurred following chemical restraint.	N/A									

Comments:
47-49. There were no occurrences of crisis intervention chemical restraint during this entire review period.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.

Summary: Criteria were met for all investigations. This showed excellent and continual progress compared to previous reviews. Given this was the first time this level of performance was demonstrated, this indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 32	263	249	127	341	425	291		
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	100% 8/8	1/1	1/1	1/1	1/1	2/2	1/1	1/1		

Comments:
The Monitoring Team reviewed eight investigations that occurred for seven individuals. Of these eight investigations, six were DFPS investigations of abuse-neglect allegations (two confirmed, four unconfirmed). The other two were for facility investigations of a discovered toe fracture, and of an unauthorized departure. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #32, 096-06-15-16, DFPS 44423684, unconfirmed allegation of neglect, 6/15/16
- Individual #263, 114-07-26-16, DFPS 44570168, unconfirmed and inconclusive allegation of neglect, 7/26/16
- Individual #249, 086-05-23-16, DFPS 44360835, confirmed allegation of neglect, 5/23/16
- Individual #127, 103-06-30-16, DFPS 44482085, unconfirmed allegation of neglect, 6/30/16
- Individual #341, 125-08-16-16, DFPS 44651539, confirmed allegation of neglect, 8/16/16
- Individual #341, 119-08-01-16, Discovered toe fracture, 8/1/16
- Individual #425, 116-07-27-16, DFPS 44575105, unconfirmed allegation of neglect, 7/27/16
- Individual #291, 083-05-16-16, Unauthorized departure, 5/16/16

1. For all eight investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes (a) the occurrence of staff criminal background checks and signing of duty to report forms, (b) facility and IDT review of trends

of prior incidents and related occurrences, and the (c) development, implementation, and (d) revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator and other facility staff met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management. All eight of the investigations met the criteria for this indicator, including reviewing and acting upon previous occurrences and trends as typically evidenced in the ISP, PBSP, PNMT, and/or ISPAs (or the incident did not involve any prior occurrences or trends). This was excellent progress and improvement for the facility and its incident management department.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.											
Summary: Austin SSLC demonstrated excellent performance on this indicator, and showed continued improvement from the past two reviews, too. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	263	249	127	341	425	291		
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	100% 8/8	1/1	1/1	1/1	1/1	2/2	1/1	1/1		
Comments: 2. All incidents were reported correctly. This was very good to see. Two incidents were reported after the facility conducted a video review of the incidents and suspected neglect. This was a good practice.											

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting.											
Summary: These indicators showed 100% performance for this review and the previous two reviews, too. Therefore, all three indicators will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	32	263	249	127	341	425	291		
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated		
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 8/8	1/1	1/1	1/1	1/1	2/2	1/1	1/1		
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 8/8	1/1	1/1	1/1	1/1	2/2	1/1	1/1		

Comments:
3. Because indicator 1 was met for all seven individuals, this indicator was not scored for them. Even so, during the onsite week, the Monitoring Team had the chance to review the typical questions with four staff, all of whom answered all of the questions correctly.

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.											
Summary: The facility took immediate action as demonstrated by the 100% score for this indicator. This performance also showed continual improvement compared with the previous two reviews, too. With sustained high performance, this indicator might move to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	263	249	127	341	425	291		
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 8/8	1/1	1/1	1/1	1/1	2/2	1/1	1/1		
Comments:											

Outcome 5– Staff cooperate with investigations.											
Summary: Scores for this indicator was at 100% for this review and for the last review, and 93% for the review before that one. The exception was for a non-serious injury investigation. Given this sustained high performance, this indicator will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	32	263	249	127	341	425	291		
7	Facility staff cooperated with the investigation.	100% 8/8	1/1	1/1	1/1	1/1	2/2	1/1	1/1		
Comments: 7. Long delays in DFPS investigation completion (see indicator 12 below) can have the potential to compromise testimonial evidence. While finding no examples of this in this set of investigations, the facility should be mindful of this when reviewing DFPS investigation reports.											

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.	
Summary: Austin SSLC showed 100% performance on this review and the last two reviews, too, for indicators 8 and 10 (with one exception in April 2015 due to a document not being submitted). Given this sustained high performance, these two indicators (8, 10) will be moved to the category of requiring less oversight. Indicator 9 will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	32	263	249	127	341	425	291		
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 8/8	1/1	1/1	1/1	1/1	2/2	1/1	1/1		
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	88% 7/8	1/1	1/1	1/1	1/1	1/2	1/1	1/1		
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	100% 8/8	1/1	1/1	1/1	1/1	2/2	1/1	1/1		

Comments:

9. For Individual #341 119-08-01-16, the UIR identified a specific staff member who discovered the injury. The staff member was not interviewed. Also, it was unclear which staff was assigned one-to-one supervision. Therefore, not all relevant evidence was collected, weighed, etc.

10. For Individual #263 114-07-26-16, after request from the facility director, DFPS conducted a review of their findings, considered additional evidence, and changed the finding to a confirmation. This was very good to see and showed that the appeal/review process was active and valid.

Outcome 7– Investigations are conducted and reviewed as required.

Summary: All investigations commenced as required for this review and the previous two reviews, too. Therefore, indicator 11 will be moved to the category of requiring less oversight. DFPS did not complete its investigations within the required 10 calendar days and extension requests did not identify reasonable extraordinary circumstances. This is a major concern of the Monitoring Team, especially considering the long delays in initial interviews of staff. These delays can compromise the investigation. Indicators 12 and 13 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	32	263	249	127	341	425	291		
11	Commenced within 24 hours of being reported.	100% 8/8	1/1	1/1	1/1	1/1	2/2	1/1	1/1		
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	38% 3/8	0/1	1/1	0/1	0/1	1/2	0/1	1/1		

13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	88% 7/8	1/1	1/1	1/1	1/1	1/2	1/1	1/1		

Comments:
12. Five of the six DFPS investigations were completed in more than 10 days and did not have extension requests with satisfactory explanations of extraordinary circumstances. Of concern was that there were long delays in conducting the first staff interviews, sometimes as many as 15 days and 19 days after the allegation (Individual #249 086-05-23-16, Individual #127 103-06-30-16). In its response to the draft report, the State wrote that these delays were caused by extraordinary circumstances not under the investigator's control. However, without a detailed explanation of what circumstances were extraordinary and were not under the investigator's control, the Monitoring Team has no basis to reconsider this scoring.

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

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

Summary: Injury audits were conducted very well at Austin SSLC and had been for many years. As a result, indicator 14 will be moved to the category of requiring less oversight. Non-serious injury investigations were also done well and with sustained high performance, indicator 15 might move to the category of requiring less oversight after the next review. It will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 32	263	249	127	341	425	291		
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	1/1		
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	1/1		

Comments:

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
Summary: Recommendations related to findings, and both disciplinary and programmatic recommended actions were taken and in a timely manner. This is reflected in all three of these indicators scoring at 100%, as they did during the last two reviews, too (with one exception due to a paperwork submission omission in April 2015. Therefore, all three indicators will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	32	263	249	127	341	425	291		
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 6/6	1/1	N/A	1/1	1/1	2/2	N/A	1/1		
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 2/2	N/A	N/A	1/1	N/A	1/1	N/A	N/A		
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 5/5	1/1	N/A	N/A	1/1	2/2	N/A	1/1		
Comments:											

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
Summary: This outcome consists of facility indicators. The facility had a very good system; one data aspect should be included (by staff work shift). With sustained high performance, this set of indicators may move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	No									
20	Over the past two quarters, the facility's trend analyses contained the required content.	No									
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	Yes									
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was	Yes									

	modified.										
23	Action plans were appropriately developed, implemented, and tracked to completion.	Yes									

Comments:
19-20. Full data sets were collected, with the exception of missing an examination by staff work shift.

21-23. Trend reports included a section that identified trends to be addressed, actions to be taken, intended goal (outcome), and the timeline for follow-up. Information was clearly stated and intended outcomes (goal) were described in measurable terms. Data related to changes resulting from the action plan was also displayed in measurable terms. Overall, this was an impressive system for tracking, trending, and acting on data regarding abuse, neglect, exploitation, and injuries.

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. The Center had a policy entitled: “Guidelines: IV Sedations/Anesthesia (TIVA),” dated 9/1/15, which included dental criteria for selection of individuals for TIVA. This policy provided some guidance as to which individuals would benefit from dental care under TIVA/general anesthesia. Although the dental criteria for TIVA outlined were largely consistent with those included in the Dental Audit Tool [i.e., the following procedures must be anticipated: Deep Cleaning (D4341/D4342), Restorative (D2140-D2999), Endodontics (D3110-D3999), and Extractions (D7111-D7999),” other requirements were not included. Specifically, the audit tool states the following: “There are some procedures, such as pulling wisdom teeth or deep scaling that people in the community would expect some form of sedation. For other procedures, three failed attempts must occur first before TIVA is used. If the individual met this criterion before and has another dental need, then only one failed attempt would be necessary, utilizing any desensitization or other strategies developed for the individual. The dentist should describe in detail what issues were observed during the trials. The only exceptions to this would be emergencies. Even if there are failed attempts, teams should document discussion of the need for programmatic interventions to increase cooperation in the future.].” The Center’s policy did not address these components, and the Center should modify its policy to be consistent with these guidelines. If the Center has questions regarding the need to modify its policy, then State Office should provide additional guidance.

Additionally, the Medical Department should have policies and procedures that describe which individuals are medically appropriate

for TIVA/GA on campus or require dental treatment in a hospital setting. Additionally, there should be a medical policy related to comprehensive perioperative management of individuals who will have TIVA/general anesthesia. Perioperative management includes the process of preoperative evaluation. The Dental policies only identified information that the Center should provide to the anesthesiologist/dentist. . If the Center has questions regarding the need to modify its policy, then State Office should provide additional guidance.

For these two instances of the use of TIVA, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, an operative note defined procedures and assessment completed, and post-operative vital sign flow sheets were submitted.

b. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	40% 2/5	0/1	N/A	1/1	N/A	N/A	0/2	1/1	N/A	N/A

Comments: a. For Individual #127, on 4/6/16, documentation was not submitted to show completion of pre-procedure vital signs. From review of Individual #127's ISP and AMA, it also was unclear if the PCP sought input from the IDT with regard to the medication and dosage range. The ISP narrative should summarize the discussion about pre-treatment sedation.

For a mammogram on 6/3/16 for Individual #153 for which pre-treatment sedation was administered, the consent was dated 7/29/16, close to two months later. In addition, a note stated: ""Both drivers were out that day… received PTS [pre-treatment sedation] at the time it was ordered but there were no drivers available to get her to her appointment on time. The mammogram appt was re-scheduled very late the same day, but the PCP did not want to administer another dose of PTS, so by the time she arrived at the later appt the PTS was no longer in her system and was not working to reduce her anxiety." It appeared the appointment was rescheduled for 6/30/16, and Individual #153 was administered another dose of pre-treatment sedation. Again, the consent was dated after the procedure occurred (i.e., 7/29/16).

In its response to the draft report, the State indicated: "Consent for PTS was obtained 8/20/15 and 7/29/16. The copy of the most recent consent was requested and therefore was submitted. The previous consent that covered the 6/3/16 and 6/30/16 PTS administrations was not requested and therefore not submitted with the document request." This is an inaccurate statement. Specifically, the Monitoring Team requested: "For individuals who received TIVA or medical and/or dental pre-treatment sedation, copy of informed consent, documentation of committee or group discussion related to use of medication/anesthesia, and Medical/Dental Restraint Checklist, as applicable." The State/Center should have provided the consent that was relevant to the medical pre-treatment sedation.

Outcome 1 - Individuals' need for pretreatment chemical restraint (PTCR) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTCR.											
Summary: It was good to see that IDTs were talking about PTCR and developing plans. The plans were implemented for some of the individuals, though teams were not determining whether the plans were effective and if any changes should be made. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	263	406	249	394	127	341	425	
1	IDT identifies the need for PTCR and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
2	If PTCR was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTCR, or (b) determined that any actions to reduce the use of PTCR would be counter-therapeutic for the individual.	100% 4/4	1/1	N/A	N/A	N/A	1/1	N/A	1/1	1/1	
3	If treatments or strategies were developed to minimize or eliminate the need for PTCR, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTCR, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	100% 4/4	1/1	N/A	N/A	N/A	1/1	N/A	1/1	1/1	
4	Action plans were implemented.	75% 3/4	1/1	N/A	N/A	N/A	1/1	N/A	0/1	1/1	
5	If implemented, progress was monitored.	75% 3/4	1/1	N/A	N/A	N/A	1/1	N/A	0/1	1/1	
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/4	0/1	N/A	N/A	N/A	0/1	N/A	0/1	0/1	

Comments:

1. Eight of the nine individuals (Individual #32, Individual #263, Individual #406, Individual #249, Individual #394, Individual #127, Individual #341, Individual #425) had the need for PTCR identified and approved in their ISPs.

2-3. Documentation provided by the facility indicated that PTCR had been used in the previous 12 months with Individual #32, Individual #394, Individual #341, and Individual #425. For three of these individuals (Individual #32, Individual #394, Individual #425), there was evidence of a SAP for toothbrushing and plans to increase opportunities for visits to the dental clinic. The team had not developed an action plan for Individual #341.

4-6. There was evidence that toothbrushing SAPs had been implemented for Individual #32, Individual #394, and Individual #425.

However, for all three individuals, progress was not evident, nor was there evidence of revisions to the SAPs to improve progress. This was particularly concerning when progress had not been observed for several consecutive months. Although there were narrative reports regarding Individual #32's visits to the clinic, there was no documentation available regarding this plan for either Individual #394 or Individual #425.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	316	306							
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 2/2	1/1	1/1							
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/2	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% 0/2	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% 0/2	0/1	0/1							
e.	Recommendations are followed through to closure.	0% 0/2	0/1	0/1							

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

- On 2/2/16, Individual #316 died at the age of 74 with causes of death listed as aspiration pneumonia, and septic shock; and
- On 5/18/16, Individual #306 died at the age of 84 with causes of death listed as pneumonia, and renal cell carcinoma.

For Individual #316, the documentation submitted for the Administrative Death Review (ADR) was confusing. The Center submitted two documents labeled ADR and follow-up ADR, both with signature sheets. The follow-up ADR provided evidence of recommendation completion and would have been more appropriately included in the file of evidence for recommendation completion. Otherwise, it appeared the initial ADR was incomplete and needed a follow-up meeting for completion. Moving forward, the Center should submit the one completed ADR document with clear explanation of any follow-up meetings.

b. through d. Some of the concerns with regard to recommendations included:

- Evidence was not submitted to show the Facility conducted thorough reviews of nursing care, or an analysis of nursing reviews to determine additional steps that can be incorporated in the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews. Overall, some of the problems with the QA Death Review of Clinical/Nursing Services included:
    1. The reviews lacked sufficient information to support the findings;
    2. They did not reflect a comprehensive review of nursing care and practices (e.g., IHCPs, acute care plans, ongoing assessments, etc.). For neither of the individuals reviewed did the Center conduct a critical review of the nursing care and services provided to the individual in the six months prior to his/her deaths. If done correctly, such reviews likely would have generated similar findings to those in this report related to nursing supports (e.g., nursing assessments that do not sufficiently analyze individual's risks; IHCPs that do not address the cause of the individuals problems, IHCPs that fail to identify necessary proactive nursing assessments and preventative measures, etc.);
    3. The reviews were limited to the 72 hours prior to the individuals' deaths, as opposed to at least six months prior to the death; and
    4. The QA Nurse Mortality review template did not support performance of a comprehensive review.

e. Although more work was still needed, it was positive to see that in some cases recommendations were written in a format that allowed the Center to determine whether or not practice was improving. For example, for Individual #306, recommendations related to ensuring the accuracy of active problem lists, and including more definable goals and information in the action plan sections of the annual medical assessments were followed by a recommendation for random chart audits every six months to review active problem lists and action plans. These audits were to include at least three annual medical assessments per PCP, and the Medical Director was to provide written feedback to the PCPs. As is discussed elsewhere in this report, it appeared that implementation of this action step had resulted in improvements to annual medical assessments.

Other recommendations did not include follow-up monitoring or assessment to ensure Center practice had improved. For example, a recommendation that read: "In-service QIDPs on the development of appropriate goals for individuals involved with Hospice Care," resulted in an in-service training session. However, it did not appear specific measures/monitoring were in place to determine whether or not practices changed.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: These indicators will be reviewed until the Center's quality assurance/improvement mechanisms related to ADRs can be assessed and are deemed to meet the requirements of the Settlement Agreement.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	ADRs are reported immediately.	100%	N/A	N/A	1/1	N/A	N/A	1/1	N/A	N/A	N/A

#	Indicator	Score									
		2/2									
b.	Clinical follow-up action is completed, as necessary, with the individual.	100% 2/2			1/1			1/1			
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	100% 2/2			1/1			1/1			
d.	Reportable ADRs are sent to MedWatch.	N/A			N/A			N/A			

Comments: a. through d. It was positive that when two of the individuals reviewed experienced potential ADRs Center staff reported them immediately, and completed necessary clinical follow-up. The Pharmacy and Therapeutics Committee thoroughly reviewed both ADRs.

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.

Summary: Given that during the last two reviews and during this review, the Center completed clinically significant DUEs and followed up to closure on recommendations, this Outcome (i.e., indicators a and b) will move to the category of requiring less oversight.

Individuals:

#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 2/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 1/1

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

- A DUE on antidepressants that was presented to the Pharmacy and Therapeutics Committee on 5/31/16. On 8/31/16, a follow-up DUE was completed; and
- A DUE on probiotics that was presented to the Pharmacy and Therapeutics Committee on 8/31/16. Follow-up was scheduled for this DUE for November 2016.

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. Sixteen of these indicators, in psychiatry, psychology/behavioral health, medical, dental, occupational and physical therapy (OT/PT), and skill acquisition had sustained high performance scores and will be moved the category of requiring less oversight. No entire outcomes were moved to 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>Assessments</u>
Assessments that were needed were considered, identified, and obtained by the IDTs, with one exception.

Psychiatry's CPEs were present, formatted correctly, and with comprehensive content. Annual psychiatric documentation was done, was complete, and was submitted.

Functional assessments were current for all individuals. Full behavioral assessments were missing some components for some individuals.

Each individual had a current FSA, PSI, and vocational assessment in place, but not all of these assessments met all of the criteria for content.

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 over half 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.

On a positive note, for this review and the previous two reviews, Medical Department staff completed the medical assessments in a timely manner. As a result, the related indicator will be placed in the category of requiring less oversight.

Although some additional work was needed, the Center made good progress with regard to the quality of medical assessments. Six of the nine individuals had quality annual medical assessments that included the necessary components and addressed

individuals' needs. In particular, for a number of individuals reviewed, the action plans for significant diagnoses appeared to meet the individuals' needs. The Medical Director was reviewing the annual medical assessments, and discussing them with the PCPs, which appeared to be having a positive effect on their quality. The Center should focus on incorporating these improved action plans into individuals' IHCPs in an integrated fashion with other disciplines.

For individuals reviewed, dental exams and summaries generally were completed timely. Although additional work was needed, the quality of the exams and summaries also showed improvement, which was good to see.

Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible. In addition, often, when individuals experienced changes of status, nurses did not complete assessments consistent with current standards of practice.

In addition to the need to improve the timeliness of referrals to the PNMT, work is needed to ensure that PNMT reviews are complete and thorough, and that they recommend comprehensive assessments as appropriate to meet individuals' needs. When comprehensive assessments are completed, it is essential that the PNMT identify, whenever possible, the potential cause(s) of the physical and/or nutritional problem, and offer clinically justified recommendations, including, but not limited to recommendations for goals/objectives, as well as strategies to address the problem.

The Center should focus on improving the timeliness of Occupational Therapy (OT) and Physical Therapy (PT) consults when individuals experience changes in status. The quality of OT/PT assessments also needs improvement.

Individualized Support Plans

The development of individualized, meaningful personal goals in six different areas, based on the individual's preferences, strengths, and needs was not yet at criteria, but progress was evident. All six ISPs, for instance, included at least one goal that met criteria, and two ISPs had three goal areas that met criteria. Focus is needed to ensure that goals are written in a way that can be measured (i.e., its achievement can be determined) and that data are collected.

Another focus area for the facility (and its QIDP department) is to ensure the actions plans meet the various 11 items in outcome 3, which is regarding the full set of action plans.

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.

The development of individualized psychiatric goals was being addressed by state office. Those activities have started to positively impact Austin SSLC's psychiatric goals as seen in the new table inserted into the psychiatry quarterly review forms.

Individuals had goals/objectives related to psychological/behavioral health services that were measurable and based upon assessments. PBSPs were current for all individuals, but content needed improvement.

Individuals had skill acquisition plans and they were measurable. Tying the SAPs to assessments and ensuring they are practical, functional, and meaningful are areas of focus for IDTs and SAP developers.

It was positive that the individuals' ISPs that were reviewed included a description of how the individual functions from an OT/PT perspective, and the IDTs of individuals reviewed updated PNMPs/Positioning Schedules at least annually, or as the individual's needs dictate. Given the Center's consistent performance with the related indicators, they will move to the category of requiring less oversight.

ISPs were revised annually for all individuals, but implementation within 30 days (as required) was only occurring for some individuals. QIDPs were more regularly completing monthly reviews, which was good to see. Still needed were actions to be taken and regular revisions of the ISP to be made as needed.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: The development of individualized, meaningful personal goals in six different areas, based on the individual's preferences, strengths, and needs was not yet at criteria, but progress was evident as described below. All six ISPs, for instance, included at least one goal that met criteria, and two ISPs had three goal areas that met criteria. This was very good progress since the last review. Focus is needed to ensure that goals are written in a way that can be measured (i.e., its achievement can be determined) and that data are collected. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	249	127	354	422	406	341			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	3/6	3/6	2/6	2/6	1/6	1/6			
2	The personal goals are measurable.	0%	3/6	3/6	2/6	2/6	1/6	1/6			

		0/6									
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	1/6	0/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #249, Individual #127, Individual #354, Individual #422, Individual #406, and Individual #341. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Austin SSLC campus.

1. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and also need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

None of the six individuals had individualized goals in all six areas, therefore, none had a comprehensive set of goals that met criterion. Outcomes for the six ISPs remained very limited in scope and provided few opportunities to learn new skills or ensure that the individual would be involved in meaningful activity. Thus, it was unlikely that personal goals developed by the IDT would have a significant impact on their day.

That being said, there was some improvement in the individualization of personal goals. Each individual had at least one goal in one area that met criterion with this indicator. Two individuals had goals that met criterion in three of the six areas.

To be specific, these goals met criterion:

- Individual #249: recreation, relationships, and independence
- Individual #127: leisure, relationships, and day/work
- Individual #354: leisure and relationships
- Individual #422: leisure and living options
- Individual #406: independence
- Individual #341: independence

For example, these goals were individualized and based on preferences and strengths.

- Individual #249's greater independence goal to buy snacks from the vending machine.
- Individual #127's leisure goal to operate her DVD player and work/day goal to work part-time for a delivery service.
- Individual #354's relationship goal to learn to call his family.
- Individual #422's leisure goal to have "beauty hour" in the community.
- Individual #341's greater independence goal to choose between two sensory items.

Examples of goals that did not meet criterion because they were not individualized and/or based on preferences included:

- Individual #249's work/day goal to prepare her table for snacks was not developed with consideration for where she might want to work or spend her day.
- Individual #354's work/day goal to make more money was not individualized.
- Individual #406's living option goal to live at 788 did not support preferences identified in the ISP.

2. Overall, personal goals for the ISPs did not meet the criterion described above in indicator 1. When a personal goal does not meet criterion, there can be no basis for assessing compliance with measurability or the individual's progress towards its achievement. The presence of a personal goal that meets criterion is a prerequisite to this process. It was good, however, to see that the 12 personal goals that met criterion for indicator 1 also met criterion for measurability.

3. For the 12 goals that were determined to be measurable, only one had reliable and valid data available to determine if the individual met, or was making progress towards achieving, his/her overall personal goals. This was Individual #127's leisure goal. Examples, where data were not considered reliable included:

- Individual #354's QIDP noted in his monthly review that data were not consistently gathered and reviewed. His September 2016 monthly review noted regression, probably due to lack of implementation.
- Individual #249's monthly reviews did not include data that would define progress towards her goal to swim. Staff interviews onsite conflicted on whether or not this goal was consistently implemented.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: When considering the full set of ISP action plans, the various criteria included in the set of 11 indicators in this outcome were not met, but in a handful of cases. A focus area for the facility (and its QIDP department) is to ensure the actions plans meet these various 11 items. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	249	127	354	422	406	341			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	1/6	1/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	33% 2/6	1/1	0/1	1/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0%	0/1	0/1	0/1	0/1	0/1	0/1			

		0/6										
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	33% 2/6	0/1	0/1	1/1	0/1	1/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments: Once Austin SSLC develops more individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals and, thus, the facility can achieve compliance with this outcome and its indicators.

8. Many personal goals did not meet criterion in the ISPs, as described above in indicator 1, therefore, action plans could not be evaluated in this context. A personal goal that meets criterion is a prerequisite for such an evaluation. Action plans are evaluated further below in terms of how they may address other requirements of the ISP process.

For the 12 personal goals that did meet criterion under indicator 1, two met criterion for this indicator. These were:

- Individual #127's action plan to turn her DVD player on supported her outcome to learn to use her DVD player, however, the IDT will need to develop next step action plans when she achieves this first step.
- Individual #354 also had action plans to support his leisure goal to operate his CD.

Examples of action plans that were unlikely to support achievement of personal goals included:

- Individual #127's work related action plans to work outside of her assigned work center did not appear to relate to her outcome to work part-time in a delivery job.
- Action plans to support Individual #406's goal to wash his laundry included a plan to assess his skill level then develop SAPs for laundry washing. The IDT did not develop SAPs based on a current assessment.
- Individual #422 did not have action plans to support her living option goal.

An area of focus for Austin SSLC is to ensure that each personal goal has action plans that specifically related to, and support, each

specific personal goal. Inclusion of additional action plans that are related to the goal area are good to include, but there should always be action plans specific for each personal goal, too.

9. Preferences and opportunities for choice were not routinely integrated in the individuals' ISP action plans. The one exception was Individual #422's ISP. She had action plans to give her the opportunity to choose a preferred sensory activity. SAPs developed to support her action plans, however, addressed compliance with staff requests, not opportunities to make choices. Additional training to develop SAPs that lead to accomplishment of goals is still needed in many cases.

10. ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making for any of the six individuals. No action plans were identified that clearly supported decision-making skills.

11. Two individuals had action plans to support greater independence. Those that did not have action plans to support greater independence were:

- Individual #127 had action plans to buy an item from the vending machine and clean her glasses, however, the IDT did not develop SAPs to ensure consistent implementation.
- Individual #422 had little in her plan that might lead to greater independence. Her team considered that choosing activities would increase her independence, however, action plans appeared to measure compliance rather than making a choice.
- Individual #406 did not have action plans to support his goal to do his own laundry.
- Individual #341's action plans for greater independence (accept lotion massage, participate in ball activity, and look at colorful fruits) were compliance based and not likely to lead to greater independence.

12. IDTs did not fully integrate strategies to minimize risks in ISP action plans. Further discussion regarding the quality of strategies to reduce risks can be found throughout this report. Examples where strategies were not integrated in the ISP included:

- Individual #249's action plans to walk did not integrate PT strategies to prevent falls. Her action plan to make a purchase from vending machines did not integrate strategies to reduce her risk for choking.
- Individual #127's strategies to prevent choking were not integrated into her action plans to make a purchase from vending machines. Mobility supports to prevent falls were not integrated into her action plans for participation in Special Olympics or work SAPs.
- Individual #406's IDT did not adequately integrate strategies to lose weight throughout his ISP. His behavior support strategies were not integrated into teaching strategies for SAPs.
- Individual #341, Individual #354, and Individual #422's strategies to address healthcare risks were not integrated throughout their ISPs.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated in five of six ISPs. The exception was Individual #406's ISP. In addition to the examples provided in #11 and #12 above, examples included:

- Per onsite observation, Individual #249's adaptive equipment for mealtime was not being used for snacks in the day program.
- Individual #127's team had not taken an integrated approach to addressing the root cause of her numerous falls.
- Individual #422's communication strategies were not well integrated throughout her ISP.

14. Meaningful and substantial community integration was absent from the ISPs. There were no specific plans for community participation that would have promoted any meaningful integration for any individual. Individual #422 had a goal for a beauty hour in the community, however, action plans did not support implementation in the community.

15. Two of six ISPs considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Individual #406 and Individual #354's action plans met criterion for this indicator.

16. None of six ISPs had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Observations did not support that individuals had opportunities to spend a majority of their day engaged in functional or meaningful activities. Day programming was rarely based on an adequate assessment of preferences or skills, but rather chosen from a limited list of opportunities for programming offered by the facility.

The facility had begun to offer a wider range of activities and programming for meaningful engagement, including cooking, computer, new arts and craft classes, and swimming. More attention needs to be paid to individuals participating in these offerings as well as an additional focus on opportunities for skill building in the community. The Monitoring Team had the opportunity to observe Individual #249 in the swimming class. She did not attend the class on Tuesday or Thursday, as scheduled. On Friday, her staff reported that she would be going for a swim assessment by a specialist. Staff did bring her to the pool that day, however, the assessment did not occur. Individual #127 was observed in the cooking program. Some individuals were actively involved in the class and supported to learn new cooking skills. Individual #127, however, was not an active participant and her staff did little to encourage her participation. Her staff may need additional training to support her participation in a meaningful way.

17. Barriers to various outcomes were not consistently identified and addressed in five of six ISPs. Individual #406's ISP was the exception. For example, Individual #341 and Individual #354's IDTs identified barriers to increased community integration (transportation and staffing issues) that were not addressed in their ISPs. In particular, community integration and living options barriers were frequently not addressed with individualized and measurable action plans.

18. ISPs did not consistently include collection of enough or the right types of data to make decisions regarding the efficacy of supports. SAPs were often missing key elements, as described elsewhere in this report. Living options action plans generally had no measurable outcomes related to awareness.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.	
Summary: Criterion was met for some indicators for some individuals, but overall, more work was needed to ensure that all of the activities occurred related to supporting most integrated setting practices within the ISP. Of the eight indicators scored for this outcome for this review, three showed improvement since the last review, one showed decreased performance, and four remained at zero percent scores. Primary areas of focus are the conduct of a thorough discussion of living	Individuals:

options, and the identification and implementation of actions to address obstacles to referral. It may be that a majority of individuals at Austin SSLC might have LAR choice as the sole reason a referral did not occur. If so, additional support and direction from facility administration and state office may be helpful to the transition department at Austin SSLC. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	249	127	354	422	406	341			
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).	50% 3/6	0/1	1/1	0/1	1/1	0/1	1/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	67% 4/6	0/1	1/1	1/1	1/1	0/1	1/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	67% 4/6	0/1	1/1	1/1	1/1	0/1	1/1			
23	The determination was based on a thorough examination of living options.	33% 2/6	0/1	1/1	0/1	1/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	67% 4/6	0/1	1/1	0/1	1/1	1/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/5	0/1	0/1	0/1	N/A	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.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/5	0/1	0/1	0/1	N/A	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A			

Comments:
19. Three of six ISPs included a description of the individual's preference and how that was determined, namely, the ISPs for Individual #127, Individual #354, and Individual #341.

20. None of these six individuals had an annual ISP meeting scheduled the week of the onsite visit, so this item was not reviewed.

21. Four of six ISPs fully included the opinions and recommendation of the IDT's staff members.
- Individual #249's ISP did not include a rationale for opinions expressed by each team discipline. The team did not have a consensus opinion and no recommendations were made.
- Medical, nursing, psychiatry, and behavioral services did not include a rationale for their opinion in Individual #406's ISP.

22. Four of six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR.
- The consensus statement for Individual #406 did not reflect the rationale expressed by some team members for not making a referral to the community.
- Individual #249's ISP did not include a consensus statement.

23. Two of the individuals (Individual #127, Individual #422) had a thorough examination of living options based upon their preferences, needs, and strengths.
- Individual #127's team noted that she had lived in the community and was familiar with community living options. Individual #127 told her team that she wanted to continue to live in her current home.
- Individual #422's team acknowledged that she was unable to express her living preferences, however, the IDT developed a list of preferences based on staff observations and her preferences in her current living environment.

24. Four of six ISPs identified a thorough and comprehensive list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed.
- Individual #249's ISP noted LAR choice was an obstacle. Other obstacles were mentioned in discipline opinions, however, consensus was not reached.
- Individual #354's team identified his lack of knowledge of community options, however, the narrative portion of the ISP indicated that he had lived in the community and was familiar with community living options.

26. None of the five individuals had individualized, measurable action plans to address obstacles to referral. (Individual #422 was already referred.)

28. The LAR's choice was identified as a barrier for Individual #249, Individual #127, Individual #354, Individual #406, and Individual #341. None of the IDTs developed a plan to educate the LAR on specific living options that might better support the individuals. Although all ISPs included generic visits into the community, individualized exposure to other living options, or other approaches, were not considered.

29. Individual #422 had been referred to the community. Her ISP did not include specific action plans to move forward with the

referral.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.												
Summary: Performance remained about the same as last time for all indicators in this outcome. ISPs were revised annually for all individuals, but implementation within 30 days (as required) was only occurring for some individuals. All indicators met criteria for one individual, which shows that the facility has the capability for more timely implementation of ISPs and their action plans. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	249	127	354	422	406	341				
30	The ISP was revised at least annually.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1				
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A	N/A	N/A	N/A	N/A	N/A	N/A				
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	33% 2/6	0/1	1/1	1/1	0/1	0/1	0/1				
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	67% 4/6	1/1	0/1	1/1	1/1	0/1	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.	50% 3/6	0/1	0/1	1/1	0/1	1/1	1/1				

Comments:

30. ISPs were developed on a timely basis.

32. Action plans were only implemented on a timely basis for two individuals (Individual #127, Individual #354). Examples in which timeliness criteria were not met were:

- For Individual #249, the Monitoring Team was not able to confirm implementation of the ISP within 30 days due to the lack of data for her action plans to swim, walk with a volunteer, and purchase snacks from a vending machine.
- For Individual #422, her relationship goal was not implemented within 30 days. There was no documentation that she went to beauty hour in the community. Her QIDP monthly reviews noted that no data were available for her leisure goal for June 2016. Her ISP was developed in May 2016.
- For Individual #406, action plans to do laundry, visit a canine club, and swim were not implemented within 30 days.
- Individual #341's action plan to activate his radio using a switch was not implemented in the first 60 days following ISP development.

33. Four of six individuals participated in their ISP meetings. Individual #127 and Individual #406 did not attend their meetings.

34. Three of six individuals did not have an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. Examples included:

- For Individual #249, no participation by DSP, physical therapy, or dietician.
- For Individual #127, no participation by her LAR.
- For Individual #422, her PCP and dietician did not attend her meeting. Her RN was not present at her ISP preparation meeting, thus, the IDT was unable to comment on the status of healthcare goals.

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

Summary: Assessments that were needed were considered, identified, and obtained by the IDTs, with one exception. This was good to see and was reflected in the high scores for both indicators. The one exception was the absence of the health-related input to the ISP preparation meeting for one individual. These indicators will remain in active monitoring. With sustained high performance, these indicators might move to the category of requiring less oversight after the next review.

#	Indicator	Overall Score	Individuals: 249	127	354	422	406	341			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	83% 5/6	1/1	1/1	1/1	0/1	1/1	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	83% 5/6	1/1	1/1	1/1	0/1	1/1	1/1			

Comments:

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, as documented in the ISP preparation meeting, for five of six individuals.

- The nurse case manager and PCP were not present at Individual #422's ISP preparation meeting, thus, the IDT was unable to determine what medical assessments might be needed.

36. For five of six individuals, IDTs arranged for and obtained needed, relevant assessments prior to the IDT meeting per the QIDP assessment submission data. Individual #422's PSI and dental assessment were not submitted 10 days prior to her annual meeting and her behavioral assessment was submitted after the meeting data.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
Summary: It was good to see that QIDPs were now more regularly completing monthly reviews (indicator 38), but what was still needed were actions to be taken and regular revisions of the ISP as needed. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	249	127	354	422	406	341			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
37. IDTs did not consistently meet to review progress or revise supports and services as needed. Reliable and valid data were seldom available to guide decision-making, in any event. As noted throughout this report, little progress was made towards achieving personal goals.

For all individuals, the IDTs did not meet to discuss lack of progress and address barriers or revise supports. When additional assessments were completed during the ISP year, there was rarely documentation that the team met to discuss recommendations from the assessment. For example,

- Individual #249's IDT did not make a referral to the PNMT to assess her increase in falls until she had six documented falls. An orientation and mobility assessment in the pool was requested when progress was not made on her goal to swim. The assessment had not been completed as of October 2016. On 8/24/16, the IDT met to discuss her falls. The ISPA noted that sleep data were not available and recommended that the team reconvene when those data were available. There was no evidence that the team subsequently met to discuss sleep data related to falls.
- Individual #354's ISP preparation documentation indicated that data were not being tracked on his action plans for participating in a choir and attending ballgames. Action plans for his work and relationship goals were discontinued without being replaced with new action plans to ensure that he made progress on his goals.
- Individual #406's action plans to visit divine canine and do his laundry were never fully implemented or revised. Data were not consistently gathered or reviewed for his leisure and living option goals. The IDT did not meet to discuss barriers to implementation.

38. Overall, QIDPs were completing monthly reviews, however, there was rarely data available to determine progress towards meeting goals. QIDPs rarely documented action taken when there was a lack of progress or inconsistent implementation.

QIDPs had recently begun using the IRIS system to populate monthly reviews of services. There was still quite a bit of inconsistency in how this information was being used. The QIDPs will need to be sure that they are not only gathering data for the month, but also summarizing progress, and revising the ISP as needed. Many individuals remained needlessly at risk due to the failure of IDTs to

analyze data and revise supports when needed.

Outcome 1 – Individuals at-risk conditions are properly identified.											
Summary: In order to assign accurate risk ratings, IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings within no more than five days. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	The individual's risk rating is accurate.	39% 7/18	1/2	0/2	2/2	0/2	1/2	1/2	0/2	0/2	2/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	33% 6/18	0/2	0/2	2/2	0/2	0/2	1/2	1/2	0/2	2/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas [i.e., Individual #127 – falls, and dental; Individual #249 – falls, and fluid imbalance; Individual #45 – fractures, and infections; Individual #354 – dental, and respiratory compromise; Individual #75 – cardiac disease, and weight; Individual #153 – skin integrity, and dental; Individual #442 – urinary tract infections (UTIs), and other: cognitive status changes; Individual #422 – skin integrity, and weight; and Individual #224 – skin integrity, and dental].

a. The IDTs that effectively used supporting clinical data, used the risk guidelines when determining a risk level, and as appropriate, provided clinical justification for exceptions to the guidelines were those for Individual #127 – falls; Individual #45 – fractures, and infections; Individual #75 – weight; Individual #153 – dental; and Individual #224 – skin integrity, and dental.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs did not review the IRRFs, and make changes, as appropriate. The exception to this was for Individual #45 – infections for whom the IDT documented discussion of his change of status, including review of his risk rating. The following individuals did not have changes of status requiring modifications to their IRRFs and/or risk ratings: Individual #45 – fractures; Individual #153 –dental; Individual #442 – UTIs; and Individual #224 – skin integrity, and dental.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: The development of individualized psychiatric goals was being addressed by state office. Those activities have started to positively impact Austin SSLC's psychiatric goals as seen in the new table inserted into the psychiatry quarterly review forms. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

4-7. The facility had not yet fully developed psychiatric goals/objectives that delineate the derivation of psychiatric indicators, treated with the psychotropic medications, from the underlying psychiatric diagnosis. As noted in previous reports, moving towards having psychiatric goals/objectives, indicators, and measurement systems was a statewide project designed to support each facility in meeting these requirements.

At Austin SSLC, during the course of the onsite review, it became apparent that the psychiatric department had made progress toward eventually meeting this goal. A table was inserted into the psychiatry quarterly reviews for many individuals (i.e., three of the individuals in the group reviewed by the Monitoring Team [Individual #127, Individual #263, Individual #341], and 24 others reported by the facility). The table was based upon the work that the state office discipline coordinator for psychiatry had done and shared with the Monitoring Team over the past six months.

The table included space for goals, psychiatric indicators, and derivations. The specific method for achieving this progress involved using the free text capability in the derivation section of the table. This allowed the author to describe how the symptoms of the underlying psychiatric disorder produced the overt behaviors (i.e., the psychiatric indicators) that the psychotropic medications were prescribed to reduce. There was also the capability to develop multiple goals/objectives, which allows for inclusion of specific prosocial psychiatric indicators. The table accomplishes some, but not all, of the requirements to meet criteria for this outcome and its indicators, but it showed progress. The Monitoring Team welcomes the opportunity to continue to work with state office and the discipline coordinator for psychiatry to accomplish this.

Another challenge will be for the facility to get this information (especially the goals/objectives) into the IHCP.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
Summary: CPEs were present, formatted correctly, and with comprehensive content. These indicators were at 100% for this review and for the previous two reviews, too (with one exception not meeting criterion for one individual for one indicator). As a result, these three indicators (12, 13, 14) will be moved to the category of requiring less oversight. The other two indicators, with sustained high performance, might move to the category of requiring less oversight after the next review. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
12	The individual has a CPE.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
13	CPE is formatted as per Appendix B	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	CPE content is comprehensive.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A
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.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
13. The CPEs were all formatted as specified.

14. The documentation was extensive and fulfilled all of the criteria.

15. Only one individual, Individual #291 had been admitted recently. He had previously resided at the facility and this was a re-admission. His admission occurred on 3/1/16 and the CPE was dated 3/17/16. The IPN alluding to the admission orders and physical was dated 3/1/16.

16. The psychiatric diagnoses were consistent in the psychiatric, behavioral and medical sections of the record for all of the individuals

except Individual #32. The diagnosis that appeared in the psychiatric and behavioral health sections of the record for Individual #32 were Autism Spectrum Disorder and Major Depressive Disorder, but only the Autism Spectrum Disorder diagnosis was present in the medical section.

Outcome 5 – Individuals' status and treatment are reviewed annually.												
Summary: Annual psychiatric documentation was done, was complete, and was submitted for all individuals for this review and for the last two reviews (with one exception, that was for one individual's documentation in April 2015). Given this high and sustained performance, these three indicators (17, 18, 19) will be moved to the category of requiring less oversight. With sustained performance, indicator 20 may move to the category of less oversight after the next review. Indicator 21 will require some focused effort, primarily to ensure that the psychiatrists' good participation gets documented. These two indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
17	Status and treatment document was updated within past 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1

Comments:
17-19. Annual CPE updates were completed as required and contained the necessary information. They were also submitted to the IDT within the required time frame.

20-21. The treating psychiatrist attended the ISP for all of the individuals with the exception of Individual #32. During the onsite review, the ISP for Individual #394 was observed, on 11/3/16. The scoring for this ISP was based on those observations and indicated that all of the identified essential elements were present. A discussion with the ISP facilitator indicated that the written report would not be finalized for several days. This was the only ISP that met the criteria and had the scoring been based on the written report for the prior 1/4/15 ISP, it would not have met criteria. A persistent deficit in all of the Austin ISPs was a complete absence of any mention of the psychiatrist's direct participation in the meeting (although they did sign the attendance sheet). There were additional deficits in documentation in all of these (with the exception of Individual #32) for whom the documentation in the 11/18/15 ISP was thorough

and would have met criteria, again except for the lack of any specific mention of the psychiatrist's participation. As noted above, this was the only ISP meeting that the psychiatrist did not attend.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.											
Summary: This indicator was not at criteria at the time of the last review. With sustained high performance, it might move to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	100% 3/3	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
Comments: 22. Five of the 65 individuals who were prescribed psychotropic medication at Austin SSLC had a PSP. One of these individuals was Individual #249 whose PSP was dated 3/24/16. This plan met the various criteria that have been developed for these plans. Two additional plans were also reviewed and were also found to meet criteria.											

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
Summary: Improvements in the signed consent process and documentation at Austin SSLC was a focus since the last review and the results were evident in these improved scores. With sustained high performance, these indicators might move to the category of requiring less oversight after the next review. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	67% 6/9	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
32	HRC review was obtained prior to implementation and annually.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments:											

28-32. The records contained signed consents for all of the prescribed psychotropic medications. These consents also contained the required information regarding side effects, a risk benefit analysis and non-pharmacological alternatives.

28. The signed consents for Individual #406, Individual #394, and Individual #425 had combined two medications into one consent form, although the side effect and related information was specific to each medication. These consents were within the last year, but antedated the last monitoring review. It was after that review that the psychiatry department implemented the requirement that each medication have a separate consent.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: Austin SSLC showed good performance on indicators 1, 2, 3, and 4. This was an improvement compared with performance for the last two reviews. With sustained high performance, these four indicators might move to the category of requiring less oversight after the next review. Ensuring that PBSP and PBSP-related are reliable and valid is a focus area for the facility. These five indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 13/13	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	88% 7/8	1/1	1/1	1/1	N/A	1/1	1/1	0/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1

Comments:
1. Eight of the nine individuals reviewed by the behavioral health Monitoring Team had PBSPs. The exception was Individual #249 who had a PSP. Discussion at her psychiatry clinic indicated this was an appropriate support. It should be noted, however, that

mouthing was not addressed and, throughout the week of the onsite visit, this behavior was frequently observed by the Monitoring Team. Of the seven individuals reviewed by the physical health monitoring team, five (Individual #153, Individual #224, Individual #354, Individual #75, Individual #442) had PBSPs. Observation by the Monitoring Team and discussion with facility staff suggested that all of those who needed PBSPs had them in place, and those who did not have a PBSP did not need one.

A discussion was held with the Behavioral Health Services director and assistant director regarding the bib that was used with Individual #422 during her sensory program. Staff are advised to observe Individual #422 throughout the day, during different activities to ensure that this is not utilized continuously and does not serve as an unintended form of restraint to prevent her from sucking on her index finger.

2. The eight individuals reviewed by the behavioral health Monitoring Team had goals related to the services outlined in their PBSPs. However, it was not possible to determine whether Individual #291 had a counseling goal because his counseling plan was not provided to the Monitoring Team. Therefore, seven of eight individuals were rated as having goals/objectives related to their behavioral health needs.

3. All of the behavioral goals were measurable.

4. All of the identified goals were based upon the individuals' assessments.

5. Although it was clear that IOA and data timeliness were being assessed, this did not continue once the electronic data collection system was introduced. Assessing data timeliness remained a challenge at the time of the visit.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.											
Summary: Functional assessments were current for all individuals and for all individuals (with one exception in April 2015) for the last two reviews, too. Therefore, indicator 11 will be move to the category of requiring less oversight. The other two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
10	The individual has a current, and complete annual behavioral health update.	67% 6/9	1/1	1/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1
11	The functional assessment is current (within the past 12 months).	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
12	The functional assessment is complete.	88% 7/8	1/1	1/1	1/1	N/A	0/1	1/1	1/1	1/1	1/1

Comments:
10. Six of the nine individuals had current and complete behavioral health assessments. The exceptions were Individual #263, Individual #127, and Individual #291. Although their reports were current, these lacked information about the individual's

physical/medical health over the previous 12 months.

11. The functional assessment was current for the eight individuals who had a PBSP.

12. Seven of the eight functional assessments were considered complete. The exception was Individual #394 for whom a direct observation had not been completed. It was commendable to see multiple observations conducted at different times of day and in various settings (e.g., Individual #263) and observations clearly described (e.g., Individual #406).

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
Summary: PBSPs were current for all individuals and for all individuals (with one exception in April 2015) for the last two reviews, too. Therefore, indicator 14 will be move to the category of requiring less oversight. The other two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	50% 4/8	0/1	1/1	1/1	N/A	0/1	0/1	1/1	1/1	0/1
14	The PBSP was current (within the past 12 months).	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/8	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1

Comments:
13. There was evidence that the PBSP was implemented within 14 days of required consents for four of the eight individuals (Individual #263, Individual #406, Individual #291, Individual #425).

14. The PBSP for all eight individuals was current within the past 12 months.

15. Although none of the PBSPs were complete, the majority of the indicators were met. In general, operational definitions were provided, antecedent and consequent strategies were identified, data collection systems were described, and treatment objectives were included.

Absent from plans were the use of positive reinforcement specific to the individual and guidelines to ensure sufficient opportunities for the strengthening of identified replacement behaviors.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A
Comments: 24-25. One of the nine individuals (Individual #291) was receiving counseling services with a community-based therapist. Although requested, his counseling plan and progress notes were not provided. As a result these notes could not be assessed. It was reported by the director of behavioral services that Individual #291 had requested that counseling be provided on campus. A qualified individual had recently been hired to fill this position.											

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely medical assessments (Round 9 – 78%, Round 10 – 89%, and Round 11 - 89%), Indicators a and b will move to the category of requiring less oversight. Indicator c for this Outcome will be assessed once the ISPs reviewed integrate the revised periodic assessment process.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
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.	N/A									
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.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	N/R									
Comments: c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.											

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Although some additional work was needed, the Center had made good progress with regard to the quality of medical assessments. Given that over the last two review periods and during this review, individuals reviewed had diagnoses justified by appropriate criteria (Round 9 – 100% for Indicator 2.e, Round 10 – 100% for Indicator 2.e, and Round 11 -100% for Indicator 3.b), Indicator b will move to the category of requiring less oversight. Indicator c for this Outcome will be assessed once the ISPs reviewed integrate the revised periodic assessment process.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	Individual receives quality AMA.	67% 6/9	1/1	1/1	1/1	0/1	0/1	1/1	1/1	0/1	1/1
b.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	N/R									

Comments: a. It was very positive to see that six of the nine individuals had quality annual medical assessments that included the necessary components and addressed individuals' needs. In particular, for a number of individuals reviewed, the action plans for significant diagnoses appeared to meet the individuals' needs. The Medical Director was reviewing the annual medical assessments, and discussing them with the PCPs, which appeared to be having a positive effect on their quality.

For Individual #354, there was no section specific to a plan of care. Early in the AMA, a section entitled: 'Treatments/Consultation" listed many of the active diagnoses, but this needed updating as the information was two or more years earlier than the current AMA. For Individual #75, the plan of care for hypertension only listed two of the four medications prescribed at the time of the AMA. Individual #422's Active Problem List did not include obesity.

b. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. It was good to see that clinical justification was present for the diagnoses reviewed.

c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
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.	28% 5/18	1/2	1/2	0/2	0/2	0/2	0/2	0/2	1/2	2/2
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, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #127 – falls, and infections; Individual #249 – constipation/bowel obstruction, and cardiac disease; Individual #45 – respiratory compromise, and gastrointestinal (GI) problems; Individual #354 – cardiac disease, and osteoporosis; Individual #75 – cardiac disease, and weight; Individual #153 – diabetes, and osteoporosis; Individual #442 – aspiration, and GI problems; Individual #422 – aspiration, and weight; and Individual #224 – weight, and osteoporosis]. The IHCPs that included medical plans consistent with current standards to address individuals' chronic or at-risk conditions were for: Individual #127 – infections, Individual #249 – constipation/bowel obstruction, Individual #422 – weight, and Individual #224 – weight, and osteoporosis. b. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.											

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.	
Summary: Given that during the past two reviews and this one, individuals had timely dental exams (i.e., Round 9 – 100%, Round 10 – 100%, and Round 11 – 100%, Indicator a.ii will move to the category of requiring less oversight. Since Round 9, the Center had made progress with regard to ensuring that dental summaries were completed timely. If this progress continues, Indicator a.iii will likely move to requiring less oversight at the next review. The Center should continue to focus on the quality of dental exams and summaries.	Individuals:

#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A			N/R		N/R				
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	100% 7/7	1/1	1/1		1/1		1/1	1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 7/7	1/1	1/1		1/1		1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	22% 2/9	1/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	43% 3/7	0/1	0/1		0/1		1/1	1/1	1/1	0/1

Comments: For Individual #45 and Individual #75, who were at low risk for dental and who were in the outcome sample, the "deep review" items were not scored, but other items were scored.

b. It was positive that the dental exams for Individual #127 and Individual #249 addressed the required components. Problems varied across the remaining exams. On a positive note, all of those reviewed included a description of the individual's cooperation, an oral cancer screening, an oral hygiene rating completed prior to treatment, periodontal charting, a description of periodontal condition, an odontogram, caries risk, periodontal risk, specific treatment provided, the recall frequency, and a treatment plan. Moving forward, the Center should focus on ensuring dental exams include, as applicable: a description of sedation use; information regarding last x-ray(s) and type of x-ray, including the date; and a summary of the number of teeth present/missing.

c. It was positive that the dental summaries for Individual #153, Individual #442, and Individual #422 addressed the necessary components, and the individual's needs. On a positive note, all of the remaining dental summaries addressed: a summary of the number of teeth present/missing, which is important due to the fact that odontograms might be difficult for IDTs to interpret; effectiveness of pre-treatment sedation; provision of written oral hygiene instructions; recommendations for the risk level for the IRRF; and dental care recommendations. Most provided a description of the treatment provided, and treatment plan, including the recall frequency. Problems varied across summaries, but moving forward the Center should focus on ensuring dental summaries include the following, as applicable: recommendations related to the need for desensitization or other plan (e.g., for Individual #249, the template did not use the proposed or recommended verbiage concerning dental desensitization or other definitive word indicating whether or not the Dental Department was requesting/recommending desensitization or other strategies for this individual; and for Individual #75 both the hard copy and the electronic copy indicated this section of the template was not completed); and identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health.

Nursing

<table>
<tr><td colspan="12">Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.</td></tr>
<tr><td colspan="3">Summary: Continued focus is needed to ensure nurses complete timely annual and quarterly reviews, nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice.</td><td colspan="9">Individuals:</td></tr>
<tr><td>#</td><td>Indicator</td><td>Overall Score</td><td>127</td><td>249</td><td>45</td><td>354</td><td>75</td><td>153</td><td>442</td><td>422</td><td>224</td></tr>
<tr><td>a.</td><td>Individuals have timely nursing assessments:</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.</td><td>N/A</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>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.</td><td>78%
7/9</td><td>1/1</td><td>0/1</td><td>0/1</td><td>1/1</td><td>1/1</td><td>1/1</td><td>1/1</td><td>1/1</td><td>1/1</td></tr>
<tr><td></td><td>iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.</td><td>44%
4/9</td><td>0/1</td><td>1/1</td><td>0/1</td><td>1/1</td><td>1/1</td><td>0/1</td><td>0/1</td><td>0/1</td><td>1/1</td></tr>
<tr><td>b.</td><td>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.</td><td>0%
0/18</td><td>0/2</td><td>0/2</td><td>0/2</td><td>0/2</td><td>0/2</td><td>0/2</td><td>0/2</td><td>0/2</td><td>0/2</td></tr>
<tr><td>c.</td><td>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.</td><td>8%
1/12</td><td>0/2</td><td>0/2</td><td>0/1</td><td>0/2</td><td>1/1</td><td>0/1</td><td>0/2</td><td>0/1</td><td>N/A</td></tr>
<tr><td colspan="12">Comments: a. Problems noted included:
No weight graph was included in the annual comprehensive nursing review for Individual #249, who was at medium risk for weight.
Individual #45's annual nursing physical assessment was dated 3/23/16, but the annual comprehensive nursing review was dated 8/31/15, and the ISP was dated 9/17/15.
For a number of individuals, only one nursing quarterly review was provided in response to the Monitoring Team's request for the last two.
b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #127 – falls, and dental; Individual #249 – falls, and fluid imbalance; Individual #45 – fractures, and infections; Individual #354 – dental, and respiratory</td></tr>
</table>

compromise; Individual #75 – cardiac disease, and weight; Individual #153 – skin integrity, and dental; Individual #442 – UTIs, and other: cognitive status changes; Individual #422 – skin integrity, and weight; and Individual #224 – skin integrity, and dental).

None of the nursing assessments sufficiently addressed the risk areas reviewed. Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

c. The following provide a few of examples of concerns related to nursing assessments in accordance with nursing protocols or current standards of practice in relation to individuals' changes of status:

- The episode tracker indicated that on 7/22/16, Individual #127 fell. No nursing IPN was found showing completion of an assessment. Of note, the Monitoring Team observed Individual #127 during medication administration. She was sliding on the floor while wearing only socks on her feet. When asked about her sliding on the floor while wearing socks and her risk for falls, nursing staff reported she received the socks from her mother and they had the no-slip bottoms (ever though she was clearly sliding). Staff did not appear to recognize the increased risk that the socks presented.
- A 5/23/16 IPN noted Individual #249 fell and hit the back of her head. No specifics were included regarding where she fell and on what she hit her head. The IPN did not include any neurological checks. From other IPNs that day, she had experienced a fall earlier and possibly one later that day (i.e., the IPNs were not clear). Also, a note indicated that she had on "non-skid socks" when she fell, further raising the concern about the safety of these socks for individuals at risk of falls.
- An IPN on 5/23/16 indicated that Individual #45 had rapid breathing and was fatigued, and his oxygen level was 90%. The nursing assessment did not include lung sounds, indications of any pain, appearance and temperature of skin, if diaphoretic, quality of heart rate, or bowel sounds. The individual was sent and admitted to the hospital.
- For Individual #354, on 3/16/16, no nursing assessment was found addressing his toothache. The only IPN found was from the dentist noting the toothache and that tooth #21 was mobile. No assessment was found from nursing staff after the dental appointment during which the individual would not let the dentist extract the tooth. Nursing staff should have assessed him for pain, infection, changes in appetite, or if the tooth came out naturally.
- On 5/18/16 at 7:00 p.m., an IPN noted Individual #442 complained of pain "all over." There was no indication that nursing staff used a pain scale to assess the intensity of the pain, or when it began, what made it better or worse, or if it was joint versus muscle pain, if able to determine. Similarly, on 5/13/16, an IPN from the Nurse Practitioner indicated Individual #442 complained of abdominal pain with increasing behaviors that morning. No nursing assessment was found in the IPNs.
- For Individual #422, on 8/26/16, the Campus RN wrote an IPN addressing redness and swelling to the right side of the individual's face, but did not include a complete assessment of pain, possible dental issue, or assessment of other areas of her skin.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.											
Summary: Given that over the last three 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.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
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.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	2/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	22% 4/18	0/2	1/2	0/2	0/2	1/2	0/2	0/2	0/2	2/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	22% 4/18	0/2	1/2	1/2	0/2	1/2	0/2	0/2	0/2	1/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	17% 3/18	0/2	1/2	0/2	0/2	1/2	0/2	0/2	0/2	1/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	28% 5/18	0/2	1/2	1/2	0/2	1/2	0/2	0/2	0/2	2/2

Comments: a. The IHCPs that addressed individuals' health risks in accordance with DADS SSLC nursing guidelines of current standards of practice were those for Individual #224 – skin integrity, and dental.

b. The IHCPs that included preventative measures were those for Individual #249 – fluid imbalance, Individual #75 – cardiac disease, and Individual #224 – skin integrity, and dental.

c. The IHCPs that included a measurable objective 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) were those for Individual #249 – fluid imbalance, Individual #45 – infections, Individual #75 – cardiac disease, and Individual #224 – skin integrity.

e. The IHCPs that included the specific clinical indicators to be monitored were those for Individual #249 – fluid imbalance, Individual #75 – cardiac disease, and Individual #224 – skin integrity.

f. The IHCPs that specified the frequency for monitoring of the individuals' health risks were those for Individual #249 – fluid imbalance, Individual #45 – infections, Individual #75 – cardiac disease, and Individual #224 – skin integrity, and dental.

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 addition to timely referrals to the PNMT, work is needed to ensure that PNMT reviews are complete and thorough, and that they recommend comprehensive assessments as appropriate to meet individuals' needs. When comprehensive assessments are completed, it is essential that the PNMT identify, whenever possible, the potential cause(s) of the physical and/or nutritional problem, and offer clinically justified recommendations, including, but not limited to recommendations for goals/objectives, as well as strategies to address the problem.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	40% 2/5	N/A	0/1	0/1	N/A	0/1	N/A	1/1	1/1	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	60% 3/5		0/1	1/1		0/1		1/1	1/1	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	67% 2/3		N/A	1/1		N/A		1/1	0/1	
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	20% 1/5		0/1	0/1		0/1		1/1	0/1	
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	50% 1/2		N/A	N/A		0/1		1/1	N/A	
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	75% 3/4		N/A	1/1		0/1		1/1	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	0% 0/4		0/1	0/1		0/1		N/A	0/1	

	might be impacted by event reviewed, or a recommendation for a full assessment plan.										
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/3		N/A	0/1		N/A		0/1	0/1	

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

- For Individual #249, PNMT minutes stated assessment was due if she had three emeses in 30 days then stated six emeses in 60 days. Due to her previous history, at a minimum a PNMT review was warranted.
- Individual #45 had recurrent emesis and coughing. When trended back to July 2015, a worsening trend in their frequency is noted. For multiple months, the PNMT monitored him, but provided no comprehensive assessment despite an increasing trend in emesis. The PNMT did not conduct an assessment until Individual #45 experienced a second pneumonia. If the PNMT had conducted a sufficient review, they would have identified the need for a comprehensive assessment.
- On 5/25/16, Individual #75 was diagnosed with aspiration pneumonia. The PNMT did not conduct a review. PNMT minutes briefly discussed the incident, but sufficient detail was not provided to consider this a PNMT review. At least a review was warranted due to the individual's past history of persistent penetration per a modified barium swallow study (MBSS). No PNMT member was present at the hospital discharge meeting as stated in the PNMT minutes. No documentation was found to show the PNMT followed up on a statement that the Speech Language Pathologist (SLP) was reviewing the individual for a possible diet texture upgrade, so that this information could be incorporated into the PNMT's review. The Center also did not submit an ISPA to discuss the SLP's findings. No evidence was found of a PNMT RN post-hospitalization review for Individual #75's aspiration pneumonia on 5/25/16.
- The PNMT referral and assessment for aspiration were completed timely for Individual #442, which was good to see.
- For Individual #224, the PNMT initiated a review of emesis in a timely manner. No evidence was provided that as part of their review the PNMT completed a positioning evaluation as the IDT requested. In addition, clear recommendations from the PNMT were absent from the review provided. Although the 8/25/16 PNMT minutes indicated an assessment was warranted, the PNMT did not conduct an assessment, and did not provide justification for not conducting one.

h. As noted above, one individual who should have had a comprehensive PNMT assessment did not (i.e., Individual #422). The two assessments that the PNMT did complete varied in quality, but both were missing key components. The following provide some examples of strengths as well as problems noted:

- Once the PNMT initiated the assessment for Individual #45, it provided some nice information regarding medications and whether or not the potential side effects were noted in the individual. The assessment also provided review of the risk areas and levels with recommended changes. The primary concern noted with the assessment was that there was no evidence of completion of many of the recommendations, which would have addressed the necessary components of a comprehensive PNMT assessment. For example, the PNMT made a recommendation for a head-of-bed evaluation (HOBE), but this was not produced to the Monitoring Team nor was it found in the IPNs or ISPAs in a form that would reflect an assessment. Monitoring frequency was vague and only stated monitoring would occur, but did not provide frequency or duration.
- Most of the components of the assessment for Individual #442 did not meet the requirements. The only components that met criteria were identification of the presenting problem; discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs; and review of the applicable risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification. Overall, there was limited to no assessment or

analysis of the potential etiology(ies) of the individual's decrease in function and eating status. Recommendations were vague and essentially stated to continue therapy.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: It was good to see improvement with regard to the inclusion of clinical indicators in IHCPs. Otherwise, no improvement was seen with regard to these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	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.	89% 16/18	1/2	2/2	2/2	2/2	1/2	2/2	2/2	2/2	2/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	8% 1/12	01/	0/1	0/1	0/1	0/2	1/1	0/2	0/1	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: choking, and falls for Individual #127; choking, and falls for Individual #249; aspiration, and GI problems for Individual #45; choking, and aspiration for Individual #354; choking, and aspiration for Individual #75; falls, and choking for Individual #153; choking, and aspiration for Individual #442; aspiration, and falls for Individual #422; and choking, and aspiration for Individual #224.

a. and b. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP, and did not include preventative physical and nutritional management interventions to minimize the individuals' risks.

c. All individuals reviewed had PNMPs and/or Dining Plans. The PNMPs and/or Dining Plans for Individual #422, and Individual #224 included all of the necessary components to meet the individuals' needs. Problems varied across the remaining PNMPs and/or Dining Plans. Some of the problems noted included:

- For Individual #75, aspiration risk was not listed, and the risk level for choking was not listed. For the remaining six PNMPs, risk categories were stated, but not risk levels.
- For Individual #224, Individual #153, and Individual #249, the photographs for gait belts were stock photos, and did not reflect the individual's stature, and/or placement of the belt. An individual's weight can affect the placement of the gait belt. The lack of individualized photographs likely contributed to the misplacement of individuals' gait belts under their arms and/or around their breasts.
- PNMPs for Individual #127, Individual #249, and Individual #45 stated that the individuals stood when receiving medications, but there was no justification or rationale provided within the related assessments regarding why sitting would not be an option. Moreover, as the State pointed out in its comments in which they argued with the Monitoring Team's finding, Individual #45 was not able to stand. However, as the State quoted, the PNMP states: "Stand face-to-face with him while giving meds."
- Individual #442 could tolerate thin liquids, but without explanation his PNMP indicated he received suction tooth brushing.
- Communication instructions were incomplete for Individual #249 (i.e., did not mention to stand in front of her as stated in the ISP), and Individual #442 (i.e., only stated that he "speaks," and did not address communication instructions on page 1 of his ISP that indicated staff need to sit next to him so he can hear them).

e. It was good to see that generally the IHCPs reviewed identified the necessary clinical indicators. The exceptions were those for choking for Individual #127, and aspiration for Individual #75.

f. The IHCP that identified triggers and actions to take should they occur was for choking for Individual #153.

g. The IHCPs reviewed did not include PNMP monitoring, and/or did not define the frequency of monitoring.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
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.	67% 2/3	N/A	N/A	1/1	N/A	N/A	N/A	1/1	0/1	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to	67%			1/1				1/1	0/1	

	progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	2/3									
Comments: a. In assessing the least restrictive method of enteral nutrition, Individual #422's OT/PT assessment stated that in 2011 a trial was completed, and she showed no interest. As part of the April 2016 update, a dry spoon was used to conduct a trial, and did not produce a positive response from Individual #422. These trials were the basis for determining that she had no interest in eating. However, these efforts did not reflect a sufficient assessment. b. The SLP for Individual #442 did a nice job providing the needed therapy and trials to return him to oral intake.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center should focus on improving the timeliness of consults when individuals experience changes in status. The quality of OT/PT assessments also needs improvement. The Monitoring Team will continue to review these indicators			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
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	N/A	N/A	N/A	N/A	N/A	N/R	N/A	N/A	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	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	63% 5/8	0/1	0/1	0/1	1/1	1/1		1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	63% 5/8	0/1	0/1	0/1	1/1	1/1		1/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills;	N/A									

	• 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.									
d.	Individual receives quality Comprehensive Assessment.	0% 0/1	N/A	N/A	N/A	N/A	N/A		0/1	N/A	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/7	0/1	0/1	0/1	0/1	0/1		N/A	0/1	0/1

Comments: a. and b. Individual #153 was in the outcome group, and made progress on two goals/objectives that were clinically relevant, and measurable. As a result, these indicators were not assessed for her.

Five of the eight individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status. The following concerns were noted:

- For Individual #127, an assessment for an increase in falls was not provided until she had experienced greater than six falls in two months.
- Although Individual #249 had an Assessment of Current Status completed in a timely manner, no evidence was found until 8/18/16 of a consult in response to her increase in falls. Greater than 12 falls had occurred before the PT completed the consult.
- For Individual #45, the PNMT recommended multiple assessments. At times, a statement was documented related to one of these assessments, but the information and format were insufficient to consider it a comprehensive assessment. Examples included positioning and Head-of-Bed Evaluation.

d. Individual #442's OT/PT Comprehensive Assessment sufficiently addressed a number of the required components. The therapists did a nice job comparing handling and transfers to previous assessments, but the assessment lacked comparative analysis for range of motion and musculature.

e. A number of issues were noted with regard to the quality of the OT/PT updates. The following summaries some examples of concerns noted with regard to the required components of OT/PT assessments:

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: In some instances, the updates discussed the risks, but not the level of risk (e.g., Individual #249, and Individual #45). For Individual #75, his risk for

aspiration was not addressed in the assessment;

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: For some individuals, the updates failed to identify whether or not the individual experienced potential side effects (e.g., Individual #127, and Individual #249);
- 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: This component was not fully addressed for many individuals (i.e., the only exceptions were Individual #45, and Individual #75);
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: Individual #249's update indicated that her PNMP was effective, despite numerous falls. None of the assessments reviewed discussed monitoring findings;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services: Because some individuals did not have goals/objectives that were clinically relevant and measurable, the updates did not include evidence regarding progress, maintenance, or regression. In other instances, the justification provided was not clinically sound (e.g., for Individual #249's update indicated that her PNMP was effective, despite numerous falls and injuries related to falls; and Individual #422's update stated that she would not likely pick up functional skills without the assistance of staff trained in vision impairment, but given staff at AUSSLC should have such training, it was unclear why the update did not indicate that she should have such supports added); and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Most updates reviewed did not include recommendations to address strategies, interventions, and programs necessary to meet individuals' needs. The only exceptions were for Individual #127, and Individual #45.

On a positive note, all of the updates provided:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale); and
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day.

Outcome 3 – Individuals for whom OT/PT supports and services are indicated have ISPs that describe the individual's OT/PT-related strengths and needs, and the ISPs include plans or strategies to meet their needs.	
Summary: Given that during the past two reviews and this one, individuals' ISPs that were reviewed included a description of how the individual functions from an OT/PT perspective (i.e., Round 9 – 100%, Round 10 – 89%, and Round 11 – 100%), and the IDTs of individuals reviewed updated PNMPs/Positioning Schedules at least	Individuals:

annually, or as the individual's needs dictate (i.e., Round 9 – 100%, Round 10 – 100%, and Round 11 – 88%), Indicators a and b will move to the category of requiring less oversight. The Monitoring Team will continue to review the remaining indicators.											
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/R	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.	88% 7/8	1/1	1/1	1/1	1/1	1/1		0/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	70% 7/10	1/1	0/1	1/1	0/1	1/1		1/2	1/1	2/2
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	20% 1/5	1/1	0/1	0/1	N/A	N/A		0/2	N/A	N/A

Comments: c. and d. Examples of concerns noted included:

- Individual #249's need for leather toe supports was not included in the IHCP and/or PNMP, and modifications the PT recommended to the toe supports in a note, dated 8/18/16, were not discussed in an ISPA.
- Individual #354's assessment recommended that staff assist him to focus on brushing quadrants of his teeth rather than focusing on time. The ISP documented IDT discussion and appeared to indicate IDT agreement, but the goal included in the action plan section still focused on brushing for a specified time period.
- For Individual #442, no ISPA was held to initiate the OT/PT direct treatment beginning in July 2016.
- For Individual #45, no evidence was found of IDT meetings in response to a HOB evaluation and changes made to the tilt in his wheelchair.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
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.	56% 5/9	1/1	0/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	56% 5/9	1/1	0/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	N/A								
d.	Individual receives quality Comprehensive Assessment.	0% 0/4	N/A	N/A	0/1	N/A	N/A	N/A	0/1	0/1	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/5	0/1	0/1	N/A	0/1	0/1	0/1	N/A	N/A	N/A

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

- Individual #249's last assessment was in 2014, with no updates in the interim. She had a goal related to the use of an Environmental control switch to request to go outdoors. This goal focused on cause and effect, which is a deficit that must be

overcome for an individual to benefit from speech therapy. Because of this, this was a speech-related goal, and, therefore, the SLP should have reviewed the effectiveness of the support and conducted further assessment, as appropriate.

- No update was provided for Individual #75. His last assessment was completed in June 2014. Individual #75 had multiple issues for which the SLP should have assisted in the development of a speech-related goal, and, therefore, an update would have been warranted.
- For Individual #153, no update was provided. Her last assessment was completed in August 2014. Since the IDT requested further evaluation and the IDT was considering implementing a program related to the use of environmental control, then an update was warranted. In addition, Individual #153 experienced lower extremity cellulitis, which impeded her ability to ambulate. Given that direct seeking was Individual #153's primary method of communication, at a minimum, an additional consult was needed.
- On 3/23/16, Individual #442's IDT expressed concern over being able to communicate with him. The SLP stated they were looking at various options, but provided no further input or evidence of options reviewed to address his decline in communication at the time.

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

- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills: Assessments primarily focused on existing skills and did not provide an in-depth analysis of individuals' potential for expansion or development of skills. The exception was the assessment for Individual #422;
- The effectiveness of current supports, including monitoring findings: Assessments did not provide a clear summary regarding the effectiveness of individuals' communication dictionaries or other speech-related strategies designed to bridge the communication gap. The exception was the communication assessment for Individual #442;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services: In some cases, it was unclear whether additional assessment was needed (e.g., Individual #224), whether AAC device assessment in more functional settings and throughout the day would have yielded different results (e.g., Individual #422, and Individual #224), and/or based on statements in the assessment, a program/goal should have been recommended (i.e., Individual #422 for whom although the assessment stated Individual #422 might benefit from an EC device to activate the radio, it did not provide information in the recommendation section or assist in the development of a goal);
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated: No discussion was found of the impact of Individual #442's intelligibility on behavior, and no explanation was found of specifically why pica behavior was seen as a barrier to further development of Individual #224's communication skills and/or discussion of strategies to overcome this barrier; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: None of the assessments contained recommendations to fully address assessment findings, and/or justification for not including recommendations (e.g., for speech intelligibility for Individual #442, environmental control and/or further AAC/EC trials for Individual #422, and presentation of EC devices to Individual #224 to expand her current level of functioning, for which

justification was not present, because it was not tied to findings in the assessment or the individual's preferences, and it did not offer individualized recommendations related to prompting).

On a positive note, all three assessments provided:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- The individual's preferences and strengths are used in the development of communication supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services; and
- A comparative analysis of current communication function with previous assessments.

e. As noted above, Individual # 249, Individual #75, and Individual #153 should have had updates completed, at a minimum, but did not. The following summaries some examples of concerns noted with regard to the required components of the two communication updates reviewed:

- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills: Improvement was needed with regard to including actual comparisons from year to year that were based on assessment of the individual and data (e.g., from SAPs) (e.g., Individual #354's data regarding his picture book);
- The effectiveness of current supports, including monitoring findings: The lack of monitoring findings to assist in the assessment of the effectiveness of current supports was an area needing focused efforts;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services: Individual #354's update focused on AAC and increasing the use of the iPad, but did not address his past experience with sign language, and the potential for expanding it; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Individual #127's assessment stated that a SAP should be developed, but provided no recommendations regarding what a SAP might resemble.

On a positive note, both updates provided:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- The individual's preferences and strengths are used in the development of communication supports and services; and
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services.

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.	
Summary: Over the past three review cycles, it was positive to see improvement with regard to individuals' ISPs including a description of how the individual communicates and how staff should communicate with the individual, as well as	Individuals:

documentation of IDT review of the individuals' Communication Dictionaries to ensure they comprehensively addressed the individuals' non-verbal communication. If this progress is sustained for the latter, after the next review, Indicator b might move to the category requiring less oversight.											
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
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.	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	88% 7/8	1/1	1/1	0/1	1/1	1/1	1/1	N/A	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	64% 7/11	1/1	0/1	1/1	2/3	0/1	1/1	1/1	0/1	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									
Comments: a. and b. For Individual #45, the ISP description did not include use of Go Talk 9 as a means of communication.											

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: Individuals had skill acquisition plans and they were measurable. This was the case for this review and the previous two reviews for indicator 1 and the last review for indicator 2. Therefore, these two indicators will move to the category of requiring less oversight. Tying the SAPs to assessments and ensuring they are practical, functional, and meaningful are areas of focus for IDTs and SAP developers. The number of SAPs that had good data (indicator 5) improved from 0% scores during the previous two reviews. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	32	406	263	249	394	127	291	341	425

		Score									
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	100% 26/26	3/3	3/3	3/3	3/3	3/3	3/3	2/2	3/3	3/3
3	The individual's SAPs were based on assessment results.	65% 17/26	2/3	0/3	2/3	3/3	2/3	2/3	1/2	3/3	2/3
4	SAPs are practical, functional, and meaningful.	54% 14/26	2/3	0/3	1/3	2/3	3/3	2/3	0/2	2/3	2/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	77% 20/26	3/3	2/3	2/3	1/3	3/3	2/3	2/2	2/3	3/3

Comments:

1. All nine individuals had skill acquisition plans. Three SAPs were reviewed for eight of the nine individuals. The exception was Individual #291 for whom only two SAPs were provided.

2. All of the SAPs reviewed, 26 in total, were measurable.

3. Seventeen of the 26 SAPs were based on assessments. Exceptions included skills that had been identified as mastered in the individual's functional skill assessment (e.g., Individual #394 – communicate a choice; Individual #127 – choose a task; Individual #291 – make a pizza which involves cooking and reading) or vocational assessment (e.g., Individual #263 – set up work area; Individual #406 – sit at work). In other cases, it was noted in the SAP that the individual could perform the skill (e.g., Individual #32 – wash hands; Individual #425 – drink from a cup).

4. Fourteen of the 26 SAPs were considered practical, functional, and meaningful. In addition to those skills that had been identified as mastered, exceptions included the following: Individual #263 was to hand over her money envelope upon staff request – there was no assurance that she would not do the same when asked by a stranger; Individual #249 was to learn to place a magazine in a bin after she dropped it on the floor – it would be advisable to teach her where to keep these materials prior to dropping them; Individual #291 was to learn to plan an event, but he indicated he was not interested in learning to do so; and Individual #341 was to choose between two different weighted items – it was unclear how two different visual patterns of a similar object were meaningful, and further, a structured preference assessment indicated that these were not highly preferred items.

5. Of the 26 SAPs, there was evidence that 20 had been monitored for data reliability once in the past six-month period.

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: Austin SSLC maintained performance for all three indicators for this and the last two reviews. With some additional focus, all three indicators might improve to the point where higher scores are regularly occurring. All three will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
10	The individual has a current FSA, PSI, and vocational assessment.	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	56% 5/9	1/1	1/1	0/1	1/1	0/1	1/1	0/1	1/1	0/1
12	These assessments included recommendations for skill acquisition.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1

Comments:

10. Seven of the nine individuals had assessments that were current with the ISP that was reviewed. The exceptions were Individual #263, for whom a current PSI could not be provided for the October 2015 ISP meeting, and Individual #425, for whom a current FSA could not be provided for the November 2015 meeting.

11. For five of the nine individuals (Individual #32, Individual #406, Individual #249, Individual #127, Individual #341), their assessments were available to the IDT at least 10 days prior to the ISP meeting.

12. For eight of the nine individuals, the assessments included SAP recommendations. The exception was Individual #291, whose vocational assessment did not include recommendations.

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

This domain contains 40 outcomes and 176 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Twenty-nine of these, in psychiatry, psychology/behavioral health, medical, pharmacy, dental, and OT/PT, had sustained high performance scores and will be moved the category of requiring less oversight. This included four outcomes: Outcomes 1, 12, and 14 for psychiatry, and Outcome 7 for dental.

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
Without measurable psychiatric goals, progress could not be determined. Even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. Psychiatric quarterly reviews were scheduled and occurred quarterly, and the content of the quarterly reports met all criteria. Attendance was almost always comprehensive as required. Psychiatric clinics included excellent interdisciplinary work among team members, and excellent participation by behavioral health services staff. The review and management of polypharmacy met criteria for a number of years. There was a decrease in the rate of the timely review of the MOSES/AIMS by the prescriber.

In behavioral health, there were adequate measures for target behaviors and replacement behaviors, as well as methodologies and goals for ensuring data collection timeliness, IOA, and treatment integrity. However, there were problems in the actual collection of the data and in data summarization for PBSPs; these are areas for focus for the facility.

With the recent establishment of an electronic health record data recording system, some challenges became evident. The outcome of the facility's ability to address these challenges will be assessed at the next review.

Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress with regard to individuals' physical and/or dental health. In addition, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. 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
There was evidence of interim/urgent psychiatric consultations when there was a negative change in an individual's status in between scheduled reviews.

With regard to acute illnesses/occurrences, improvement was needed with regard to nursing staff's assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis until the issue resolved; timely notification of the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification; the development of acute care plans for all relevant acute care needs; and development of acute care plans that are consistent with the current generally accepted standards.

It was positive that for the individuals reviewed who required Emergency Department (ED) visits, hospitalizations, or Infirmary admissions, individuals received treatment and/or interventions for the acute illness. It was also good to see that for the individuals reviewed, upon their return to the Center, there was evidence IDTs held ISPA meetings to address follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate, and that the PCPs 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. The Center should focus on ensuring the individual has a quality assessment documented in the IPN, and the PCP or nurse communicates necessary clinical information with hospital staff.

Implementation of Plans

Some exceptionally positive outcomes had been realized for several individuals. For example, the use of PMR-SIB had been faded for one individual. Another individual had learned to sleep in her bed after years of sleeping in the living room of her home.

There needs to be improvement in the use of individual-specific positive reinforcement in the PBSPs. Most plans included praise as the sole identified reinforcer for alternative or replacement behaviors and/or the absence of targeted problem behavior.

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

Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. On a positive note, documentation generally was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs. Although additional work is needed, it was also positive that the Center had made progress on ensuring individuals with chronic conditions or at high or medium risk for health issues received medical assessment, tests, and evaluations consistent with current standards of care, and for a number of individuals reviewed that PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible. The Center is encouraged to continue its efforts in this regard. However, these treatments, interventions, and strategies need to be included in IHCPs.

It was positive that over the last two review periods and during this review, for the non-Facility consultations reviewed, the PCPs generally reviewed consultations and indicated agreement or disagreement, did so in a timely manner, and wrote IPNs that included necessary components. This resulted in three indicators moving to the category requiring less oversight. During this review, the Center also showed progress with regard to providers ordering agreed-upon recommendations.

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

During this review and the previous two reviews, the Center's performance was high for tooth brushing instruction, dental x-rays, restorative work, and extractions. As a result, four indicators will move to the category requiring less oversight. The Center should focus on ensuring that individuals with periodontal disease have treatment plans that meet their needs, and the plans are implemented.

Based on the individuals' reviewed, the Austin SSLC Pharmacy Department was completing QDRRs timely, and practitioners reviewed them timely. As a result, two indicators will be placed in the category requiring less oversight. The quality of QDRRs, and implementation of the agreed-upon recommendations are areas in which the Center needs to continue to improve its performance.

The Center made some progress with regard to developing and implementing plans for individuals with enteral nourishment for whom it was clinically appropriate to move along the continuum to oral eating. In fact, the SLP for Individual #442 did a nice job providing the needed therapy and trials to return him to oral intake. He was now eating orally three meals a day, which was great to see.

Adaptive equipment was generally clean and in good working order. The two related indicators will move to the category requiring less oversight. Proper fit was sometimes still an issue.

Based on observations, there were still many instances (over 40% of 37 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

<u>Restraints</u>

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.

Summary: There was one crisis intervention restraint for this review period, thus, there were no instances of more than three occurrences in any rolling 30-day period. This was good to see. Moreover, the facility made progress in reducing restraints as noted in indicator 1 in domain 1 as well as in the comments below. The facility had 100% performance on all of these indicators at the time of the previous two reviews. If there are no occurrences at the time of the next review, or if criteria are met for any occurrences, these indicators might move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score									
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	N/A									
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	N/A									
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	N/A									
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	N/A									
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	N/A									
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	N/A									

#	Indicator	Overall Score									
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	N/A									
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	N/A									
26	The PBSP was complete.	N/A									
27	The crisis intervention plan was complete.	N/A									
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	N/A									
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	N/A									

Comments:
18-29. In the six months prior to the scheduled visit by the Monitoring Team, there were no individuals who had crisis intervention restraint more than three times in a rolling 30-day period. This was good to see.

It should be noted that since the last visit, the facility staff had eliminated the use of a protective mechanical restraint for the self-injurious behavior exhibited by Individual #389. A fading plan was being implemented to reduce the use of a protective mechanical restraint for the self-injurious behavior exhibited by Individual #341. Staff also reported progress in helping Individual #91 learn to tolerate having he hands washed and fingernails trimmed. While both activities often required restraint in the past, through a gradual desensitization program, she was now cooperating with placing her hands in the sink where both washing and trimming occurred.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.

Summary: Reiss screens were conducted as required and referrals to psychiatry were made as also required for this review and for the previous two reviews. Therefore, all three of the indicators of this outcome will be moved to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	153	45	422	354					
1	If not receiving psychiatric services, a Reiss was conducted.	4/4 100%	1/1	1/1	1/1	1/1					
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was	N/A	N/A	N/A	N/A	N/A					

#	Indicator	Overall Score									
	conducted.										
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	1/1 100%	N/A	N/A	N/A	1/1					

Comments:
1. There were 16 unique individuals in the combined behavioral and medical monitoring team groups. Of these, all but the following four were followed in the psychiatry clinics and, thus, did not require a Reiss. Of those who were not seen in the psychiatry clinics: Individual #422 had a Reiss on 6/13/11 with a score of 7; Individual #153 had a Reiss on 9/23/15 with a score of 8; and Individual #45 had a Reiss on 8/28/16 with a score of 7. All of these scores were below the clinical cutoff score of 9.

3. The only individual with a score above the clinical cutoff was Individual #354, who's Reiss dated 6/25/14 produced a score of 18, which was above the clinical cutoff. A referral was made to psychiatry on the basis of this and he had a CPE performed on 7/25/14. The review of the 24-page report indicated that it was formatted as specified and contained the required information. The final recommendation was for the development of a PBSP and it was not felt that treatment with psychotropic medication was required.

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.

Summary: Without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledges that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 32	406	263	249	394	127	291	341	425
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 8/8	1/1	N/A	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	N/A	1/1	1/1	1/1	1/1	N/A	1/1	1/1

Comments:
8-9. Due to the absence of appropriate meaningful goals, it was not possible to assess progress or make the determinations necessary to formulate new goals. Therefore, these indicators were scored at 0%.

10-11. However, it was clear from the record review and onsite observations that the psychiatry department did respond when the available data and information indicated that an individual was deteriorating. The corresponding documentation appeared in the form of interim psychiatric clinics, psychiatric consultations, and IPN notes. These types of interventions were documented for all of the individuals (except for Individual #406 who was stable throughout this review period). There was also documentation that the

recommendations described in these consults were implemented. The result of the interim consultation for Individual #291 was that no additional intervention was necessary.

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

Summary: Indicator 23 was at 100% performance for this review and the previous review. It will be moved to the category of requiring less oversight. With sustained performance, indicator 24 might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.

#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
			Individuals:								
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

23. The psychiatric quarterlies, the CPEs, and the annual CPE updates all referenced the behavioral aspects of the individual's presentation as well as the relevant data. The psychiatric aspects of the individual's presentation were also incorporated into the behavioral assessment.

24. The psychiatrist participated in the development of the behavioral plans through their participation in the monthly meeting of the behavioral support committee during which the plans were reviewed, amended, and approved. The attendance of the psychiatrist was verified by a review of the attendance sheets for these meetings as well as the psychiatrist's signature on the document, which confirmed the review and approval of the plan by the committee members.

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: Indicators 25 and 27 were at 100% performance for this, and for the last two reviews, too. They will be moved to the category of requiring less oversight. Indicator 26 was scored not applicable this time, was at 100% performance for one of one individual last review, but was at 25% in the April 2015 review. It will remain in active monitoring, but with high performance, might move to the category of requiring less oversight after the next review.

#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
			Individuals:								

25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
26	Frequency was at least annual.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A

Comments:
25-27. Individual #249 was the only individual reviewed by the Monitoring Team for whom there was dual use of an anticonvulsant medication. She had been prescribed Tegretol for years for mood stabilization. During the course of tapering the Tegretol, due to side effects, she had two seizures and it was thus continued for both mood stabilization and seizure control. The related documentation indicated close collaboration between psychiatry and neurology concerning both the treatment with Tegretol and the plan to replace it with Depakote, which is another anticonvulsant that may provide both mood stabilization and control her seizure disorder.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: Quarterly reviews were scheduled and occurred quarterly. This was good to see, as was that the content of the quarterly reports met all criteria. Attendance was almost always comprehensive as required, and data were almost always presented by behavioral health services staff. With sustained high performance for indicators 33 and 34, and improvement in indicator 35, all three indicators might move to the category of requiring less oversight after the next review. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
33	Quarterly reviews were completed quarterly.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
34	Quarterly reviews contained required content.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
35	The individual's psychiatric clinic, as observed, included the standard components.	50% 1/2	N/A	N/A	1/1	N/A	N/A	N/A	N/A	0/1	N/A

Comments:
33. The quarterly reviews were completed as specified for all of the individuals.

34. The documentation in the quarterly reviews was complete and met standards. However, the attendance sheet for the most recent quarterly review for Individual #341 indicated that a DSP was not present. All of the quarterly reviews for him and for the other individuals were attended by the psychiatrist, the psychiatry assistant, the nurse case manager, the behavioral health specialist, the QIDP, and at least one DSP. The psychiatry department had been monitoring the discipline attendance for the quarterlies as part of their on going quality improvement process and noted that for October 2016 members of the required disciplines were present for all of the psychiatry clinics.

35. During the onsite review, the Monitoring Team observed the psychiatric clinical reviews for two individuals. Individual #263's review took place on 11/1/16. All of the required staff members were present and the content of the meeting met criteria. The psychiatric clinical review for Individual #341 took place on 11/3/16. All of the required staff members were present. Although several aspects of his current status were discussed, the behavioral data were not specifically reviewed.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: This indicator will remain in active monitoring. Given that a corrective action plan was put in place, it is likely that performance will improve at the next review.			Individuals:								
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	22% 2/9	0/1	0/1	0/1	0/1	1/1	1/1	0/1	0/1	0/1
Comments: 36. The completion of these side effect evaluations and their timely review by the prescriber were completed according to the requirements for only two of the individuals: Individual #127 and Individual #394. However, most of the deficits were related to the requirements for timely review by the prescriber. For example the MOSES was completed as required on schedule for all of the individuals, except Individual #32. The DISCUS/AIMS had been completed as required for all of the individuals, except Individual #406, Individual #291, and Individual #341. The psychiatry department was aware of these deficits and had already developed a corrective action plan to address the problem. During the onsite review, there was also a discussion of linking the schedule for the MOSES/AIMS to the quarterly review schedule so that would serve as a prompt to both the nurse case manager and the psychiatrist.											

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary: The availability, provision, and documentation of emergency/urgent and/or follow/up interim clinics met the criteria required for these indicators for a number of years. These three indicators will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
39	Was documentation created for the emergency/urgent or follow-	100%	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	up/interim clinic that contained relevant information?	8/8									

Comments:
37-39. Eight of the individuals required interim clinic reviews or urgent consultations during the last review period. The only exception was Individual #406 who had been stable throughout this time period. The psychiatry department had an internal policy of reviewing individuals who have had a change in their psychotropic medication on a monthly basis until stabilized. There was also evidence of interim reviews due to a change in status and urgent psychiatric consults which could involve the psychiatrist going to the home.

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.

Summary: These indicators met criteria during this review and the previous two reviews, too. They will, however, remain in active monitoring. Some may be considered for less oversight after the next review.

#	Indicator	Overall Score	Individuals: 32	406	263	249	394	127	291	341	425
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
40-41. There was no evidence of prescribed medications exceeding the usually accepted dosage ranges, nor was there any indication that psychotropic medication was being used for punishment or for the convenience of staff.

42. All of the individuals also had a behavioral plan.

43. The facility did not utilize PEMA.

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

Summary: The review and management of polypharmacy met the criteria required for these indicators for a number of years. These indicators will be moved to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
45	There is a tapering plan, or rationale for why not.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
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.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
Comments: 44-45. Nine of the 65 individuals who were prescribed psychotropic medications at the facility met the criteria for polypharmacy. Individual #249 was the only individual reviewed by the Monitoring Team whose medications met the criteria for polypharmacy. A tapering plan was in place for the Tegretol and there was evidence of efficacy for her other medications. 46. On 11/1/16, the polypharmacy committee was observed. The committee met quarterly and all of the individuals who met the criteria for polypharmacy were reviewed. The discussions were detailed and current plans to maintain or reduce the number of medications were discussed.											

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Problems in data collection and data summarization for PBSPs led to poor performance on all of these indicators. Moreover, performance had deteriorated on indicators 7 and 9. Improvement in data collection, summarization, and response to status of progress are area for focus that, if addressed, will likely lead to improved scores for this outcome's indicators. All four indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
6	The individual is making expected progress	0% 0/8	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	0% 0/2	N/A	0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A

9	Activity and/or revisions to treatment were implemented.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
6. Although information included in the progress notes for six of the eight individuals suggested progress in the majority of their targeted problem and replacement behaviors, this indicator was rated as zero due to the identified problems with data timeliness and the reported lack of confidence in the accuracy of the data following the introduction of the electronic data collection system. In the most recent progress note for Individual #291 and Individual #425, staff reported that due to the difference in data collection, it was difficult to compare data from before to after the introduction of this new electronic system.

7. Based upon the data provided, none of the individuals had met their goals/objectives.

8-9. There was no evidence that corrective actions had been suggested to address the lack of progress in the replacement behaviors identified for Individual #263 and Individual #406.

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

Summary: All individuals' PBSPs met criterion for qualifications of the author for this review and for the last two reviews, too (with one exception last review). Therefore, indicator 18 will be moved to the category of requiring less oversight. With sustained high performance, indicator 17 might move to the category of requiring less oversight after the next review. Staff training (indicator 16) will require additional focus. Indicators 16 and 17 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 32	406	263	249	394	127	291	341	425
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	63% 5/8	0/1	1/1	1/1	N/A	0/1	1/1	1/1	1/1	0/1
17	There was a PBSP summary for float staff.	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1

Comments:
16. For five individuals (Individual #263, Individual #406, Individual #127, Individual #291, Individual #341), there was evidence that 80% or more of their home staff and at least one day program/work site staff member had been trained in the PBSP. Although there was evidence that at least one day program staff member for Individual #32 and Individual #394 had received training, documentation indicated that, respectively, 70% and 66% of their home staff had been trained. Although 90% of Individual #425's home staff had been trained, there was no evidence of work site staff having been trained.

17. All individuals had a PBSP summary for float staff. These ranged in length from half a page to three pages. While most included

important information from the PBSP, staff are advised to review the plans for Individual #406 (include critical antecedent strategies including moving him to a less crowded or quieter environment and avoid excessive prompting) and Individual #425 (include all targeted problem behaviors – brief change refusal and picking at sores).

18. All assessments and PBSPs were written by a BCBA or a behavior health specialist who was completing or had completed BCBA coursework.

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

Summary: Criteria were met for two individuals for all indicators. Progress notes commented on the progress of the individual. This had been the case for a number of years at Austin SSLC. Therefore, indicator 19 will move to the category of requiring lesser oversight. Indicator 20 maintained the same level of performance, and needs improvement. Indicators 21 and 22 showed decreased performance. Indicator 23 improved and with sustained high performance might move to the category of requiring less oversight after the next review. These four indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 32	406	263	249	394	127	291	341	425
19	The individual's progress note comments on the progress of the individual.	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
20	The graphs are useful for making data based treatment decisions.	38% 3/8	1/1	0/1	1/1	N/A	0/1	0/1	0/1	0/1	1/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	50% 1/2	N/A	N/A	1/1	N/A	N/A	N/A	N/A	0/1	N/A
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	50% 1/2	0/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100%									

Comments:
19. For all eight individuals, their progress notes commented on their progress or lack thereof.

20. Although the graphs were useful for reviewing the individual's progress, for five individuals (Individual #406, Individual #394, Individual #127, Individual #291, Individual #341), the introduction of their PBSP was not accurately noted with a phase change line.

21. An observation was conducted of the psychiatry clinic for two individuals, Individual #263 and Individual #341. At Individual #263's meeting, there was good presentation of current data, both graphically and verbally. It was noted by staff that the data may not be accurate because staff continued to adapt to and become familiar with the electronic data collection system. Although data were not presented and reviewed with the clinical staff who were present at the meeting for Individual #341, there was good discussion and it was clear that staff were working to rule out any medical conditions that may contribute to his SIB. In its response to the draft report, the State presented many of the details about this individual's treatment that were discussed at the clinic, including that the behavioral health specialist reported her observations of Individual #341. The Monitoring Team again acknowledges the good discussion at the clinic, however, criteria for this indicator were not met because the behavioral health specialist did not actually present data nor were data updated as recently as required.

22. There was evidence that two individuals had been reviewed in internal and/or external peer review in the six-month period prior to the Monitoring Team's visit. For Individual #263, there was evidence that her PBSP had been revised to include the identified recommendations. In Individual #32's case, there was no evidence that a trial with small headphones (e.g., ear buds) had occurred as recommended.

23. There was evidence that over a six-month period, internal peer review occurred at a minimum of three times each month and external peer review occurred monthly.

Outcome 8 – Data are collected correctly and reliably.											
Summary: Austin SSLC developed adequate measures for target behaviors and replacement behaviors, as well as methodologies and goals for ensuring data collection timeliness, IOA, and treatment integrity. With the recent establishment of an electronic health record data recording system, some challenges became evident. The outcome of the facility's ability to address these challenges will be assessed at the next review and, with high sustained performance, indicators 26-29 might be moved to the category of requiring less oversight. For now, all five indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
29	If the individual has a PBSP, there are established goal frequencies	100%	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1

	(how often it is measured) and levels (how high it should be).	8/8									
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/8	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1

Comments:
26-27. It was determined that the data collection system described in the PBSP for all eight individuals allowed for adequate measures of his/her target and replacement behaviors across all treatment sites. It should be noted, however, that staff consistently reported challenges in using different measures with the introduction of the new electronic data collection system.

28-29. Prior to the introduction of the electronic data collection system, there were established acceptable measures of data collection timeliness, IOA, and treatment integrity. Similarly, there were established goal frequencies and levels. This had become a challenge with the change in data collection.

30. Prior to the introduction of the electronic data collection system, there was evidence of monthly assessment of IOA and staff knowledge of the PBSP (via interview) for Individual #32, Individual #263, Individual #127, Individual #341, and Individual #425. In every instance, goal levels were achieved. Treatment integrity and data timeliness were not assessed on a monthly basis and/or did not meet the established levels.

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 generally did not have a way to measure outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 127	249	45	354	75	153	442	422	224
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.	17% 3/18	2/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #127 –

falls, and infections; Individual #249 – constipation/bowel obstruction, and cardiac disease; Individual #45 – respiratory compromise, and GI problems; Individual #354 – cardiac disease, and osteoporosis; Individual #75 – cardiac disease, and weight; Individual #153 – diabetes, and osteoporosis; Individual #442 – aspiration, and GI problems; Individual #422 – aspiration, and weight; and Individual #224 – weight, and osteoporosis).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #127 – falls, and infections; and Individual #153 – osteoporosis.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. Although QIDPs were now including some information on these goals/objectives in monthly reviews, specific data and analysis of meaningful data were still not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of medical supports and services to these nine individuals.

Outcome 4 – Individuals receive preventative care.											
Summary: Six of the nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to preventative care can be assessed, and is deemed to meet the requirements of the Settlement Agreement. In addition, the Facility needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	Individual receives timely preventative care:										
	i. Immunizations	78% 7/9	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 5/5	N/A	1/1	1/1	N/A	N/A	N/A	1/1	1/1	1/1
	iii. Breast cancer screening	100% 5/5	1/1	1/1	N/A	N/A	N/A	1/1	N/A	1/1	1/1
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	vi. Osteoporosis	86% 6/7	1/1	1/1	0/1	N/A	N/A	1/1	1/1	1/1	1/1
	vii. Cervical cancer screening	100% 4/4	1/1	1/1	N/A	N/A	N/A	1/1	N/A	1/1	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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

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

- Individual #127 had not received a Prevnar 13 immunization. Because she had a history of a splenectomy, this immunization was indicated as a preventive step in reducing specific severe infectious illness.
- On 1/11/12, Individual #45 had a DEXA scan that showed a T-score of -2.2. The recommendation was to repeat it in one to three years. He is prescribed Reclast, and Vitamin D. On 9/21/16, a repeat DEXA was completed, which was four years and nine months after the prior DEXA. Based on the recommendation of the prior DEXA, this most recent DEXA was overdue by one year and nine months to three years nine months.
- Individual #75 did not receive a pneumovax immunization.

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.

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 remain in active oversight. Individuals:

#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
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: None.

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.

Summary: Given that over the last two review periods and during this review, prior to the transfer to the hospital or ED, individuals reviewed received timely treatment and/or interventions for the acute illness requiring out-of-home care (Round 9 – Individuals:

100% for Indicator 4.e, Round 10 – 91% for Indicator 4.e, and Round 11 - 100% for Indicator 6.e), Indicator e will move to the category requiring less oversight. The Monitoring Team will continue to review the remaining indicators.

#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	100% 13/13	N/A	2/2	1/1	2/2	1/1	2/2	2/2	1/1	2/2
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	100% 5/5		N/A	1/1	N/A	N/A	1/1	2/2	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.	83% 10/12	N/A	2/2	2/2	1/2	1/1	2/2	1/2	1/1	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	50% 2/4		N/A	1/1	N/A	N/A	1/2	N/A	0/1	
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	100% 10/10		2/2	2/2	1/1	1/1	1/1	2/2	1/1	
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	73% 8/11		1/2	2/2	1/1	1/1	0/2	2/2	1/1	
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	100% 6/6		N/A	2/2	1/1	1/1	1/1	N/A	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.	100% 11/11		2/2	2/2	1/1	1/1	2/2	2/2	1/1	

Comments: a. and b. For eight of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 14 acute illnesses addressed at the Center, including the following with dates of occurrence: Individual #249 (allergies on 5/13/16, and abrasion on 3/8/16), Individual #45 (abrasion near eye on 4/3/16), Individual #354 (dermatitis on 7/6/16, and tinea pedis on 6/13/16), Individual #75 (blisters on hand on 3/27/16), Individual #153 (paronychia on 6/27/16, and local reaction to vaccine on 4/20/16), Individual #442 (erythema of buttocks on 4/21/16, and fever on 5/6/16), Individual #422 (emesis and wheezing on 6/7/16), and Individual #224 (nasal drainage on 5/16/16, and allergies on 4/23/16).

It was positive that for the acute illnesses/occurrences reviewed for which follow-up was needed, documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized.

For seven of the nine individuals reviewed, the Monitoring Team reviewed 12 acute illnesses requiring hospital admission, Infirmary admission, or ED visit, including the following with dates of occurrence: Individual #249 (ED visit for fever and tachypnea on 5/15/16, and ED for hand injury on 6/20/16), Individual #45 (hospitalization for UTI and hypoxia on 5/23/16, and hospitalization for aspiration pneumonia and sepsis on 4/18/16), Individual #354 (hospitalization for chest pain on 3/29/16, and Infirmary for fever on 4/12/16), Individual #75 (hospitalization for pica on 5/25/16), Individual #153 (hospitalization for cellulitis on 8/11/16, and ED for cellulitis of foot on 8/21/16), Individual #442 [ED for clogged jejunostomy tube (J-tube) on 7/9/16, and ED for clogged J-tube on 7/8/16], and Individual #442 (hospitalization for cellulitis of face).

c. For Individual #354's hospitalization for chest pain on 3/29/16, and Individual #442's ED visit for a clogged J-tube on 7/9/16, no PCP IPNs were included at the time of their transfer to the hospital, or the next business day.

d. For Individual #153's hospitalization for cellulitis on 8/11/16, no IPN was found documenting the PCP's assessment prior to the individual's transfer, even though a nursing note indicated the PCP conducted an assessment. Medical staff did not document review of vital signs or comment on the vital signs (e.g., stable, etc.) in the IPN for Individual #442's hospitalization for cellulitis of the face.

e. For the acute illnesses reviewed, it was positive the individuals reviewed received timely treatment at the SSLC.

f. The individuals that were transferred to the hospital for whom documentation was not submitted to confirm that the PCP or nurse communicated necessary clinical information with hospital staff were Individual #249 (ED for hand injury on 6/20/16), and Individual #153 (hospitalization for cellulitis on 8/11/16, and ED for cellulitis of foot on 8/21/16).

g. It was good to see that for the individuals reviewed IDTs held ISPA meetings to address follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.

h. For the individuals reviewed, upon their return to the Facility, there was 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, which was good to see.

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

Summary: Given that over the last two review periods and during this review, for the consultations reviewed, the PCP reviewed consultations and indicated agreement or disagreement (Round 9 – 100%, Round 10 – 100%, and Round 11 – 100%), did so in a timely manner (Round 9 – N/A, Round 10 – 100%, and Round 11 – 100%), and wrote an IPN that included necessary components (Round 9 – 82%, Round 10 – 94%, and Round 11 – 77%), Indicators a, b, and c will move to the category of requiring less oversight. The Center made progress with regard to PCPs ordering agreed-upon recommendations (Round 9 – 23%, Round 10 – 79%, and Round 11 – 100%), which was good to see.

#	Indicator	Overall Score	Individuals: 127	249	45	354	75	153	442	422	224
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	100% 13/13	2/2	2/2	2/2	2/2	1/1	N/A	2/2	2/2	N/A
b.	PCP completes review within five business days, or sooner if clinically indicated.	100% 13/13	2/2	2/2	2/2	2/2	1/1		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.	77% 10/13	2/2	2/2	2/2	0/2	0/1		2/2	2/2	
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	100% 12/12	1/1	2/2	2/2	2/2	1/1		2/2	2/2	
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	N/A									

Comments: For seven of the nine individuals reviewed, the Monitoring Team reviewed a total of 13 consultations. The consultations reviewed included those for Individual #127 for neurology on 4/18/16, and surgery on 4/18/16; Individual #249 for neurology on 7/22/16, and neurology on 8/26/16; Individual #45 for urology on 5/11/6, and gastrointestinal (GI) on 5/18/16; Individual #354 for neurology on 4/15/16, and hematology on 4/19/16; Individual #75 for optometry on 4/28/16; Individual #442 for neurology on 7/22/16, and sleep clinic of 7/25/16; and Individual #422 for neurology on 3/10/16, and ophthalmology on 6/2/16.

a. and b. It was positive that for these individuals PCPs reviewed and initialed the consultation reports reviewed timely, and indicated agreement or disagreement with the recommendations.

c. PCP IPNs related to the consultations reviewed were not found for the following: Individual #354 for neurology on 4/15/16, and hematology on 4/19/16; and Individual #75 for optometry on 4/28/16. In the State's comments on the draft report, it argued that an

IPN was not needed for an optometry visit, but this was not consistent with State Office policy that did not exclude certain types of consultations from the expectation that PCPs would write IPNs.

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

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
Summary: Although additional work is needed, it was positive that the Center had made progress on ensuring individuals with chronic conditions or at high or medium risk for health issues received medical assessment, tests, and evaluations consistent with current standards of care, and for a number of individuals reviewed that PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible. The Center is encouraged to continue its efforts in this regard.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
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.	72% 13/18	1/2	2/2	1/2	1/2	0/2	2/2	2/2	2/2	2/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #127 – falls, and infections; Individual #249 – constipation/bowel obstruction, and cardiac disease; Individual #45 – respiratory compromise, and GI problems; Individual #354 – cardiac disease, and osteoporosis; Individual #75 – cardiac disease, and weight; Individual #153 – diabetes, and osteoporosis; Individual #442 – aspiration, and GI problems; Individual #422 – aspiration, and weight; and Individual #224 – weight, and osteoporosis).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #127 – falls; Individual #249 – constipation/bowel obstruction, and cardiac disease; Individual #45 – respiratory compromise; Individual #354 – cardiac disease; Individual #153 – diabetes, and osteoporosis; Individual #442 – aspiration, and GI problems; Individual #422 – aspiration, and weight; and Individual #224 – weight, and osteoporosis. The following provide examples of concerns noted regarding medical assessment, tests, and evaluations, and/or identification of the necessary treatment(s), interventions, and strategies:

- Individual #127 was at risk for infectious disease processes. In 1997, she had a splenectomy for thrombocytopenia, with a subsequent weaning from Prednisone, and had done well. She had various minor infectious illnesses since that time. The main treatment was preventive monitoring. She received periodic testing, with findings indicating maintenance of a normal platelet count. The action plan indicated the PCP would make a referral to hematology if there were signs of declining platelet counts or bleeding. Immunizations were reviewed. She had not received a Prevnar 13, which is indicated as a preventive step in reducing specific severe infectious illness as she has had a splenectomy.

- Over the past year, Individual #45 had three bouts of aspiration pneumonia/pneumonia requiring hospitalization that were preceded by coughing and vomiting. He had a diagnosis of gastrointestinal reflux disease (GERD). During his most recent hospitalization, a change in head-of-bed elevation to 30 degrees while enterally fed appeared to allow him to tolerate his feedings. The angle of his wheelchair was also changed to reduce compression of his stomach. The PNMP was updated to include this information. His feeding was changed from bolus to continuous feeding. Reglan was added, and he had done well since that time. It was noted that he had no residuals, and that he was more comfortable and engaging with the changes made to his wheelchair. The submitted documentation did not appear to include information regarding the severity of GERD, and whether plans were made for any next step should there be repeat aspiration pneumonia or when to consider a next step given the severity of his recent illnesses. For instance, the submitted documentation indicated the individual had a DNR Order in place during his last hospitalization, but remained full code at AUSSLC. The PCP indicated that during the May 2016 hospitalization, the surgeon and gastroenterologist determined he was not a candidate for a fundoplication, but documentation of the clinical reasons for this determination were not found in the submitted documentation. It might have been due to the increased risk of attempting the procedure due to the individual's body habitus, but this was not clarified in documentation provided. It was unclear whether the decision was actually that the individual was not a candidate at that time or whether he was not a candidate for surgical intervention at any time in the future. There was no information concerning additional steps to be considered and the threshold/timing of additional medical/surgical interventions if he continued to have events of acute respiratory distress due to GERD and reflux aspiration requiring ventilator support. As he was in full code status at AUSSLC, aggressive steps would be appropriate to consider, document, and implement prior to the next life threatening respiratory illness. From the document review, there was concern that waiting until the next episode of respiratory distress to consider a next step might be too late in his clinical course. The individual's medical record was extensive and the recent clinical complex course appears to have escalated from prior years (his prior hospitalization for pneumonia was in 2013). The medical record needed clarity as to the next step in the clinical care of this individual to prevent further decline. His current clinical stability might be an opportunity to review and consider additional options.
- In 2010, Individual #354 was diagnosed with osteoporosis. A DEXA scan reading in 2010 indicated a T-score of -3.6 at the left femoral neck. He was started on Fosamax, Vitamin D, and calcium at that time. In February 2013, the Fosamax was stopped when he commenced hospice services. On 6/9/14, a DEXA scan was done, and it continued to show osteoporosis, with a T score of -3.5 at the left femoral neck. Although he receives Vitamin D twice daily, an anti-resorptive medication and/or calcium were not restarted due to Individual #354 receiving hospice services. The last Vitamin D level was obtained on 7/9/14 (i.e., level of 28 documented as low according to the QDRR), and which was lower than the level from 11/19/13. A significant therapeutic dosage was currently prescribed long-term. Pharmacy Department personnel indicated the reason lab testing was reduced was that Individual #354 had a terminal condition. The PCP indicated his risk of osteoporosis fracture was low due to his terminal status and short life expectancy. There was no follow-up testing to ensure his Vitamin D level was in the therapeutic range (neither too low or too high) since 7/9/14. Labs are periodically drawn to monitor his polycythemia, and additional testing would have been possible without additional needle sticks. Additionally, Individual #354 has been considered terminal for several years. Although his prognosis is poor, offering optimal treatment of other comorbid conditions should be an ongoing consideration. Palliative care (as opposed to hospice care) might be an appropriate approach to his care, in which comfort is a priority, but other conditions remain treated. For instance, ensuring a therapeutic level of Vitamin D might improve his health and safety with the many benefits affecting other organ systems. Additionally, given his osteoporosis has been present for several years, ensuring a more aggressive monitoring, evaluation, and treatment of his bone health might

prevent a future painful fracture. Although his condition is considered terminal, he has been relatively stable for the past three to four years. It is clear that his longevity is not predictable, and it might not be in his best interest to plan active and preventive care based on a terminal condition that has been present for years.

- Individual #75 had a long history of cardiovascular disease. Hypertension was evaluated for secondary causes. The lability of the hypertension required adjustment of medication choices over time. At one point, the individual was prescribed Minoxidil. This medication was subsequently associated with a pericardial effusion requiring hospitalization and drainage. After the Minoxidil was stopped, and the effusion drained, there was no recurrence by echocardiogram. Individual #75 had additional short-stay hospitalizations for diaphoresis and other systemic symptoms suggesting an acute cardiac event, but evaluations were completed and there were no findings. The PCP continued to monitor Individual #75's blood pressure monthly and it was considered controlled. Based on documentation submitted, no restriction had been placed on his sodium intake in his diet, and no reference was found regarding the reason for not prescribing a low sodium diet, which might allow for more optimal control of blood pressure and potentially a reduction of medication. The heart healthy diet prescribed included specific parameters such as low cholesterol, no concentrated sweets, low fat and additional fiber, but did not mention the amount of sodium in the prescribed diet. There was also a recommendation noted in the IRRF to increase his physical activity to at least 30 minutes per day of aerobic physical activity on most days of the week. The submitted documentation did not reflect such a program of activity, which would be of additional therapeutic benefit.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. Although documentation often was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs, the Monitoring Team will continue to review this indicator until IHCPs include necessary action steps and they are implemented.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	94% 15/16	1/2	2/2	N/A	2/2	2/2	2/2	2/2	2/2	2/2
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed generally were implemented. The exception was the immunizations for Individual #127. As is discussed elsewhere in this report, she should have received Prevnar 13, but did not.											

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; recommendations are made about any necessary additional laboratory testing regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.											
Summary: N/R			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	Not Rated (N/R)									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.											

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
Summary: Given the timely completion of QDRRs at Austin SSLC (Round 9 – 94%, Round 10 – 94%, and Round 11 - 100%), and timely practitioner review (Round 9 – 100%, Round 10 – 100%, and Round 11 - 100%), indicators a, and c will be placed in the category of requiring less oversight. The quality of QDRRs, and implementation of the agreed-upon recommendations are areas in which the Center needs to continue to improve its performance.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	QDRRs are completed quarterly by the pharmacist.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	ii. Benzodiazepine use;	86%	2/2	2/2	2/2	0/2	N/A	2/2	2/2	N/A	2/2

		12/14									
	iii. Medication polypharmacy;	57% 8/14	2/2	0/2	0/2	N/A	2/2	2/2	0/2	2/2	N/A
	iv. New generation antipsychotic use; and	100% 8/8	2/2	2/2	N/A	N/A	N/A	N/A	2/2	N/A	2/2
	v. Anticholinergic burden.	44% 8/18	1/2	1/2	2/2	0/2	0/2	2/2	0/2	2/2	0/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 10/10	2/2	2/2	N/A	N/A	2/2	N/A	2/2	N/A	2/2
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.		N/A	2/2	0/1	N/A	N/A	1/1	1/1	N/A	0/1
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	N/R									

Comments: b. In summary, problems included:

- With regard to medication polypharmacy, the copies of the medication profiles from the IRIS did not include the diagnosis for each medication. This made it difficult to determine which medications were ordered for which diagnoses, as some medications are prescribed to treat several different diagnoses.
- With regard to anticholinergic burden, there are several scales that the Center/State could use to score anticholinergic activity for classes of medication and/or specific medications in a class. These scoring systems vary in final scoring of anticholinergic activity and breadth of review of medications reviewed. The State Office should determine/clarify the anticholinergic burden scoring system(s) that all SSLCs should use for the QDRRs to ensure consistency.

Additionally, going forward, for those individuals prescribed atypical antipsychotics and at risk for metabolic syndrome, each risk and the most recent values should be included in a table or discussed separately, as opposed to simply referring to the lab data provided in the lab section of the QDRR. There should be evidence of pharmacy review and interpretation of the lab and other risk factors to guide the PCP to consider whether metabolic syndrome is present or discussion of the number of risk factors present. One of the difficulties with IRIS is the presence of the table for the risk factors for metabolic syndrome that simply states “yes” or “no” for each risk factor, but does not include the actual values. This is compounded when a print copy is made, and the table does not print on the hard copy.

c. For the individuals reviewed, it was good to see that prescribers were reviewing QDRRs timely, and documenting agreement or

providing a clinical justification for lack of agreement with Pharmacy's recommendations.

d. Problems noted included:
- Individual #45's QDRR recommended an AIMs screening due to the use of Reglan. The PCP agreed, but the response provided to the Monitoring Team indicated: "individual does not require AIMs test." The most recent 90/180-day orders indicated Reglan was still prescribed.
- Individual #224's QDRR recommended adding the frequency for Hemoglobin A1C labs to the 180-day order per psychiatry. However, the Monitoring Team did not find documentation to show this was completed.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/5	0/1	0/1	N/A	0/1	N/A	0/1	N/A	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/5	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% 0/5	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% 0/5	0/1	0/1		0/1		0/1			0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/5	0/1	0/1		0/1		0/1			0/1

Comments: a. and b. Individual #45, Individual #75, Individual #442, and Individual #422 were at low risk with regard to dental health. The Monitoring Team reviewed five individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, progress reports on existing goals, including data and analysis of the data, were not available to IDTs in an integrated format. 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 Individual #127, Individual #249, Individual #354, Individual #153, and Individual #224, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services. Individual #442, and Individual #422 were in the core group, so a complete review was completed for them as well. For Individual #45, and Individual

#75, who were at low risk for dental and who were in the outcome sample, the "deep review" items were not scored, but other items were scored.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: These are new indicators, which the Monitoring Team will continue to review.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	Individuals have no diagnosed or untreated dental caries.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Since the last exam:										
	i. If the individual had gingivitis (i.e., the mildest form of periodontal disease), improvement occurred, or the disease did not worsen.	N/A									
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	100% 2/2	N/R	N/R	N/R	1/1	N/R	N/R	N/R	1/1	N/R
c.	Since the last exam, the individual's fair or good oral hygiene score was maintained or improved.	N/R									
Comments: b. When individuals' exams identified them as having periodontal disease, but no serial periodontal charting was available, the Monitoring Team could not rate this indicator (e.g., Individual #127, Individual #249, Individual #45, Individual #75, Individual #153, Individual #442, and Individual #224). The Monitoring Team is applying the "N/R" score to this round of reviews to allow State Office to work with the Centers to improve practice. However, beginning in the next round of reviews, if an individual should have had periodontal charting, and it was not completed, or a justification was not provided for a lack of periodontal charting, then this indicator will be scored 0. c. As indicated in the dental audit tool, this indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will be marked "N/R." At the time of the review, State Office had not yet developed a process to ensure inter-rater reliability with the Centers.											

Outcome 5 – Individuals receive necessary dental treatment.	
Summary: Based on scores of 100% during this review and high scores during the previous two reviews for tooth brushing instruction (Round 9 – 86%, and Round 10 – 100%), dental x-rays (Round 9 – 100%, and Round 10 – 88%), restorative work (Round 9 – 100%, and Round 10 – 100%), and extractions (Round 9 – 100%, and Round 10 – N/A), Indicators b, c, f, and g will move to the category of requiring less	Individuals:

oversight. The remaining indicators are new, do not have a history of high scores, and/or need improvement, and will remain in active oversight.											
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
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.	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	100% 5/5	1/1	1/1	N/A	1/1	1/1	1/1	N/A	N/A	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	1/1
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	67% 6/9	0/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
f.	If the individual has need for restorative work, it is completed in a timely manner.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: It was positive that a number individuals reviewed received the dental care they needed.

b. For individuals who receive suction tooth brushing, a formal class is provided.

e. Individual #127 and Individual #249 require general anesthesia for deep cleaning. However, plans were not found to prevent the need for scaling and root planing. If the individual still needs deep cleaning requiring general anesthesia, the goal and steps to achieve that goal should address the underlying cause, so the need for this procedure (scaling and root planing) is reduced, as well as the need for general anesthesia. This might require one or more options, such as the following examples: creation or amending of a SAP or staff support objective (SSO) in the home; frequent (such as monthly) visits for prophylaxis; development and implementation of a long-term desensitization plan in the home and dental office, or other strategies to improve compliance; monitoring of staff and the individual to determine adequacy of tooth brushing in the home, etc. However, that the individuals still need deep cleaning indicates the need for more steps to be taken.

Similarly, Individual #354 cannot tolerate general anesthesia due to other medical conditions. Although he was on hospice, he should have had supports in place to prevent painful dental conditions. However, his history suggested that his care plan was inadequate with end state exfoliation of a tooth.

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: Given that the Center had attained 100% scores for these indicators during this and the previous two reviews, indicators a through c will move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary	100% 2/2	N/A	N/A	N/A	1/1	N/A	1/1	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 2/2				1/1		1/1			
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	100% 1/1				1/1		N/A			
Comments: a. through c. On 3/16/16, Individual #354 received necessary emergency dental care, and on 6/8/16, Individual #153 did as well.											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: The Center had made progress with monitoring the quality of the suction tooth brushing. However, over the last two reviews, results were variable for the other indicators within this outcome. If the progress seen during this review continues, likely during the next review, Indicator c might move to requiring less oversight. The Center does need to focus on improving its performance on the other indicators.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	25% 1/4	N/A	N/A	0/1	N/A	N/A	N/A	0/1	0/1	1/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	25% 1/4			0/1				0/1	0/1	1/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	100% 4/4			1/1				1/1	1/1	1/1
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/4			0/1				0/1	0/1	0/1

Comments: a. and b. The copy the Center submitted of Individual #45's IHCP was largely crossed through, and no information was found concerning suction tooth brushing. Neither Individual #442 nor Individual #422's ISPs/IHCPs referenced suction tooth brushing. As a result, it was unclear whether or not the documentation submitted for suction tooth brushing demonstrated compliance with the schedule the individuals' IDTs agreed-upon. c. It was positive that Dental Department staff were monitoring staff's implementation of suction tooth brushing for quality. d. Problems varied with regard to the inclusion of data in the ISP monthly reviews. A primary problem was that a number of individuals did not have measurable goals/objectives against which to compare the data. Other problems included missing monthly reviews, or incomplete data in the monthly reviews.

Outcome 9 – Individuals who need them have dentures.											
Summary: Since the last review, improvements were made with regard to the dentist's assessment of the need for dentures for individuals with missing teeth, which was good to see.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: For the individuals reviewed with missing teeth, the Dental Department documented assessments regarding dentures, and justification for not providing them.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.	
Summary: Nursing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis for acute illnesses/occurrences remained an area on which the Center needs to focus. It is also important that nursing staff timely notify the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification. Nursing staff were not developing acute care plans for all relevant acute care needs, and those that were developed needed	Individuals:

improvement. These indicators will remain in active oversight.											
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0% 0/7	N/A	0/2	0/1	0/1	N/A	0/1	0/1	0/1	N/A
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	0% 0/6		0/2	0/1	0/1		0/1	N/A	0/1	
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	13% 1/8		0/2	0/1	0/1		0/1	0/1	1/2	
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0% 0/4		0/1	0/1	0/1		N/A	N/A	0/1	
e.	The individual has an acute care plan that meets his/her needs.	0% 0/8		0/2	0/1	0/1		0/1	0/1	0/2	
f.	The individual's acute care plan is implemented.	0% 0/8		0/2	0/1	0/1		0/1	0/1	0/2	

Comments: The Monitoring Team reviewed eight acute illnesses and/or acute occurrences for six individuals, including Individual #249 – ED visit for fever and tachypnea on 5/15/16, and swelling to right hand on 6/20/16 (i.e., the Center indicated this individual had no acute issues, but the Monitoring Team identified these acute occurrences through record review); Individual #45 – urinary tract infection (UTI) on 5/27/16; Individual #354 – chest pain, right abdomen pain, and hypoxemia on 4/1/16; Individual #153 – cellulitis of finger on 6/28/16; Individual #442 – UTI on 6/9/16; and Individual #422 – UTI on 6/10/16, and hospitalization for facial cellulitis in August 2016.

a. and b. Individual #422's UTI was found on urine culture, so these indicators were not applicable. For Individual #442, indicator b was not applicable, because he was put on the sick-call list due to a fever.

c. The nursing assessments documented in the IPNs for Individual #422's UTI were consistent with current standards, despite the fact that the acute care plan did not define such assessments in a measurable way. In other words, nurses assigned to work with him implemented related nursing guidelines without the direction that an acute care plan should have provided.

e. No acute care plans were provided for Individual #249 – ED visit for fever and tachypnea on 5/15/16, and swelling to right hand on 6/20/16, or Individual #422 – hospitalization for facial cellulitis in August 2016.

Common problems with the acute care plans reviewed included a lack of: instructions regarding follow-up nursing assessments that

were consistent with the individuals' needs (the exceptions were Individual #45 – UTI on 5/27/16, and Individual #153 – cellulitis of finger on 6/28/16); alignment with nursing protocols (the exception was Individual #45 – UTI on 5/27/16); specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; clinical indicators nursing would measure; and the frequency with which monitoring should occur (the exception was Individual #153 – cellulitis of finger on 6/28/16). The following provide some examples of concerns noted with regard to this outcome: • Although nursing staff did conduct assessments related to Individual #45's UTI, nurses did not included criteria from the acute care plan. For example, nurses often did not document color of urine, any odor, intake and output, and/or the presence of pain. • For Individual #354, an IPN, dated 3/29/16 at 3:17 p.m., indicated that 6200 (i.e., emergency call) was initiated for chest pain. The IPN did not include a complete assessment, including mental status, quality of heart rate, where was the skin that was "pale blue," circulation status, description of pain, any nausea, sweating, numbness, skin temperature, or his responsiveness. Although 6200 was initiated, there was no indication in the IPNs that nursing staff notified the PCP of his status. Based on the IPNs, the Monitoring Team was unable to determine when he returned from the hospital. After his 3/29/16 transfer to the hospital, no nursing IPNs were documented until 4/12/16, at which time it was noted that the individual was admitted to the Infirmary from "home." The Hospital Liaison notes did not indicate when he returned to the Center. The acute care plan indicated it was initiated on 4/1/16, after his discharge from hospital. The acute care plan failed to address the acute issue in accordance with current standards of care. For example, it indicated to check vitals signs periodically. It did not include assessments regarding cardiac status, pain assessment, and/or mental status assessments.

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	17% 3/18	1/2	0/2	1/2	0/2	0/2	0/2	0/2	1/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e.,											

Individual #127 –falls, and dental; Individual #249 – falls, and fluid imbalance; Individual #45 – fractures, and infections; Individual #354 – dental, and respiratory compromise; Individual #75 – cardiac disease, and weight; Individual #153 – skin integrity, and dental; Individual #442 – UTIs, and other: cognitive status changes; Individual #422 – skin integrity, and weight; and Individual #224 – skin integrity, and dental).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #127 –falls, Individual #45 – infections, and Individual #422 – skin integrity.

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

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.											
Summary: Given that over the last three 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.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	11% 2/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	1/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/1
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2

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

a. through c. 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. 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 (i.e., the exceptions were Individual #75 – cardiac disease, and Individual #224 – skin integrity), IDTs took immediate action in response to risk, or that nursing interventions were implemented

thoroughly (i.e., the exception was for Individual #224 for skin integrity).

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
Summary: For the Round 9 review (i.e., observations not conducted in Round 10), as well as this review, the Center did well with the indicators related to administering medications according to the nine rights (c), and nurses following infection control practices during medication pass (g, and formerly f). However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review all of these indicators until the Center's quality assurance/improvement mechanisms related to medication administration are assessed, and deemed to meet the requirements of the Settlement Agreement.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	Individual receives prescribed medications in accordance with applicable standards of care.	72% 13/18	1/2	1/2	2/2	1/2	1/2	2/2	1/2	2/2	2/2
b.	Medications that are not administered or the individual does not accept are explained.	29% 2/7	0/1	0/1	1/1	0/1	0/1	1/1	0/1	N/A	N/A
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	N/R									
	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	N/R									

	IHCP or acute care plan should define.										
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	86% 6/7	1/1	0/1	1/1	N/A	N/A	1/1	1/1	1/1	1/1
f.	Individual's PNMP plan is followed during medication administration.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	13% 1/8	0/1	0/1	0/1	N/A	0/1	1/1	0/1	0/1	0/1
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.	14% 1/7	0/1	0/1	0/1	N/A	0/1	1/1	N/A	0/1	0/1
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/A									
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/A									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	29% 2/7	0/1	0/1	N/A	0/1	0/1	1/1	0/1	N/A	1/1
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.	0% 0/5	0/1	0/1	N/A	0/1	0/1	N/A	0/1	N/A	N/A

Comments: The Monitoring Team conducted record reviews for nine individuals and observations of nine individuals, including Individual #127, Individual #249, Individual #45, Individual #354, Individual #75, Individual #153, Individual #442, Individual #422, and Individual #224.

Of note, due to problems with the IRIS (i.e., electronic health record) system's ability to produce documentation in an easily digestible format, the Monitoring Team conducted a limited review of documentation of medication administration. Specifically, documentation for the months of June and July was available in hand-written format, so it was used for this review.

a. and b. Problems noted included:

- The Medication Administration Records (MARs) for Individual #127, Individual #249, Individual #354, Individual #75, and Individual #442 showed omissions and/or MAR blanks for which variance forms were not provided.

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

d. This indicator was not assessed during this review, but will be during upcoming reviews. State Office is working with the Centers to comply with these requirements.

e. For Individual #249, on 6/30/16, a provider ordered a one-time dose of Potassium Chloride for hypokalemia. However, documentation was not found in the IPNs to show nursing staff administered it, or conducted an associated assessment for any muscle twitching, cramps, increased irritability, confusion, increased urination, poor appetite, constipation, vomiting, or diarrhea.

f. For two individuals, nursing staff did not refer to the PNMPs to confirm they were implementing them.

g. With one exception, for the individuals observed, nursing staff followed infection control practices. The exception was for Individual #249. While administering medication, the nurse touched the floor and did not wash her hands.

h. For the records reviewed, evidence was generally not present to show that nursing staff provided instructions to the individuals and their staff regarding new orders or when orders changed. The exception was for Individual #153.

i. When a new medication was initiated, when there was a change in dosage, and after discontinuing a medication, documentation was generally not present to show individuals were monitored for possible adverse drug reactions. The exception was for Individual #153.

l. As noted above, MAR blanks were not reconciled and reported.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Overall, IDTs and/or the PNMT did not have a way to measure outcomes related to individuals' physical and nutritional management at-risk conditions. In addition, it was concerning that IDTs did not consistently refer individuals meeting criteria for PNMT review and/or assessment to the PNMT and/or that the PNMT did not self-refer these individuals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
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% 0/13	0/2	0/2	N/A	0/2	0/1	0/2	0/1	0/1	0/2
	ii. Individual has a measurable goal/objective, including	69%	0/2	1/2		2/2	1/1	1/2	1/1	1/1	2/2

		timeframes for completion;	9/13									
	iii.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/13	0/2	0/2		0/2	0/1	0/2	0/1	0/1	0/2
	iv.	Individual has made progress on his/her goal/objective; and	0% 0/13	0/2	0/2		0/2	0/1	0/2	0/1	0/1	0/2
	v.	When there is a lack of progress, the IDT takes necessary action.	0% 0/13	0/2	0/2		0/2	0/1	0/2	0/1	0/1	0/2
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:											
	i.	If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	40% 2/5	N/A	N/A	0/2	N/A	0/1	N/A	1/1	1/1	N/A
	ii.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/5			0/2		0/1		0/1	0/1	
	iii.	Individual has a measurable goal/objective, including timeframes for completion;	60% 3/5			2/2		0/1		1/1	0/1	
	iv.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/5			0/2		0/1		0/1	0/1	
	v.	Individual has made progress on his/her goal/objective; and	0% 0/5			0/2		0/1		0/1	0/1	
	vi.	When there is a lack of progress, the IDT takes necessary action.	0% 0/5			0/2		0/1		0/1	0/1	

Comments: The Monitoring Team reviewed 13 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: choking, and falls for Individual #127; choking, and falls for Individual #249; choking, and aspiration for Individual #354; choking for Individual #75; falls, and choking for Individual #153; choking for Individual #442; falls for Individual #422; and choking, and aspiration for Individual #224.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: choking for Individual #249; choking, and aspiration for Individual #354; choking for Individual #75; choking for Individual #153; choking for Individual #442; falls for Individual #422; and choking, and aspiration for Individual #224.

b.i. The Monitoring Team reviewed five 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 goal/objectives were included. These areas of need included: aspiration, and GI problems for Individual #45; aspiration for Individual #75; aspiration for Individual #442; and aspiration for Individual #422.

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

- Individual #45 had recurrent emesis and coughing. When trended back to July 2015, a worsening trend in their frequency is noted. For multiple months, the PNMT monitored him, but provided no comprehensive assessment despite an increasing trend in emesis. The PNMT did not conduct an assessment until Individual #45 experienced a second pneumonia.
- On 5/25/16, Individual #75 was diagnosed with aspiration pneumonia. The PNMT did not conduct a review. PNMT minutes briefly discussed the incident, but sufficient detail was not provided to consider this a PNMT review.

b.ii. and b.iii. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: aspiration, and GI problems for Individual #45, and aspiration for Individual #442.

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

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
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.	39% 7/18	1/2	0/2	0/2	1/2	0/2	0/2	1/2	2/2	2/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	14% 1/7	0/1	0/1	0/2	N/A	0/1	0/1	1/1	N/A	N/A
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/2	N/A	N/A	0/2	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, the IHCPs for which documentation was found to confirm the implementation of the PNM action steps that were included were those for choking for Individual #127; choking for Individual #354; aspiration for Individual #442; aspiration, and falls for Individual #422; and choking, and aspiration for Individual #224.

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

• Individual #127 had an increase in falls, but the PT did not review of assess the individual's status until 8/3/16, which was two months after the initial onset of falls. • Individual #249's IDT did not refer her to the PNMT despite more than three falls occurring within 30 days. • Individual #153's IDT did not revise her IHCP to reflect changes in mobility recommendations. c. For Individual #45, evidence was presented to show that the PNMT met with the IDT to discuss discharge, but there was a lack of evidence that the PNMT and IDT shared necessary information. Thresholds were reviewed, but other than a note stating all recommendations were completed, there was little to no evidence of a comprehensive discharge.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
Summary: Additional work is still needed to ensure staff implement individuals' PNMPs as written. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	57% 21/37
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	25% 1/4
Comments: a. The Monitoring Team conducted 37 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during seven out of 10 observations (70%). Staff followed individuals' dining plans during 13 out of 25 mealtime observations (52%). Transfers were completed correctly one out of two times (50%).		

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: It was positive that the Center had made progress on this indicator.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
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.	100% 2/2	N/A	N/A	1/1	N/A	N/A	N/A	1/1	N/A	N/A

Comments: a. As noted above, the SLP for Individual #442 did a nice job providing the needed therapy and trials to return him to oral intake. He was now eating orally three meals a day, which was great to see.

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: It was good to see that some OT/PT goals/objectives developed for individuals reviewed were clinically relevant, and measurable. However, for individuals reviewed, IDTs overall did not have a way to measure outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	58% 7/12	0/1	0/1	1/1	0/1	0/1	2/2	2/2	0/1	2/2
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	75% 9/12	1/1	0/1	1/1	0/1	0/1	2/2	2/2	1/1	2/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	33% 4/12	0/1	0/1	0/1	0/1	0/1	2/2	0/2	0/1	2/2
d.	Individual has made progress on his/her OT/PT goal.	17% 2/12	0/1	0/1	0/1	0/1	0/1	2/2	0/2	0/1	0/2
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/10	0/1	0/1	0/1	0/1	0/1	N/A	0/2	0/1	0/2
Comments: a. and b. The goals/objectives that were clinically relevant and achievable, as well as measurable were those for Individual #45 (i.e., self-propelling), Individual #153 (i.e., sit to stand, and walking), Individual #442 (i.e., stand-pivot and surface-to-surface transfers, and ambulation with walker), and Individual #224 (i.e., washing hands, and drying stomach). Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: falls for Individual #127, and brushing hair for Individual #422. c. through e. An area that required continued efforts was making progress reports, including data and analysis of the data, available to IDTs in an integrated format. On a positive note, Individual #153's IDT developed clinically relevant, measurable goals, and the PT documented daily data in the IPNs. The QIDP also included a summary of the individual's progress in the monthly progress notes. Individual #153 made progress on both goals. Individual #153 was in the outcome group, so the remaining "deep review" items were not rated.											

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	30% 3/10	0/1	0/1	0/1	0/1	0/1	N/R	1/2	0/1	2/2
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. Some examples of the problems noted included:

- Lack of evidence (i.e., specific data) in integrated ISP reviews that supports were implemented.
- Goals/programs discussed in ISP, but no information to show they were ever implemented (e.g., goal to self-propel for Individual #45, goal/program for Individual #354 to focus on brushing quadrants of teeth).

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: Given that during Round 9 and during this review, individuals observed generally had clean adaptive equipment (Round 9 – 97%, Round 10 – not rated, and Round 11 - 100%) that was in working order (Round 9 – 100%, Round 10 – not rated, and Round 11 - 100%), Indicators a and b will move to the category requiring less oversight. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's varying scores (Round 9 – 89%, Round 10 – not rated, and Round 11 - 76%), 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	429	92	280	453	416	223	353	224	181
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	100% 34/34	1/1	1/1	1/1	1/1	1/1	2/2	1/1	1/1	2/2

b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	100% 34/34	1/1	1/1	1/1	1/1	1/1	2/2	1/1	1/1	2/2
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	76% 23/33	1/1	0/1	1/1	1/1	1/1	2/2	1/1	1/1	2/2
		Individuals:									
#	Indicator		433	102	222	405	191	174	103	153	249
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	2/2	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	2/2	1/1
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	0/1	0/1	0/1	1/1	1/1	0/1
		Individuals:									
#	Indicator		45	442	450	422	354	75	406	127	246
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		16	260	310						
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		2/2	1/1	1/1						
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		2/2	1/1	1/1						
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		2/2	0/1	1/1						

Comments: a. The Monitoring Team conducted observations of 34 pieces of adaptive equipment. The individuals the Monitoring Team observed had clean adaptive equipment, which was good to see.

b. It was positive that the equipment observed was in working order.

c. Based on observation of Individual #92, Individual #102, Individual #405, Individual #191, Individual #174, and Individual #260 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.

Individual #433 was a lady of small stature, yet her dining chair was oversized, which resulted in less than adequate trunk and back support.

Individual #249's gait belt was loose, and at the level of her breasts.

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. None of the indicators had sustained high performance scores to be moved 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.

Many ISP personal goals were not yet individualized and, therefore, progress could not be determined. The personal goals that were individualized, however, did not have data to allow progress to be assessed (with one exception).

Austin SSLC had data on SAPs and used those data. That being said, attending to the status of SAPs is a focus area for Austin SSLC. No SAPs contained the required components and most were not implemented as written.

There were many new opportunities for engagement and participation in activities at the Austin SSLC. Further, the facility had a system for managing engagement that included measurement and goals. Examples of activities included cooking classes, shopping for food in the community for cooking, greater use of the Aquadome, supported employment at a local Chili's restaurant, and an arts and crafts area with an embroidery machine, a sewing machine, a tee-shirt press, and a kiln for ceramic pieces. Special focus is required to improve the activities offered at the day program in Building 775.

There was a limited group of individuals from which to select a sample for observation of personal communication devices. Only 33 out of 184 individuals have personal communication devices. Based upon experience with the population AUSSLC supports, it is highly likely that many more individuals would benefit from a personal device and associated programs to assist them to learn to utilize the devices. Speech Language Pathologists (SLPs) heavily recommended shared devices, but based on observation, they were used on a limited basis, and when utilized, they were not used correctly (e.g., staff pressing the button as they walked by on their way to the dining room). In addition, data was not taken on the usage of these shared devices so their benefit or value to the individuals was unknown.

For individuals that did have personal communication devices, it was concerning that often individuals' devices were not present or readily accessible, and that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Goals that were not yet individualized and did not meet criterion with ISP indicators 1-3, also did not meet criteria for the indicators of this outcome. The goals that were developed did not have data to allow progress to be assessed (with one exception). These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	249	127	354	422	406	341			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	1/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
Comments: Once Austin SSLC develops individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals, and thus, the facility can achieve compliance with this outcome and its indicators.

4-7. Overall, personal goals did not meet criterion as described above, therefore, there was no basis for assessing progress in these areas. See Outcome 7, Indicator 37 for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans. For the personal goals that met criterion:

- Data indicated that Individual #127 was making progress on her leisure goal to operate her DVD.

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: It was good to see that criterion were met for half of the individuals for indicator 39 and one third of the individuals for indicator 40. Although not yet near being able to move to requiring less oversight, there was very good progress since the last review and the facility's performance for some individuals should be expanded to apply to all individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	249	127	354	422	406	341			
39	Staff exhibited a level of competence to ensure implementation of the	50%	0/1	0/1	1/1	0/1	1/1	1/1			

	ISP.	3/6									
40	Action steps in the ISP were consistently implemented.	33% 2/6	0/1	1/1	1/1	0/1	0/1	0/1			

Comments:
39. Staff were generally able to describe supports and risks included in the ISP. Observations throughout the week confirmed that staff were generally well trained on supports described in the ISP. Overall, interaction between support staff and individuals was very respectful and positive in nature.

In fact, criterion for indicator 39 was met for three individuals, and for indicator 40 for two individuals. This showed good progress. For the others:

- Observations and interviews with Individual #249's staff did not support that staff were knowledgeable regarding implementation of her ISP. There was confusion regarding implementation of her goals/action plans to swim and clear her dishes from the table. Neither plan was being implemented as written.
- Due to conflicting implementation data, it was not possible to confirm that staff were competent to implement Individual #422's ISP as written.
- Individual #127 was observed in her cooking class as a passive participant. Her staff did not encourage or support her participation. Her staff may need additional training to support her participation in a meaningful way. Similarly, Individual #127 completed very little of her work task. Staff should consider ways to support her to become more independent in completing work tasks.

40. Action steps were not consistently implemented for four of six individuals as documented 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: Attending to the status of SAPs is a focus area for Austin SSLC. That being said, attending to SAP data was at 100% for this review and the last review. However, given the overall need for attention to SAP progress, all four indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
6	The individual is progressing on his/her SAPS	17% 4/24	0/3	2/3	0/3	0/3	1/3	1/3	0/2	0/1	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	33% 1/3	N/A	0/2	1/1	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	0% 0/18	0/3	0/1	0/2	0/3	0/2	0/1	0/2	0/1	0/3

9	Decisions to continue, discontinue, or modify SAPs were data based.	100% 26/26	3/3	3/3	3/3	3/3	3/3	3/3	2/2	3/3	3/3

Comments:
6. Four SAPs (Individual #406 – sanitize hands and hug his mother; Individual #394 – make a choice; Individual #127 – turn on DVD player) had data that suggested progress and had been assessed for integrity. For all other SAPs, data either did not reflect progress or integrity had not been assessed.

7. Individual #263 had met her SAP to set up her work area. While the Monitoring Team was onsite, staff provided two SAPs that had recently been developed to replace this SAP. Although Individual #406 had achieved two of his SAPs (sanitize his hands and hugging his mother), there was no evidence that new or updated goals had been introduced.

8. In no case was there evidence of action steps taken when the individual was not making progress on his or her SAP. In some cases, this was true even when a lack of progress had been evident for months (e.g., Individual #32 – brush teeth and wash hands; Individual #263 – hand over money envelope; Individual #394 – hang up coat and do laundry; Individual #291 – event planning; and Individual #425 – brush teeth).

9. There was evidence of data based decisions for all SAPs.

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

Summary: Much continued work is needed in this area. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 32	406	263	249	394	127	291	341	425
13	The individual's SAPs are complete.	4% 1/26	0/3	0/3	0/3	0/3	0/3	0/3	1/2	0/3	0/3

Comments:
13. Only one of the 26 SAPs was considered complete (Individual #291 – make a pizza). The most consistent problems included objectives that did not specify the expected level of independence, specific instructions related to the actual teaching of the skill, teaching schedules that included the number of expected trials, and the use of positive reinforcement specific to the individual.

Regarding this last component, the consequence for correct responding was often solely praise. As the function of praise as a reinforcer is often dependent on the person delivering the praise, this was not likely to be effective in teaching new skills. Exceptions included Individual #291 enjoying his pizza, Individual #127 watching a DVD, and Individual #341 listening to music.

It was very positive to learn of a recently established SAP Review Committee. During the onsite visit, an observation of this meeting revealed a comprehensive review of two newly developed SAPs, with discussion among all participants, including members of the behavioral health service department (including two staff members with backgrounds in special education), consulting BCBAs, and the individual's QIDP.

Outcome 5- SAPs are implemented with integrity.											
Summary: Correct implementation of SAPs must be ensured. Both indicators showed progress compared with the last two reviews, which was good to see. That being said, much more work is needed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
14	SAPs are implemented as written.	40% 2/5	0/1	1/1	N/A	0/1	0/1	1/1	N/A	N/A	N/A
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.	77% 20/26	3/3	2/3	2/3	1/3	3/3	2/3	2/2	2/3	3/3

Comments:

14. Five SAPs were observed, with two implemented as written. Individual #406 pressed the power button to turn on the iPad he used to communicate with his mother. Individual #127 turned on the power button on the DVD player, although it took several instructions and some assistance for her to complete this task. She appeared to be prepared to learn the entire chain because she chose a DVD and tried to insert it into the tray. Staff may want to consider purchasing a DVD player that has a touch screen so that operation can be less difficult, thereby fostering greater independence.

Regarding those not implemented as written: Individual #32 did not stop at an intersection when told to do so and a correction trial was not implemented as described in the SAP. Individual #249 did not place her plate in the bin after finishing her meal. The staff member then told her to place her cup in the bin, but according to the SAP, this is an incorrect response. Lastly, Individual #394 chose television when presented with two icons, however, this was not provided contingent upon his response.

15. The facility's policy was to assess each SAP at a minimum of once every six months. Expected goal levels were established at 80%. There was evidence that 20 of the 26 SAPs had been assessed for integrity during the previous six-month period.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.											
Summary: These two indicators received high scores on this review and relatively high scores on the previous two reviews. This was good to see, however, given that the indicators related to SAP quality, SAP data, and SAP implementation integrity were far from meeting criteria, these two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
16	There is evidence that SAPs are reviewed monthly.	100%	3/3	3/3	3/3	3/3	3/3	3/3	2/2	3/3	3/3

		26/26									
17	SAP outcomes are graphed.	100% 26/26	3/3	3/3	3/3	3/3	3/3	3/3	2/2	3/3	3/3

Comments:
16-17. There was evidence that monthly data based reviews had occurred for all 26 SAPs. Additionally, graphic display of SAP progress was provided in the Client SAP Training Progress Note. It was positive to find that the percentage of correct trials typically reflected independent performance.

Staff are advised to ensure that all measures depicted in the graphs correspond to the data recorded on the data sheets. For example, errors were found in the progress note for Individual #32's performance on his toothbrushing SAP from June 2016 through August 2016.

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

Summary: Many new opportunities for engagement and participation in activities were available at the Austin SSLC. Some of the benefit of this is reflected in higher scores for indicators 18 and 21 compared with the previous two reviews. Continued work is needed. Further, the facility had a system for managing engagement that included measurement and goals (indicators 19 and 20). With sustained high performance, these two indicators might move to the category of requiring less oversight after the next review. All four indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 32	406	263	249	394	127	291	341	425
18	The individual is meaningfully engaged in residential and treatment sites.	63% 5/8	0/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	N/A
19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
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	1/1	0/1	1/1	1/1

Comments:

18. During the onsite visit, the Monitoring Team was able to observe eight of the nine individuals. The exception was Individual #425 because he was not present when visits were made to both his home and workshop program.

Five of the eight individuals who were observed were found to be engaged most of the time when observed in their home and work

programs. The exceptions were Individual #32, who spent his day walking around campus without clear guidelines for programming; Individual #249, who was repeatedly observed sitting idly or walking about, either with or without a magazine; and Individual #341, who was not participating or actively engaged during his sensory program or day program. Staff did interact with him in a thoughtful and supportive manner during scheduled 10-minute sessions when his glove was removed. However, on one of two occasions, he became quite distressed and he repeatedly tried to hit his head.

The facility had, since the time of the last review, greatly expanded the opportunities for activity participation across the campus and across the week. The opportunities were described in document request item I.S. Examples observed by the Monitoring Team while onsite included cooking classes, going shopping in the community for groceries, the Aquadome, supported employment in the community, and arts and crafts that included an embroidery machine, a sewing machine, a tee-shirt press, and a kiln for ceramic pieces.

19. The facility's policy regarding assessment of engagement indicated that 5% of the population was to be observed each month. This would result in only 60% of the population being assessed annually. However, for the nine individuals reviewed by the Monitoring Team, engagement was assessed between one and six times over a six-month period. This was completed during the monthly assessment of IOA and treatment integrity completed by the behavioral health services staff.

20. The facility has established a goal of 80% engagement.

21. It could not be determined that engagement had been assessed regularly (i.e., monthly) in each individual's day and treatment sites. However, the engagement assessments completed by behavioral health services staff reflected 80% engagement or better for five individuals who were assessed once each month over a six-month period. These individuals were Individual #263, Individual #249, Individual #127, Individual #341, and Individual #425.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: It was good to see that most individuals had goals for the frequency of community recreational activities and those goals were achieved. The same needs to occur for community SAP training. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	32	406	263	249	394	127	291	341	425
22	For the individual, goal frequencies of community recreational activities are established and achieved.	78% 7/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
22. Seven of the nine individuals (Individual #32, Individual #263, Individual #406, Individual #249, Individual #127, Individual #291, Individual #425) had goal frequencies for community recreational activities in their ISPs. In each case, these frequencies were achieved or exceeded. Although goal frequencies had not been established for Individual #394 and Individual #341, there was evidence of community-based activities over the previous six-month period. 23. None of the individuals had goal frequencies of SAP training in the community in their ISPs. There was evidence of community-based training on one SAP for Individual #425 only. 24. As community recreational goals were achieved for those for whom these were identified and there were no identified community-based training goals, this indicator is not rated.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
Summary: This indicator was not assessed during this review because there were no individuals who were entitled to, or received, educational services. This indicator will remain in active monitoring so that it can be assessed if applicable at the next review.			Individuals:								
#	Indicator	Overall Score									
25	The student receives educational services that are integrated with the ISP.	N/A									
Comments: 25. There were no school-aged individuals residing at the facility at the time of the visit.											

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the	N/A									

	measurable goal(s)/objective(s);										
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									
Comments: Based on documentation the Center provided, none of the individuals reviewed had dental refusals.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: The Center had made no progress on these indicators. They will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	36% 4/11	1/1	0/1	1/1	2/3	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	55% 6/11	1/1	0/1	1/1	2/3	0/1	1/1	0/1	0/1	1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	18% 2/11	0/1	0/1	1/1	0/3	0/1	1/1	0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/11	0/1	0/1	0/1	0/3	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.	9% 1/11	0/1	0/1	1/1	0/3	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. The goals/objectives that were clinically relevant, as well as measurable were Individual #127's goal/objective related to using her picture book to choose her job; Individual #45's goal/objective to make a choice by pushing a picture; and Individual #354's goals/objectives for using a picture book to choose an activity, and activating messages using Touch-chat on an iPad. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #153's goal/objective to activate a switch to turn on a CD player (i.e., the IDT asked the SLP to further evaluate Individual #153 and set up a relevant goal/objective, but no evidence was found to show the SLP conducted the further evaluation), and Individual #224's goal to touch staff on the hand to request a break (i.e., a skill she already had). c. through e. For Individual #45's goal to make a choice between two activities by pushing a picture, the QIDP reviewed the data, and when no progress was made for a few months attributed the decline to significant changes in health. The IDT met and determined the goal should continue as stated.											

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

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: There was a need for continued focus to improve staff's implementation of measurable communication strategies and actions plans. It was good to see IDTs were continuing to meet to discuss termination of communication services and supports, as needed for the individuals reviewed. The Center's score during the previous review was also 100%. If the Center sustains this performance, after the next review, Indicator b might move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	127	249	45	354	75	153	442	422	224
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	30% 3/10	1/1	0/1	1/1	1/3	0/1	0/1	N/A	0/1	0/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	100% 2/2	N/A	N/A	N/A	2/2	N/A	N/A	N/A	N/A	N/A
Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. Evidence often was not present to show that the strategies were implemented. Another problem noted was a lack of information about whether or not shared devices were used and/or their effectiveness.											

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 is encouraged to focus on ensuring individuals' AAC/EC devices are available in all appropriate settings, and individuals use them functionally.			Individuals:								
#	Indicator	Overall Score	450	45	354	280	429	406	127	439	394
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	40% 4/10	1/1	1/1	0/1	0/2	0/1	0/1	0/1	1/1	1/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	20% 2/10	1/1	1/1	0/1	0/2	0/1	0/1	0/1	0/1	0/1

c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	0% 0/3
	Comments: a. and b. It was concerning that often individuals' AAC devices were not present or readily accessible, and that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them. It should be noted that there was a limited group of individuals from which to select a sample for observation of personal communication devices. Only 33 out of 184 individuals have personal communication devices. Based upon experience with the population AUSSLC supports, it is highly likely that many more individuals would benefit from personal devices and associated programs to assist them to learn to utilize the devices. SLPs heavily recommended shared devices, but based on observation, they were used on a limited basis, and when utilized, they were not used correctly (e.g., staff pressing the button as they walked by on their way to the dining room). In addition, data was not taken on the usage of these shared devices so their benefit or value to the individuals was unknown.	

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

This Domain contains five outcomes and 20 underlying indicators. At this time, none will be moved to the category requiring less oversight. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. In addition, earlier this year, the Center just had begun to take on additional post-move monitoring responsibilities, and was beginning to follow individuals in the community for a year as opposed to 90 days.

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.

More work was needed to make supports in Community Living Discharge Plans (CLDPs) measurable. Although IDTs included a number of important pre- and post-move supports, a number of essential supports were missing from the CLDPs reviewed, and this should be a focus for Center staff.

In addition to ensuring timely post-move monitoring visits (or providing justification for late visits), areas in which further efforts were needed related to the Post-Move Monitor (PMM) basing decisions about supports on reliable and valid data, and IDTs following up in a timely and thorough manner when the PMM notes problems with the provision of supports.

Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of some components of transition assessments. Although Center staff provided training to community provider staff, the CLDPs did not define the training well, and the training did not appear to meet the individual's needs.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.											
Summary: More work was needed to make supports in CLDPs measurable. Although IDTs included a number of important pre- and post-move supports, a number of essential supports were missing from the CLDP reviewed, and this should be a focus for Center staff. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall	159								

		Score									
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: 1. The IDT developed 17 pre-move and 36 post-move supports for Individual #159. Overall, these were not consistently measurable. Pre-move supports primarily focused on exchange of information, transportation, ensuring that equipment requirements were in place, and in-service training. Eleven of the 17 pre-move supports were for in-services to be provided prior to the transition. Of these, four included substantial detail about the content of the in-service, which was positive. While it was positive the IDT developed supports for training of provider staff, these training supports did not include any descriptions of the training methodologies or competency demonstration criteria. The evidence required for all of the in-service supports called for signed rosters showing competency/completion, but none clearly indicated which competency criteria would apply. The IDT also did not specify how direct support staff would receive training on health care needs or physical and nutritional management requirements. These two supports called only for nursing and administrative staff to receive the training.

Many of the post-move supports related to staff knowledge, and it was positive the IDT included staff interview as required evidence for these. Supports for communication strategies and assistive equipment needs provided substantial detail as to what the Post-Move Monitor (PMM) should include in staff interviews. Many others did not. For example, supports for staff to be knowledgeable of choking and falls provided no precautions or preventative techniques that staff should know. The staff knowledge for behavioral supports stated staff should be aware of, able to locate and utilize the PBSP, but there were no specific measurable indicators or competency criteria.

Many other post-move supports did not describe the specific intent or define measurable outcomes that the PMM could use to determine if the individual's needs were being addressed as needed. For example, the support for a licensed SLP to see Individual #159 within 90 days of transition was not written in such a manner as to include the purpose of obtaining a baseline swallow study, but should have been. Supports for learning, skill acquisition and vocational needs called only for assessments to be completed within 30 days, but defined no expectation for implementation of any related programs. A support stated sleep data would be collected, but there was no expectation for how these data should be used or reviewed.

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 #159 and it was positive they had made a diligent effort to address her needs. Despite these efforts, this CLDP did not comprehensively address support needs and did not meet criterion, as described below:

a. Past history, and recent and current behavioral and psychiatric problems: Supports called for pre-move training related to behavioral needs, but did not specify the training methodologies or any criteria for competency demonstration. Supports did not sufficiently reflect Individual #159's past history and recent and current behavioral and psychiatric problems in a consistent manner. Examples included:
    - Individual #159 had a history of being sexually assaulted and frequently demonstrated aggression during check and change, particularly at night. This issue should have been addressed across several supports, including her need for

specific staffing level, staff knowledge regarding trauma and appropriate/therapeutic interaction techniques, and behavioral strategies. For example, shortly before transition, the IDT clarified she required two to three staff during nighttime check and change due to the aggression. The social work assessment noted staff should be aware of her history in this regard, but there was no specific support related to staff knowledge.

- The nutrition assessment noted a remote history of pica that had resulted in a bowel obstruction, but there was no staff knowledge support.

b. Safety, medical, healthcare, therapeutic, risk, and supervision needs: Many safety, medical, healthcare, therapeutic, risk, and supervision needs were insufficiently addressed with supports or not addressed at all in Individual #159's CLDP. Examples included:

- The IDT did not clearly specify the requirements for staffing to meet her needs. Until 1/5/16, she had been on enhanced supervision with 15-minute checks for aggression and falls, at which time the IDT met to revise it to routine. Per the ISPA, the IDT provided the rationale that this staffing change was possible due to a reduction of peer-to-peer aggression and because she was not initiating getting up from her chair very often. This did not address her need for additional staffing at night for check and change every two hours, which was a critical support to prevent urinary tract infection (UTI) and skin breakdown. The IDT expressed concern on several occasions that she required two to three staff at night due to her resistance to the two-hour check and change. As late as 12/10/16, there was an ISPA documenting she was still requiring two staff at night and sometimes during the day. At that time, the provider reiterated they would not be able to provide this level of staffing overnight. It was also documented at that same ISPA meeting that the AUSSLC direct support professional (DSP) who accompanied Individual #159 on a recent dinner visit to the provider home expressed concern about the staffing ratios. The DSP who made this observation was unable to attend the ISPA meeting, but there was no further documentation indicating the IDT pursued this to examine why this concern was expressed.
- Individual #159 was known to seek water to drink from the bathroom tap, which put her at risk because she required thickened liquids. The discussion and ensuing supports in the CLDP related to the need for a door alarm to the bathroom were conflicting. The narrative appeared to indicate a door alarm would not be needed for the bathroom because staff would be aware if she left her bedroom and would take appropriate action, but there was no supervision or staff knowledge support in this regard. The support for her assistive equipment needs indicated there would be two alarms, one for the bedroom and one for bathroom, but a later support indicated there would be a door alarm for the bedroom only.
- Overall, the approach to dysphagia and risk for aspiration lacked clarity. As recommended in the speech assessment and discussion in the CLDP narrative, it was agreed she would need a new swallow test to be completed within 90 days of transition, but this was not in the final recommendations and there was no support to that effect. Instead, the supports called only for a community clinician to see Individual #159 within 90 days of transition and to consult with an SLP if there were any noted changes to communication. The only support related to a swallow study was for the provider to receive the most recent study results from the Center. Based upon the Monitoring Team's review of assessments, the IDT should have developed the following supports: initial, annual and as-needed speech therapy evaluations for baseline swallowing and development and monitoring of a dining plan to mitigate risk of aspiration and choking.
- Individual #159's risk for falls was not sufficiently addressed. Pre-move supports included an in-service regarding

physical and nutritional management needs, including but not limited to diet and texture of her diet, but the support did not call for any specific staff knowledge regarding mobility. Another support that listed her assistive equipment and physical needs did list the required gait belt and knee pads, but a support calling for staff to be aware of risks, triggers, and precautions for falls provided no detail regarding precautions or interventions.

- The IDT did not specify any need for OT/PT monitoring or consultation, which was particularly troubling given her many equipment needs and documentation of possible deterioration in mobility. Based upon the Monitoring Team's review of her assessments, supports needed to include initial, annual and as-needed OT/PT evaluations to ensure appropriateness of adaptive equipment and ongoing efficacy with a special focus on adaptive equipment, potential impact of arthritis on her knees, feet and joints, and altered gait. A support should also have included the development of a plan to monitor falls as well as establish thresholds for the PT to be notified.
- Examples of other needs for which the IDT did not develop supports included:
    - The nutrition assessment recommended pushing fluids (water), five extra eight ounces per day, related to her history of hyponatremia of unknown cause as well as recent small bowel obstruction, but no support was developed.
    - The nutrition assessment also called for access to a registered dietitian for annual assessment at minimum, but the support called only for an assessment to be completed within 90 days, with no specific expectation for frequency. Per the assessment, weight changes of more than 5% in a month or 7.5% in three months were to be monitored and the dietitian and PCP notified of any such weight changes. The CLDP support called for weekly weights, but did not specify the weight changes that should trigger any notifications as indicated.
    - There was no support to notify the PCP and dentist of an elevated creatine phosphokinase (CPK) level, which would cause an increased risk of myoglobinura/ renal damage if any anesthesia or medication changes were planned, or if she had any infection or fever. This was noted in several assessments. In its response to the draft report, the State indicated that notes provided to the PCP included this information. However, this missed the point of this indicator, which required that the IDT identify a specific support to ensure this information was transmitted to the PCP and to the dentist, and identify the means by which such information should be transmitted (e.g., depending on the nature of the issue, a phone call, as part of documentation sent, in a letter or email to highlight information, etc.). The presence of this information in the notes to the PCP (which really was basically sending the assessment and various documents to the PCP) would have been one way of documenting the support had been implemented if the team agreed it did not need to be highlighted in some other manner. However, it would not take the place of the IDT identifying the support in the first place. This also did not address the need to inform the dentist.
    - The IDT did not develop a support related to her need to avoid Non-Steroidal Anti Inflammatory Drugs (NSAIDs) due to renal insufficiency.
    - The CLDP discussion noted a need to sit up one hour after meals, but this was not included in the final recommendations or supports.
    - The dental assessment recommendation for being seen by the dentist every three to four months was changed to being seen by the community dentist by August 2016 (or within six months), but there was no ongoing frequency prescribed.

- In September 2015, a Change of Status (CoS) IRRF recommended she be closely monitored for any episodes of emesis, but the IDT did not develop a support in this regard.
- She was to have a pulse volume recording (PVR) every November related to urinary retention, but the IDT did not develop a related support. Similarly, she was to have an annual EKG while on Clozaril, but the IDT did not develop a related support.
- The IDT did not specify any nursing oversight or routine monitoring, apart from staff notifying the nurse if she had no bowel movement in 24 hours or no urination within four hours. This was again concerning given her diagnoses of renal insufficiency and two hospitalizations in the past year for pneumonia, small bowel obstruction, and gallbladder surgery, as well as some indication of declining health overall.

c. What was important to the individual: The CLDP profile indicated she liked to interact with staff and observe people and their actions. It further stated a desired environment would encourage independent skill development and greater social skills. None of these was addressed to any extent with supports. Examples included:
   - The ISP included a strategy for having staff read a book to her to support more quality time with preferred staff and to participate in turn-taking activities, but there were no such social skills/interaction support in the CLDP.
   - The only support for independent skill development was to complete an assessment of her needs within 30 days of transition, with no expectation for implementation of any ongoing skills development.

d. Need/desire for employment, and/or other meaningful day activities: The Individual Behavioral Health Assessment (IBHA) recommended that vocational opportunities should be available as "she has many different skills and interests." The vocational assessment made recommendations for the SAPs that were included in her ISP, including watering plants, cleaning the table, planting seeds, choosing between two activities and throwing away her trash after a snack. None of these were addressed in the CLDP. The only CLDP recommendation related to employment was to evaluate and determine meaningful training objectives within 30 days, with minimal input from the AUSSLC IDT. This support also had no outcome other than an evaluation; there was no specific expectation for the development and implementation of plans for teaching, maintenance, participation, and acquisition of specific skills.

e. Positive reinforcement, incentives, and/or other motivating components to an individual's success: The communication supports provided some good strategies such as offering praise and how to best provide physical assistance and prompting, which was positive. Individual #159's Positive Behavior Support Plan (PBSP) documented a number of other strategies for positive reinforcement, incentives, and/or other motivating components. These included that she responded best to praise paired with clapping or pats on back, liked bubble baths, bubble lights, upbeat music and to hold a hard back book in her hands. Other components included that she liked to be greeted by staff and others when entering an environment and would do best with this interaction and that she would be more likely to be successful when given attention of preferred staff. None of these were specifically included in the CLDP discussion narrative or incorporated into any supports.

f. Teaching, maintenance, participation, and acquisition of specific skills: The IDT developed few supports related to teaching, maintenance, participation, and acquisition of specific skills. The Functional Skills Assessment (FSA) recommended only that she would benefit from continued formal and informal training on activities of daily living (ADLs) to increase independence, or at least participation, in needed areas, but it did not specify what ADLs should be considered. The FSA summary indicated she could do a lot of ADLs with little to no assistance and that it was just a matter of her wanting to do them, and drawing a connection between what she's doing and why it was necessary. There was no information about formal plans that had been tried and what worked or did not work in this regard. The only CLDP support was to evaluate and determine meaningful

	training objectives within 30 days, with minimal input from the AUSSLC IDT. This support also had no outcome other than an evaluation; there was no specific expectation for the development and implementation of plans for teaching, maintenance, participation, and acquisition of specific skills. g. All recommendations from assessments are included, or if not, there is a rationale provided: There were many recommendations and important supports described in the discharge assessments that were not included, and for which no rationale was provided to justify non-inclusion. Many of these are described in the examples included for safety, medical, healthcare, therapeutic, risk, and supervision needs above.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.											
Summary: In addition to ensuring timely post-move monitoring visits (or providing justification for late visits), areas in which further efforts were needed related to the PMM basing decisions about supports on reliable and valid data, and IDTs following up in a timely and thorough manner when the PMM notes problems with the provision of supports. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	159								
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	0% 0/1	0/1								
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 scoring 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, the IDT/Facility implemented corrective actions 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	N/A	N/A								

	post-move monitoring.										
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A	N/A								

Comments: 3. Post-move monitoring was not consistently completed at required intervals. The seven- and 90-day PMM visits were completed on a timely basis but the 45- and 180-days visit were one to four days late. All locations were visited and reports completed in the proper format.

4. Reliable and valid data that report/summarize the status regarding the individual's receipt of supports was not consistently available. This was due in part to supports that did not provide measurable indicators, such as the lack of identification of precautions for choking and falls as described under Indicator #1 above. In other instances this was due to insufficient documentation from the PMM. While comments were provided for every support, these were not consistently as detailed as needed to confirm whether supports were in place as required. For example, a support called for Individual #159 to be seen by the PCP for various needs, including referrals for lab work and consultations. The comments did not address either of these needs. A support to continue suction tooth brushing twice a day called for staff interview and documentation as evidence, but the comments at the time of the 45-day PMM visit did not document testing of staff knowledge.

5. Based on information the PMM collected, Individual #159 had not consistently received supports as listed and/or described in the CLDP. Examples included:

- At the time of the seven-day PMM visit, provider staff were not collecting sleep data as required, the provider was not keeping a needed log for documenting urinary retention or the log for tracking bowel movements, and the weekly weight was not available.
- Documentation related to a possible medication error was not available at the seven-day PMM visit.
- Documentation did not clearly indicate whether a behavioral support plan was being implemented as required. The support calling for the PBSP from the SSLC to be reviewed was not being tracked consistently. At the time of the 45-day PMM visit, the Post-Move Monitor asked to see the report from the community psychologist, but was told only that the SSLC PBSP had been continued.
- At both the 90- and 180-day PMM visits, the required dietitian assessment had not been completed.

6. The evidence did not always support the PMM's scoring. For example, the PMM noted at the seven-day PMM visit that staff could not locate the Communication Strategies document at the day program as required, and asked that a copy be printed and placed in the appropriate book. It was positive the Post-Move Monitor took appropriate action, but the PMM should have scored the support as not having been in place. The evidence cited also was not always sufficient to confirm whether the PMM's scoring was correct. For example, for two supports calling for staff to be familiar with risks, triggers, and precautions for choking and falls, the Post-Move Monitor stated staff were able to identify these, but the actual support did not list precautions. The comment did not provide any evidence of specific staff knowledge or what the PMM tested for related to precautions.

7. and 8. The PMM made good effort in most cases to follow-up on supports the provider was not offering as required, but the documentation indicated corrective action was not consistently implemented in a timely manner. At times, the IDT or Facility Director might need to intervene to attain the needed response from the community provider. For example:

- Individual #159 did not see the Speech Language Pathologist for evaluation until more than two months after it was due.
- At the time of the 90- and 180-day PMM visits, the community dietician had not yet seen Individual #159 for evaluation, which was to occur within 90 days, but Center staff had not received evidence of completion at the time of the Monitoring Team's visit. In response to the Monitoring Team's request for any updates related to this evaluation, a document was provided, dated 6/6/16, that indicated the provider stated such an assessment was not due because AUSSLC had completed one in January 2016. The document further stated the next assessment would not be due until January 2017. There was no evidence the IDT met to consider whether this was acceptable in light of the CLDP support calling for an evaluation to be completed in her new environment within 90 days of transition.

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

Outcome 3 – Supports are in place to minimize or eliminate the incidence of preventable negative events following transition into the community.											
Summary: The Monitoring Team will continue to assess this indicator.			Individuals:								
#	Indicator	Overall Score	159								
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.	0% 0/1	0/1								

Comments: 11. On 7/27/16, Individual #159 experienced law enforcement contact, during which she was handcuffed, and then was subsequently hospitalized with a UTI. The IDT met on a timely basis to review the incident. The PDCT documentation indicated law enforcement contact was not preventable, but did not comment on whether the hospitalization for UTI might have been preventable. The PDCT ISPA did not document any IDT discussion as to whether there had been ongoing issues related to two-hour nighttime check and change. This was relevant and should have been considered. On 12/1/15, the IDT had noted during a pre-move meeting that this was a critical component of preventing UTIs and that it often required two to three staff due to her resistance. At that time, the provider indicated it would not be able to accommodate having two staff overnight for this purpose. Instead, staff would attempt the check and change and come back later if Individual #159 resisted. The IDT reiterated the importance that this support be implemented with the required frequency, but did not set a specific support for two-hour check and change or require any specific data be tracked in this regard. A sleep data record had been implemented, but there was no information as to what specific sleep data were to be recorded and PMM Checklists only noted whether she was awake or asleep. There were no data regarding any difficulty the staff experienced in implementing the two-hour check and change, per the PMM's comments. It was not documented if these data were found in the hygiene log and this was not included in the PDCT ISPA meeting documentation. The IDT also had not developed a specific support for water intake despite a recommendation in the nutrition assessment to increase her intake, as described above under Indicator #2. As a part of the PDCT ISPA, the IDT did not document a review of the current preventative supports in these areas to determine if they were adequate or needed to be revised and/or further monitored. In interview, the Admissions Placement Coordinator stated some of these

concerns were at least discussed during the ISPA meeting. There was documentation that the provider purchased a larger water bottle after the PDCT event so Individual #159 could have easier access to more fluid, which was positive, but the IDT still did not consider whether they should have defined a specific support in this area or add one for further monitoring.

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: Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of some components of transition assessments. Although Center staff provided training to community provider staff, the CLDPs did not define the training well, and the training did not appear to meet the individual's needs. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	159								
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.	0% 0/1	0/1								
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/1	0/1								
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/1	0/1								
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/1	0/1								
17	Based on the individual's needs and preferences, SSLC and	100%	1/1								

	community provider staff engage in activities to meet the needs of the individual.	1/1									
18	The APC and transition department staff collaborates with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition.	100% 1/1	1/1								
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 consistently meet criterion for this indicator. The Monitoring Team considers four sub-indicators when evaluating compliance.

- Assessments updated with 45 days of transition: Many assessments were updated, per the noted completion date, but some of these did not appear to have current information other than recommendations. Examples included:
    - The nursing assessment provided was dated 8/11/15, and indicated it was the annual assessment, but it was signed on 1/29/16. While AUSSLC also provided a quarterly review, dated 11/9/15, and monthly reviews from October 2015 and November 2015, the CLDP summary indicated the date of the nursing assessment update was 1/29/16. This could not have been considered an update within 45 days of transition, as all data in that assessment were from prior to 8/15.
    - The OT/PT assessment was dated 1/11/16, but also did not contain updated information. For instance, the assessment indicated further data collection and monitoring was underway to determine if she was truly much more lethargic or weak, a process starting on 8/5/15 and to be concluded in three weeks. There was no update regarding the results of that monitoring. The assessment also included her "current" weight from 8/4/15, and referred to SAPs to be developed at the next ISP on 8/19/15.
    - The Center did not review or update the Integrated Risk Rating Form (IRRF), but should have, or should have indicated that the IRRF was reviewed and no updates were required. The IRRF section of the ISP typically contains a great amount of information. The APC should ensure that the IDTs review the status of the IRRF as part of the transition assessment process.
    - No pharmacy assessment was provided for review.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: In addition to the nursing and OT/PT assessments having limited updated information, the speech assessment had only a brief update to a 2014 comprehensive assessment.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments did not consistently meet criterion. Examples included:
    - The IBHA noted significant problems with moves to new environments, with a good discussion, but offered no specific recommendations regarding strategies to address these.
    - The OT/PT assessment indicated further data collection and monitoring was underway to determine if she was truly much more lethargic or weak, beginning on 8/5/15, but offered no findings or recommendations from this assessment process.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not consistently meet criterion. For example, the only recommendations from the FSA and vocational assessments were to evaluate and

determine meaningful training objectives within 30 days. They provided little input regarding her specific needs and preferences and how they might be addressed in the new community home and day/work settings.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator, including the following:

- There was documentation to show IDT members actively participated in the transition planning process: The IDT held a number of ISPA meetings to review transition activities, with good participation documented, and provided in-service training. Provider staff also shadowed AUSSLC staff.
- The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed: The PMM was identified as responsible for post-move supports, but pre-move supports indicated only "IDT member" or "AuSSLC designee." The CLDP should clearly state at least the specific discipline or position assigned responsibility for each support.
- 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: Documentation reflected that the LAR was very involved in process. The QIDP also routinely documented attempts to review proceedings with individual.

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: As indicated above, several training supports provided substantial detail about the content of the in-service needed, which was positive, but none included descriptions of the training methodologies or competency demonstration criteria. The evidence required for all of the in-service supports called for signed rosters showing competency/completion, but none clearly indicated what competency criteria would apply. The IDT also did not specify how direct support staff would receive training on health care needs or physical and nutritional management requirements. These two supports called only for nursing and administrative staff to receive the training. In interview, the APC indicated it was the practice for all in-service training for provider staff to be completed at the Center and typically this included having provider DSPs shadow their AUSSLC counterparts. In addition to identifying staff to be trained, as well as the methods of training required and the competency criteria in the CLDP, the IDT should clearly document its consideration of whether providing all training at the Center is sufficient to meet the needs of each individual, as there may be specific and unique circumstances in the community settings that are not equivalent to those at AUSSLC.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: There was no evidence that there was collaboration between Center staff and community clinicians, or any statement in the CLDP that this was considered. It was concerning that the IDT did not consider whether a physician-to-physician discussion was necessary given her overall health needs and the importance need for the physician and dentist to be aware of the risk related to elevated CPK levels if any anesthesia or medication changes were planned. The APC noted in interview that AUSSLC protocol for every transition did include a letter to the community physician with a packet of health care information for the purpose of facilitating medical continuity of care. The letter typically provided the name and phone number of the Center PCP. This was a positive practice, but would not necessarily ensure that criterion was met for this indicator as some individuals' transitions might require actual contact between PCPs, based upon individual needs. It is still incumbent upon the IDT to discuss in the CLDP whether any direct and specific collaboration between community clinicians would be needed. The Placement Coordinator did provide such a letter and packet to the

community physician for Individual #159. The letter did not call attention to or otherwise emphasize the critical importance of the risks described above.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results: The CLDP did not provide any details as to whether any settings assessments were needed and there was no documentation that any IDT member had visited either the home or day program before Individual #159's transition took place. According to the APC, it was the practice for the IDT to review descriptions and pictures of the proposed sites prior to pre-move visits and determine from that activity whether any additional on-site assessment was needed. The Center provided copies of the pictures of Individual #159's home for the Monitoring Team to review, but was unable to locate a copy of the email documenting that the IDT received the pictures for review. There was also no indication in the pre-move ISPA documentation that the pictures were reviewed and discussed by the IDT as a whole. The pictures, standing alone, did raise possible concerns that would have borne discussion and resolution. For example, the pictures provided showed two bathrooms. One had a bathtub and one had what appeared to be a fairly narrow shower stall with a lip at the entrance. Individual #159 had a rolling shower chair, and the IDT indicated in the 180-day ISPA on 12/1/15 that she needed a walk-in shower. It was not completely clear if the shower stall could accommodate a rolling chair or if it would be acceptable for her to step over the lip of the stall with assistance to reach the chair. Also, her PNMP stated that she required a grab bar or stable surface to complete cleaning and changing following toileting. The pictures provided did not show a grab bar in the vicinity of the toilets and the IDT did not discuss whether another stable surface sufficient for this purpose was available.

In addition, there was an apparently significant weight gain noted at the time of the 45-day PMM visit, the resolution to which had not been documented in the available PMM materials provided for review. The Monitoring Team requested such documentation from the APC, which indicated this was a discrepancy due to the method by which Individual #159 was being weighed at the home rather than an actual weight gain. She could not stand on the scale available at the home, so DSPs were assisting her to balance by holding her arms and gait belt. This resulted in an inaccurate weight and might even have represented a hazard. An on-site assessment of the home by habilitation therapists would have likely led to the discovery of this concern prior to her transition.

17. The CLDP should provide a specific statement about the types and level of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences. Examples include provider direct support staff spending time at the Center, Center direct support staff spending time with the individual in the community, and Center and provider direct support staff meeting to discuss the individual's needs. For Individual #159, provider direct support staff shadowed center staff on more than one occasion, which was a positive practice. The Center should consider formalizing this process to the extent of defining the purpose and expectation of the shadowing as well as documenting specifically who participated.

18. The APC and transition department staff collaborated with the LIDDA staff when necessary to meet Individual #159's needs during the transition and following the transition. LIDDA staff attended the CLDP meeting, participated in the PDCT ISPA, and provided documentation to the PMM of its ongoing attempts to have her seen by an optometrist.

19. Documentation that pre-move supports were in place in the community settings on the day of the move was not clearly demonstrated. For example, the Pre-Move Site Review indicated only that the PMM had spoken with AUSSLC staff and provider staff who indicated pre-move in-services had been completed as required. There was no indication that, at a minimum, the PMM reviewed

copies of signed training rosters showing competency/completion, or that the PMM obtained copies of training materials. More importantly, there was no evidence to substantiate that provider staff had adequate knowledge or had demonstrated competency to meet Individual#159's needs. There was also no evidence the PMM made observations for the presence in the new home of required documents, such as the communication dictionary and strategies, and the copy of Flomax results. Rather, the Post-Move Monitor relied on knowledge that these documents had been sent, either by mail or with AUSSLC staff. The purpose of the Pre-Move Site Review is to ensure that pre-move supports are in place prior to the move, and the PMM should make observations to confirm supports are in place.

Outcome 5 – Individuals have timely transition planning and implementation.											
Summary: It was positive that for the individual reviewed documentation was present to show justifiable reasons for the delays in her transition. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	159								
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	100% 1/1	1/1								
Comments: Individual #159 did not transition within 180 days of referral, but documentation reflected adequate justification. The initial referral date was 9/25/14, and transition occurred on 2/4/16. The Transition Specialist log indicated ongoing activity, and that any delays were generally related to ongoing community exploration, provider availability to meet her needs, and some health issues, including hospitalization and surgery. There was a period in which the guardian was noted to be prioritizing needs of other residents, because their homes were closing while Individual #159's was not, but that did not appear to cause a significant delay as her health issues occurred soon after that statement was made.											

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

- Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
- In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic);
- Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
- In the past six months, individuals with dental emergencies;
- Individuals with Do Not Resuscitate Orders, including qualifying condition; and
- In the past six months, individuals with adverse drug reactions, including date of discovery.

- Lists of:
  - Crisis intervention restraints.
  - Medical restraints.
  - Protective devices.
  - Any injuries to individuals that occurred during restraint.
  - DFPS cases.
  - All serious injuries.
  - All injuries from individual-to-individual aggression.
  - All serious incidents other than ANE and serious injuries.
  - Non-serious Injury Investigations (NSIs).
  - Lists of individuals who:
    - Have a PBSP
    - Have a crisis intervention plan
    - Have had more than three restraints in a rolling 30 days
    - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
    - Were reviewed by external peer review
    - Were reviewed by internal peer review
    - Were under age 22
  - Individuals who receive psychiatry services and their medications, diagnoses, etc.

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

c. Medical
d. Nursing
e. Pharmacy
f. Dental

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

The individual-specific documents listed below:

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

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

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

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

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

- Functional Skills Assessment <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 after 1/1/14, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.
- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.
- Data that summarize the individual's community outings for the last six months.
- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- The individual's daily schedule of activities.
- Documentation for the selected restraints.
- Documentation for the selected DFPS investigations for which the individual was an alleged victim,
- Documentation for the selected facility investigations where an incident involving the individual was the subject of the investigation.

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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