United States v. State of Texas

Monitoring Team Report

Austin State Supported Living Center

Dates of Onsite Review: July 24th to July 28th, 2017

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Background

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

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

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

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

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

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

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

Methodology

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

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

Organization of Report

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

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

Executive Summary

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

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at 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. At the time of the last review, 21 of these indicators, including five entire outcomes, had sustained high performance scores and moved to the category requiring less oversight. Presently, five additional indicators will move to the category of less oversight, which places the entirety of Outcome #3 for restraints, and Outcome #8 for abuse, neglect, and exploitation in less oversight. One indicator, which represents the entirety of Outcome #5 in the area of restraints, will return to active oversight.

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>
Crisis intervention restraint usage was extremely low at Austin SSLC. There were two crisis intervention physical restraints in the nine-month review period (and no usage of crisis intervention chemical or mechanical restraint); the lowest rate in the state. Protective mechanical restraint for self-injurious behavior (PMR-SIB) and medical restraint received attention and fading/removal. All restraints received thorough review. For both of the crisis intervention restraints, however, proper documentation was not fully completed and criteria regarding restraint monitor date/time of arrival were not met.

Nursing staff need to include in IPNs descriptions of thorough assessments completed with regard to restraints such as mittens and abdominal binders. For crisis intervention physical restraints, nurses should assess individuals within 30 minutes of the initiation of restraint, and clearly document whether or not an injury occurred.

Abuse, Neglect, and Incident Management

Important protections were in place prior to all 10 incidents, including background checks, duty to report forms, and related treatment programs (e.g., PBSP, PNMP). Unusual Incident Reports (UIRs) were well written and easy to follow, with information presented in a logical sequential order. Facility review practices were extensive and well documented. Recommendations that came out of these reviews were appropriate to the circumstances, and documentation showed they were carried out in a timely manner. Of particular positive note, there were about a dozen allegations that were unconfirmed by DFPS (primarily neglect allegations that were unconfirmed because there was no injury to the individual). Following facility review, they were changed to a confirmation by the facility director (as policy allowed) because, although no injury occurred, the investigation found that the staff actions did occur, the actions put the individual at risk, and an injury could have occurred.

For facility investigations of discovered serious injuries, investigations did not, but should, establish the last time the individual was observed without the injury, and the first time the individual was observed with the injury. This is necessary to establish a window for investigatory activity.

Trend analysis was extensive. It focused almost exclusively on trends specific to specific individuals. This was good to see and should continue, however, there also needs to be trend analysis to identify potential systemic issues to potentially reveal important variables that need more intensive administrative oversight, planning, and/or actions.

Other

IDTs were considering the use of pretreatment sedation, the benefits versus the risks of using/not using it, and whether treatment strategies should be used to reduce future likelihood of need. Proper consent and HRC review, however, were not occurring as required.

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 two reviews. Given the importance of these facility and individual indicators, both will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
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% 11/11	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 (September 2016 through May 2017) were reviewed. There were two occurrences of crisis intervention physical restraint in the nine-month period, zero occurrences of crisis intervention chemical restraint, and zero occurrences of crisis intervention mechanical restraint. One crisis intervention physical restraint was for two minutes, the other was for one minute (average of 1.5 minutes). These were the lowest rates and lowest average duration in the state.

There were no injuries to individuals during crisis intervention restraint and crisis intervention restraint occurred for two individuals across the nine-month period. One individual had protective mechanical restraint for self-injurious behavior (PMR-SIB) and actions were being taken to reduce the type of device (mittens to finger sleeves) and the amount of time in the device. There were no instances of PMR-SIB being moved to the category of medical restraint or supportive devices.

Regarding medical restraints, there were no occurrences of non-chemical restraint for implementing medical or dental procedures or for long-term use. There were two uses of non-chemical restraint for healing, both of which were no longer in use at the time of the onsite review. The use of pretreatment sedation for medical procedures was slightly ascending during the nine-month period, though the director of behavioral health services pointed to a two-year graph that showed the somewhat cyclical nature of this prescribing due to many annual exams being required. The number of individuals who needed pretreatment sedation for dental procedures was low. The list of individuals who needed pretreatment sedation for medical or dental procedures indicated that informal plans were being implemented to try to reduce the need for these medications. The use of TIVA (for dental procedures) was lower during the past year than during the year before that.

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; the number with PMR-SIB; the use of non-chemical restraints for medical and dental procedures; and the use of pretreatment sedation and TIVA).

The restraint reduction committee (called the restraint review board at Austin SSLC) met each month to review any occurrences of crisis intervention restraint, medical restraint, and PMR-SIB. It included a checklist of items that prompted discussion of various topics. This monthly meeting was another positive aspect of restraint management at Austin SSLC.

2. One of the individuals reviewed by the Monitoring Team was subject to crisis intervention restraint, and one was subject to PMR-SIB (Individual #421, Individual #341). In addition, two other individuals were chosen for inclusion in this indicator and the indicators below who had a crisis intervention restraint (Individual #56) and a non-chemical medical restraint for healing (Individual #181). Data from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for all four. The other seven 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. The three indicators that were scored for this outcome will remain in active monitoring for review next time.			Individuals:									
#	Indicator	Overall Score	421	341	181	56						
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
4	The restraint was a method approved in facility policy.											
5	The individual posed an immediate and serious risk of harm to him/herself or others.											
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	67% 2/3	1/1	0/1	N/A	1/1						
7	There was no injury to the individual as a result of implementation of the restraint.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.											
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	Not rated	Not rated	Not rated	Not rated	Not rated						
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	75% 3/4	1/1	1/1	1/1	0/1						

Comments:
The Monitoring Team chose to review four restraint incidents that occurred for four different individuals (Individual #421, Individual #341, Individual #181, Individual #56). Of these, two were crisis intervention physical restraints, 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. Good progress was noted for Individual #341, however, this indicator was scored 0 for him because, over the nine-month review period, the plan for reduction was not fully implemented and was discontinued for a time.

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

11. For Individual #56, the ISP (IRRF section) stated that he had a seizure disorder that should be taken into account when considering restraint. This was too vague to be useful for staff during a crisis situation.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
Summary: This indicator will be moved to the category of requiring less oversight due to sustained high performance for this review and the previous two reviews, too.			Individuals:								
#	Indicator	Overall Score	421	341	181	56					
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	N/A	N/A	1/1					
Comments:											

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.											
Summary: Restraint monitor presence needs to occur and be documented as required (indicator 13). Proper procedures were implemented for indicator 14 for this review and the previous two reviews, too and, therefore, it will be moved to the category of requiring less oversight. Indicator 13 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	421	341	181	56					
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	0% 0/2	0/1	N/A	N/A	0/1					
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	100% 2/2	N/A	1/1	1/1	N/A					
Comments: 13. For Individual #421, there was no documentation of arrival time of restraint monitor. For Individual #56, the restraint monitor arrived at a time later than the maximum allowed.											

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.

Summary: Nursing staff need to include in IPNs descriptions of thorough assessments completed with regard to restraints such as mittens and abdominal binders. For crisis intervention physical restraints, nurses should assess individuals within 30 minutes of the initiation of restraint, and clearly document whether or not an injury occurred. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 421	341	181	56					
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	25% 1/4	1/1	0/1	0/1	0/1					
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	25% 1/4	0/1	0/1	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.	25% 1/4	0/1	0/1	0/1	1/1					

Comments: The restraints reviewed included those for: Individual #421 on 3/13/17 at 6:45 p.m. (physical), Individual #341 for seven days of PMR for SIB - mittens from 4/24/17 to 4/30/17, Individual #181 for seven days of medical restraint for healing – abdominal binder from 5/8/17 to 5/14/17, and Individual #56 on 12/13/16 at 12:27 p.m. (physical).

a. through c. The following provide some examples of issues noted:

- For Individual #421, the post-injury reports provided for this request did not include the necessary information, and no nursing IPNs were provided. In addition, Center staff indicated that they could not find documentation in IRIS that the PCP was notified. Thus, no PCP order was provided. Also, none of the post-injury reports specifically addressed the restraint episode at 6:45 p.m., so there was no way to determine if an injury occurred during this episode.
- For Individual #341, no nursing IPNs were provided addressing the use of mittens for this individual. Such IPNs should have included the reason for the mittens, effectiveness, condition of the skin from the mittens, tolerance, and effect on functioning from the mittens as well as how that was addressed. Much of the IView documentation had information cut off of the pages.
- For Individual #181, no nursing IPNs were provided addressing the use of an abdominal binder for this individual, including the reason of its use, the condition of the site and surrounding skin, effectiveness of the binder, tolerance of the binder, and any changes in functioning because of its use and/or assistance needed due to the binder. Much of the IView documentation had information cut off of the pages.
- For Individual #56, the nurse's assessment was not initiated within 30 minutes of the assessment. However, other criteria were met for this restraint.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary: Crisis intervention restraint occurred infrequently at Austin SSLC. Even so, proper documentation must be fully completed when restraint does occur. For both occurrences during this review period, documentation aspects were noted to be missing and, therefore, this indicator will be moved back to active monitoring for review at the next onsite review.			Individuals:									
#	Indicator	Overall Score										
15	Restraint was documented in compliance with Appendix A.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. But given problems with documentation in both occurrences, it will be moved back under active monitoring.										
Comments: 15. For each of the two crisis intervention physical restraints, there were documentation problems. For Individual #56, the names of staff who implemented the restraint were not recorded. For Individual #421, an injury (non-serious abrasion) occurred, but was not properly documented by the nurse. The nurse should always check for injury after crisis intervention restraint. In this case, the individual was checked, but not timely. The restraint occurred at 6:42 pm and the injury report shows nurse entries at 10:20 pm. Also, this information belongs on the restraint checklist. Moreover, in this case, the injury report states that the individual banged her head at the time of the restraint, clearly indicating that this behavior/injury was occurring during restraint application.												

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.												
Summary: Crisis intervention restraints were thoroughly reviewed at various levels at Austin SSLC. This was the case for all crisis intervention restraints during this review period and during the previous two reviews, too. Therefore, indicator 16 will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	421	341	181	56						
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 2/2	1/1	N/A	N/A	1/1						
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
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 at Austin SSLC. This was good to see. These indicators will remain in active monitoring for possible scoring at the next monitoring review.			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:												

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
Summary: Performance maintained at a high level, which was good to see, and demonstrated the Center's attention to risk, plans, and follow-up. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	369	193	118	341	376	56	291		
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	100% 10/10	2/2	2/2	1/1	2/2	1/1	1/1	1/1		

Comments:

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

- Individual #369, UIR FY17-057-12-29-16, DFPS 45034365, unconfirmed allegations of sexual and physical abuse, 12/29/16
- Individual #369, UIR FY17-114-05-16-17, discovered finger fracture, 5/16/17
- Individual #193, UIR FY17-110-05-12-17, DFPS 45281505, unconfirmed allegation of neglect, 5/12/17
- Individual #193, UIR FY17-084-03-17-17, discovered femur fracture, 3/17/17
- Individual #118, UIR FY17-094-03-30-17, DFPS 45216856, confirmed and unconfirmed allegations of neglect, 3/30/17

- Individual #341, UIR FY17-044-12-05-16, DFPS 44993218, confirmed allegation of neglect, 12/5/16
- Individual #341, UIR FY17-051-12-19-16, DFPS 45012425, confirmed allegation of neglect, 12/19/16
- Individual #376, UIR FY17-045-12-13-16, DFPS 45004507, unconfirmed allegation of emotional abuse, 12/13/16
- Individual #56, UIR FY17-118-05-22-17, DFPS 45294260, confirmed allegation of emotional abuse, 5/22/17
- Individual #291, UIR FY17-052-12-19-16, suicide threat, 12/19/16

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

Criteria were met for all 10 investigations. For all 10 investigations, related background checks and duty to report forms were done correctly. For seven of the 10, the investigation was regarding allegations of staff misconduct and, for each of these, there were no relevant individual-related trends to be reviewed. For the remaining three, the behaviors exhibited by the individual had been trended and were part of their treatment programs (e.g., PBSP, PNMP). This was good to see.

There were no individuals at Austin SSLC deemed for streamlined investigations due to chronic calling as per DFPS and DADS protocols.

Of particular positive note, there were about a dozen allegations that were unconfirmed by DFPS, primarily neglect allegations that were unconfirmed because there was no injury to the individual. Following facility review, they were changed to a confirmation by the facility director (as policy allowed) because, although no injury occurred, the investigation found that the staff actions did occur, the actions put the individual at risk, and an injury could have occurred.

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

Summary: Overall, there was good performance demonstrated in all but one incident. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 369	193	118	341	376	56	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.	90% 9/10	2/2	2/2	1/1	2/2	0/1	1/1	1/1		

Comments:
2. For Individual #376 UIR 045, the allegation was reported the day after it allegedly occurred.

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: See comment below regarding indicator 5.			Individuals:									
#	Indicator	Overall Score										
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.											
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.											
Comments: 5. For Individual #376 UIR 045, there were references in both the DFPS report and the UIR about possible retaliation being the reporter's motivation. The UIR did not include any specific information on whether or not possible retaliation was investigated.												

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.												
Summary: Given 100% performance on this review and the last review, and 92% on the previous review (11 out of 12), this indicator will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	369	193	118	341	376	56	291		
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 10/10	2/2	2/2	1/1	2/2	1/1	1/1	1/1		
Comments:												

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

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.												
Summary: Some additional work is needed to ensure that all relevant evidence is collected, especially regarding serious injuries. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	369	193	118	341	376	56	291		
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	70% 7/10	0/2	1/2	1/1	2/2	1/1	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)	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

9. Three investigations did not meet criteria for this indicator.
    - Two of these (Individual #369 UIR 114, Individual #193 UIR 084) were investigations of discovered serious injuries. When there is a discovered serious injury, the investigation should interview enough staff to try and determine the last time the individual was observed without the injury and the first time he or she was observed with the injury. This establishes a window of time for the investigation, for video review, and for assessment of all potentially relevant information.
    - For Individual #369 UIR 057, the reporter was not interviewed. If DFPS had a rationale for this, it should have been articulated in the report. Further, facility review should also have questioned this. DFPS relied on the reporter's email to the facility as sufficient testimonial evidence, however, by interviewing the reporter, DFPS could potentially have gained information to further substantiate the unconfirmed finding, or may have gained additional information potentially leading to additional issues to be probed before ruling out abuse. In a comment on the draft version of this report, DFPS stated that the reporter was interviewed, however, upon re-review of the documentation, the allegation was reported to the facility in an email from a reporter and then the facility reported it to DFPS. DFPS interviewed the facility staff member who reported it to DFPS, but did not interview, or seek to interview, the original reporter of the allegation.

Outcome 7– Investigations are conducted and reviewed as required.												
Summary: There was good improvement in the completion of investigations within the required timeframes. The 90% score was the highest of the last three reviews. Austin SSLC's review process was sometimes thorough, even resulting in challenges to DFPS' findings (e.g., Individual #341 UIR 044), but sometimes did not pick up on some aspects of the investigation that were lacking. These two indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall	369	193	118	341	376	56	291		

		Score									
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	90% 9/10	2/2	1/2	1/1	2/2	1/1	1/1	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.	70% 7/10	0/2	1/2	1/1	2/2	1/1	1/1	1/1		

Comments:
12. Individual #193 UIR 110 was completed in 11 days.

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

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

Summary: Non-serious injury investigations continued to be conducted when needed and to be conducted correctly. This was the case for all individuals for this review and for the past two reviews, too. Therefore, indicator 15 will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 369	193	118	341	376	56	291		
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	100% 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:			Individuals:									
#	Indicator	Overall Score										
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.											
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.											
Comments: 17. There were two investigations that confirmed physical abuse category 2. In both cases, the employment of the involved staff was not maintained.												

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.												
Summary: This outcome consists of facility indicators. Austin SSLC collected and reviewed data. Analyses of individuals' data were done, which was good to see. The next step, and to meet criteria with these indicators, is to look at data and analyses facility-wide, systemically. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score										
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	No										
20	Over the past two quarters, the facility's trend analyses contained the required content.	No										
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	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 modified.	No										
23	Action plans were appropriately developed, implemented, and tracked to completion.	No										

Comments:
19-23. Trend analysis was extensive. It focused almost exclusively on trends specific to specific individuals. Focus on individuals is a good thing to do and was good to see and should continue, however, there was little evidence that trend analysis attempted to identify potential systemic issues, either facility wide issues, or more focused issues, such as a particular living area or shift. More of this type of analysis could reveal important variables that need more intensive administrative oversight, planning, and/or actions.

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	0/1	N/A	N/A	N/A	0/1	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. As discussed in the last report, the Center's policy with regard to criteria for the use of TIVA needs to be expanded and improved. Until this occurs, the Center cannot make assurances that it is following proper procedures.

On a positive note, Center staff developed a policy entitled: "Medical Clearance Guidelines for Dental Anesthesia," with an implementation date of 6/13/17. The implementation date was after the two occurrences of the use of TIVA that the Monitoring Team reviewed. However, the Guidelines represent a positive step forward. They appear to be based on relevant source documents. It would be helpful for the document to site specific articles with volume and date, book chapters, websites, etc. However, this document offers PCPs guidance regarding the need for and type of preoperative evaluation that individuals with specific medical conditions and diagnoses should undergo.

For these two instances of the use of TIVA, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, and an operative note defined procedures and assessment completed. Post-operative vital sign documentation also was submitted, and showed compliance with the related policy.

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: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
Comments: a. On 3/16/17, Individual #223 received valium 2.5 milligrams (mg) intravenous (IV) off site, but the record also indicated she received Lorazepam by mouth on site. More specifically, according to IView, she received 1 mg of Ativan via gastrostomy tube for a medical/dental restraint while on site prior to leaving for the procedure. The ISP stated she had not needed pretreatment sedation in the past. An ISPA, dated 3/6/17, discussed the upcoming procedure, but made no decision about pre-treatment sedation. In response to the Monitoring Team's document request, file #48 indicated Individual #223 had not had medical pre-treatment sedation. No consent form was submitted for the 1 mg of Ativan Center staff administered. Nursing staff did document pre- and post-procedure vital signs, which was good to see.										

Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	23	341	376						
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	0% 0/3	0/1	0/1	0/1						
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	100% 3/3	1/1	1/1	1/1						
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	N/A	N/A	N/A	N/A						
4	Action plans were implemented.	N/A	N/A	N/A	N/A						
5	If implemented, progress was monitored.	N/A	N/A	N/A	N/A						
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A	N/A	N/A	N/A						
Comments: 1-6. Based upon the documentation provided, three of the nine individuals (Individual #23, Individual #341, Individual #376) had											

pretreatment sedation over the previous 12 months. Each of their ISPs included a description of their observed behavior when pretreatment sedation was not used for medical appointments, and team approval of pretreatment sedation as a rights restriction.

For none of the individuals was there evidence that consent for the procedure had been obtained from the LAR or facility director.

At an ISPA held on 3/13/17 for Individual #341, his PCP recommended general anesthesia for his next eye exam. The team determined that because the appointment was scheduled for off campus, there was no need for a referral to the Human Rights Committee. When the Monitoring Team checked in with DADS, the response was that HRC review was still required. The exception was when sedation is used in an emergency procedure.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	198	213	90	332					
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 4/4	1/1	1/1	1/1	1/1					
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1					

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

- On 12/22/16, Individual #90 died at the age of 61 of aspiration pneumonia;
- On 1/9/17, Individual #398 died at the age of 72 of acute on chronic respiratory failure due to recurrent aspiration, and recurrent aspiration pneumonia;

- On 2/21/17, Individual #332 died at the age of 48 of acute respiratory failure secondary to anoxic brain injury, recent cardiac arrest, and aspiration pneumonia;
- On 3/30/17, Individual #213 died at the age of 62 of esophageal adenocarcinoma metastatic, kyphoscoliosis, and restrictive lung disease; and
- On 4/19/17, Individual #198 died at the age of 72 of hypotension (fluid refractory), presumably septic shock; and acute on chronic hypoxemic, hypercapnic respiratory failure.

b. through d. The Clinical and Administrative Death Reviews included some valuable recommendations. For example, based on review of the off-site choking incident involving Individual #322, management staff identified a number of important actions designed to ensure that mealtime management and PNMP implementation occurs properly when individuals are in the community with staff from the Center.

However, evidence was not submitted to show the Center conducted thorough reviews of individuals' care and treatment, or an analysis to determine additional steps that should be incorporated in the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the Administrative and Clinical Death Reviews.

For example, for each of the deaths reviewed, the Center provided a voluminous (i.e., 52- to 86-page) Quality Assurance Nurse Death Review that largely consisted of the verbatim reiterations of discipline reports, such as the PCP's Medical Record review, Comprehensive Psychiatric Evaluation, Dental summary, a recent Quarterly Drug Regimen Review, the IRIS list of Immunizations, weights, Medical and Nursing Progress Notes for the months preceding the individual's death, the Behavioral Health Assessment, Day Programing Assessment, Functional Skills Assessment, IHCP goals, the IRRF, ISPAs, the Nursing Annual Comprehensive Assessment, the Nutrition Services assessment, the PBSP, the PNMP, the Habilitation Therapy assessment, QIDP Monthly Review(s), and the Speech-Language Pathology assessment. Many of these assessments were from the time of the individuals' most recent ISP meeting. These verbatim reports did not include any comprehensive review or analysis of the care and services provided to the individuals up to the time of death.

These reports included almost identical conclusions, but as a result of the lack of analysis, none of the findings were supported. Some of these findings, included, for example, IDT meetings showed evidence of an integrated approach; IDT plans addressed risks from a proactive, preventative approach rather than a reactive approach; IDT plans were periodically reviewed and modified; and IDT plans identified root cause for problems.

These nursing reviews generally generated no recommendations. It was very concerning that voluminous reports that provided no critical review of the individuals' care and services were accepted as part of the mortality review process.

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 #90, a recommendation was included for the Medical Director to review 10% of AMAs every six months to ensure that PCPs documented the prostate-specific antigen (PSA risks/benefits discussion. Similarly, in response to Individual #322's death, Habilitation Therapy staff were to monitor mealtime during some community outings. These types of activities helped to ensure that practice that needed to change actually did.

However, a number of recommendations did not include follow-up monitoring or assessment to ensure Center practice had improved.

In addition, although documentation was present to show completion of a number of recommendations as written, documentation was not supplied to confirm implementation of one or more recommendations for each of the mortalities reviewed. In other instances, it was difficult to determine from the documents provided whether or not recommendations were completed. For example, recommendations related to Individual #322's choking event in the community required training of large groups of staff on certain topics. Although sign-in sheets were provided, no summary was provided to show staff that still required training (i.e., percent of eligible staff that completed the training versus percentage of staff for whom training remained outstanding). In the draft report, the Monitoring Team indicated that for the medical staff in-service topics that were included in the recommendations, training rosters of attendees were not provided. The training rosters were not provided in hard copy format, as the Monitoring Team requested. However, upon review of the electronic documents, the Monitoring Team found the necessary sign-in sheets.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	ADRs are reported immediately.	N/A									
b.	Clinical follow-up action is completed, as necessary, with the individual.	N/A									
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A									
d.	Reportable ADRs are sent to MedWatch.	N/A									
Comments: a. through d. Center staff had not identified and/or reported adverse drug reactions for any of the individuals reviewed.											

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: N/A		Individuals:
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	
Comments: None.		

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the time of the last review, 16 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, four additional indicators will move to the category of less oversight in the areas of ISPs, psychiatry, and psychology. No entire outcomes will move 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.

Assessments

For half of the individuals, the IDT considered what assessments the individual needed and would be relevant to the development of the ISP, and half of the IDTs arranged for and obtained these assessments prior to the annual meeting. Attendance at annual ISP meetings did not include all relevant participants, such as Legally Authorized Representatives (LARs) and primary care providers (PCPs). There was, however, improvement in psychiatrist attendance and participation in the annual ISP meeting.

All individuals had preferences strengths inventories (PSIs), functional skills assessments (FSAs), and vocational assessments that were current.

IDTs met routinely when a serious incident occurred. This was good to see, however, when recommendations were made or supports were revised, IDTs rarely met again to ensure recommendations were implemented.

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

It was very positive that seven of the nine individuals' annual medical assessments (AMAs) included all of the necessary components, and addressed individuals' medical needs with thorough plans of care. It was clear that the Medical Director's focus on improving the quality of AMAs had a positive impact. Moving forward, Center staff should ensure individuals' ISPs/IHCPs

define the interim medical reviews individuals need, based on current standards of practice, and accepted clinical pathways/guidelines.

It was also very positive that for all nine individuals reviewed, the dental exams as well as the dental summaries included all of the required components. This represented significant improvement from the last review. However, for six individuals reviewed, dental examinations were not completed within 90 days of the ISP meeting. Adherence to this requirement is necessary to ensure that dental summaries include the most up-to-date information for IDTs' use.

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.

It was positive that for the one individual reviewed who required it, a RN Post Hospitalization Review was completed, and the PNMT discussed the results. The Center should focus on improving the timely referral of all individuals that meet criteria for PNMT review, involvement of the necessary disciplines in the PNMT review/assessment process, and improvement in the quality of the PNMT comprehensive assessments.

It was positive that for most individuals reviewed, Occupational Therapists/Physical Therapists (OTs/PTs) had completed timely assessments. The quality of OT/PT assessments continues to be an area on which Center staff should focus.

It was positive that that individuals reviewed generally had timely communication assessments. The Center should continue to focus on improving the quality of communication assessments and updates.

<u>Individualized Support Plans</u>

The development of individualized, meaningful personal goals was not yet at criteria, but progress was evident. All six ISPs included two or more goals that met criteria, and one ISP had goals that met criteria in four areas, for a total of 18 goals that met criteria (compared with 11 at the last review). Further, 17 of these goals were written in measurable terms. None of the individuals, however, had goals that met criteria in the health/wellness/Integrated Health Care Plan (IHCP) area.

All action plans were implemented in a timely manner for one of the six individuals. Goals that had not been implemented from the last ISP were either recommended for continuation without addressing barriers to implementation and/or progress, or were revised only slightly and continued for another year. Action plans often did not show a path towards accomplishment of personal goals. In some cases, action plans were unrelated. In those cases where action plans were related to the goal, they

usually did not include thorough staff instructions or implementation strategies. When considering the full set of ISP action plans, the various criteria included in the set of indicators in Outcome #3 were not met.

In psychiatry, more work was needed to create individualized diagnosis-specific personal goals that referenced/measured psychiatric indicators regarding problematic symptoms of the psychiatric disorder, as well as psychiatric indicators regarding positive pro-social behaviors. For psychiatric medications, Human Rights Committee (HRC) review was routinely obtained as required, and good performance was seen regarding signed consent and consent content regarding detail, understandability, and risks-benefits.

In behavioral health, all individuals had measurable goals related to psychological/behavioral health. The quality of the content of PBSPs had improved, but was not yet at the point where it met the criteria for Indicator 15. There was not, however, an adequate system in place to ensure data timeliness. Additionally, there were other concerns regarding data accuracy. During the onsite visit, the Monitoring Team observed four individuals displaying problem behaviors identified in their PBSPs. None of their data sheets for those time periods reflected accurate recording of these behaviors.

Regarding Skill Acquisition Plan (SAPs), two behavioral health services staff members, one a BCBA with special education experience, were providing oversight in the development and implementation of SAPs. These two staff accompanied the Monitoring Team during SAP observations during the onsite review week. They provided thoughtful feedback and were very receptive to suggestions made during follow-up discussions.

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.

It was good to see that individuals' ISPs and ISPAs often reflected the strategies, interventions, and programs that OTs/PTs recommended.

ISPs

<table>
<tr><td colspan="2">Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.</td></tr>
<tr><td>Summary: Continued progress was seen. Although the development of individualized, meaningful personal goals in all six different ISP areas was not yet at criteria, but much progress was evident. All six ISPs, for instance, included two or more goals that met criteria, and one ISP had goals that met criteria in four of the six areas, for a total of 18 goals that met criteria. Further, 17 of these goals were written in measurable terms, also demonstrating good progress. None had goals</td><td>Individuals:</td></tr>
</table>

that meet criteria in the health/wellness/IHCP area, and one was implemented sufficiently, correctly, and with adequately collected data to determine progress. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	193	96	341	376	173	5			
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	2/6	4/6	3/6	3/6	3/6			
2	The personal goals are measurable.	0% 0/6	3/6	2/6	4/6	2/6	3/6	3/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	1/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #193, Individual #96, Individual #341, Individual #376, Individual #173, Individual #5). 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.

The ISP relies on the development of personal goals as a foundation. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. 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 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 areas. Therefore, none had a comprehensive set of goals that met criterion. Goals were still somewhat limited in scope and were not likely to result in a significant change in the quality of individual's lives.

For these six individuals, the IDT had defined some personal goals that met criterion for being individualized based on the individual's preferences and strengths. Overall, 18 of 36 personal goals met criterion for this indicator. This was an improvement from the past review when 12 of 36 goals met criterion. IDTs particularly struggled with writing individualized day/work/vocational and health care IHCP goals. Goals that met criterion were:

- Individual #193's goals for leisure/recreation, relationships, and greater independence.
- Individual #96's goals for leisure/recreation, and greater independence.
- Individual #341's goals for leisure/recreation, relationships, greater independence, and work/day programming.
- Individual #376's goal for leisure/recreation, relationships, day programming, and greater independence.
- Individual #173's goals for leisure/recreation, relationships, and living options.
- Individual #5's goals for recreation/leisure, relationships, and greater independence.

Although IDTs had created the above goals (ones that were more individualized and based on known preferences than in the past), few had been fully implemented. Thus, individuals did not have person-centered ISPs that were really leading them towards achieving their personal goals. The facility needs to focus on barriers that are preventing individuals from achieving their goals and develop plans to address those barriers.

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

- Five individuals had living option goals to continue living where they currently lived. IDTs should focus on aspirational goals for the future and address barriers identified by the ISP. Individual #376 had a living option goal to move to the community.
- Individual #173's vocational goal to earn $100 a month at the ASH workshop. She was already working successfully at the ASH workshop 30+ hours a week, making $75 -$80 per month. Work was noted to be a very important part of her life. Her IDT should explore supporting her to develop new job skills and interest that might lead to a job in the community making at least minimum wage in the future.
- Individual #96 reportedly had few meaningful relationships in her life. Her relationship goal to make smoothies was unlikely to lead to developing new relationships.

2. Of the 18 personal goals that met criterion for indicator 1, 17 also met criterion for measurability. This was another sign of progress for the QIDPs and IDTs. Individual #193's leisure/recreation goal was not measurable.

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

3. One of the goals had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals: there were data to support implementation of Individual #173's greater independence goals. As noted throughout this report, it was not possible to determine if ISP supports and services were being regularly implemented or to determine the status of goals because of the lack of data and documentation provided by the facility. It appeared that few action plans were regularly 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 indicators in this outcome were not met. A focus area for the facility (and its QIDP department) is to ensure the actions plans meet these various 11 items. These indicators refer to the full set of action plans. That is, the qualities that are being monitored by these indicators may be evident in different action plans within the set of goals and action plans for the individual. For these 11 indicators, performance was about the same as at the last review. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	193	96	341	376	173	5			
8	ISP action plans support the individual's personal goals.	0% 0/6	1/6	0/6	0/6	0/6	1/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	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	0/1	0/1	0/1	1/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	0/6	1/6	1/6			

Comments:
8. Some personal goals did not meet criterion in the ISPs, as described above in indicator 1, therefore, those 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.

Action plans often did not support accomplishment of personal goals. In some cases, action plans were unrelated. For example, Individual #96 had a goal to make her own smoothie. Action plans included to use a towel to dry her face, choose her own mirror when shopping online, and self-propel in her wheelchair for 10 minutes a day. These are not necessarily inappropriate action plans. In fact,

they made sense for the individual. These were additional action plans that fell under the same ISP topic, in this instance, independence. ISPs also need action plans to help the individual achieve the personal goal.

In those cases when action plans were related to the goal, they usually did not include staff instructions or implementation strategies that would ensure staff could consistently teach a new skill or accurately collect data on progress. IDTs need further guidance on developing action plans/ staff instructions that might lead to progress or achievement of goals.

For the 18 personal goals that met criterion under indicator 1, two had action plans that were likely to lead to the accomplishment of the goal. IDTs were struggling with developing action steps that would lead to measurable progress towards goals. Goals that met criterion were:

- Action plans for Individual #193's greater independence goal.
- Action plans for Individual #173's greater independence goal.

9. ISPs did not include action plans that integrated preferences and opportunities for choice. ISPs generally included action plans based on preferences, however, these were limited to one or two known preferences and few opportunities to make choices.

10. ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making.

11. Two of six ISPs (Individual #193, Individual #5) met criterion for this indicator. Individual #193's action plans included putting away his supplies, requesting magazines and music using his adaptive switch, and independently eating finger foods. Individual #5's ISP included action plans to use her adaptive switch to turn on her radio, brush her teeth, and wash her hands.

12. ISPs did not fully integrate strategies to minimize risks in ISP action plans. Specific support strategies should be included in staff instruction for implementing action plans, when relevant, to minimize risks in all settings. Further discussion regarding the quality of strategies to reduce risks can be found throughout this report. Some examples where strategies were not integrated in the ISP included:

- Individual #193's IDT did not integrate mobility strategies into action plans.
- Individual #96's mobility strategies were not integrated into action plans. Her IHCP addressed her weight and risk for seizures, however, strategies were not integrated into other action plans.
- A skill acquisition plan had not been developed for Individual #341's swimming goal. There were no written instructions to ensure that staff safely supported him in the pool.
- Individual #193, Individual #96, Individual #341, and Individual #376 did not have goals to related to reduction of psychiatric symptoms.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well integrated in ISPs. In particular communication, medical, and psychiatric supports were rarely integrated into support plans developed by other disciplines. A positive exception was that Individual #193's IDT did integrate communication, occupational therapy, and medical supports into other action plans. In addition to the examples provided in indicators 11 and 12 above, other examples where discipline assessments and recommendations were not fully integrated included:

- Individual #96's IDT reported that her most effective communication was through her behavior (not always appropriate). Her behavioral health specialist, OT, and SLP should work together to develop more appropriate communication supports.
- Individual #341's IDT has not developed implementation strategies for his action plans to swim independently that addressed his medical risks and ensured his safety in the pool. Additionally, his SAPs did not address his vision impairments.
- Action plans to support Individual #376's goal to prepare a meal did not integrate her health and therapy supports.
- Individual #173's communication assessment did not include recommendations for building new communication skills, though staff indicated that her communication skills were a barrier to her independence.
- Individual #5 did not have a PBSP. Assessments indicated that she screamed, threw materials, and pushed staff away in efforts to communicate. Her behavioral health specialist and SLP should work collaboratively to address her behavior and communication supports.

14. Meaningful and substantial community integration was absent from the ISPs. Although individuals had opportunities to go into the community, none of the individuals had formalized training with adequate teaching strategies that might lead to integration into the community.

15. One of six ISPs considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Individual #376 had a goal to volunteer at a local animal shelter, however, the goal had not been implemented and it was not likely that her action plans would lead to progress on this goal. Overall, vocational/day assessments were not adequate for determining preferences and teaching new skills. For example:

- Individual #173 had a work goal to increase her production on a contract that she reportedly could complete independently at a sheltered workshop. Her vocational assessment indicated that she had many good work skills. The IDT did not consider further job exploration or training to learn new job skills that might lead to a job in the community.
- Individual #96 attended day programming for one hour a day away from her home.
- Individual #341 spent a minimum amount of time during the day away from his home. He did not have a day/work assessment that identified possible skills and preferences that might lead to new activities during the day.

16. One of six ISPs (Individual #173) supported substantial opportunities for functional engagement described with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Based on observations, five individuals were rarely engaged in functional training during the day that might lead to gaining new skills and greater independence. While Individual #173's goal met the criteria for functional engagement during the day, as noted above, it did not focus on developing new skills. A greater focus should be placed on goals and action plans that support community integration and job skills.

17. ISPs did not adequately address barriers to achieving goals and learning new skills. Most notably, barriers to consistent implementation of action plans were not addressed, including:

- Individual #376's ISP preparation meeting was observed. The IDT recommended continuing most of her action plans from the previous year without addressing barriers to implementation or progress.
- Individual #341's goal for using his adaptive switch was continued from the previous year without addressing barriers to progress. Barriers to living in the community had not been addressed.
- Individual #173's IDT has not addressed barriers to her living and working in the community.

- Individual #5 had made little progress on her goals. Her IDT did not address barriers to progress.

18. Two action plans were found to describe detail about data collection and review, however, overall, ISPs did not usually include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action plans were broadly stated and, in many cases, skill acquisition plans were not developed when needed to ensure consistent training strategies were implemented. Action plans that met criterion were:

- Individual #173 and Individual #5's goal for greater independence.

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, and overall, there was some improvement in performance, with three indicators scoring slightly higher and one scoring slightly lower than at the last review. More focus was needed to ensure that all of the activities occurred related to supporting most integrated setting practices within the ISP. Primary areas of focus are including all relevant IDT member opinions, and putting plans into place to address obstacles to referral. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 193	96	341	376	173	5			
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	1/1	1/1	0/1	0/1	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.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	83% 5/6	1/1	1/1	1/1	1/1	1/1	0/1			
23	The determination was based on a thorough examination of living options.	50% 3/6	0/1	1/1	0/1	1/1	1/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any	0%	0/1	0/1	0/1	0/1	0/1	0/1			

	identified obstacles to referral or, if the individual was currently referred, to transition.	0/6									
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% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1			

Comments:

19. Three ISPs included a description of the individual's preference and how that was determined.
    - Individual #193, Individual #96, and Individual #5's ISPs based the determination on known preferences observed by staff. Although not comprehensive, the determination appeared to be thoughtful and a good start to exploring living options.
    - Individual #341's ISP noted that his preferences were largely unknown. The preferences/needs listed (quiet environment, access to sensory stimulation, access to behavioral services), while present in his current environment, could also be available in a community setting.
    - Individual #376's IDT agreed that a group home in the community might meet her needs, however, noted preferences were limited to a quieter environment.
    - Individual #173's IDT determined that she liked living at Austin SSLC. They stopped short of identifying what it was that she liked about her current placement. It was noted that she had limited exposure to other living options.

21. One (Individual #173) of the six ISPs fully included the opinions and recommendation of the IDT's staff members. Those that did not meet criteria included:
    - Relevant team members were not present at the IDT meetings for Individual #193, Individual #96, and Individual #341. Most notably, the IDT needed input from the PCP regarding medical supports that would be needed in the community if transition was considered. Without input regarding complex medical needs and supports, it was unlikely that the team could have made an informed decision.
    - Individual #5 and Individual #376's ISP did not include a clear summary statement based on recommendations of the IDT members.

22. Five ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR.
    - Individual #5's ISP indicated that the discipline members agreed to referral. There were conflicting statements regarding her LAR's decision, but it appeared that she was open to exploring options. The summary statement, however, indicated that she would not be referred due to the LAR's wishes for her to remain at Austin SSLC.

23. Three of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths. For the remaining three, the ISPs did not reflect a robust discussion of available settings that might meet individuals' needs.
    - Individual #193's ISP indicated that a small community group home would support his living preferences, however, the IDT

concluded that he should continue to live at Austin SSLC.

- Similarly, Individual #341's IDT determined that a home in the community could meet his need for a quiet space and allow him to have as much space as he desires. They further noted that he had significant behavioral support needs, but did not discuss how those might be met in the community.
- As noted above in indicator 22, Individual #5's IDT determination was not clearly supported by discussion at her ISP meeting.

24. Six 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. Obstacles were primarily related to complex medical needs and the individual and/or LAR's lack of knowledge regarding community living options

26. None of the six individuals had individualized, measurable action plans to address obstacles to referral or transition, if referred. For the most part, action plans were not measurable, as noted above. All individuals had broad-based general action plans to participate in group home tours and attend provider fairs. Individual #376's IDT agreed that she could live in the community, however, measurable action plans for referral/transition were not developed. Individual #193, Individual #96, and Individual #341 had medical and/or behavioral obstacles listed. The IDTs did not quantify what medical or behavioral thresholds would need to be met for community transition to be considered, which was needed to develop a specific action plan.

28. None of the ISPs included specific action plans to educate individuals on living options when relevant. As noted above, all individuals had broad-based general action plans that were not individualized regarding specific living options that might support the individual's needs.

29. Individual #5's team did not identify significant obstacles to referral, however, she was not referred.

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

Summary: ISPs were revised at least annually. This was the case for all individuals for the last two reviews, too. Therefore, indicator 30 will be moved to the category of requiring less oversight. Other aspects of ISP development need attention, specifically, timely implementation (indicator 32) and participation/attendance at the annual meeting (indicator 34). These, and indicators 31 and 33, will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	193	96	341	376	173	5			
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	17%	0/1	1/1	0/1	0/1	0/1	0/1			

	indicated.	1/6									
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).	83% 5/6	0/1	1/1	1/1	1/1	1/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

30-31. ISPs were revised annually. No one in the review group had been admitted to the facility in the last year.

32. Documentation was not submitted that showed that all action plans were implemented within a timely basis for five of six ISPs. The exception was for Individual #96. Examples in which timeliness criteria were not documented included:

- For Individual #341, his new goals should have been implemented by 4/7/17. QIDP monthly reviews indicated that his previous ISP goals were still being implemented in April 2017 and May 2017. Recreation, relationship, and living option goals were not implemented within 30 days.
- For Individual #193, new goals should have been implemented in May 2017. Data were not recorded for all goals in May 2017 and, in June 2017, the QIDP monthly review indicated that data were recorded for goals from the previous ISP.
- QIDP monthly reviews did not include data for Individual #376's relationship/day goal, though noted that she did not seem to enjoy this goal with little evidence of implementation.
- Individual #173's action plans had not been fully implemented.
- Individual #5's recreation and relationship goals were not implemented within 30 days.

33. Five of six individuals attended their ISP meetings. Individual #193 did not attend his annual ISP meeting. It was not always evident, however, that individuals were encouraged to participate in the development of their ISP. For example, Individual #376's ISP did not include recommendations for involving her in the discussion, but rather described how to keep her occupied during the meeting (e.g., provide her with magazines and Coke).

34. None of the individuals had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.

- Two of five LARs did not attend the annual IDT meeting.
- Most notably, the PCP did not attend any of the ISP meetings, although all individuals had significant medical needs that impacted their supports and services.
- Additionally, it was not evident that QIDP and other team members actively reviewed, monitored, and revised supports in a timely manner.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: Both indicators showed decreased performance from the last review. Determining and obtaining needed assessments sets the stage for informed decision making and planning by the IDT. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	193	96	341	376	173	5			
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.	50% 3/6	1/1	0/1	0/1	1/1	0/1	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	50% 3/6	1/1	0/1	1/1	1/1	0/1	0/1			

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 three of six individuals.

- Individual #96's IDT did not consider recommendations for a comprehensive communication assessment that addressed her behavior related to communication efforts.
- Individual #341's team did not consider a vision/ophthalmology assessment, though the ISP indicated that staff were not sure of his visual acuity.
- Individual #173's team did not consider an updated vocational assessment that included work exploration even though work was a priority for her. Her last assessment was completed July 2016 and did not include exploration of new interest and preferences.

36. Three of the IDTs arranged for and obtained needed, relevant assessments prior to the IDT meeting. Without relevant assessments available to IDTs prior to the annual ISP meeting, it was unlikely that all needed supports and services were included in the ISP. QIDP assessment data showed the following:

- Individual #96's ISP indicated that the IDT had recommended an orientation and mobility assessment to address her fear of walking. It was not clear if this was obtained prior to her ISP.
- Individual #173's annual medical assessment information had not been updated since 2015. It appeared that information was cut and pasted into her 2017 annual medical assessment without necessary updated information.
- Individual #5's last comprehensive communication assessment was from 2014. Team members noted that recommendations were needed to expand her limited communication skills.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
Summary: Teams met routinely, however, progress was not being adequately reviewed by QIDPs and IDTs. Consequently, actions were not developed or taken. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	193	96	341	376	173	5			
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 met routinely when a serious incident occurred. This was good to see, however, when recommendations were made or supports were revised, IDTs rarely met again to ensure recommendations were implemented. Furthermore, reliable and valid data were often not available to guide decision-making. IDTs rarely revised goals when progress was not evident. Other examples where the IDT failed to take adequate action included:

- For Individual #376 and Individual #341, goals were not consistently implemented. The IDT did not meet to revise their goals or address barriers to implementation.
- For Individual #193, IDT met numerous times to discuss his medical status and made frequent recommendations for revision of medical and therapy supports. The IDT did not meet, however, to discuss his lack of progress towards his goals or consider implementing new action plans for skill building while he was recovering.

38. Consistent implementation and monitoring of ISP action steps remained areas of concern. ISP action plans were not regularly implemented for any of the individuals. QIDP monthly reviews included some data, but rarely included an analysis of those data to determine what progress had been made towards achievement of goals. Information regarding behavioral supports, habilitation therapy, and medical supports was inserted in the monthly reviews without a summary of status, statement on the efficacy of supports, or efforts made to follow-up on outstanding issues. There was little documentation of follow-up when plans were not implemented or not effective.

The Monitoring Team attended a number of meetings while onsite to review the IDT process and the facility response to incidents. At all meetings, reliable data were not available for review to facilitate decision making and ensure that supports were revised when not effective.

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

Outcome 1 – Individuals at-risk conditions are properly identified.											
Summary: In order to assign accurate risk ratings, IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings within no more than five days. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	The individual's risk rating is accurate.	22% 4/18	0/2	0/2	0/2	0/2	1/2	1/2	0/2	1/2	1/2
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.	39% 7/18	1/2	1/2	0/2	1/2	1/2	1/2	1/2	0/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed IRRFs addressing 18 specific risk areas (i.e., Individual #96 – weight, and fractures; Individual #193 – falls, and skin integrity; Individual #268 – cardiac disease, and infections; Individual #223 – constipation/bowel obstruction, and skin integrity; Individual #173 – falls, and constipation/bowel obstruction; Individual #151 – cardiac disease, and fractures; Individual #198 – weight, and constipation/bowel obstruction; Individual #5 – dental, and falls; and Individual #152 – choking, and weight).

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 #173 – falls, Individual #151 – fractures, Individual #5 – dental, and Individual #152 – choking.

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 often did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #96 – fractures, Individual #193 – falls, Individual #223 – skin integrity, Individual #173 – constipation/bowel obstruction, Individual #151 – fractures, Individual #198 – constipation/bowel obstruction, and Individual #152 – choking.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.	
Summary: This outcome requires individualized diagnosis-specific personal goals be created for each individual and that these goals reference/measure psychiatric indicators regarding problematic symptoms of the psychiatric disorder, as well as psychiatric indicators regarding positive pro-social behaviors. It was encouraging to see some progress along these lines. These indicators will remain in active	Individuals:

monitoring.											
#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
4	The individual has goals/objectives related to psychiatric status.	0% 0/7	0/1	N/A	0/1	N/A	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/7	0/1	N/A	0/1	N/A	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/7	0/1	N/A	0/1	N/A	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% 0/7	0/1	N/A	0/1	N/A	0/1	0/1	0/1	0/1	0/1

Comments:

4. During the course of the onsite review, it became apparent that the psychiatric department had continued to make progress toward eventually meeting criteria with this set of indicators. The current status of this project was not readily apparent, however, in the CPE updates, quarterly reviews, and ISP documentation.

During the onsite discussions with the psychiatric team, they noted that the tables that were developed to formulate the psychiatric goals will not print out from IRIS as they appear on the screen and that explained why they did not appear in the aforementioned documents. The team was able to print out these tables separately and make them available for review. This material reflected the work that the psychiatry team continued to devote to this project.

The current tables began with the identification of a monitored target behavior, such as aggression or self-injury. The link between this target behavior and the psychiatric diagnosis was then explained in a text box that described how the specific behavior was derived from the psychiatric disorder. It would be preferable if the process could begin with the identification of the symptoms of the psychiatric disorder that lead to the monitored behavior.

In other words, much like the other SSLCs:

- There need to be personal goals that target the undesirable symptoms of the psychiatric disorder and that are tied to the diagnosis, and personal goals that would indicate improvement in the individual's psychiatric status.
- The goals need to be measurable, have a criterion for success, be presented to the IDT, appear in the IHCP, and be tracked/reviewed in subsequent psychiatry documents, as well as be part of the QIDP's monthly review.

5. The goals should also be numerically/quantitatively based and not subjective. There also needs to be more work on developing the positive pro-social goals. The current goal tables appeared in the electronic format of the CPE updates and the quarterly reviews. Ultimately, it will be necessary to use this information to develop IHCPs that would appear in the ISP.

6. Although the goals that currently existed were derived from the psychiatric assessment, they did not meet criteria for the reasons cited above.

7. The review of the behavioral data collection methods at the facility also concluded that the data were not reliable and this remained a fundamental problem.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: Clarity and consistency in diagnoses can help with treatment decisions. Some additional attention to this (indicator 16) is needed. This indicator will remain in active monitoring. Indicator 15 will also remain in active monitoring for potential review at the next onsite visit.

#	Indicator	Overall Score	Individuals: 369	193	421	96	23	16	118	341	376
12	The individual has a CPE.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B										
14	CPE content is comprehensive.										
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.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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.	71% 5/7	1/1	N/A	0/1	N/A	1/1	1/1	1/1	0/1	1/1

Comments:

15. There were no individuals in the review group who had been admitted since 1/1/14.

16. The psychiatric diagnoses were consistent in the psychiatric, behavioral and medical sections of the record for all of the individuals, except Individual #421 and Individual #341. The diagnosis that appeared in the psychiatric and behavioral health sections of the record for Individual #341 were Autism Spectrum Disorder and Mood Disorder secondary to a medical condition, but only the Autism Spectrum Disorder diagnosis was present in the medical section. For Individual #421, the diagnosis of IED and ADHD appeared in the medical and behavioral sections, but the psychiatric sections referenced only the IED diagnosis.

Outcome 5 – Individuals' status and treatment are reviewed annually.

Summary: Austin SSLC showed improvement in psychiatrist participation in the annual ISP. Both indicators scored higher than ever before. With sustained high performance, indicator 20 might be moved to the category of requiring less oversight. Both will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
17	Status and treatment document was updated within past 12 months.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).										
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.										
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	100% 7/7	1/1	N/A	1/1	N/A	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.	57% 4/7	0/1	N/A	1/1	N/A	1/1	1/1	1/1	0/1	0/1

Comments:
20. The treating psychiatrist attended the ISP for all of the seven individuals who were prescribed psychotropic medications.

21. The final ISP documentation included the essential elements and showed evidence of the psychiatrists' participation for all but three individuals (Individual #369, Individual #341, Individual #376). The discussion of the pharmacological aspects of the treatment for these individuals was complete and comprehensive. The deficits were in the review and discussion of the behavioral aspects of treatment, which were brief and superficial.

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

Summary: This indicator did not apply to any of the individuals in the review group. It will remain in active monitoring for possible review at the next onsite visit.

Individuals:

#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
22. None of the individuals in the review group had a PSP. There were two individuals at Austin SSLC who had a PSP. The content of those PSPs met criteria, though the Monitoring Team did not make a determination as to whether a PSP was appropriate for the individual.

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

Summary: HRC review was routinely obtained as required for this review and the last two reviews, too. Therefore, indicator 32 will be moved to the category of requiring less oversight. Good performance was also seen regarding the presence of

Individuals:

signed consent as well as content regarding detail, understandability, and risks-benefits. With sustained high performance, indicators 28, 29, and 30 might be moved to the category of requiring less oversight after the next review. Reference to alternate/non-pharmacological treatments needed some attention (indicator 31). These four indicators will remain in active monitoring.											
#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 7/7	1/1	N/A	1/1	N/A	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	100% 7/7	1/1	N/A	1/1	N/A	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	100% 7/7	1/1	N/A	1/1	N/A	1/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	43% 3/7	0/1	N/A	1/1	N/A	0/1	0/1	1/1	1/1	0/1
32	HRC review was obtained prior to implementation and annually.	100% 7/7	1/1	N/A	1/1	N/A	1/1	1/1	1/1	1/1	1/1

Comments:
28. The records contained signed consents for all of the prescribed psychotropic medications that had been completed within the prior year.

29. These consents also contained the required information regarding side effects, and were written in a clear and understandable manner.

30. Each consent contained a thorough risk benefit discussion.

31. There was adequate reference to alternate and non-pharmacological treatments for Individual #421, Individual #118, and Individual #341. For the other individuals, the discussion of alternate treatments did not include anything other than the PBSP.

32. HRC review was completed for everyone on an annual basis.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.	
Summary: One individual who likely should have had a PBSP did not. For the others, there were goals/objectives related to behavior services and they were measurable and based on assessments. This was the case for this review for all	Individuals:

individuals for this review and the last two reviews, too, for indicators 3 and 4 (with one exception for the latter in January 2016). Therefore, these two indicators (3 and 4) will be moved to the category of requiring less oversight. Indicators 1 and 2 might be moved to this category if high performance is sustained after the next review. Attention definitely needs to be paid to ensuring reliable data (indicator 5). These three indicators will remain in active monitoring.											
#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
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.	92% 11/12	1/1	1/1	1/1	1/1	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	100% 9/9	1/1	1/1	1/1	1/1	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% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

1. Each of the nine individuals reviewed by the behavioral health Monitoring Team had a PBSP. Two of the six individuals reviewed by the physical health Monitoring Team, Individual #152 and Individual #151, also appropriately had PBSPs. Of the remaining four individuals, three did not need (and did not have) a PBSP. For the fourth, a PBSP should be considered (i.e., for Individual #5). Her current behavioral health assessment noted screaming and throwing materials to the floor. She was also observed pushing staff during the onsite visit.

2-4. All nine of the individuals had measurable goals related to psychological/behavioral health. These goals were based upon the individuals' assessments.

The new director of behavioral health services had drafted a proposal for involving behavioral health services department staff in addressing individuals' medication refusals.

5. The behavioral health services director indicated that there was not an adequate system in place to ensure data timeliness. Additionally, there were notes in PBSP progress reports (e.g., for Individual #23, Individual #118, and Individual #376) regarding

questions about data accuracy. Lastly, during the onsite visit, four individuals, including Individual #16, Individual #341, and Individual #376, were observed displaying problem behaviors identified in their PBSPs. None of their data sheets for those time periods reflected accurate recording of these behaviors.

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

Summary: The quality of these two behavioral health-related assessments deteriorated from higher scores at the last two reviews. For the functional assessments, this was due, in part, to the lack of thorough information being included and updated. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 369	193	421	96	23	16	118	341	376
10	The individual has a current, and complete annual behavioral health update.	22% 2/9	0/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
11	The functional assessment is current (within the past 12 months).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
12	The functional assessment is complete.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

10. Although all nine individuals had current behavioral health assessments that included results of cognitive and adaptive behavior assessments, only two (Individual #193, Individual #16) included a review of the individual's physical/medical health over the previous 12 months.

12. None of the functional assessments were considered complete. It was commendable that all of the assessments indicated that multiple observations had been completed. However, only Individual #341 and Individual #376 exhibited any problem behaviors during these observations. It may be helpful for behavioral health service staff to review videotapes or receive a call from staff during occurrences of problem behavior so that greater information can be gathered regarding antecedents and consequences.

The assessment for two individuals (Individual #118, Individual #341) referenced an acceptable indirect assessment and, although informants and their specific responses were not reviewed, the behavior analyst/health specialist did indicate that staff were interviewed regarding possible function. Only Individual #376 did not have an acceptable indirect assessment. For her, the Identification of Challenging Behavior was completed with one direct support professional, but potential function was not discussed.

None of the assessments provided a clear summary statement based on the hypothesized antecedent and consequent conditions that affect the target behavior(s). It should be noted that many of the assessments referenced preference assessments that had been completed in 2015. Staff are advised to update these assessments to ensure that preferred items/activities can be provided contingent upon appropriate behavior in an effort to reduce unwanted behavior.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.												
Summary: Performance improved for indicator 13 since the last review. The quality of the content of PBSPs had also improved, but was not yet at the point where it was meeting all of the criteria for indicator 15. These two indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1
14	The PBSP was current (within the past 12 months).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

13. Based upon the documentation provided, seven of nine PBSPs were implemented within 14 days of attaining all necessary consents/approvals. The exceptions were Individual #96, whose plan identified a finalization data prior to the consent date, and Individual #376, for whom staff training was completed more than 14 days after the consent was obtained.

15. Although none of the PBSPs were complete, the majority of the indicators were met in each of the plans. This included operational definitions of target and replacement behaviors, antecedent and consequent strategies, functional replacement behaviors, baseline/comparison data, and treatment objectives.

Absent from all of the plans were sufficient scheduled opportunities to practice the identified replacement behaviors. Two plans (i.e., those for Individual #96 and Individual #376) identified a schedule for using positive reinforcement. Staff were directed to provide attention to Individual #96 at least six times per hour. Although Individual #376's plan included reference to differential reinforcement every hour for the absence of targeted problem behaviors, staff were instructed to "try" to implement this strategy. Therefore, only Individual #96's plan was rated as meeting criterion with the use of reinforcement in a manner that was likely to be effective. Structured use of positive reinforcement is one of the, if not the, most potent intervention for effecting behavior change, whether its reduction of problem behavior, increase of replacement/alternative behavior, skill acquisition, and on and on.

Potential reinforcers identified in six plans (i.e., those for Individual #369, Individual #193, Individual #96, Individual #23, Individual #118, and Individual #341) were the result of preference assessments that had been completed in 2015. As noted above, staff are advised to update these assessments.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.												
Summary: None of the individuals in the review group were participating in counseling services. These indicators will remain in active monitoring for possible scoring at the next monitoring review.			Individuals:									
#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments:												

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Center staff should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. Indicator c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.										
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	22% 4/18	0/2	0/2	2/2	0/2	1/2	0/2	0/2	0/2	1/2
Comments: c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." Interval reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interval reviews will need to occur more frequently. Austin SSLC had continued to complete quarterly reviews. Unfortunately, most of the IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. As a result, it was not clear that the quarterly review process met their needs. Center staff should ensure individuals' ISPs/IHCPs define the frequency of interim medical										

reviews, based on current standards of practice, and accepted clinical pathways/guidelines. On a positive note, for the few individuals for whom the IHCPs defined the frequency of review, PCPs had completed the necessary interim reviews timely for Individual #268 – gastrointestinal (GI) problems, and seizures; Individual #173 – osteoporosis; and Individual #152 – weight.

Outcome 3 – Individuals receive quality routine medical assessments and care.

Summary: The Medical Department had continued its progress in improving the quality of the medical assessments, which was very good to see. Indicators a and c will remain in active oversight.

#	Indicator	Overall Score	Individuals: 96	193	268	223	173	151	198	5	152
a.	Individual receives quality AMA.	78% 7/9	1/1	1/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	22% 4/18	0/2	0/2	2/2	0/2	1/2	0/2	0/2	0/2	1/2

Comments: a. It was extremely positive that seven of the nine individuals' AMAs included all of the necessary components, and addressed individuals' medical needs with thorough plans of care. It was clear that the Medical Director's focus on improving the quality of AMAs had a positive impact. Problems noted for the two AMAs that did not meet criteria included:

- For Individual #151, not all pertinent laboratory information was included.
- Individual #173's AMA, dated 10/27/16, did not include 2016 data. For example, it did not include relevant lab information, and no plans of care were included. The active problem list did not include an ankle ulcer. It appeared the 2016 physical was simply inserted into the 2015 AMA.

c. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #96 – urinary tract infections (UTIs), and seizures; Individual #193 – osteoporosis, and skin integrity; Individual #268 – gastrointestinal (GI) problems, and seizures; Individual #223 – osteoporosis, and UTIs; Individual #173 – osteoporosis, and skin integrity; Individual #151 – GI problems, and falls; Individual #198 – constipation/bowel obstruction, and osteoporosis; Individual #5 – GI problems, and weight; and Individual #152 – weight, and seizures].

As noted above, many of the ISPs/IHCPs reviewed did not define the frequency of the interim medical reviews individuals needed, based on current standards of practice, and accepted clinical pathways/guidelines. On a positive note, for the few individuals for whom the IHCPs defined the necessary reviews, PCPs had completed quality interim reviews, including for Individual #268 – gastrointestinal (GI) problems, and seizures; Individual #173 – osteoporosis; and Individual #152 – weight.

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	96	193	268	223	173	151	198	5	152
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	22% 4/18	0/2	1/2	0/2	1/2	0/2	1/2	0/2	0/2	1/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	22% 4/18	0/2	0/2	2/2	0/2	1/2	0/2	0/2	0/2	1/2
Comments: a. The IHCPs that sufficiently addressed individuals' chronic or at-risk conditions were those for Individual #193 – skin integrity, Individual #223 – osteoporosis, and UTIs, Individual #151 – falls, and Individual #152 – seizures. b. As noted above, most of the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. Those that did were for Individual #268 – gastrointestinal (GI) problems, and seizures; Individual #173 – osteoporosis; and Individual #152 – weight.										

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: It was very positive that for all nine individuals reviewed, the dental exams as well as the dental summaries included all of the required components. This represented significant improvement from the last review. However, for six individuals reviewed, dental examinations were not completed within 90 days of the ISP meeting. Because there appeared to be confusion about this requirement, the Monitor has chosen not to pull Indicator a.ii back into active monitoring. However, if this is not corrected at the time of the next review, this indicator might return to active monitoring. Adherence to this requirement is necessary to ensure that dental summaries include the most up-to-date information for IDTs' use. Indicator a.iii will remain in active oversight at least until exams meet the requirement of completion within 90 days of the ISP meeting.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152

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					
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 8/8	1/1	1/1	1/1		1/1	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	100% 8/8	1/1	1/1	1/1		1/1	1/1	1/1	1/1	1/1

Comments: Individual #223 was at low risk for dental, and was part of the outcome group, so the Monitoring Team conducted a limited review.

a. Based on the Monitoring Team's review of dental exams for other indicators, for six individuals reviewed, dental examinations were not completed within 90 days of the ISP meeting. Because there appeared to be confusion about this requirement that is defined in the interpretive guidelines in the audit tool, the Monitor has chosen not to pull Indicator a.ii back into active monitoring. However, if this is not corrected at the time of the next review, this indicator might return to active monitoring. In the future, failure to correct this issue will also impact scores for Indicator a.iii, because dental summaries need to include up-to-date exam information for the IDTs' use.

b. It was very positive that for all nine individuals reviewed, the dental exams as well as the dental summaries included all of the required components.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.											
Summary: Due to issues with IRIS, full annual or quarterly physical assessments were not documented for a number of individuals (i.e., fall assessments, and assessments of reproductive systems were missing). The remaining indicators require focused efforts to ensure 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.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	Individuals have timely nursing assessments:										

	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	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.	10% 1/10	0/1	0/2	0/1	0/2	1/1	N/A	0/1	0/2	N/A

Comments: a. Problems were noted for all of the individuals reviewed with regard to a lack of complete annual physical assessments, including fall assessments, and assessments of reproductive systems. Similar problems were noted with quarterly physical assessments. This largely appeared to be due to issues with IRIS. The nurses on the Monitoring Team have discussed this issue with the State Office Nursing Discipline Lead, and work is underway to correct the issues. In addition, for Individual #5, only one quarterly assessment was completed/submitted (i.e., the Center submitted two copies of the same document).

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #96 – weight, and fractures; Individual #193 – falls, and skin integrity; Individual #268 – cardiac disease, and infections; Individual #223 – constipation/bowel obstruction, and skin integrity; Individual #173 – falls, and constipation/bowel obstruction; Individual #151 – cardiac disease, and fractures; Individual #198 – weight, and constipation/bowel obstruction; Individual #5 – dental, and falls; and Individual #152 – choking, and weight).

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. The following provide a few examples of problems noted:

- An overall trend in nursing assessments was a singular focus on the insufficient goals included in the IHCPs. In other words, if an IHCP erroneously focused only on the absence of falls, then the nursing assessment only commented on the presence or absence of falls. This resulted in a lack of information about, for example, how steady an individual was when walking, how often the individual ambulated daily, tolerance for walking activities, etc. This significant problem needs to be corrected.
- Individual #96's assessment did not mention her past right ankle fracture, or offer an analysis of how it might have impacted her mobility and subsequently her weight issue.

- In December 2016, Individual #193 fell resulting in an orbital fracture and a right hip fracture. He later underwent hip repair surgery, and a femoral fracture after hip surgery. The annual nursing assessment did not provide a summary that allowed a reader to determine the sequence of these events. The assessment also did not mention the skin ulcers to his heels and elbows, or the wound care required. Moreover, the summary section concluded that Individual #193 "had a healthy year."
- Individual #268's annual did not reflect the chronic and ongoing issues he had regarding ear infections, tube placement, continued follow-up with the Ear, Nose, and Throat consultant, or his moderate to severe hearing loss.
- Individual #151's assessment merely stated that he "has had very few BP's [blood pressures] outside of the desired range and his pressures are well controlled at this time. He has had no circulation or edema issues." This was not a clinical review of the cardiac risk area.
- Individual #5's annual nursing assessment contained more detailed information about each fall than found in other documents. Although the RN Case Manager clearly attempted to analyze the fall data, issues and trends such as why Individual #5 falls, where she falls, time of day, any associations with issues such as lighting, medications changes, or seizure activity were not assessed and analyzed.
- Individual #152's annual nursing assessment provided data on choking, and analyzed the data. However, it did not offer relevant recommendations.

c. On a positive note, the nursing assessment completed on 4/21/17, after Individual #173 was found sitting on the floor was appropriate and complete. 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:

- Individual #96 was to have at least 2000 milliliters (ml) of fluid each day and the PCP also ordered monitoring of her daily intake. A review of the data from January through July 2017 showed missing intake data and discrepancies in the total daily fluid intake amounts between the Fluid Intake Record and the Fluid Intake Log for Direct Support Professionals and Nursing staff. For example, the fluid log for February 2017 only had two days of intake data included without explanation. There was no indication that nursing staff were assessing the intake daily along with the individual's status to ensure that intake data were accurate.
- An IPN, dated 1/6/17, noted Individual #193 was red in the face and grimacing, but repositioning did not give the individual any relief. The nurse documented that "PRN [as needed] pain med" was given. However, the nurse did not conduct and/or document any further assessment and no vital signs were noted. In addition, the name or the medication, dosage, and route were not appropriately documented in the IPN.
- For Individual #193 who had bilateral heel ulcers and a surgical incision from a right hip replacement, nursing staff did not conduct and/or document daily shift skin assessments.
- For Individual #268, nursing staff conducted and/or documented no regular assessments or measurements of leg edema in order to determine if there was a change in status. This was particularly concerning since he was also overweight in spite of frequent episodes of emesis. There was no indication from the documentation that the IDT was considering edema as a factor in his weight status since he is enterally fed.
- An IPN, dated 4/9/17, indicated that the Individual #223's last recorded bowel movement was on 4/6/17. The nurse administered a Fleets enema. However, the nurse did not document any assessment of bowel sounds, abdominal distension, intake, or palpation of the abdomen. An assessment needed to be conducted to clinically justify the need for an enema rather than solely depending on the Log Book, which might not always be accurate. Giving a PRN medication for constipation

without an associated assessment could be a factor in the individual's episodes of loose stool.

- Individual #198's weight graph indicated that his weight dropped from 126.6 pounds on 2/3/17 to 122.8 on 2/10/17. There was no nursing assessment found in the IPNs or documentation of notification of the PCP and IDT of the weight loss. In addition, there was no indication that the weight was retaken to ensure it was accurate.
- Individual #5's Quarterly Nursing Assessment, dated 1/5/17 through 4/21/17, noted she fell in the workshop. No IPN was found addressing this fall or documenting a nursing assessment.

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.

#	Indicator	Overall Score	Individuals: 96	193	268	223	173	151	198	5	152
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	22% 4/18	0/2	1/2	1/2	1/2	1/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	11% 2/18	1/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	6% 1/18	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	22% 4/18	0/2	1/2	1/2	1/2	1/2	0/2	0/2	0/2	0/2

Comments: b. and f. The IHCPs that included preventative measures, and identified the frequency of monitoring were for Individual #193 – skin integrity, Individual #268 – infections, Individual #223 – skin integrity, and Individual #173 – constipation/bowel obstruction.

c. The IHCPs that incorporated measurable objectives to allow teams to track progress were for Individual #96 – weight, and Individual #268 – infections.

d. Individual #96's IHCP on weight identified and supported the specific clinical indicators to be monitored.

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: It was positive that for the one individual reviewed who required it, a RN Post Hospitalization Review was completed, and the PNMT discussed the results. The Center should focus on improving the timely referral of all individuals that meet criteria for PNMT review, involvement of the necessary disciplines in the PNMT review/assessment process, and improvement in the quality of the PNMT comprehensive assessments.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	50% 2/4	1/1	1/1	N/A	N/A	N/A	0/1	N/A	0/1	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	33% 1/3	N/A	1/1				0/1		0/1	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	67% 2/3	1/1	0/1				1/1		N/A	
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	25% 1/4	1/1	0/1				0/1		0/1	
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 1/1	N/A	1/1				N/A		N/A	
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	25% 1/4	1/1	0/1				0/1		0/1	
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that	0% 0/1	N/A	N/A				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	0/1	0/1				0/1		N/A	

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

- It was positive that Individual #96's IDT made a timely referral with regard to her weight gain, and that the PNMT completed a timely assessment, which is discussed in further detail below with regard to quality.
- Individual #193's IDT referred him timely with regard to falls, which was good to see. However, the PNMT assessment, dated 1/19/17, stated that the PNMT would finalize the assessment after surgery was completed. Outside of PNMT minutes, no summary or document was provided that showed the PNMT reconvened formally to complete the assessment. Information from the minutes should be pulled together for inclusion in the individual's record. Such documentation should at a minimum include a summary detailing any PNMT involvement, assessment, and/or recommendations. Moreover, only the Occupational Therapist (OT), Registered Dietician (RD), and RN were listed as team members. While other disciplines' reports were referenced, evidence was not found to show that the following disciplines contributed to the discussion and development of the assessment: Speech Language Pathologist (SLP), Physical Therapist (PT), Behavior Health Services (BHS) staff, and/or a PCP. All these disciplines should have actively participated as their services directly impacted the risk/health issues at hand. For example, according to the PNMT assessment, BHS staff found a potential relationship between seizures and SIB, specifically an increase in self-injurious behavior (SIB) just before his seizures. It would have been important for BHS staff to participate in the assessment process to further explore this possible connection.
- In February 2017, Individual #151 was discharged from the PNMT. The PNMT indicated that a new referral would be needed if he had more than three episodes of emesis of unknown origin. According to document TX-AU-1707-V.1-20, during April 2017, the individual experienced three incidences of emesis (i.e., 4/6/17, 4/20/17, and 4/25/17), as well as another two in May 2017 (5/30/17, and 5/31/17). The PNMT noted only two incidences in minutes (i.e., 4/5/17, and 5/31/17). Given the incidences the Center reported to the Monitoring Team, the PNMT should have, but did not conduct a formal review or re-assessment. This was particularly concerning, because the original assessment did not meet standards for quality. The PNMT had concluded that he did not need a Head-of-Bed Evaluation (HOBE), because the emesis had not occurred while he was in bed. However, given the ongoing issue with emesis, he was at increased risk when he was in bed, and so a HOBE was warranted. The only participants in his assessment were the OT, RN, and RD. It did not appear the SLP or PT participated. Given the issues, Individual #151 was facing, the PNMT should have identified a more discreet measurement for re-referral.
- On 5/26/17, Individual #5 was sent to the ED to rule out pneumonia. She had exhibited shortness of breath, and possibly low oxygen saturation rates. However, the PNMT did not conduct a review, or proactively participate in the ISPA meeting at which the IDT discussed her status and ED visit.

  In its comments on the draft report, the State contended that Individual #5 did not need PNMT review. It stated: "A chest x-ray was done at the ER which was read as LLL [left lower lobe] atelectasis versus possible infiltrate. The ER physician felt she only had atelectasis, but to err on the side of caution, she recommended Augmentin 500mg TID x 7 days. The PCP stated that low O2 [oxygen] was probably due to poor reading on that particular pulse oximeter as subsequent readings on different pulse oximeters were within normal limits as were O2 sats [saturations] at the ER. (see TX-AU-1707-ll.12, page 39 IPN dated 5/26/17). 5/26/17 was a Friday. Her case was discussed at Medical Rounds on 5/30/17. PNMT OT was present, reviewed

PCP IPN dated 5/29/17 and concluded that her case did not meet criteria for PNMT involvement."

Having considered the State's argument, the Monitoring Team still concludes that the PNMT should have conducted a review of Individual #5 and/or been involved in discussions with the IDT. This was a significant change in status for Individual #5. The ISPA, dated 5/30/17 for which the PNMT was absent, documented IDT discussion of the event, and indicated that Individual #5 demonstrated an irregular breathing pattern. The IDT's plan was to track irregular breathing episodes. PNMT involvement was warranted to assist the team in addressing the potential impact of irregular breathing on the entire person. Becoming short of breath might impact the individual's safety during eating, the ability to complete activities of daily living (ADLs), as well as safety during ambulation. Due to the potential implications, a review was warranted to check on these systems in a proactive manner. Moreover, mucous plugs can initiate atelectasis in the lungs.

e. It was positive that for the one individual reviewed who required it, a RN Post Hospitalization Review was completed, and the PNMT discussed the results.

h. The following provide some comments with regard to the three assessments that the PNMT completed:

- Individual #96's PNMT assessment did a nice job of reviewing the relevant risk areas, as well as her medications. The PNMT did not, though, complete a thorough assessment of her current physical assessment, review the impact of her weight gain on completion of activities of daily living, review her actual intake and/or activity levels, recalculate her height, determine whether or not behavior or communication skills had an impact on her participation in activities, and/or research the history of her current inability to walk. The PNMT assessment also did not offer a thorough review, including data to substantiate findings, of whether or not existing supports were effective and appropriate. In its comments on the draft report, the State indicated that: "Current services section on page 3 of the assessment lists the supports that were in place and their effectiveness." On page 4, the current services were listed, but as indicated in the draft report, no data was included to substantiate the findings related to the effectiveness of supports. For example, the PNMT indicated on page 4: "Continued decrease in caloric intake 2015 to present – not effective." However, the PNMT did not provide data to show whether Individual #96 actually had a decrease in calories, including data to show whether or not she obtained food beyond her prescribed diet. If the IDT had not collected such data, this would have been an important piece of information to include in the assessment. Although the PNMT made recommendations for the IDT's consideration, the lack of a complete assessment made it unclear whether or not the PNMT developed a full set of recommendations. The PNMT also did not offer the IDT options for measurable goals/objectives.
- Individual #193's PNMT assessment provided little in the form of assessment and represented more of a quick review. As noted above, the PNMT assessment, dated 1/19/17, stated that the PNMT would finalize the assessment after surgery was completed. Outside of PNMT minutes, no summary or document was provided that showed the PNMT reconvened formally to complete the assessment. While certain aspects of behavior-related supports were listed, the PNMT did not conduct a review of their effectiveness. Evidence was not offered of observation of the individual's supports in his program areas. The potential causes of the individual's physical and nutritional management problems were not identified. The PNMT assessment also did not offer a thorough review, including data to substantiate findings, of whether or not existing supports were effective and appropriate. In addition, the lack of a complete assessment made it unclear whether or not the PNMT developed a full set of recommendations.

- Individual #151's PNMT assessment was more of a review as opposed to a complete assessment, and did not investigate the underlying cause(s) of his emesis. The PNMT did not review medications. Although the PNMT made a recommendation for a Pharmacy consult, such a consult should have been done as part of the assessment. The results of such a consult were not noted in any ISPA, so it was unclear if it was completed. Evidence was not offered of observation of the individual's supports in his program areas. The PNMT assessment also did not offer a thorough review, including data to substantiate findings, of whether or not existing supports were effective and appropriate. In addition, the lack of a complete assessment made it unclear whether or not the PNMT developed a full set of recommendations.

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

Summary: 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	96	193	268	223	173	151	198	5	152
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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	0% 0/11	0/1	N/A	0/1	0/2	0/1	0/1	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 weight for Individual #96; skin integrity, and falls for Individual #193; aspiration, and GI problems for Individual #268; aspiration, and choking for Individual #223; aspiration, and choking for Individual #173; choking, and GI problems for Individual #151; aspiration, and choking for Individual #198; choking, and falls for Individual #5; and aspiration, and choking for Individual #152.

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

c. All individuals reviewed had PNMPs and/or Dining Plans. On a positive note, all PNMPs had been updated annually, and contained many of the required components. However, none of the PNMPs reviewed included the levels of risk. For some individuals, the PNMPs and/or Dining Plans were missing one or more identified risk (e.g., for Individual #198, Individual #5, and Individual #152). Several of the PNMPs included stock photos of gait belts, as opposed to a picture of the individual using his/her gait belt.
The communication section of Individual #5's PNMP did not address the use of tactile cues to improve receptive language.

e. The IHCP reviewed that identified the necessary clinical indicators was for choking for Individual #152.

g. Often, the IHCPs reviewed did not include the frequency of PNMP monitoring.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	50% 1/2	N/A	N/A	0/1	1/1	N/A	N/A	N/A	N/A	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/2			0/1	0/1					

Comments: a. and b. Since 1999, Individual #268 had received nothing by mouth (NPO). He started receiving small pleasure items by mouth, but this was discontinued when he had a series of coughs. Neither the IRRF nor the OT/PT assessment provided information regarding attempts to return to oral intake or consideration of therapy directed at resuming these trials.

Individual #223 had a swallowing program in place with by mouth (PO) trials. However, SLP staff were instructed to look for overt/covert signs and symptoms of aspiration as indicators to stop intake. The concern was that Individual #223 was known to silently aspirate, so overt/covert signs and symptoms would need to be clearly identified and listed, so that they could be measured.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: It was positive that for most individuals reviewed, OTs/PTs had completed timely assessments. The quality of OT/PT assessments continues to be an area on which Center staff should focus. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have	N/A									

	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.	N/A									
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. Individual #173's ankle-brachial index (ABI) recommended an off-campus Doppler. As of 1/13/17, based on review of PT IPNs and ISPAs, no evidence was found that the PT followed-up.

e. The following summaries some examples of concerns noted with regard to the required components of OT/PT updates:

- The individual's preferences and strengths are used in the development of OT/PT supports and services: Many of the updates reviewed incorporated individuals' preferences, but at times, individuals' strengths were not used to expand upon individuals' skills;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: For two of the nine individuals, the updates did not address their risk of aspiration;
- 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: Individual #96's update did not describe her ambulation prior to 2009, explain why she no longer ambulated, or provide any assessment of her refusals to bear weight. Individual #151's update lacked detail with regard to his oral motor status, and did not provide objective measurements, as opposed to just relying on meal observation;
- 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: Without an updated HOBE, Individual #173's update did not provide a sufficient comparative analysis. Similarly, without an updated assessment, Individual #151's update was lacking information with which to make comparisons with previous assessments;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: None of the assessments met this criterion. An overriding problem was that the only "outcome" addressed was the lack of a serious negative outcome occurring. Measurements should be in place to test a plan's effectiveness prior to a bad outcome occurring;
- 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 individuals often did not have goals/objectives that were clinically relevant and measurable, the updates did not include evidence regarding progress, maintenance, or regression. As noted above, more discreet measurements than a serious injury or decline were needed to determine whether or not an individual was benefitting from OT/PT supports and services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Given that complete assessments were not available of individuals' OT/PT needs, it often was unclear whether or not the assessments included a full set of

recommendations to address individuals' needs.

On a positive note, as applicable, all of the updates reviewed 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;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: and
- 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).

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: It was good to see that individuals' ISPs and ISPAs often reflected the strategies, interventions, and programs that OTs/PTs recommended. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 96	193	268	223	173	151	198	5	152
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
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.										
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	73% 8/11	1/2	2/2	1/1	1/1	0/1	1/1	1/1	0/1	1/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	100% 4/4	N/A	2/2	N/A	1/1	1/1	N/A	N/A	N/A	N/A

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

- For Individual #96, the IDT did not discuss or document discussion of a goal related to the use of a hand mitt during bathing recommended as part of the 2017 update, nor did the ISP include an explanation as to why the IDT did not adopt the recommendation.
- For Individual #173, the recommended Doppler was not included.
- An ISPA, dated 1/27/17, stated that the IDT would meet after video monitoring was reviewed regarding Individual #5's fall to determine whether changes were needed to her plan, but there was no evidence this occurred.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: It was positive that that individuals reviewed generally had timely communication assessments. The Center should continue to focus on improving the quality of communication assessments and updates. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication;	N/A									

	• Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/5	0/1	0/1	0/1	0/1	N/A	N/A	N/A	N/A	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/4	N/A	N/A	N/A	N/A	0/1	0/1	0/1	0/1	N/A

Comments: a. and b. It was positive that individuals reviewed generally had timely communication assessments. Because Individual #5 had not had a comprehensive assessment in three years, the Speech Language Pathologist (SLP) should have included a statement justifying why a comprehensive assessment was not needed and an update was appropriate to meet Individual #5's needs. A justification statement should go beyond simply stating: "current assessment is consistent with previous," and should provide information regarding effectiveness of current supports and whether they remain appropriate or if there is a need to modify supports.

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

- The individual's preferences and strengths are used in the development of communication supports and services: Individual #223's assessment identified the use of objects to express needs and wants as a strength, but did not make recommendations to expand this strength through a communication program or use of an AAC device. Due to Individual #223's ability to use real objects, an investigation and trial of an object-based board was warranted.;
- The effectiveness of current supports, including monitoring findings: For most individuals, results of monitoring/observations over the previous year were not cited, and/or the assessors concluded that supports were effective, but provided no data to support this conclusion;
- 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: As noted above, Individual #223's assessment did not provide an assessment of AAC options. A proper investigation including AAC trials was not part of the assessment. Trials supported by data was missing in the AAC portion of the assessment;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated: Evidence to show compliance with this sub-indicator was present for Individual #96, and Individual #193. However, for Individual #152, the behavior section discussed reduction of aggression as being the target of the PBSP, but did not provide input regarding the potential impact of direct communication therapy on the presenting behaviors; 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: Given that complete assessments were not available of individuals' communication needs, it was unclear whether or not the assessments included a full set of recommendations to address individuals' needs.

On a positive note, all five assessments provided:

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

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills; and
- A comparative analysis of current communication function with previous assessments.

e. The following provide examples of concerns noted with regard to the required components of the four communication updates reviewed:

- The individual's preferences and strengths are used in the development of communication supports and services: Individual #173 update indicated she had the ability to follow one-step requests and had simple reading skills, but no programs were recommended or developed to address expansion of these skills;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services: Most updates reviewed met criteria. However, although Individual #5's update listed side effects of medications, it did not include discussion regarding whether or not such side effects were thought to impact speech/communication currently;
- 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: Two of the updates did not provide evidence of actual assessment to identify potential changes, and did not include discussion of expressive and receptive language based on current observations;
- The effectiveness of current supports, including monitoring findings: The updates did not include reviews of monitoring findings;
- Assessment of communication needs (including AAC, EC, or language-based) in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services: Three of the four updates did not provide an assessment of AAC; 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: Given that complete assessments were not available of individuals' communication needs, it was unclear whether or not the assessments included a full set of recommendations to address individuals' needs.

On a positive note, the updates did sufficiently address:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication.

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.	
Summary: It was positive that the Center sustained its progress with regard to including descriptions of individuals' communication status in their ISPs. At the time of the next review, if this level of performance is sustained, then Indicator a might move to the category requiring less oversight. Unfortunately, the Center	Individuals:

regressed with regard to IDTs reviewing Communication Dictionaries. These indicators will remain in active oversight.											
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
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	1/1	1/1	1/1	1/1	1/1	1/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	91% 10/11	1/1	1/1	2/2	1/1	1/1	1/1	1/1	0/1	2/2
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. Individual #152's ISP still included the use of sequence boards, but according to the SLP assessment, these were discontinued. b. Individual #5's ISP did not reflect the tactile input on buttons on her AAC device that the SLP recommended. For other individuals, simply including a stock statement such as "Team reviewed and approved communication strategies" did not provide evidence of what the IDT reviewed, revised, and/or approved.											

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: These three indicators scored the same or lower than at the last review. All three will remain in active monitoring. Details regarding the criteria are in the comments below.			Individuals:								
#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
1	The individual has skill acquisition plans.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The SAPs are measurable.										

3	The individual's SAPs were based on assessment results.	46% 12/26	1/3	2/3	2/3	3/3	0/3	0/3	2/3	1/2	1/3
4	SAPs are practical, functional, and meaningful.	54% 14/26	2/3	2/3	2/3	2/3	1/3	1/3	2/3	1/2	1/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	8% 2/26	0/3	0/3	1/3	0/3	0/3	0/3	1/3	0/2	0/3

Comments:

3. Three SAPs were reviewed for eight individuals. The exception was Individual #341 who had two SAPs. Twelve of the 26 SAPs were based on assessment results. Exceptions included:

- Skills that had been identified as mastered in the individual's functional skills assessment (e.g., Individual #421 – bathing; Individual #23 – choose an item; Individual #376 – greet staff, release seatbelt).
- Those that were identified as mastered through baseline assessment (e.g., Individual #369 – fold paper to make a card, choose music; Individual #193 – use AAC device; and Individual #16. place an object symbol on a board, raise his arm to participate in hand sanitizing following a verbal instruction).
- In other cases, baseline assessment was not completed (e.g., Individual #23 – turn on fan, push chair into table; Individual #16 – put papers in bag; and Individual #118 – hand item to another individual).

4. Fourteen of the 26 SAPs were considered practical, functional, and/or meaningful. In addition to those skills that had been identified as mastered, exceptions included the following:

- Individual #369 was to learn to make a card for eventual use in inviting others to an on-campus event – it would be more meaningful for him to learn to send cards (including addressing the card and mailing it at the local post office) to his mother with whom he had a close relationship.
- Individual #96 was to learn to pour milk on her cereal, but it was noted that she had learned to pour her cereal into a bowl – as she occasionally performed the targeted skill, this may have been more appropriately addressed through generalization.
- Individual #16 was to learn to plan his schedule, but it was unlikely that he could truly choose when certain activities occur; and Individual #16 was to learn to recycle, but if staff are required to hold the bag into which he places paper, this will limit his degree of independence.

5. Of the 26 SAPs, there was evidence that 14 had been assessed for SAP integrity. Nine of these assessments had been completed through role-play, which is not an acceptable method for determining whether teaching is implemented as planned. For three of the integrity assessments completed through observation, two produced scores of 80% or better (i.e., Individual #421 – turn on radio; and Individual #118 – access You Tube). For the remaining SAPs, it was unclear whether integrity had been assessed through role-play or observation.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.	
Summary: Performance improved to 100% for indicators 10 and 11. This was good to see and the Center should ensure this high performance continues. One aspect to	Individuals:

focus upon is to be sure to include recommendations for skill acquisition in these assessments. This was the case for most, but not near all, day program assessments. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	78% 7/9	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1

Comments:
10-11. All nine of the individuals had assessments that were current with their ISPs. For two individuals, Individual #193 and Individual #96, it would be advisable to complete or update a vocational assessment because both of these individuals may be able to participate in work activities. All of the assessments were available to the IDT at least 10 days prior to the individual's ISP.

12. For seven of the nine individuals, their assessments included recommendations for skill acquisition. The exceptions were Individual #23 and Individual #118 whose day program assessments 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. At the time of the last review, 29 of these indicators, including four entire outcomes, had sustained high performance scores and moved to the category requiring less oversight. Presently, five additional indicators will move to the category of less oversight in the areas of psychiatry, psychology, and dental. This results in the entirety of Outcome #7 for psychiatry now being in the category of less oversight.

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

Goals/Objectives and Review of Progress

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

Psychiatry quarterly review completion timeliness and content met criteria for all individuals. Psychiatrist participation in the development of the PBSP was evident for all individuals. The completion of side effect evaluations and their timely review by the prescriber were completed according to the requirements for all but two of the individuals.

It was good to see that behavioral health services took action for many (but not all) cases when their own progress notes indicated progress/no progress in problem behavior occurrences. However, without reliable data, a determination could not be confidently made regarding progress. Various challenges in data collection resulted in poor performance scores for all five indicators of Outcome #8. This was a marked deterioration in scoring compared with previous reviews. This was discussed at length while the Monitoring Team was onsite.

Acute Illnesses/Occurrences

It was good to see that for the individuals reviewed with Emergency Department (ED) visits or hospitalizations, upon their return to the Center, 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. Some of the areas on which the Center should continue to focus include: 1) when individuals are transferred to the hospital, the PCP or a nurse communicates necessary clinical information with hospital staff; 2) as appropriate, prior to the hospitalization, ED visit, or Infirmary admission,

the PCP or another provider completes and documents a quality assessment in the IPNs; and 3) ISPA meetings are held and IDTs identify follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.

Based on information the State provided, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected.

No individuals were placed in restraints more than three times in any rolling 30-day period.

In psychiatry, without measurable goals, progress could not be determined. Even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals.

Implementation of Plans

Ensuring all staff were trained in PBSPs remained an area of need for Austin SSLC.

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.

It was very positive that during an observation for one applicable individual, the medication nurse completed lung sounds in accordance with the IHCP that defined these assessments. Unfortunately, for another individual at high risk for aspiration, the IHCP did not include regular lung sound assessments. During the Monitoring Team's observation of this second individual, the Nurse Educator pulled two medication nurses off the floor for immediate retraining, because they did not know the correct procedure to obtain lung sounds. The Nurse Educator performed the lung sounds to facilitate the medication pass. It was noteworthy that the Center had implemented a stringent medication administration monitoring procedure to ensure staff are competent and to provide immediate retraining if any issues are found. The procedure to provide nurses with immediate skills retraining was conducted in a professional and educational manner and did not use a punitive approach, which was good to see.

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, and PCPs need to implement them timely and thoroughly.

Regression was noted with regard to PCPs writing orders for agreed-upon consultant recommendations. In addition, the Center should ensure that PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

The Center made progress with regard to PCPs reviewing and addressing, as needed, risks related to the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

At the time of the last review, the Center had sustained good performance with regard to a number of indicators related to the provision of dental care and treatment, so these indicators moved to the category of less oversight. Based on this review, the indicator related to prophylactic care also will move to the less oversight category. Improvements also were noted in relation to suction tooth brushing, and the development and implementation of care plans for individuals with periodontal disease. The Center should focus on sustaining its progress in these areas.

During this review, approximately 33% of the QDRRs were completed late. It appeared that this was due to Center staff's use of outdated criteria for timeliness. During the onsite review, it appeared this misunderstanding was corrected. However, failure to correct this problem could result in the related indicator moving back to active monitoring. In comparison with the previous review, the quality of the QDRRs improved in relation to the review of polypharmacy, and anticholinergic burden. Improvement also was noted with regard to prescribers implementing agreed-upon recommendations.

It was good to see that most individuals' adaptive equipment observed appeared to fit properly.

Based on observations, there were still numerous instances (43% 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.

Restraints

<table>
<tr><td colspan="2">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.</td></tr>
<tr><td>Summary: No individuals were placed in restraints more than three times in any rolling 30-day period during this monitoring review period (and during the</td><td>Individuals:</td></tr>
</table>

previous monitoring review period, too). This was good to see. These indicators will remain in active monitoring for possible scoring at the next review.											
#	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									
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:											

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.												
Summary: Individuals at Austin SSLC had Reiss screens. One of the two individuals who were not currently receiving psychiatric services and who also had scores above the clinical cut-off, did not have a CPE. In addition, there was much confusion in the documentation submitted to the Monitoring Team for two individuals. For example, different Reiss screens and different CPEs were submitted at different times during the tier 2 and onsite document requests. Indicator 3 will remain in less oversight, however, the facility needs to ensure that Reiss screens and appropriate, required follow-up occurs or this indicator might be moved back to active monitoring after the next review.			Individuals:									
#	Indicator	Overall Score										
1	If not receiving psychiatric services, a Reiss was conducted.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. Instances of individuals scoring above the clinical cut-off, but not receiving a CPE resulted in this indicator being moved back to active monitoring.										
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.											
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.											
Comments: 3. Five of the seven individuals who were not seen in the psychiatry clinics had Reiss scores below the clinical cutoff score of 9. The two individuals who had a score above the clinical cutoff were Individual #96, whose 6/13/14 Reiss had a score of 9.5, and Individual #5, whose 2/15/13 Reiss had a score of 15.5. Additional documentation submitted to the Monitoring Team showed that a CPE was conducted within 30 days for Individual #96, but the additional documentation for Individual #5 did not clarify this. The facility should do a review and ensure that all individuals who have Reiss scores above the clinical cut-off and who are not currently												

receiving psychiatric services, have had a CPE (or indication of why a CPE was not necessary).

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.			Individuals:								
#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
8	The individual is making progress and/or maintaining stability.	0% 0/7	0/1	N/A	0/1	N/A	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% 0/7	0/1	N/A	0/1	N/A	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% 5/5	1/1	N/A	1/1	N/A	1/1	N/A	1/1	1/1	N/A
11	Activity and/or revisions to treatment were implemented.	100% 5/5	1/1	N/A	1/1	N/A	1/1	N/A	1/1	1/1	N/A

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.

10. 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 five of the individuals: Individual #369, Individual #421, Individual #23, Individual #118, and Individual #341.

11. There was also documentation that the recommendations described in these consults were implemented. The other individuals were either not prescribed psychotropic medication (Individual #96, Individual #193) or were stable on their psychiatric medications (Individual #16, Individual #376) and, thus, had not required urgent or interim interventions during the year.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary: Psychiatrist participation in the development of the PBSP was evident for all individuals for this review and the past two reviews, too, with one exception in January 2016. Therefore, this indicator (24) will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall	369	193	421	96	23	16	118	341	376

		Score									
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
24	The psychiatrist participated in the development of the PBSP.	100% 7/7	1/1	N/A	1/1	N/A	1/1	1/1	1/1	1/1	1/1

Comments:
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: Criteria were met for the one individual to whom indicator 26 applied. Given that only one individual was assessed for this indicator, it will remain in active monitoring for scoring at the next monitoring review.			Individuals:								
#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
26	Frequency was at least annual.	100% 1/1	N/A	N/A	1/1	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
26. Individual #421 was the one individual in the review group for whom there was dual use of an anticonvulsant medication. She had both a seizure disorder and a psychiatric diagnosis of IED. During the onsite review, multiple neurology notes for 2017, 2016, and 2015 were identified for Individual #421.

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

Summary: Quarterly review completion timeliness and content met criteria for all individuals for this review and for the past two reviews, too, with one exception for each during that time period. Therefore, indicators 33 and 34 will be moved to the category of requiring less oversight. Indicator 35 will remain in active monitoring	Individuals:

for scoring at the next review, at which time, if sustained high performance is maintained, it might also be moved to the category of requiring less oversight.											
#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
33	Quarterly reviews were completed quarterly.	100% 7/7	1/1	N/A	1/1	N/A	1/1	1/1	1/1	1/1	1/1
34	Quarterly reviews contained required content.	100% 7/7	1/1	N/A	1/1	N/A	1/1	1/1	1/1	1/1	1/1
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A

Comments:
33. The quarterly reviews were completed as specified for all of the individuals that were prescribed psychotropic medication. Individual #193 and Individual #96 were not prescribed psychiatric medications and, thus, were not reviewed by the psychiatrists.

34. The documentation in the quarterly reviews was complete and met standards.

35. During the onsite review, the Monitoring Team observed the 7/27/17 psychiatric clinical review for Individual #23. All of the required staff members were present and the content of the meeting met criteria.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: The corrective action plan put into place following last reviews performance of 22% showed positive effects and improvements. This was good to see. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	71% 5/7	1/1	N/A	1/1	N/A	1/1	0/1	1/1	1/1	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 all but two of the individuals: Individual #16 and Individual #376. The deficits for these two individuals related to the requirement for timely review by the prescriber. The MOSES and AIMS were completed as required on schedule for all of the individuals. The results of the current review represent significant progress when compared to the prior review at which time there were deficits in both the timely completion and review of these documents.

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

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: These important indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 7/7	1/1	N/A	1/1	N/A	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% 7/7	1/1	N/A	1/1	N/A	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% 7/7	1/1	N/A	1/1	N/A	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:			Individuals:									
#	Indicator	Overall Score										
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
45	There is a tapering plan, or rationale for why not.											
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.											
Comments: 46. The facility policy was to review each individual who met the criteria for polypharmacy on a quarterly basis. The 7/27/17 polypharmacy committee meeting was attended the Monitoring Team. It was noted that Individual #376 was not reviewed in this meeting and did not appear on the polypharmacy list. The discontinuation of the Lexapro had decreased her total number of psychotropic medications from three to two. However, as she was still prescribed two mood stabilizers in the form of Lithium and Depakote, she would continue to meet the criteria of two medications from the same class and, thus, will need to be reviewed by the polypharmacy committee.												

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: It was good to see that behavioral health services took action for many (but not all) cases when their own progress notes indicated progress/no progress in problem behavior occurrences. However, without reliable data, a determination could not be confidently made regarding progress (indicator 6). These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
6	The individual is making expected progress	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	60% 3/5	1/1	N/A	0/1	1/1	0/1	N/A	N/A	1/1	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	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 the graphs for eight of the nine individuals suggested progress, this indicator was rated zero due to the identified problems with data timeliness and the lack of confidence in the accuracy of the data. The graphs depicting Individual #341's problem behaviors reflected a recent increase.

It was noteworthy that the graphs for several individuals, including Individual #193, Individual #421, Individual #96, Individual #16 and Individual #341 reflected a noticeable change in targeted problem behavior and occasionally replacement behavior following the introduction of the electronic data system.

7. Based upon the information provided in their progress notes, five individuals (Individual #369, Individual #421, Individual #96, Individual #23, Individual #341) had met some or all of their goals. For three of these individuals (Individual #369, Individual #96, Individual #341), the criteria for their achieved goals were changed. Individual #376 was an exception. Although the data suggested that she had achieved her goals, the BCBA decided not to make any changes because she was not confident in the accuracy of the reported data.

8. Although Individual #341 had achieved his goal addressing the reduction in self-injurious behavior, the data indicated that progress was not being made in meeting his other behavior reduction goals. There was no evidence that corrective actions had been identified or suggested.

9. Because none of the individuals' teams had recommended revisions to treatment, this indicator was rated not applicable.

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

Summary: Ensuring all staff were trained remained an area of need for Austin SSLC. There was, however, a PBSP summary for all staff for all individuals for this review and the past two reviews, too. Therefore, indicator 17 will be moved to the category of requiring less oversight. Indicator 16 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 369	193	421	96	23	16	118	341	376
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.	44% 4/9	1/1	1/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1
17	There was a PBSP summary for float staff.	100% 9/9	1/1	1/1	1/1	1/1	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
16. For four individuals, Individual #369, Individual #193, Individual #23, and Individual #341, documentation indicated that 80% or more of their assigned staff had been trained on their PBSP. For the other five individuals, documentation indicated between 45% and 76% of their assigned staff had been trained.

While onsite, the Monitoring Team observed the behavioral health specialist for Individual #341 directly implementing a fading program for the use of PMR-SIB. He also provided support to staff, demonstrated the approach to use during mitten removal, and provided on-the-job training.

17. All nine individuals had a PBSP summary for float staff. It was positive to see that for seven of these individuals, the summary was dated, ensuring that it corresponded with the individual's current PBSP. The exceptions were the summaries for Individual #369 and Individual #23.

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

Summary: Graphs were not yet useful for all individuals. In clinical meetings, data were sometimes presented and follow-up sometimes occurred. Peer review was occurring as required and, if high performance is sustained, indicator 23 might be moved to the category of requiring less oversight after the next review. These four indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 369	193	421	96	23	16	118	341	376
19	The individual's progress note comments on the progress of the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
20	The graphs are useful for making data based treatment decisions.	22% 2/9	0/1	1/1	0/1	0/1	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.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	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	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	0/1
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100%									

Comments:
20. The graphs for two individuals (Individual #193, Individual #376) were considered useful for making data-based treatment decisions. Individual #369's graphs that were included in his progress notes were too small to interpret easily. In all other cases, phase

changes lines were not consistently included when major events occurred, including the introduction of a new PBSP.

21. An observation was conducted of Individual #23's psychiatry clinic. There was a good review of his data, both graphically and verbally. The behavior analyst noted the absence of data for one to two months due to problems with data collection.

22. There was evidence that two of the nine individuals had been reviewed by the internal peer review committee in the six-month period prior to the Monitoring Team's onsite visit. For Individual #421, there was evidence that the IDT had held an ISPA meeting to review the recommendations regarding staff scheduling personal time during which one to one attention could be provided. For Individual #341, recommendations included completing an updated preference assessment, adding a wristband to his PBSP, and introducing an item for him to hold during scheduled mitten releases. The evidence provided indicated that only this third recommendation had been introduced.

23. There was evidence that three meetings of the internal peer review committee were held each month between December 2016 and May 2017. At one of these meetings each month, members of the external peer review committee also participated. The Monitoring Team observed the internal peer review committee meeting and saw good discussion from and among attendees.

Outcome 8 – Data are collected correctly and reliably.

Summary: Various challenges in data collection resulted in poor performance scores for all five of these indicators. This was a marked deterioration in scoring compared with previous reviews. This was discussed at length while the Monitoring Team was onsite. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
26-27. Due to the observed and reported problems with data collection, it was determined that adequate data collection systems were not in place for any of the nine individuals. Two plans (i.e., those for Individual #96 and Individual #376) specifically directed staff to record data within two hours, or as soon as possible after the behavior occurred. These same plans further indicated that staff should

not wait until the end of their shift.

Several plans (e.g., those for Individual #369, Individual #193, Individual #16, and Individual #118) directed staff to record data as soon as possible after the targeted problem behavior or replacement behavior occurred. However, these same plans indicated nonoccurrence should be recorded once per shift, or in Individual #118's case, at the end of the shift.

The plans for Individual #421 and Individual #23 had documentation strategies that pre-dated the electronic data system. It is suggested that these should have been updated when the new system was introduced.

Finally, Individual #341's PBSP directed staff to enter data after they were relieved from their 1:1 responsibilities. While it is appropriate to support a staff member's full attention for providing a safe environment for Individual #341, it very likely will lead to inaccurate data recording. This is particularly true during his mitten release and pool time during which two staff are working closely to provide adequate support. When viewing the graph depicting the rate of targeted problem behaviors during these scheduled activities, it was unclear how one staff person could ensure reliable measures of his targeted problem behavior. As these are interventions that are reported to have a positive effect, it will be critical to have accurate data so that treatment efficacy can be objectively assessed. It may be helpful to recruit a third staff member to record data, to increase assessment of IOA, and/or to videotape sessions to help ensure reliable documentation. Further, staff should make every effort to objectively assess the efficacy of medication that is being used to treat Individual #341's hypothesized migraine headaches. This should include a clear operational definition of behavioral indicators of headache pain, and reliable pre- and post-treatment documentation of targeted problem behaviors.

28-29. The facility had developed a system for assessing IOA and treatment integrity. It was expected that each would be assessed at least monthly, with goal levels of 80% or better. There were no acceptable measures of data timeliness in place at the time of the onsite visit.

30. Due to the problems identified in assessing data timeliness, this indicator was rated zero for all nine individuals.

It should be noted, however, that goal frequencies and levels of IOA and treatment integrity were achieved for Individual #96 and Individual #118. For all others, problems included a lack of monthly assessments and/or inconsistent review of IOA. When IOA was reported, it was noteworthy that for seven individuals (i.e., Individual #369, Individual #193, Individual #96, Individual #23, Individual #16, Individual #118, and Individual #341), agreement was based solely upon non-occurrence of the targeted problem behavior(s).

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	6% 1/18	1/2	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% 3/17	2/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/16	0/2	0/2	0/2	0/2	0/2	0/2	N/A	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/16	0/2	0/2	0/2	0/2	0/2	0/2	N/A	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/16	0/2	0/2	0/2	0/2	0/2	0/2	N/A	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 #96 – urinary tract infections, and seizures; Individual #193 – osteoporosis, and skin integrity; Individual #268 – GI problems, and seizures; Individual #223 – osteoporosis, and urinary tract infections; Individual #173 – osteoporosis, and skin integrity; Individual #151 – GI problems, and falls; Individual #198 – constipation/bowel obstruction, and osteoporosis; Individual #5 – GI problems, and weight; and Individual #152 – weight, and seizures). The following goal was clinically relevant, achievable, and measurable: Individual #96 – urinary tract infections.

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 #96 - seizures; and Individual #223 –urinary tract infections (for which the goal/objective did not address one of the suspected underlying etiologies of her UTIs).

c. through e. Individual #198 died before his ISP was implemented. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, although integrated progress reports on these goals often included data, analysis of the data was generally not completed. 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: Eight 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 are deemed to meet the requirements of the Settlement Agreement. The Center made progress with regard to PCPs reviewing and addressing, as needed, risks related to the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. All of these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	Individual receives timely preventative care:										
	i. Immunizations	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	86% 6/7	1/1	N/A	1/1	1/1	0/1	1/1	1/1	1/1	N/A
	iii. Breast cancer screening	100% 4/4	1/1	N/A	N/A	1/1	1/1	N/A	N/A	1/1	N/A
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
	vii. Cervical cancer screening	100% 4/4	1/1	N/A	N/A	1/1	1/1	N/A	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.	75% 6/8	1/1	1/1	0/1	1/1	N/A	0/1	1/1	1/1	1/1

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

- On 7/11/16, Individual #173 had a colonoscopy, during which a rectal polyp was found. The report included a recommendation to repeat a sigmoidoscopy in six months and a colonoscopy in three years. However, it did not appear Individual #173 had a repeat sigmoidoscopy in January 2017. The PCP reordered colo guard on 4/4/17 (i.e., it was previously

ordered on 11/18/15, but no results were found), and on 4/26/17, the sample was positive. On 7/27/17, Individual #173 saw the gastroenterologist, who recommended a colonoscopy.

b. Often, in AMAs, PCPs reviewed and addressed, as needed, risks related to the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. The following concerns were noted:

- Individual #268's PCP discussed anticholinergic burden, but not polypharmacy for anti-epileptic drugs (AEDs).
- Individual #151's PCP addressed polypharmacy and benzodiazepine use, but did not analyze and/or address the anticholinergic burden.

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

Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
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.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
Comments: a. Individual #173 did not have a condition that justified the DNR Order consistent with the State Office Guidelines. More specifically, the reason given on the 12/5/14 out-of-hospital DNR was severe dysphagia without G-tube.											

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

Summary: Some of the areas on which the Center should continue to focus include: 1) when individuals are transferred to the hospital, the PCP or a nurse communicates necessary clinical information with hospital staff; 2) as appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the PCP or another provider completes and documents a quality assessment in the IPNs; and 3) ISPA meetings are held and IDTs identify follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
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.	88% 7/8	N/A	2/2	1/1	2/2	0/1	N/A	2/2	N/A	N/A
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments	67% 2/3		N/A	N/A	1/1	0/1		1/1		

	and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.										
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	75% 6/8	N/A	1/2	N/A	0/1	N/A	2/2	2/2	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.	67% 4/6		0/1		0/1		1/1	2/2	1/1	
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	43% 3/7		1/2		0/1		1/1	0/2	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.	50% 1/2		N/A		1/1		N/A	0/1	N/A	
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	100% 7/7		2/2		1/1		2/2	1/1	1/1	

Comments: a. and b. For five of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed eight acute illnesses addressed at the Center, including the following with dates of occurrence: Individual #193 (pruritus on 3/3/17, and incision redness on 3/4/17), Individual #268 [gastrostomy tube (G-tube) site leaking on 2/10/17], Individual #223 (conjunctivitis on 12/29/16, and bleeding from G-tube on 1/25/17), Individual #173 (lateral ankle ulcer on 12/6/16), and Individual #198 (abrasion of scalp on 3/7/17, and agitation on 4/10/17).

It was positive that for most acute illnesses reviewed, documentation was present to show that medical providers assessed the individuals according to accepted clinical practice, and as applicable, documentation was found to show the PCPs conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized.

The exception was for Individual #173. On 12/6/16, the individual complained of left ankle pain, and, according to nursing documentation, had ulcer development. In the following days and weeks, the PCP ordered Habilitation Therapy staff to complete dressings, ordered an ankle-brachial index (ABI) on site, and eventually sent Individual #173 to the cardiothoracic surgeon for ABIs. However, the PCP did not document a note(s) indicating that the PCP saw and examined the individual.

c. through h. For five of the nine individuals reviewed, the Monitoring Team reviewed eight acute illnesses requiring hospital admission, Infirmary admission, or ED visit, including the following with dates of occurrence: Individual #193 (ED visit for head injury on 12/17/16, and hospitalization for hip fracture on 12/19/16), Individual #223 (hospitalization for UTI on 12/12/16), Individual #151 (Infirmary admission for post-procedure bleeding on 12/13/16, and ED visit for fall on 5/13/17), Individual #198 (hospitalization for restlessness and agitation on 4/6/17, and hospitalization for UTI on 4/15/17), and Individual #5 (ED visit for dyspnea on 5/26/17).

c. and d. For Individual #193 (hospitalization for hip fracture on 12/19/16), which occurred on a Monday, a PCP IPN was not completed to show evaluation prior to the transfer. On the day before the transfer, the PCP assessed the individual, and ordered x-rays, but no PCP IPN for 12/19/16 was submitted.

For Individual #223 (hospitalization for UTI on 12/12/16), the Center provided no information prior to this hospitalization except a brief nursing IPN, dated 12/12/16 at 5:16 p.m., which appeared to have been abruptly stopped in the middle of a sentence. There was no further documentation until the post-hospitalization PCP IPN note. As a result, it was unclear when the PCP ordered transfer to the ED.

f. The individuals that were transferred to the hospital for whom documentation was not submitted to confirm that the PCP or a nurse communicated necessary clinical information with hospital staff were Individual #193 (hospitalization for hip fracture on 12/19/16), Individual #223 (hospitalization for UTI on 12/12/16), and Individual #198 (hospitalization for restlessness and agitation on 4/6/17, and hospitalization for UTI on 4/15/17).

g. Although it appeared that on 4/12/17, Individual #198's IDT met, no ISPA documentation was submitted for this date.

h. It was good to see that for the individuals reviewed, upon their return to the Center, there was evidence 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.

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

Summary: Regression was noted with regard to PCPs writing orders for agreed-upon consultant recommendations. In addition, the Center should ensure that PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

#	Indicator	Overall Score	Individuals: 96	193	268	223	173	151	198	5	152
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
b.	PCP completes review within five business days, or sooner if clinically indicated.										
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.										
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	43% 6/14	0/2	1/2	2/2	2/2	N/A	0/2	1/1	0/1	0/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	50% 2/4	0/1	2/2	N/A	N/A	N/A	N/A	N/A	N/A	0/1

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 16 consultations. The consultations reviewed included those for Individual #96 for ophthalmology on 4/7/17, and neurology on 3/24/17; Individual #193 for podiatry on 5/11/17, and podiatry on 5/17/17; Individual #268 for epileptology on 1/10/17, and neurology on 4/28/17; Individual #223 for endocrinology on 3/1/17, and urology on 1/9/17; Individual #173 for vascular surgery on 1/25/17; Individual #151 for gastroenterology (GI) on 2/6/17, and neurology on 2/24/17; Individual #198 for orthopedics on 4/11/17, and neurology on 3/24/17; Individual #5 for neurology on 12/16/16; and Individual #152 for neurology on 5/18/17, and optometry on 3/30/17.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, with the exceptions of the following: Individual #193 for podiatry on 5/17/17 (i.e., increasing dressing changes from daily to twice a day); Individual #96 for ophthalmology on 4/7/17, and neurology on 3/24/17 (i.e., for recheck appointments); Individual #151 for GI on 2/6/17 (i.e., continue pantoprazole and reflux measures, and follow-up colonoscopy), and neurology on 2/24/17 (i.e., follow-up in four months); Individual #5 for neurology on 12/16/16 (i.e., follow-up in six months); and Individual #152 for neurology on 5/18/17 (follow-up in six months), and optometry on 3/30/17 (follow-up in one year).

e. For Individual #96's neurology consultation on 3/24/17, the PCP made a referral to the IDT. However, no ISPA documentation was found to show that the IDT met and discussed integration into existing supports of the use of Diastat at the beginning of a seizure cluster, and tapering Zonisamide.

For Individual #152's optometry consultation on 3/30/17, the PCP did not provide information about whether or not a referral to the IDT was necessary.

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

Summary: Although additional work was necessary, it was positive that for a number of individuals' chronic or at-risk conditions, medical 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. This indicator will remain in active oversight.

#	Indicator	Overall Score	Individuals: 96	193	268	223	173	151	198	5	152
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.	78% 14/18	2/2	0/2	2/2	2/2	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 #96 – urinary tract infections, and seizures; Individual #193 – osteoporosis, and skin integrity; Individual #268 – GI problems, and seizures; Individual #223 – osteoporosis, and urinary tract infections; Individual #173 – osteoporosis, and skin integrity; Individual #151 – GI problems, and falls; Individual #198 – constipation/bowel obstruction, and osteoporosis; Individual #5 – GI problems, and weight; and Individual #152 – weight, and seizures).

a. It was positive that for a number of individuals' chronic or at-risk conditions, 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. This included: Individual #96 – urinary tract infections, and seizures; Individual #268 – GI problems, and seizures; Individual #223 – osteoporosis, and urinary tract infections; Individual #151 – GI problems, and falls; Individual #198 – constipation/bowel obstruction, and osteoporosis; Individual #5 – GI problems, and weight; and Individual #152 – weight, and seizures. The following summarizes some of the concerns noted:

- In Individual #173's AMA, no information was included concerning whether secondary causes for osteoporosis were ruled out (e.g., parathormone level, etc.). If such work-ups were completed in the past, this information should be carried forward in subsequent AMAs. There was little routine lab information in the AMA.

- On 12/6/16, Individual #173 developed a break in skin integrity at her left lateral ankle associated with discomfort. The PCP provided orders for the Physical Therapist (PT) and nursing staff to complete wound care to this area. There was a concern of decreased arterial circulation to the area, and on 12/28/16, ABIs were scheduled. On 1/4/17, ABI results indicated mild bilateral arterial disease (the readings were at the lower limits of normal). At that point, a referral to the vascular surgeon was

made. On 1/10/17, a PT wound consultant in the home indicated the wound had closed, and indicated there had been a callus at this site over several years. A 1/25/17, a cardiothoracic surgeon consult was completed. Doppler studies indicated very strong pulses to both lower extremities and no evidence of vascular disease.

The submitted documentation was problematic in that there was no IPN indicating the PCP examined the break in skin integrity at the ankle. On 12/29/16, the AMA physical exam was completed, but did not mention there was an abnormality at the ankle. The wound also was not mentioned in the active problem list. Primary evaluation by the PCP appeared to be lacking. There was no information that the PCP attempted to locate pulses, although they were noted to be strong by Doppler in the consultant's office. Subsequent testing and consultation might then have changed, based on a basic physical exam. It was also problematic that the PT reviewed habilitation notes and indicated the callus formation at the ankle was a chronic problem. There was no follow-up as to cause or resolution of this chronic condition (e.g., need for further modification of the custom-made shoes, etc.)

- On 12/17/16, Individual #193 had a seizure while standing at the sink. He fell and sustained a nondisplaced superior orbital fracture on the right side of his face, which did not affect his vision nor need further treatment. He also sustained a femoral neck fracture on the right. Since he was not ambulatory, conservative treatment was attempted, but pain management was not successful, and on 2/27/17, he underwent a total right hip replacement. On 3/17/17, he was noted to have increased pain, and was found to have a fracture distal to the right femoral head rod (peri prosthetic fracture). On 3/18/17, this was repaired using a different femoral head rod with less stress on the osteoporotic bone. He returned from the hospital after this surgery with decubiti on both heels. A 5/9/17 x-ray of the right hip showed no evidence of hardware complication and nearly anatomic alignment. A 7/27/17 DEXA scan report indicated a femoral neck T-score of -2.6 and of the left total hip of -2.5. He had adequate pain management post-operatively.

  From the submitted information, he had adequate evaluation and medical management of his osteoporosis. However, he has a challenging diagnosis with difficulty controlling seizures. The AMA did not include further discussion and/or recommended action to change the environment to protect him if/when he falls, such as padding on the sink, hip padding/protectors, elbow/arm protectors, review of level of supervision when standing, etc. As he will likely continue to have seizures, other approaches to injury prevention need to be developed.

- Individual #193 had a previous history of chronic venous stasis of the lower extremities associated with decreased mobility. Post-operative management of this included TED hose, sequential compression device use, and prescription of enoxaparin for deep-vein thrombosis (DVT) prevention. The 3/19/17 AMA documented black eschars of both heels following discharge from the hospital for his second hip surgery. At the recommendation of the podiatrist, on 5/11/17, he was admitted to the hospital for care of his decubiti. His left heel was debrided and no infection was found, and on 5/15/17, he returned to the Center. A post-hospital ISPA listed the following steps taken to promote healing: washing with normal saline, applying a peri-wound barrier cream and a lytic wound dressing to the ulcer, keeping his heels floating, using pressure relieving heel boots, and using a pressure guard mattress. It was determined that the PNMT would not add him to its caseload. To reduce adverse behaviors and improve compliance with accepting medication, Keppra was decreased and Onfi was started. On 5/26/17, he had a Stravid treatment to the left heel wound. As of 6/2/17, direct support professionals were able to transfer him as opposed to only

Habilitation Therapies staff. During the Monitoring Team's onsite visit, staff indicated that his heels no longer had skin breakdown.

Looking to the future, there was no notation that should Individual #193 need to go to the ED, be hospitalized, or go to another consultant's office, that his heels needed to be floated, or otherwise protected, with limited time on a stretcher or gurney. Without this warning, heel breakdown might likely occur again. He had demonstrated vulnerability in skin breakdown on both heels, but the IDT with the leadership of the PCP had not addressed how to communicate this critical information (e.g., where to place it on the transfer form, where to locate it in the electronic record so it is always communicated when transport is needed, etc.). In this case, he had appropriate evaluation and treatment to the acute heel wounds, but there was no further evaluation or development of a plan for how to prevent recurrence that would include ensuring this vulnerability was communicated during transport and to ED or hospital staff.

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

Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. However, documentation was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs/ISPs. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.

#	Indicator	Overall Score	Individuals: 96	193	268	223	173	151	198	5	152
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	100% 9/9	2/2	N/A	2/2	N/A	1/1	2/2	N/A	N/A	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.

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

#	Indicator	Overall Score	Individuals: 96	193	268	223	173	151	198	5	152
a.	If the individual has new medications, the pharmacy completes a new	Not									

	order review prior to dispensing the medication; and	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: During this review, approximately 33% of the QDRRs were completed late. It appeared that this was due to Center staff's use of outdated criteria for timeliness. During the onsite review, it appeared this misunderstanding was corrected. However, failure to correct this problem could result in Indicator a moving back to active monitoring. In comparison with the previous review, the quality of the QDRRs improved in relation to the review of polypharmacy, and anticholinergic burden. Improvement also was noted with regard to prescribers implementing agreed-upon recommendations. The Center should continue its efforts to make and sustain these improvements.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	QDRRs are completed quarterly by the pharmacist.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight. During this review, approximately 33% of the QDRRs were completed late. Failure to correct this problem could result in Indicator a moving back to active monitoring.									
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;	94% 17/18	2/2	2/2	2/2	2/2	2/2	1/2	2/2	2/2	2/2
	ii. Benzodiazepine use;	93% 14/15	2/2	2/2	2/2	1/1	N/A	2/2	2/2	2/2	1/2
	iii. Medication polypharmacy;	100% 14/14	2/2	2/2	2/2	N/A	N/A	2/2	2/2	2/2	2/2

	iv. New generation antipsychotic use; and	100% 2/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2/2
	v. Anticholinergic burden.	82% 9/11	N/A	2/2	2/2	N/A	1/1	2/2	1/2	N/A	1/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	100% 4/4	N/A	1/1	1/1	N/A	N/A	1/1	N/A	N/A	1/1
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	N/R									

Comments: a. In using the QDRRs for other portions of the review, the Monitoring Team noted that six of the 18 were late. Based on conversations with staff, the Pharmacy Department was using old criteria for the timeliness of QDRRs. During the onsite review, it appeared that Austin SSLC staff clarified this issue with State Office staff, so hopefully, by the time of the next review, it will be corrected. If not, this indicator is at risk of moving back to active monitoring.

b. Overall, the QDRRs contained valuable information, and addressed the required elements. Problems noted included:

- For Individual #151, the Pharmacist did include the most recent therapeutic level of lamotrigine.
- Individual #198's QDRR, dated 2/7/17, did not list Loratadine as a medication contributing to anticholinergic burden.
- Individual #152 was prescribed diazepam rectal gel for seizures, but the Clinical Pharmacist marked benzodiazepine use as "N/A." In addition, Individual #152's QDRR, dated 12/29/16, did not list sertraline as a medication contributing to anticholinergic burden.

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

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	96	193	268	223	173	151	198	5	152
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	0/1	0/1	0/1	N/A	0/1	0/1	N/A	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/6	0/1	0/1	0/1		0/1	0/1		0/1	
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/6	0/1	0/1	0/1		0/1	0/1		0/1	
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/6	0/1	0/1	0/1		0/1	0/1		0/1	
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/1	0/1	0/1		0/1	0/1		0/1	
Comments: a. and b. Individual #223, Individual #198 (who was edentulous), and Individual #152 were at low risk for dental, so goals/objectives were not needed. Individual #223 was part of the outcome group, so the Monitoring Team conducted a limited review. Individual #198, and Individual #152 were part of the core group, so full reviews were completed. The Monitoring Team reviewed six 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, integrated progress reports with data and analysis of the data often were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.											

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: These are new indicators, which the Monitoring Team will continue to review.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	Individuals have no diagnosed or untreated dental caries.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	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.	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	0/1
c.	Since the last exam, the individual's fair or good oral hygiene score was maintained or improved.	N/R									

Comments: Individual #198 was edentulous.

b. It is important to point out that these findings indicate that except for Individual #198, who was edentulous, all individuals reviewed had periodontal disease. Individual #152's periodontal disease worsened from Type I to Type II. Five of the remaining individuals had Type II periodontal disease, and two had Type III periodontal disease.

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: It was positive that individuals reviewed received necessary prophylactic care, and fluoride applications, and that they had treatment plans for periodontal disease that staff implemented. Given that over the last two review periods and during this review, individuals generally received prophylactic care at least twice a year, or more frequently based on their needs (Round 10 – 88%, Round 11 – 100%, and Round 12 - 100%), Indicator a will move to the category requiring less oversight. Indicators d and e will remain in active oversight. With sustained performance at the time of the next review, Indicator d might move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
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	1/1	1/1	1/1	N/A	1/1	1/1
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
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.										
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	100% 3/3	1/1	1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
f.	If the individual has need for restorative work, it is completed in a timely manner.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.										
Comments: a., d, and e. Individual #198 was edentulous. It was positive that individuals reviewed received necessary prophylactic care, and fluoride applications, and that they had treatment plans for periodontal disease that staff implemented.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	Due to the Center's sustained performance with these indicators, this outcome has moved to the category requiring less oversight.									
b.	If the dental emergency requires dental treatment, the treatment is provided.										
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.										
Comments: N/A.											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: Since the last review, improvement was noted with regard to ISPs defining individuals' suction tooth brushing supports, staff implementing the suction tooth brushing as written, and QIDPs summarizing the data monthly. These indicators will remain in active monitoring. With sustained performance at the time of the next review, Indicator c might move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	If individual would benefit from suction tooth brushing, her/his ISP	100%	N/A	N/A	1/1	1/1	1/1	N/A	N/A	N/A	N/A

	includes a measurable plan/strategy for the implementation of suction tooth brushing.	3/3									
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	100% 3/3			1/1	1/1	1/1				
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	100% 3/3			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.	100% 3/3			1/1	1/1	1/1				
Comments: a. through d. For the three applicable individuals, it was good to see that ISPs included measurable action steps defining their suction tooth brushing supports, that staff generally implemented the suction tooth brushing as written, and that the QIDPs summarized the data monthly. It also was positive that Dental Department staff were monitoring staff's implementation of suction tooth brushing to ensure staff were using the proper technique.											

Outcome 9 – Individuals who need them have dentures.											
Summary: It was positive that for the individuals reviewed with missing teeth, the dentist made recommendations regarding the appropriateness of dentures.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
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: None.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Based on information the State provided, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall	96	193	268	223	173	151	198	5	152

		Score									
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0%									
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%									
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0%									
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%									
e.	The individual has an acute care plan that meets his/her needs.	0%									
f.	The individual's acute care plan is implemented.	0%									
Comments: a. through f. Based on information the State provided, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. At least in part, the conversion to the IRIS system complicated entry of acute care plans into the system. However, this is a substantial deviation from standard practice and needs to be corrected. The Monitoring Team discussed this issue with State Office. Given that Center staff acknowledged that acute care plans have not been consistently developed and entered into the system, it was decided that the Monitoring Team would not search for needed acute care plans that might not exist in the documentation provided. However, as a result of this systems issue, these indicators do not meet criteria. Center staff should work with State Office to correct this issue.										

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	96	193	268	223	173	151	198	5	152
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.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	measurable goal/objective.	0/18									
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 #96 – weight, and fractures; Individual #193 – falls, and skin integrity; Individual #268 – cardiac disease, and infections; Individual #223 – constipation/bowel obstruction, and skin integrity; Individual #173 – falls, and constipation/bowel obstruction; Individual #151 – cardiac disease, and fractures; Individual #198 – weight, and constipation/bowel obstruction; Individual #5 – dental, and falls; and Individual #152 – choking, and weight). None of the goals/objectives reviewed were clinically relevant, achievable, and/or measurable.

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

Outcome 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.

#	Indicator	Overall Score	Individuals: 96	193	268	223	173	151	198	5	152
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	1/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/9	0/1	0/2	0/1	0/1	0/1	N/A	N/A	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).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

a. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they

were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner. The exceptions were for Individual #96 for weight, and Individual #173 for constipation/bowel obstruction.

b. The following provide examples of risks for which IDTs did not take immediate action:

- Although ISPAs demonstrated that Individual #96's IDT was aware of her weight gain issues, they did not show that the IDT identified all of the necessary action steps to address the issue. For example:
    - At the 12/7/16 ISPA meeting, the IDT did not pursue why Individual #96 did not want to stand or bear weight since her fracture that occurred during the previous year.
    - The IDT did not collect and analyze data to determine whether or not she was taking in more than her 1200 calorie diet allowed.
    - At the ISPA meeting on 12/21/16, the IDT developed a service objective for Individual #96 to self-propel her wheelchair for 10 minutes twice weekly, but did not define when exactly it would happen, who was responsible to implement this action step, and/or when it would be reviewed again for progress or lack of progress, including analyzing its impact on weight loss.
    - Until 4/7/17, the IDT did not hold additional ISPA meetings addressing weight. The documentation indicated that the service objective had not resulted in weight loss, but it was not clear if staff had implemented it consistently, and if they had, whether or not it been modified (i.e., three times a week for 15 minutes). The PNMT placed her on their caseload at this time.
    - On 6/5/17, the IDT met with the PNMT. They noted the possible root causes for weight gain were being served food that exceeded 1200 calories, Individual #96's decreased mobility, advanced aging (i.e., she was 51 years old), and reduced estrogen levels. Unfortunately, in December 2016 at the initial ISPA meeting, the IDT mentioned two of these issues (i.e., compliance with diet and mobility issues), but did not thoroughly assess and analyze them at that time.
    - Other actions to which the IDT should have given consideration, but did not, included: developing a more active engagement schedule, clearly identifying Individual #96's preferences for activities and incorporating strong preferences into activities involving movement, and conducting a vocational assessment to identify ways to increase her activity-level.
- Based on review of the documentation from nursing staff, the ISPAs, Habilitation Therapy staff, the IRRF, and the QIDP reviews, it was difficult to clearly understand the sequence of events regarding Individual #193's fall that resulted in an orbital fracture, hip fracture, hip surgery, skin issues to his elbows and heels, and a femoral fracture after his hip surgery. The lack of specific detail regarding the clinical story for these events was alarming. At the time of these events, the IDT might have been aware of the sequence of events, but at the time of the Monitoring Team's onsite review, nursing and direct support professionals staff were not able to remember details such as how the hip fracture was identified and how many times Individual #193 went to the ED or was admitted to the hospital regarding these events. Unfortunately, the documentation reviewed was fragmented and did not clearly reflect the sequence of events, which made tracking the progress of his risk areas difficult, as well as determining whether or not the IDT took the necessary actions. Given the frequent turnover of staff, it is essential that staff memorialize in writing this important medical history.
- An ISPA, dated 2/1/17, indicated that at an ISPA meeting on 12/16/16, the IDT discussed Individual #223's hospital admission on 12/12/16, for a fever and chills due to a urinary tract infection (UTI). At the 12/16/16 ISPA meeting, which was prior to her

ISP meeting on 1/12/17, the IDT discussed possible causes of the UTI as staff not cleaning her properly and "excessive loose stools." However, none of the following documents defined when she began having loose stools: the ISPA from 2/1/17, the IRRF completed on 1/12/17, the Annual Nursing Assessment dated 12/23/16, the Annual Medical Assessment dated 12/29/16, or the Nutrition Assessment dated 12/28/16. In fact, the Nutrition Assessment did not mention the loose stools. The Medical Assessment noted that Fiberstat was discontinued due to her loose stools that were "contributing to the perineal skin breakdown," but did not indicate when the medication was discontinued. The ISPA noted that from 12/28/16 through 1/28/17, she had 18 liquid stools, 25 mushy stools, one soft stool with clear cut edges, three soft sausage-like stools, and one lumpy stool. The ISPA also indicated that Augmentin was stopped on 12/20/16, Lactulose was stopped from 12/21/16 to 12/24/16, Florastor was stopped on 12/22/16, and Fiberstat was stopped on 12/28/16. However, the ISPA did not provide the dates when these medications were initiated. Although the IDT met to address her loose stools, the IDT did not clarify the following issues:

  - How long Individual #223 had been having loose stools prior to the IDT's initial meeting on 12/16/16;
  - What medications was she prescribed at the time the loose stools began;
  - The Medical Assessment noted that in 2015, she had loose stools while taking Augmentin, and the ISPA indicated she was again prescribed this medication. It was unclear whether she was prescribed Augmentin prior to the hospitalization on 12/12/16, since the documentation indicated she was having loose stools before she was hospitalized for the UTI;
  - It appeared that the Dietician was not aware of her loose stools since there was no mention of it in the Annual Assessment;
  - No analysis was found regarding her loose stools to identify trends or the possible cause(s); and
  - Although the IDT thought there might have been an association between her loose stools, and a UTI and skin breakdown, the IDT did not add any action steps to the IHCP regarding loose stools.

- On 2/8/17 and 4/24/17, Individual #173's IDT met in response to two falls. The ISPAs noted that Individual #173 had not fallen in the past year, but was rated as high risk due to her osteoporosis and high risk for fractures. Although the IDT promptly met and discussed the details of both falls, they did not develop and implement a plan to further assess Individual #173 in order to identify strategies to prevent additional falls.
- No documentation was found to show that Individual #5's IDT requested Behavioral Health Services staff assistance to gain her cooperation with oral care. The IRRF noted that when she manipulated something in her hand, she was more comfortable, and playing Spanish music made the experience a more positive one. It would stand to reason that these and possibly other strategies would be valuable in the long-run to increase her cooperation during daily oral care.
- It was concerning that Individual #5's IDT did not hold an ISPA meeting to address the fall that occurred on 1/17/17. Of additional concern, the IDT had not analyzed her falls to identify trends related to how she fell, where she fell, time of day she fell, and other potential individualized factors, including her medication changes, posture issues, visual issues related to her cataracts, seizures, environmental issues, etc. The current IHCP for this risk area included no proactive interventions and only required action after she fell.

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
Summary: For this review and the last one, the Center did well with the indicators related to: 1) nurses administering medications according to the nine rights; and 2) nurses adhering to infection control procedures while administering medications. However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will remain in active oversight as well.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R							N/A		
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 8/8	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.	50% 1/2	N/A	N/A	1/1	0/1	N/A	N/A	N/A	N/A	N/A
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	N/A									
e.	If the individual receives pro re nata (PRN, or as needed)/STAT	N/R									

	medication or one time dose, documentation indicates its use, including individual's response.										
f.	Individual's PNMP plan is followed during medication administration.	88% 7/8	1/1	1/1	1/1	1/1	1/1	0/1		1/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 8/8	1/1	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.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of eight individuals, including Individual #96, Individual #193, Individual #268, Individual #223, Individual #173, Individual #151, Individual #5, and Individual #152.

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

d. The following comments are provided:

- Individual #268 was at high risk for aspiration, and his IHCP included an action step for the assessment for lung sounds during medication administration. The medication nurse assessed his lung sounds during the medication observation in accordance with this action step. This is a very positive finding.
- Individual #223 was at high risk for aspiration, but her IHCP did not include an action step for the assessment of lung sounds during medication administration. As a result, this indicator was scored negatively. During the Monitoring Team's observations, the Nurse Educator pulled two medication nurses off the floor for immediate retraining, because they did not know the correct procedure to obtain lung sounds. The Nurse Educator performed the lung sounds to facilitate the medication pass. It was noteworthy that the Center had implemented a stringent medication administration monitoring procedure to

ensure staff are competent and to provide immediate retraining if any problematic issues are found. The procedure to provide nurses with immediate skills retraining was conducted in a professional and educational manner and did not use a punitive approach, which was good to see.

f. The medication nurse for Individual #151 did not check the position of the wheelchair. The Nurse Educator sent the medication nurse for immediate retraining, which was a positive practice.

g. For the individuals observed, nursing staff followed infection control practices, which was good to see.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: It was good to see some improvement with regard to individuals being referred to the PNMT, when needed (i.e., during the last review, the Center's score was 40%). Overall, though, IDTs and/or the PNMT did not have a way to measure outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
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% 0/15	0/1	0/1	0/2	0/2	0/2	0/1	0/2	0/2	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/15	0/1	0/1	0/2	0/2	0/2	0/1	0/2	0/2	0/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/15	0/1	0/1	0/2	0/2	0/2	0/1	0/2	0/2	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/15	0/1	0/1	0/2	0/2	0/2	0/1	0/2	0/2	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/15	0/1	0/1	0/2	0/2	0/2	0/1	0/2	0/2	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;	100% 3/3	1/1	1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A
	ii.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/3	0/1	0/1				0/1			
	iii.	Individual has a measurable goal/objective, including timeframes for completion;	0% 0/3	0/1	0/1				0/1			
	iv.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/3	0/1	0/1				0/1			
	v.	Individual has made progress on his/her goal/objective; and	0% 0/3	0/1	0/1				0/1			
	vi.	When there is a lack of progress, the IDT takes necessary action.	0% 0/3	0/1	0/1				0/1			

Comments: The Monitoring Team reviewed 15 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: choking for Individual #96; skin integrity for Individual #193; aspiration, and GI problems for Individual #268; aspiration, and choking for Individual #223; aspiration, and choking for Individual #173; choking for Individual #151; aspiration, and choking for Individual #198; choking, and falls for Individual #5; and aspiration, and choking for Individual #152.

a.i. and a.ii. None of the IHCPs included clinically relevant, achievable, and/or measurable goals/objectives.

b.i. The Monitoring Team reviewed three areas of need for three 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: weight for Individual #96, falls for Individual #193, and GI problems for Individual #151.

It was positive that when the individuals reviewed met criteria for PNMT referral, their IDTs referred them to the PNMT.

b.ii. and b.iii. Working in conjunction with Individual #96's IDT, the PNMT developed a clinically relevant goal/objective related to weight (i.e., increasing exercise). Unfortunately, it was not measurable.

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

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	67% 4/6	1/1	2/2	N/A	N/A	N/A	1/2	N/A	N/A	0/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1	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. Often, integrated reviews made statements such as "in progress," or "PNMP followed" without providing any data (e.g., monitoring data) to substantiate these statements. b. Despite the fact that IDTs rated Individual #151 and Individual #152 at risk for choking, and aspiration, respectively, the IDTs did not develop corresponding IHCPs. c. For Individual #151, the PNMT had not conducted a quality comprehensive assessment. As a result, the PNMT was not able to provide comprehensive discharge information.										

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: During numerous observations, staff failed to 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	75%	

	working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	3/4
Comments: a. The Monitoring Team conducted 37 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 10 out of 17 observations (59%). Staff followed individuals' dining plans during nine out of 18 mealtime observations (50%). Staff followed transfer instructions in two out of two observations (100%).		

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
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.	50% 1/2			0/1	1/1					
Comments: a. As noted above, it was unclear whether or not a plan for Individual #268 should have been implemented. According to the Speech Language Pathologist's notes, the plan for Individual #223 was being implemented.											

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 the 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	96	193	268	223	173	151	198	5	152
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	44% 4/9	0/1	2/2	0/1	1/1	0/1	1/1	0/1	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	44% 4/9	0/1	2/2	0/1	1/1	0/1	1/1	0/1	0/1	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/9	0/1	0/2	0/1	0/1	0/1	0/1	0/1	0/1	

d.	Individual has made progress on his/her OT/PT goal.	0% 0/9	0/1	0/2	0/1	0/1	0/1	0/1	0/1	0/1	
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/9	0/1	0/2	0/1	0/1	0/1	0/1	0/1	0/1	

Comments: a. and b. Beyond a PNMP, Individual #152 did not have any OT/PT issues requiring formal OT/PT services or supports. The goals/objectives that were clinically relevant and achievable, as well as measurable were those for Individual #198 (i.e., standing, and stand-pivot transfer), Individual #223 (i.e., initiating swallow), and Individual #151 (i.e., allowing staff to brush his teeth. A number of individuals who should have had goals/objectives to address deficits in activities of daily living, wound care, and /or a lack of environmental awareness did not.

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, integrated progress reports with data and analysis of the data were generally 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.

Individual #152 was part of the core group, so a full review was conducted for him. The Monitoring Team conducted full reviews for the remaining eight individuals as well.

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

Summary: Although some progress was noted, work was still needed to ensure OT/PT strategies are implemented and documented. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	50% 5/10	1/1	2/2	0/1	1/1	0/1	1/1	0/1	0/1	0/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	N/A									

Comments: a. At times, data was not available to show implementation of OT/PT supports.

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

Summary: It was good to see that most individuals' adaptive equipment observed appeared to fit properly. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, this indicator will remain in active

oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** due to the number of individuals reviewed for this indicator, scores continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	368	416	72	100	456	389	286	299	224
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	87% 34/39	1/1	1/1	3/3	1/2	1/2	1/1	2/2	0/1	2/2
		Individuals:									
#	Indicator		353	92	429	96	280	84	433	15	338
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	2/2	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		63	51	422	268	191	62	363	34	102
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		64	204	264						
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	0/1	2/2						
Comments: c. The Monitoring Team conducted observations of 39 pieces of adaptive equipment. Based on observation of Individual #299, Individual #64, and Individual #204 in their wheelchairs, the outcome was that they were not positioned correctly. In addition, Individual #456's palm protector was not fastened properly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors. For individuals that can reposition themselves, staff should provide reminders to ensure they are positioned safely. Individual #100's protective sleeve also was not present.											

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, dental, and communication. At the time of the last review, none of these indicators had sustained high performance scores, so none moved to the category requiring less oversight. Presently, no indicators will move to the category of less oversight.

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

QIDPs were knowledgeable regarding individuals' support needs and status. Direct support professionals were also knowledgeable about goals, support needs, and risks that were identified in the ISP. The Monitoring Team observed some great interactions between staff and individuals, particularly in the pool and during choir practice.

QIDP monthly reviews were completed for all individuals. This was a major accomplishment. They included some data for some of the action plans, but rarely included an analysis, review, or commentary on those data regarding what progress had (or had not) been made towards achievement of goals. There was little documentation of follow-up when plans were not implemented or not effective.

Attending to the status of SAPs remained an area of focus for Austin SSLC. SAPs included many of the required minimum components, but SAPs were also missing some required minimum components. Correct implementation of SAPs is an important aspect of any SAP program. It will require direct observation and feedback.

Some individuals were regularly engaged in activities when directly observed by the Monitoring Team. It was good to see that Austin SSLC had established goals for engagement. The next steps are to conduct those measurements and to meet those goals.

Since the last review, it was positive that more communication goals/objectives the Monitoring Team reviewed were clinically relevant, achievable, and measurable. In addition to continuing to improve the goals/objectives, Speech Language Pathologists should work with QIDPs to ensure that data and analysis of data related to such goals are included in integrated reviews.

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

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Given that many goals were not yet individualized and that most did not meet criterion with all three ISP indicators 1-3, the indicators of this outcome also did not meet criteria. The one goal that met criteria with these indicators was not progressing. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	193	96	341	376	173	5			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	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: 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 with indicators 1 and 2, there was no evidence that action plans to support those goals were consistently implemented because reliable and valid data were not available. For the one goal that did have data, the QIDP monthly review indicated that Individual #173 had not made progress towards her goal											

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	193	96	341	376	173	5			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	67% 4/6	1/1	1/1	1/1	0/1	1/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
Comments: 39. Overall, direct support staff were generally able to describe individual's health and behavioral risks. Most staff were											

knowledgeable regarding individuals' ISPs based on observations and interviews. This was very good to see.

ISPs rarely included detailed instructions to guide staff when implementing the ISP. Due to a lack of implementation data, it was not possible to determine if Individual #376 and Individual #5's staff were familiar with their services and supports.

40. Action steps were not regularly and correctly implemented for all goals and/or action plans for four of the individuals, as noted throughout this report. Individual #96 and Individual #173's implementation data and QIDP monthly reviews indicated that their goals were implemented, however, not at the frequency determined by the ISP. IDTs need to monitor the implementation of all action plans and address barriers to implementation.

Skill Acquisition and Engagement

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

Summary: Attending to the status of SAPs remained an area of focus for Austin SSLC. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 369	193	421	96	23	16	118	341	376
6	The individual is progressing on his/her SAPS	5% 1/20	0/3	0/2	0/3	N/A	0/3	0/1	1/3	0/2	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	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, actions were taken.	5% 1/19	0/3	0/2	0/3	N/A	1/3	0/1	0/2	0/2	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	3/3	2/2	3/3

Comments:

6. Graphs depicted progress for Individual #118 learning to access You Tube. There was also evidence of SAP integrity at 80% of better. For 18 SAPs, graphs indicated a lack of progress. For six of the SAPs, there was insufficient data to assess progress. Finally, while the graph for Individual #193 using his AAC device suggested recent improvement, overall progress was poor with limited trials presented in six of eight months.

7. In no case was the SAP objective met.

8. A review of SAP Client Progress Note and QIDP Monthly Reviews indicated that actions had been identified to address one SAP, Individual #23's learning to turn on a fan. The note indicated that behavioral health services staff would inservice staff regarding his refusals to participate in this SAP.

9. All of the SAP Client Progress Notes indicated that data were reviewed when assessing progress or the lack thereof.

Outcome 4- All individuals have SAPs that contain the required components.											
Summary: SAPs included many of the required minimum components, but SAPs were also missing some required minimum components. Details are provided in the comments below. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
13	The individual's SAPs are complete.	0% 0/26	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/2	0/3

Comments:

13. None of the SAPs were considered complete. It was positive to learn, however, that in many cases, baseline performance had been assessed (though this was typically restricted to one trial of the skill). It was also positive to observe the SAP review committee's emphasis that instructions must relate to the specific skill rather than general communication strategies.

Problems included objectives that did not specify whether the skill was to be performed independently or with prompts, schedules that did not identify the number of trials to be conducted, and the use of praise only as the consequence for correct responding. Individual specific feedback is provided below.

- Four of the individuals (Individual #369, Individual #96, Individual #23, Individual #341) were identified as having a severe visual impairment. Their SAPs did not always adequately address this sensory deficit. For example, Individual #96 was to make eye contact before pouring her milk, and staff were to provide a gestural or modeling prompt following an incorrect response on her play music SAP; a gestural prompt was included as one consequence for Individual #23 not turning on his fan or choosing a game; and Individual #341's SAP for using an adaptive switch did not include instructions to help him identify the location of the switch and his accepting a sensory ball noted that he would accept the ball through eye gaze.
- Several SAPs included instructions or other information that were not related to the identified skill. These included Individual #193's AAC SAP that referenced food in the instructions section and toothbrushing in the correct response section; and Individual #193's toothbrushing SAP that noted when served his snack he would be told to brush his teeth and referenced food in the instructions section
- Individual #421's SAP for washing her clothes included an operational definition that did not correspond to the objective. Similarly, Individual #118's SAP for handing a musical instrument to a peer noted the goal was for him to play music.
- Several SAPs included guidelines for consequences following incorrect responses in which the verbal prompt was identical to the discriminative stimulus (e.g., Individual #369 – put away work materials; Individual #421 – turn on radio, wash clothes, bathing; and Individual #118 – access You Tube and adjust volume on his headphones).
- In some cases, the identified consequence for correct responding was not appropriate. This included staff rubbing or scratching Individual #96's back as she ate her breakfast or after she put on her clothing protector; and Individual #16 being engaged in a walk following his placing the object symbol for workshop on his board.
- Individual #376's SAP for unfastening her seatbelt was addressed due to the IDT's concerns that the use of the belt was a rights restriction. Further, it was noted that she did not like to weight bear due to pain in her feet. The team should consider that

unfastening her seatbelt may be a signal that she is about to experience a potentially painful event.

Outcome 5- SAPs are implemented with integrity.											
Summary: Correct implementation of SAPs is an area of high priority for Austin SSLC. Ensuring correct implementation will require direct observation and feedback. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
14	SAPs are implemented as written.	17% 1/6	1/1	0/1	Attempted	0/1	Attempted	0/1	0/1	Attempted	0/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	8% 2/26	0/3	0/3	1/3	0/3	0/3	0/3	1/3	0/2	0/3

Comments:

14. SAP implementation was observed for six individuals. Individual #421 verbally expressed her disinterest in participating in her SAP, Individual #23 repeatedly turned away from the staff member, and Individual #341 was quite agitated during the scheduled SAP observation. For the remaining six individuals, SAPs were conducted with several staff from the behavioral health services department present. The behavior technician who wrote and provided training on the SAP was present, as were the BCBA and behavioral health services staff member who were providing supervision and support to the behavior technicians. This allowed for good review and discussion regarding written instructions, materials, and teaching techniques. Outlined below is feedback regarding individual specific SAPs.

- Individual #369: The staff member followed the SAP as written. Individual #369 was able to perform the skill, therefore, staff were advised to consider the next skill he could learn to promote greater independence.
- Individual #193: The staff member did a nice job first reviewing the two alternative buttons that Individual #193 could touch to request either a magazine or the television. He pointed to and labeled each button. However, he did not first ensure that Individual #193 was prepared to respond because he then needed to prompt Individual #193 to remove his hand from the waistband of his pants. The television was not in the immediate environment, therefore, had this been chosen, there would have been a delay in accessing the requested activity. Conversely, a box of magazines had been placed on the table directly in front of Individual #193. This resulted in his ability to access these without engaging in the communicative response. Suggestions made to the staff included the use of magazines or books that display colorful photographs versus magazines filled largely with printed material.
- Individual #96: During the observation, Individual #96 frequently pushed away from her dining table. When she finally approached, staff used repeated verbal instruction to try to engage her in the SAP. When she did finally pick up the container and pour her milk into her cereal bowl, she spilled quite a bit of milk on the table. It may be helpful to use a deeper bowl, the color of which would be in greater contrast to the table. It would also be helpful to teach Individual #96 to grasp the bowl with her left hand as she pours with her right hand. She could also learn to insert her left pointer finger in the bowl to determine when there is a sufficient amount of milk in the bowl.
- Individual #16: The staff member presented an object to Individual #16 that represented workshop. He did receive praise for

placing this on his board, but then was told that he would attend workshop in one hour. Since Individual #16 has receptive and expressive language skills, it was unclear how this SAP was going to be of benefit to him. While the goal indicates he wanted to participate in arranging his daily activities, this SAP, as written, did not address that skill.

- Individual #118: During this SAP observation, the iPad was not working properly. This resulted in Individual #118 waiting for a period of time before he could practice the skill. When the staff member presented the instruction, there were a total of six icons displayed on the screen. It was not until the staff member directed Individual #118's attention to the red icon that he was able to make the correct selection.
- Individual #376: Although the SAP instructions indicated that the yogurt or food container should be presented with the seal broken to allow for easy removal of the top lid/cover, this was not done.

15. The facility had established a schedule in which integrity of SAP implementation was to occur at a minimum of once every six months. During this process staff were able to assess via role-play or observation. As discussed with the behavioral health services staff, observation is preferred because problems with SAP implementation can only be detected when observing staff-individual interactions.

Eight of the nine individuals had integrity assessed on at least one SAP over the past six months. For three individuals, Individual #421, Individual #23, and Individual #118, at least one of their SAPs was assessed for integrity via observation. For five individuals, integrity on one to two SAPs was assessed via role-play. For four individuals, it was unclear whether SAP integrity had been assessed via role-play or observation. Integrity was not assessed for any of the SAPs for Individual #369.

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

Summary: Monthly reviews of SAPs were not evident and were not nearly as evident as during the last review. On the other hand, it was good to see graphic summaries of SAP data; this had continued since the last review. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 369	193	421	96	23	16	118	341	376
16	There is evidence that SAPs are reviewed monthly.	0% 0/26	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/2	0/3
17	SAP outcomes are graphed.	100% 26/26	3/3	3/3	3/3	3/3	3/3	3/3	3/3	2/2	3/3

Comments:

16. Data-based monthly reviews of SAPs were not consistently found in the QIDP Monthly Reviews for any of the nine individuals. Documentation provided by the facility noted that seven of the individuals (Individual #369, Individual #193, Individual #421, Individual #96, Individual #23, Individual #16, Individual #376) did not have a monthly report due in their ISP preparation and/or ISP month. Data were consistently reviewed for Individual #421's SAP for turning on her radio, Individual #96's SAPs for pouring her milk and playing her music, and both of Individual #341's SAPs. In the first review month following his recent ISP meeting, data were provided for all three of Individual #16's SAPs.

17. There were graphs depicting data for all of the SAPs that were reviewed. Staff are commended for including information regarding the number of learning opportunities (i.e., trials) that were presented each month. This allowed for corrective action to be taken not only for lack of progress, but also for poor implementation.

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

Summary: Some individuals were regularly engaged in activities when directly observed by the Monitoring Team. It was good to see that Austin SSLC had established goals for engagement. The next steps are to conduct those measurements and to meet those goals. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 369	193	421	96	23	16	118	341	376
18	The individual is meaningfully engaged in residential and treatment sites.	44% 4/9	1/1	0/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

18. During the onsite visit, the nine individuals were observed on multiple occasions. Four of these individuals were most often engaged when observed. This included Individual #369, Individual #421, Individual #16, and Individual #341. The pool area was utilized by many individuals at Austin SSLC. When Individual #341 was observed on his home, staff were either brushing him or helping him to tolerate a scheduled glove removal session. Outside of his home environment, he consistently attended his scheduled pool session. For the remaining five individuals, engagement was absent or minimal.

19-20. As explained by the quality assurance director, the goal is to monitor engagement in all homes on odd numbered months and in vocational/day program sites on even numbered months. The engagement goal is set at 80%. He added that this schedule of monitoring engagement began in April 2017.

21. The facility's goal levels of engagement were not achieved for any of the individuals. While the mean engagement scores were 80% or better in both the home and workshop/day program sites for Individual #369, Individual #421, and Individual #376, the frequency of monitoring did not meet the policy. For all others, the engagement monitoring schedule and expected level were not achieved in their home and/or workshop/day program sites.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: For about half of the individuals, regularly occurring community recreational activities were occurring, and they were occurring at the goal frequencies established by their IDTs. Next steps are to establish and meet community training goals and to address any problems or barriers for those not meeting their recreational and/or training goals in the community. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	369	193	421	96	23	16	118	341	376
22	For the individual, goal frequencies of community recreational activities are established and achieved.	63% 5/8	1/1	1/1	0/1	N/A	0/1	0/1	1/1	1/1	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. The ISPs for seven of the nine individuals identified goal frequencies of community recreational activities. The exceptions were Individual #96 who's PCP had prohibited off campus trips until her seizures were under better control, and Individual #16 for whom no goal was established. Of the seven individuals who had goals, Individual #369, Individual #421, Individual #118, Individual #341, and Individual #376 met their goal frequencies for community recreational activities.

23. None of the nine individuals had goal frequencies identified for SAP training in the community. Additionally, there was no documentation of community-based SAP training.

24. There was no evidence of ISP discussion regarding barriers to community-based recreational activities or SAP training.

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:

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	96	193	268	223	173	151	198	5	152
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A									
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									
Comments: a. through e. Based on documentation the Center submitted, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed had refused dental services.											

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: Since the last review, it was positive that more communication goals/objectives the Monitoring Team reviewed were clinically relevant, achievable, and measurable. In addition to continuing to improve the goals/objectives, Speech Language Pathologists should work with QIDPs to ensure that data and analysis of data related to such goals are included in integrated reviews. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	64% 7/11	0/1	0/1	2/2	0/1	0/1	1/1	1/1	1/1	2/2

b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	64% 7/11	1/1	1/1	2/2	0/1	0/1	1/1	1/1	1/1	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	18% 2/11	1/1	1/1	0/2	0/1	0/1	0/1	0/1	0/1	0/2
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/11	0/1	0/1	0/2	0/1	0/1	0/1	0/1	0/1	0/2
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/11	0/1	0/1	0/2	0/1	0/1	0/1	0/1	0/1	0/2

Comments: a. and b. Some of the problems noted included:

- Individual #96's communication goal/objective (i.e., to independently press a switch to activate a radio) was clinically relevant and measurable, but it was not achievable. It was positive that the goal/objective built on one of her preferences, and that it was designed to assist her in learning cause and effect. The problem was that going from dependent to independent in six months with 75% consistency was unrealistic.
- The same issue was noted for Individual #193's communication goal/objective (i.e., to make an activity selection by pushing one of the buttons on his Talkable 2).
- Individual #152's goals/objectives in the ISP (i.e., naming uncommon pictures, and naming the final word in a sentence) were clinically relevant and achievable and provided mastery criteria, but did not provide expected timeframes for completion.

The goals/objectives that were clinically relevant, as well as measurable were Individual #268's goals/objectives to push the button on his AAC device to request preferred items, and to greet others using the AAC device; Individual #151's goal to turn on an adaptive switch; Individual #198's goal to press a music device to activate music, and Individual #5's goal to press an adaptive switch to turn on music. Unfortunately, integrated progress reports did not summarize and analyze data related to these goals/objectives.

c. through e. QIDP reviews included data summaries and analysis of data for Individual #96 (i.e., press switch to activate radio), and Individual #193 (i.e., make an activity selection by pushing one of the buttons on his Talkable 2), which was good to see. As noted above, though, problems were noted with the goals/objectives.

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

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	96	193	268	223	173	151	198	5	152
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	45% 5/11	1/1	1/1	2/2	0/1	0/1	0/1	0/1	1/1	0/2

b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A										

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

- No evidence was found of review of Individual #223, Individual #173, Individual #198's communication programs/strategies.
- Individual #151's integrated reviews just stated: "no change," without providing any evidence of implementation.
- Individual #152's goals/objectives required implementation four to eight times per month. According to the QIDP interim reviews, most months, SLP staff did not implement or document implementation of the programs at even the minimum frequency.

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

Summary: The Center should focus on ensuring individuals have their AAC devices with them, and that staff prompt individuals to use them in a functional manner. These indicators will remain in active monitoring.

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

#	Indicator	Overall Score	Individuals: 429	280	102	450	16	22	268	193	319
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	38% 5/13	1/1	2/2	0/1	1/1	1/1	0/1	0/1	0/1	0/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	0% 0/13	0/1	0/2	0/1	0/1	0/1	0/1	0/1	0/1	0/1

			Individuals:								
#	Indicator		264	2							
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		0/1	0/2							
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		0/1	0/2							
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% 0/4									

Comments: a. and b. It was concerning that often individuals' AAC devices often were not present or readily accessible, and/or that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them.

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. Based on information the Center provided, since the Monitoring Team's last review, none of the individuals at Austin SSLC transitioned to the community, and no post-move monitoring had occurred. As a result, none of the outcomes or indicators in Domain #5 were applicable.

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: N/A			Individuals:									
#	Indicator	Overall Score										
1	The individual's CLDP contains supports that are measurable.	N/A										
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	N/A										
Comments: N/A												

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.												
Summary: N/A			Individuals:									
#	Indicator	Overall Score										
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	N/A										
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	N/A										
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.	N/A										
6	The PMM's assessment is correct based on the evidence.	N/A										
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	N/A										

8	Every problem was followed through to resolution.	N/A										
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A										
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A										
Comments: N/A												

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.												
Summary: N/A			Individuals:									
#	Indicator	Overall Score										
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.	N/A										
Comments: N/A												

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: N/A			Individuals:									
#	Indicator	Overall Score										
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	N/A										
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.	N/A										

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.	N/A									
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	N/A									
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	N/A									
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	N/A									
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	N/A									
19	Pre-move supports were in place in the community settings on the day of the move.	N/A									
Comments: N/A											

Outcome 5 – Individuals have timely transition planning and implementation.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score									
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	N/A									
Comments: N/A											

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
RDH	Registered Dental Hygienist
RN	Registered Nurse
SAP	Skill Acquisition Plan
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