United States v. State of Texas

Monitoring Team Report

Austin State Supported Living Center

Dates of Onsite Review: February 11th through 15th, 2019

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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 Center 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.

Restraint

In January 2019, the parties notified the Monitors that they had preliminarily agreed that Austin SSLC met substantial compliance criteria with Section C of the Settlement Agreement regarding restraint and restraint management. Therefore, pending the parties fulfilling the requirements for Austin SSLC to formally exit from Section C, the Monitoring Teams did not conduct a review of the outcomes and indicators related to Section C.

Abuse, Neglect, and Incident Management

In January 2019, the parties notified the Monitors that they had preliminarily agreed that Austin SSLC met substantial compliance criteria with Section D of the Settlement Agreement regarding abuse, neglect, and incident management. Therefore, pending the parties fulfilling the requirements for Austin SSLC to formally exit from Section D, the Monitoring Teams did not conduct a review of the outcomes and indicators related to Section D.

This Domain currently contains six outcomes and 20 underlying indicators in the areas of pretreatment sedation/chemical restraint, mortality review, and quality assurance. At the time of the last review, two of these indicators, including one entire outcome, had sustained high performance scores and moved to the category requiring less oversight. Presently, two additional indicators related to adverse drug reactions 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.

Other

IDTs were discussing pre-treatment sedation (PTS) and the required aspects of this discussion were documented, including suggested actions to reduce future need. For some individuals, but not for most, actions were developed and implemented.

For three review periods, for the individuals reviewed, staff reported potential adverse drug reactions timely, and provided affected individuals with necessary clinical follow-up. As a result, two related indicators will move to the category of less oversight.

Restraint

The parties indicated that they reached preliminary agreement that Austin SSLC met the requirements of Section C during the interim period since the last onsite review. Pending the parties' fulfillment of the requirements for a Center's release from a substantive provision of the Settlement Agreement (i.e., Section III, paragraph R), the Monitors did not conduct monitoring for Section C of the Settlement Agreement during this round of monitoring.

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

Abuse, Neglect, and Incident Management

The parties indicated that they reached preliminary agreement that Austin SSLC met the requirements of Section D during the interim period since the last onsite review. Pending the parties' fulfillment of the requirements for a Center's release from a substantive provision of the Settlement Agreement (i.e., Section III, paragraph R), the Monitors did not conduct monitoring for Section D of the Settlement Agreement during this round of monitoring.

Aspects of incident management, occurrences of abuse/neglect, and investigations will remain and/or become part of the Center's quality improvement system and will be reviewed by the Monitoring Team as part of its monitoring of Quality Assurance/Improvement (i.e., section E of the Settlement Agreement). This includes what were indicators 20-23 in previous monitoring reports as well as information on non-serious injury investigations, which was indicator 15 in previous monitoring reports.

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138

a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	N/A	N/A	N/A	0/1	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	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. As discussed in the last report, the Center's policies with regard to criteria for the use of TIVA, as well as medical clearance for TIVA, need to be expanded and improved. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures. Given the risks involved with TIVA, it is essential that such policies be developed and implemented. The term "medical clearance" incorrectly implies the procedure carries no risk for the individual. Dental surgery is considered a low-risk procedure; however, the individual may have co-morbid conditions that potentially put the individual at higher risk. Risks are specific to the individual, the specific procedure, and the type of anesthesia. The outcome of a preoperative assessment should be a statement of the risk level. The evaluation should also address, perioperative management, which includes information on perioperative management of the individual's routine medications. A number of well-known organizations provide guidance on completion of perioperative evaluations for non-cardiac surgery.

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. However, post-operative vital sign flow sheets were submitted, but they showed discrepancies between the nurses' monitoring and the requirements of the policy (i.e., the nurses did not document vital signs at the frequency the policy requires).

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

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	8% 1/12	1/5	0/1	N/A	N/A	0/6	N/A	N/A	N/A	N/A

Comments: a. For the following individuals, the Monitoring Team reviewed the following instances of pre-treatment sedation for medical procedures: Individual #2 on 7/6/18, 7/19/18, 7/26/18, 8/17/18, and 8/23/18; Individual #403 on 10/30/18; and Individual #421 on 8/28/18, 8/29/18, 8/30/18, 8/31/18, 9/1/18, and 9/2/18.

As applicable, evidence was found that the PCP obtained input from the IDT on the medication and dosage (i.e., for Individual #403, the procedure and medication administration occurred offsite, so this was no applicable). It was also positive that informed consent was obtained, and nursing staff documented pre-procedure vital signs. Of concern, for all but one instance of pre-treatment sedation (i.e., Individual #2 on 8/23/18), nurses did not follow the post-procedure vital sign assessment guidelines.

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: IDTs were discussing PTS and the required aspects of this discussion were documented, including suggested actions to reduce future need. For some individuals, but not for most, actions developed and implemented. These indicators will remain in active monitoring,			Individuals:								
#	Indicator	Overall Score	369	152	151	66	403	292	296	2	69
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	100% 6/6		1/1	1/1		1/1	1/1	1/1	1/1	
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	100% 6/6		1/1	1/1		1/1	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.	33% 2/6		1/1	0/1		0/1	1/1	0/1	0/1	
4	Action plans were implemented.	33% 2/6		1/1	0/1		1/1	0/1	0/1	0/1	
5	If implemented, progress was monitored.	17% 1/6		1/1	0/1		0/1	0/1	0/1	0/1	
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	17% 1/6		1/1	0/1		0/1	0/1	0/1	0/1	

Comments:

1. Based upon the documentation provided, it was determined that six of the nine individuals reviewed by the behavioral health monitoring team had required pretreatment sedation over the previous 12-month period. These were Individual #152, Individual #151, Individual #403, Individual #292, Individual #296, and Individual #2. For all of these individuals there was evidence of the following: discussion of the usage and effectiveness of PTS; behaviors observed during procedures; other supports that could be provided in the future; the risk/benefit of using PTS; and consent for PTS usage.

While the use of PTS was documented in the rights restriction section of each individual's ISP, it is noteworthy that the IDT determined that, for all six individuals, a desensitization plan was not needed and general anesthesia was approved as a support. As the state policy regarding PTS was revised/updated in December 2018, IDTs are advised to re-assess the restrictiveness of this practice.

2. For all six of the individuals, the IDT suggested actions to reduce the usage of PTS (though none were for systematic desensitization protocols). Plans included service objectives to support thorough tooth brushing, having the individual make regular visits to the dental clinic, having familiar or preferred staff accompany the individual to appointments, bringing preferred items to appointments, and clustering appointments so the use of PTS could be reduced.

3. For Individual #152 and Individual #292, actions were identified as service objectives in their ISPs. For all other individuals, although action plans may have been noted, these were not identified as service objectives or SAPs in their ISPs.

4. A review of QIDP Monthly Reports suggested that plans had been implemented for Individual #152 and Individual #403.

5-6. Only the QIDP Monthly Report for Individual #152 provided data (i.e., number of days in the month) regarding the number of days in the month when he completed tooth brushing. Individual #403's monthly reports reviewed the supports, but no information was provided regarding their implementation. Similarly, the monthly reports for Individual #296 provided some information on tooth brushing, but the data that were presented were difficult to interpret. In the December monthly report, there was no review of data for October 2018 and November 2018.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	347	248	309	204					
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.	50% 2/4	0/1	0/1	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, six individuals died. The Monitoring Team reviewed four deaths. Causes of death were listed as:

- On 8/30/18, Individual #347 died at the age of 52 with causes of death listed as aspiration pneumonia, and acute hypoxic respiratory failure. The administrative death review was completed one day late (i.e., clinical death review, dated 9/19/18, and administrative death review, dated 10/5/18).
- On 9/5/18, Individual #248 died at the age of 82 with cause of death listed as end-stage dementia. The administrative death review was completed two days late (i.e., clinical death review, dated 9/26/18, and administrative death review, dated 10/12/18).
- On 9/28/18, Individual #309 died at the age of 75 with causes of death listed as respiratory failure, and community acquired pneumonia.
- On 10/5/18, Individual #260 died at the age of 57 with causes of death listed as acute on chronic respiratory failure, recurrent aspiration pneumonia, and chronic hypoventilation.
- On 11/23/18, Individual #204 died at the age of 80 with cause of death listed as respiratory failure secondary to severe dysphagia complicated by failure to thrive.
- On 12/19/18, Individual #417 died at the age of 72 with cause of death listed as end-stage Parkinson's disease.

b. through d. Evidence was not submitted to show the Center staff conducted thorough reviews of nursing care, or an analysis of medical/nursing reviews to determine additional steps that should be incorporated in the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews. Examples of problems included:

- Some recommendations generated from the physician reviews were not included in either the administrative or the clinical death reviews without explanation.
- For three of the individuals, the Center provided a Quality Assurance Death Review of Clinical Services that did not reflect a comprehensive review of nursing care and services for the past six months. For example, the nurse reviewer did not conduct reviews of the quality of the IRRFs, IHCPs and their implementation, risk ratings, or regular and acute assessments. At times, reports indicated that the individuals' risk areas were "aligned" in the IRRF and nursing assessments, but the reviewer did not analyze whether or not these documents were clinically sound, complete, or if the IHCP interventions met the individual's needs and staff implemented them.
- For the fourth individual (i.e., Individual #204), the Center submitted a statement that the: "Nursing death review cannot be located at this time."
- For Individual #347, the Quality Assurance Death Review of Clinical Services report identified issues regarding the documentation of the actual number of episodes of emesis that the individual experienced, and for which the nurse performed suctioning prior to the individual being sent to the hospital on 8/29/18 (i.e., the individual died on 8/30/18). However, the recommendation was: "Will develop an in-service to address emesis protocol for suctioning," which did not specifically address the issues identified.

e. The recommendations generally were not written in a way that ensured that Center practice had improved. For example, a Clinical Death Review recommendation was for nursing staff to receive an in-service training regarding the use of suctioning at the time of

emesis or when aspiration was suspected. The recommendation indicated that such training would be provided for new employee orientation training. The Center provided the curricula and training rosters for the in-service training provided to existing nurses. However, there was no indication that any monitoring was implemented to ensure the training was effective. In addition, there was no indication that the training was being included in new employee orientation.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: Given that for three review periods, staff reported ADRs for individuals reviewed timely (Round 11 – 100%, Round 13 – 100%, and Round 14 - 100%), and the individuals received necessary clinical follow-up (Round 11 – 100%, Round 13 – 100%, and Round 14 - 100%), Indicators a and b will move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	ADRs are reported immediately.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A
b.	Clinical follow-up action is completed, as necessary, with the individual.	100% 1/1								1/1	
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A								N/A	
d.	Reportable ADRs are sent to MedWatch.	N/A								N/A	
Comments: a. through d. On 1/7/19, Individual #212 was admitted to the hospital, and her sodium and potassium were low. The PCP was notified of the potential ADR, for which the bisacodyl rectal suppository was suspected. At the time of the onsite review, the P&T Committee had not met to review it yet, but a meeting was scheduled in February 2019. The low sodium and potassium levels resolved while the individual was in the hospital.											

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		
#	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, these indicators 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, 26 of these indicators 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 ISPs, psychiatry, and dental.

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

Assessments

For all individuals, IDTs considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting. Half of the IDTs then arranged for and obtained all of those needed, relevant assessments prior to the annual meeting.

In psychiatry, the comprehensive psychiatric evaluations (CPEs) and CPE updates were prepared and submitted to the IDT in a timely manner.

All individuals reviewed had a current behavioral health assessment. The assessment was complete in content for three individuals. The functional behavior assessment was complete for half of the individuals.

All nine individuals had current Functional Skill Assessments (FSAs), Preference and Strength Inventories (PSIs), and vocational assessments. Recommendations for skill development were evident in both the FSA and vocational assessment for most individuals. The recommendations, however, were for a very limited number and range of recommended skill acquisition programs (SAPs). This resulted in very limited skill development for the individuals. Staff should consider skill development across all 13 domains assessed in the FSA.

For the individuals' risks reviewed, IDTs continued to struggle to effectively use supporting clinical data (including comparisons from year to year). 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.

Four of the nine individuals had quality annual medical assessments (AMAs) that included the necessary components and addressed individuals' needs. The remaining AMAs included much of the necessary information. However, moving forward, the Medical Department should focus on ensuring AMAs include thorough plans of care for each active medical problem, when appropriate.

For this review and the previous two reviews, the Center sustained high performance with regard to the completion of quality comprehensive annual dental examinations. As a result, the related indicator will move to the category of less oversight. Center staff also attended to some timeliness issues for dental examinations noted in the two previous reports, which was good to see. The Center had also made improvement in ensuring the timeliness and quality of annual dental summaries.

For the nine individuals reviewed, nurses completed timely annual nursing reviews and physical assessments, as well as timely quarterly nursing record reviews and/or physical assessments. It was also positive that for the individuals reviewed, nurses completed annual and quarterly physical assessments that addressed the necessary components. Work is needed to ensure that nurses complete thorough record reviews on an annual and quarterly basis. Of particular concern, 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 a Registered Nurse (RN) Post-Hospitalization Review was completed for most of the individuals who needed them, and the Physical and Nutritional Management Team (PNMT) discussed the results. However, problems were noted with IDTs making timely referrals of individuals to the PNMT, and/or the PNMT making self-referrals. In addition, the PNMT should focus on the completion of PNMT reviews and/or comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT reviews and comprehensive assessments.

Seven of the nine individuals reviewed received timely Occupational and Physical Therapy (OT/PT) assessments and/or reassessments based on changes of status. The quality of OT/PT assessments continues to be an area on which Center staff should focus.

Individuals reviewed generally received timely communication assessments for ISPs and in accordance with their individualized needs (i.e., they received the type of assessment they needed). Significant work continued to be needed to improve the quality of communication assessments and updates in order to ensure speech language pathologists (SLPs) provide IDTs with clear understandings of individuals' functional communication status; IDTs have a full set of recommendations with which to develop

plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated.

Of note, as part of the onsite review week, the Monitoring Team appreciated the Habilitation Therapy Director's willingness to conduct an objective review of one individual's OT/PT and communication assessments, review the findings with the State Office Discipline Lead, and then discuss her findings openly with the members of the Monitoring Team and State Office staff. This effort showed Center staff's ability to identify strengths and weaknesses in the assessments, as well as to identify potential solutions to the essential improvements that are needed with regard to the assessments.

Individualized Support Plans

There was some progress towards writing individualized, measurable goals and IDTs were doing a better job documenting the rationale for goals.

- These goals, however, were rarely aspirational and offered few opportunities to learn new skills that might lead towards living and working in a less restrictive environment.
- For the goals that were aspirational, action plans were not developed that would lead towards the accomplishment of goals.
- Few action plans were fully implemented, and few had instructions that provided staff guidance to ensure consistent implementation.

During interviews with Qualified Intellectual Disability Professionals (QIDPs) and based upon Monitoring Team direct observations, it was evident that most IDTs were open and enthusiastic about providing new opportunities to individuals. It will be important for the IDTs to work together to develop action plans and supports that provide a clear path to implementing plans. Then teams need to closely monitor the implementation of ISPs and address any barriers to implementation and to achieving goals.

The living options discussion section of the ISP meeting observed by the Monitoring Team did not show the same depth of discussion as observed during the last review. The number of individuals who had full and appropriate attendance and participation at their annual ISP, however, increased compared with previous reviews. Individuals continued to attend their ISP meetings.

In psychiatry, progress was seen in the identification of psychiatric indicators and their relationship to diagnoses. There was also progress in the development of goals for some individuals for some of the two types of goals (regarding psychiatric indicators for decrease and for increase). The collection of reliable data remained a need at Austin SSLC.

An annual ISP observed by the Monitoring Team contained good psychiatrist participation. This was not evident in the written ISP document for the other individuals. It may be that participation was occurring, but was not being captured in the written document.

In behavioral health, Austin SSLC should focus strongly on obtaining data that are reliable. This sets the foundation for assessment and for making treatment decisions (for behavioral health, psychiatry, etc.). Further, it is a hallmark of applied behavior analytic intervention. Many behavior occurrences were not recorded at all.

One Positive Behavior Support Plan (PBSP) was considered complete in content, but all of the other plans included most required components.

SAPs continued to improve. Austin SSLC was collecting reliable data on most SAPs. This was good to see and will be an important foundation for continued development of the skill acquisition program at the Center. About one-third to one-half of SAPs were based on assessments and/or were practical, functional, and meaningful,

Behavioral Health Services (BHS) staff involved in SAP development and implementation remained very open to suggestions and further discussion regarding teaching strategies.

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. Often, IDTs had not addressed the underlying cause or etiology of the individuals' at-risk health concerns in the action steps. In addition, many action steps were not measurable.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.												
Summary: Performance remained about the same as at the previous review. That is, all individuals had at least one goal that met criterion for individualization, but just a subset of those were written in measurable terminology and there were problems in obtaining reliable data to determine individual's progress towards meeting the goal. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	403	2	152	369	421	227			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	2/6	1/6	3/6	2/6	4/6	4/6			

2	The personal goals are measurable.	0% 0/6	2/6	1/6	2/6	1/6	2/6	1/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	1/6	0/6	0/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #403, Individual #2, Individual #152, Individual #369, Individual #421, and Individual #227. The Monitoring Team reviewed in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Austin SSLC campus.

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

There was some progress towards writing individualized, measurable goals and IDTs were doing a better job documenting the rationale for goals. These goals, however were rarely aspirational and offered few opportunities to learn new skills that might lead towards living and working in a less restrictive environment. For this review period, none of the six ISPs contained individualized goals in all areas, therefore, none had a comprehensive set of goals that met criterion. However, each of the ISPs contained an individualized goal in at least one area.

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

The personal goals that met criterion were:

- Leisure goals for Individual #152, Individual #421, and Individual #227.
- These did not met criterion:
    - Individual #403 had a goal to request her weighted blanket. Staff reported that she was already able to request her blanket when wanted.
    - Individual #2's goal to use his music player daily was continued from the previous ISP and staff reported that he was able to complete this independently.
    - Individual #369's goal to plan a dance was also continued from the previous year and was only scheduled one time annually. The IDT needs to consider exposure to new activities that might expand Individual #369's leisure time choices.
- Relationship goals for Individual #152, Individual #369, Individual #421, and Individual #227.
- These did not met criterion:
    - Individual #403's relationship goal to attend community outings with peers from her home occurred routinely for all women in the home.

    - Individual #2's relationship goal to bowl in the day program with a friend was also continued from the previous year. Staff reported that this is not a new activity, he was offered the opportunity to bowl daily when attending day programming.
- Work/School/Day goals for Individual #152, Individual #369 and Individual #227.
- These did not met criterion:
    - Individual #403, Individual #421, and Individual #2's work/day goals were not aspirational (they did not offer opportunities to learn new skills).
- Independence goal for Individual #403 and Individual #421.
- These did not met criterion:
    - For the other four, goals did not address new skills that were likely to lead towards greater independence.
- Living options goals for Individual #403, Individual #2, Individual #421, and Individual #227.
- These did not met criterion:
    - Individual #152 and Individual #369's goals would not lead towards living in a less restrictive environment and were not aspirational.

The Monitoring Team observed Individual #369's annual ISP meeting. The IDT agreed to continue all of his goals from the previous year with little modification. There was no discussion regarding opportunities to learn new skills or experience new activities. His goals were unlikely to lead him towards living or working in a less restrictive setting.

2. Of the 16 personal goals that met criterion for indicator 1, nine also met criterion for measurability. Those that did not meet criterion were:

- Individual #152 and Individual #369's work/day goal did not include a proposed timeline for completion.
- Individual #421's relationship goal did not include a measurable objective to determine if it was successfully completed. Her living option goal did not include a proposed timeline for completion.
- Individual #227's recreation and work/day goals did not include a measurable objective. Her living option goal did not include a proposed timeline for completion.

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 (Individual #403's goal for greater independence) had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals. Many of the goals had not been implemented.

As noted throughout this report, for all of the other goals, it was not possible to determine if ISP supports and services were being regularly implemented or to determine the status of goals because of the lack of reliable data and documentation provided by the Center. While there were some data collected showing implementation of some action plans, there was not enough information documented to clearly determine the status of goals.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: The 11 indicators in this outcome get at the overall quality and depth of the ISP as it relates to the individual and his or her preferences, needs, and supports. The Monitoring Team looks at the action plans as well as the overall content of the ISP to making scoring determinations. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	403	2	152	369	421	227			
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.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	1/6	0/6	0/6	0/6	1/6	0/6			
Comments:											

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

IDTs still needed to focus on laying out a clear path of assertive action plans to meet each goal. Some goals had no action plans that were clearly related. For example,

- Individual #369's goal to work in a recycling job in the community had one action plan related to operating a shredder at the sheltered workshop. This action plan was unlikely to lead towards employment at a recycling job in the community.
- Individual #152's goal to compete in a special Olympics swimming event had one related action plan to attend a UT swimming event. It's not clear how this might lead towards achievement of his goal.
- Two of the goals in the six ISPs met criterion. Those were Individual #403 and Individual #421's greater independence goals.

Most of the action plans were written as service objectives and did not include staff instructions or implementation strategies that would ensure staff could consistently teach a new skill or accurately collect data on progress. Many action plans stated what staff would do, but not what action the individual would take to show progress towards accomplishing his/her goal, thus, data often indicated how many times staff had implemented the plan instead of measuring specific progress towards the goal.

9. None of the ISPs had action plans that integrated preferences and opportunities for choice. For the most part, goals and action plans were based on individual preferences, however, opportunities for making choices were limited. Action plans ensuring opportunities for work and day programming based on preferences were particularly limited.

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

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

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

11. None of the ISPs met criterion for this indicator to support the individual's overall independence.
Assessments and interviews indicated that many of the action plans were compliance plans written for skills that the individual could already complete independently.

12. None of the ISPs integrated strategies to minimize risks in ISP action plans. While risks were addressed through action plans included in the IHCP, supports were not routinely integrated into other action plans when relevant, and risks were not always identified by the IDT. Rarely were SAPs written to provide staff with strategies for implementing plans and, when SAPs were written, they did not

include specific mobility, behavioral, and safe eating supports.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well integrated in ISPs. In most cases, supports were fragmented, with little evidence that IDT members were sharing data and collaborating on developing supports. For example,

- Individual #403 did have a goal to use sign language to request her weighted blanket, however, communication strategies were not integrated into other action plans. The ISP should offer many opportunities throughout the day to expand Individual #403's functional communication skills.
- Individual #2's IDT agreed to discontinue use of his AC device without considering other ways to expand his communication skills. Communication strategies were not integrated into action plans to support his goals.
- Recommendations from Individual #369's orientation and mobility assessment were not integrated into action plans to support his goals. The IDT should work with the orientation and mobility specialist to create new opportunities to develop new skills.
- Individual #2 had complex medical issues that had not been addressed in an interdisciplinary approach. Medical and behavioral team members need to work with other team members to develop a comprehensive plan to meet his changing healthcare needs.

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

14. None of the ISPs included action plans to support meaningful integration into the community. Individuals made trips into the community, but were not given opportunities to utilize community resources that might support them to be more independent and integrated into the community. Individuals did not have goals for banking, volunteering, getting haircuts, joining a church, or joining a gym in the community. Outings were limited to specific events, such as eating out, going to the movies, or attending a sporting event. While these types of activities support community exposure, they are unlikely to lead to meaningful integration.

15. None of the ISPs documented the IDT's consideration of opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Individual #152, Individual #369, and Individual #421 were working in the sheltered workshop and had goals for more independent/integrated employment, however, none had action plans to support achievement of their work goals.

16. ISPs did not support substantial opportunities for functional engagement described with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Overall, the ISPs provided limited opportunities for learning and functional skill development. During observations, activities were rarely functional and did not provide opportunities to experience new things and learn new skills. IDTs need to expand the preference assessment to offer more opportunities to try new things and identify new interests. Document review and observations did not support that Individual #403, Individual #2, and Individual #227 were engaged in meaningful day programming or had opportunities to learn new skills that might lead towards a more meaningful day. As noted for indicator 15, Individual #152, Individual #369, and Individual #421 were working, however, they did not have

opportunities to develop new vocational skills or identify new work preferences.

Individuals were scheduled for four hours of day programming each day. During the onsite monitoring visit, it was noted that for all day programs, individuals generally arrived late to the day programs and left early. The facility had developed other activities to occur between morning and afternoon programming including art activities, swimming, cooking classes, recreational activities, and computer lab. While these sessions could have offered other opportunities for active treatment and skill building, they also were not consistently staffed and available. Attendance was low in most sessions observed and training was not functional.

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

18. Action plans did not describe detail about data collection and review, in almost all cases. The two exceptions were Individual #403 and Individual #421's action plans/skill acquisition plans related to their greater independence goal. Overall, ISPs did not usually include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action plans were broadly stated, not individualized, and, in most cases, skill acquisition plans were not developed when needed to ensure consistent training strategies were implemented.

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

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
Summary: The living options discussion section of the ISP meeting observed by the Monitoring Team did not show the same depth of discussion as observed during the last review (indicators 20, 25, and 27). For the other indicators, performance was about the same as last review, with some indicators scoring slightly higher and some slightly lower. Two indicators, however, showed sustained high performance, regarding the ISP statement (indicator 22) and listing obstacles (indicator 24). Therefore, these two indicators will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	403	2	152	369	421	227			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the	50% 3/6	0/1	1/1	0/1	0/1	1/1	1/1			

	IDT (e.g., communication style, responsiveness to educational activities).										
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	0% 0/1				0/1					
21	The ISP included the opinions and recommendation of the IDT's staff members.	67% 4/6	1/1	1/1	0/1	0/1	1/1	1/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	50% 3/6	0/1	0/1	1/1	0/1	1/1	1/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	83% 5/6	0/1	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.	0% 0/1				0/1					
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 0/1				0/1					
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	0% 0/2	0/1				0/1	0/1			

Comments:

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

- Individual #403 lived at the Center since she was nine years old. Her ISP noted that her current placement was not optimal for her and that she would prefer a less crowded environment. The team agreed to explore moving her into another home at Austin SSLC. The ISP did not document discussion regarding other living options that might support her preferences and needs.
- Individual #152 lived at Austin SSLC since 1999. His ISP noted that his preferences were based on staff observations. The IDT agreed that he should continue to live in his current home. They did not document discussion regarding other living options

that might support his preferences and needs.
- Individual #369's ISP indicated that he was unable to make an informed decision regarding living options. The IDT agreed that he should continue his current placement.

20. Individual #369's ISP meeting was observed by the Monitoring Team. The IDT did not discuss living options that might support his needs. He was asked if he wanted to "live here" at his meeting and he responded, "yes." It was not clear that he was aware of any other options.

21. Four ISPs included the opinions and recommendation of the IDT's staff members.
- Independent recommendations from Individual #152's and Individual #369's IDT all concluded that they could live in the community and recommended referral. His summary statement indicated that the IDT did not agree with making a referral to the community.

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

23. Three of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths. Individual #403, Individual #2, and Individual #369's ISPs did not indicate that the IDT had considered other living options.

24. Five ISPs identified a list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed. Individual #403's IDT did not define obstacles to living in the community in a manner that would allow the team to address barriers.

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

25 and 27. Individual #369's ISP meeting was observed. The IDT did not clearly define obstacles to referral or develop measurable action plans to address any obstacles.

28. Individuals did not have individualized and measurable action plans to educate the individual and/or LAR on living options that might be available to support their needs. All ISPs included action plans for the individual to attend a provider fair and group home tours, however, these were not individualized based on the individual or LAR's current knowledge regarding living options or specific to living options that could provide identified supports needed in the community.

29. IDTs had not developed action plans to facilitate the referral if no significant obstacles were identified.
- Individual #403's IDT did not identify significant obstacles and did not refer her for community placement.
- Individual #421's IDT agreed to refer her for community placement, however, action plans were not developed to facilitate her referral.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.												
Summary: ISPs were not fully implemented within 30 days; this was a decrease since the last review. The number of individuals who had full and appropriate attendance and participation at their annual ISP, however, increased compared with previous reviews. Individuals continued to attend their ISP meetings. This has been the case for almost all individuals (i.e., all but one) at each of the past three reviews. Given this sustained high performance, indicator 33 will be moved to the category of requiring less oversight. The other two indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	403	2	152	66	421	227				
30	The ISP was revised at least annually.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A										
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	83% 5/6	1/1	0/1	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.	67% 4/6	0/1	1/1	1/1	1/1	1/1	0/1				

Comments:

32. Documentation was not submitted that showed that action plans were implemented within a timely basis for any of the individuals.

33. Five individuals attended their ISP meetings. Individual #2's ISP indicated that neither he nor his LAR attended his ISP meeting.

34. Four of the individuals had an appropriately constituted IDT based on the individual's strengths, needs, and preferences, who participated in the planning process.

- Individual #403's PCP did not attend her ISP meeting. She had significant health issues that were impacting all areas of her life. The PCP's input would be beneficial in planning for her day and support needs.
- Individual #227's SLP did not attend her meeting. Communication supports were not integrated into her ISP.

Outcome 6: ISP assessments are completed as per the individuals' needs.	
Summary: For the first time, Austin SSLC met criteria regarding determining assessments for all individuals (indicator 35). These two indicators will remain in	Individuals:

active monitoring.											
#	Indicator	Overall Score	403	2	152	369	421	227			
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.	100% 6/6	1/1	1/1	1/1	1/1	1/1	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	0/1	1/1	0/1			

Comments:

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

36. Three IDTs did not arrange for and obtain all needed, relevant assessments prior to the IDT meeting.
    - Individual #2 and Individual #227's nutritional assessment was not submitted 10 days prior to his annual ISP meeting for review.
    - Individual #369's behavioral and psychiatric assessment were not submitted 10 days prior to his annual ISP meeting for review.

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

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
Summary: Continued attention to improving the meaningfulness of the QIDP monthly review of the ISP was needed. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	403	2	152	369	421	227			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

37. The IDT reviewed supports, services, and serious incident. This was good to see, however, IDTs did not routinely revise supports or goals or address barriers when progress was not evident. As noted in other sections of this report, data were rarely available to assist the IDT in decisions regarding revising the ISP.

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

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

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

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

Outcome 1 – Individuals at-risk conditions are properly identified.

Summary: 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.

#	Indicator	Overall Score	Individuals: 2	403	450	172	421	227	260	212	138
a.	The individual's risk rating is accurate.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	56% 10/18	1/2	1/2	1/2	1/2	1/2	2/2	0/2	1/2	2/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #2 – falls, and constipation/bowel obstruction; Individual #403 – falls, and choking; Individual #450 – osteoporosis, and seizures; Individual #172 – falls, and constipation/bowel obstruction; Individual #421 – constipation/bowel obstruction, and infections; Individual #227 – skin integrity, and choking; Individual #260 – gastrointestinal (GI) problems, and cardiac disease; Individual #212 – constipation/bowel obstruction, and choking; and Individual #138 – constipation/bowel obstruction, and fractures].

a. Although IDTs appeared to use the risk guidelines, none of the IDTs effectively used supporting clinical data when determining a risk level.

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 #2 – constipation/bowel obstruction; Individual #403 – choking; Individual #450 – osteoporosis; Individual #172 – constipation/bowel obstruction; Individual #421 – constipation/bowel obstruction; Individual #227 –skin integrity, and choking; Individual #212 – choking; and Individual #138 – constipation/bowel obstruction, and fractures.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.

Summary: Although scores for all four indicators were 0%, progress was seen as evident in the 1/2 scores for six individuals for indicator 4. This was for the identification of psychiatric indicators and their relationship to diagnoses. There was also progress in indicators 5 and 6, in that goals and updated goals were evident for some individuals for some of the two types of goals (regarding psychiatric indicators for decrease and for increase). The collection of reliable data remained a need at Austin SSLC. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	369	152	151	66	403	292	296	2	69
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	0% 0/8	1/2	1/2	1/2	0/2	1/2	0/2		1/2	1/2
5	The individual has goals related to psychiatric status.	0% 0/8	0/2	0/2	0/2	0/2	0/2	0/2		0/2	0/2
6	Psychiatry goals are documented correctly.	0% 0/8	0/2	0/2	0/2	0/2	0/2	0/2		0/2	0/2
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8	0/2	0/2	0/2	0/2	0/2	0/2		0/2	0/2

Comments:
The scoring in the above boxes has a denominator of 2, which is comprised of whether criteria were met for all sub-indicators for psychiatric indicators/goals for (1) reduction and for (2) increase.

Note that there are various sub-indicators. All sub-indicators must meet criterion for the indicator to be scored positively.

One of the individuals did not need and was not receiving psychiatry services.

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

In behavioral health services positive behavior support plans (PBSPs), the focus is upon what are called target behaviors and replacement behaviors. These are the observable, measurable behaviors for reduction and for increase, respectively. They are hypothesized to be, for the most part, under operant control. A functional assessment is conducted to determine the variables that set the occasion for, and maintain, target behaviors (i.e., their function). Replacement behaviors are chosen to provide a functionally equivalent, more socially appropriate alternative to the target behavior. Replacement behaviors sometimes need to be taught to the individual. Many times, however, replacement behaviors are already in the individual's repertoire, in which case the task for the Center is to set the occasion for those replacement behaviors to occur, be reinforced, and maintained.

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

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

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

4a. There was at least one psychiatric indicator for reduction for all of the individuals in the review group, except for Individual #66. Similarly, psychiatric indicators for increase were identified for all of the individuals, except Individual #66.

4b. There was an explanation describing the relevance of the indicators for reduction to the individual's diagnosis for all of the individuals, except Individual #66. For psychiatric indicators for increase, rationale for the indicator could be linked to the diagnosis for three individuals: Individual #369, Individual #152, and Individual #292.

4c. The indicators for reduction were defined in observable terms for six of the individuals, that is, all except for Individual #66 and Individual #292. The psychiatric indicators for increase were described in observable terminology for three of the individuals: Individual #403, Individual #2, and Individual #69.

Thus, criteria were met for all three sub-indicators (a, b, c) for psychiatric indicators for reduction for six individuals. For psychiatric indicators for increase, the criteria for all three sub-indicators were met for none of the individuals, but criteria were met for some individuals for each of the three sub-indicators. Overall, criteria were met for all three sub-indicators for both types of psychiatric indicators for none of the individuals.

5. Psychiatric goals:
The Monitoring Team looks for:
d. A goal is written for the psychiatric indicator for reduction and for increase.
e. The type of data and how/when they are to be collected are specified.

5d. A goal for the psychiatric indicator to decrease was written for seven of the individuals, that is, all except Individual #66 and Individual #69. Similarly, a goal was written for the psychiatric indicators for increase for all individuals, except Individual #66 and Individual #69.

5e. There were no further instructions for how and when the data were to be collected beyond the initial description of the indicator to decrease for any of the individuals. Similarly, for psychiatric indicators for increase, the type of data and how to collect those data were not written in an understandable manner for any of the individuals.

Thus, for indicators for reduction, both sub-indicators were met for none of the individuals. For indicators for increase, the two sub-indicators were met for no individuals. Overall, criteria were met for both sub-indicators for both types of psychiatric indicators for no individuals. That being, said, there was progress in the development of goals (sub-indicator d).

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

6f. The goals for reduction did not yet appear in the IHCP section of the ISP. The psychiatry department continued to explore methods to make it possible to have the goal grids appear in the IHCP section in the same manner as other goals for other disciplines. Thus, similarly, the goals for the psychiatric indicators for increase did not appear in the IHCP in the ISP for any of the individuals.

6g. There was documentation that the goals for the indicator to reduction were updated in the quarterly reviews for Individual #369, Individual #152, Individual #151 and Individual #2. The goals for the psychiatric indicators to increase were modified over the year for Individual #369, Individual #152, Individual #151, and Individual #2.

Thus, for indicators for reduction and increase, both of the indicators 6f and 6g were not met for any individuals, though criteria for one of these two indicators, 6g, were met for four individuals.

7. Data:
Reliable and valid data need to be available so that the psychiatrist can use the data to make treatment decisions. Data are typically presented in graphic or tabular format for the psychiatrist. Data need to be shown to be reliable. Reliability assessments are often done by behavioral health services, residential, or psychiatry staff. In addition to using data regarding psychiatric goals/indicators, psychiatrists often utilize behavioral health services target/replacement behavior data as supplemental information when making treatment decisions.

7. Data were not shown to be reliable and/or data were not available. In a comment on the draft version of this report, the Center wrote that behavioral health had recently implemented a new psychiatric template for quarterly reviews and follow-up in collaboration with psychiatry. The Center wrote that this new template included measures of data timeliness and IOA.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: With sustained high performance, both indicators might be moved to the category of requiring less oversight after the next review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 369	152	151	66	403	292	296	2	69
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 within two years prior to the onsite review, and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	100% 3/3				1/1	1/1				1/1
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	0/1

Comments:
15. Individual #69, Individual #403, and Individual #66 had been admitted within the prior two years. The records of both individuals contained a CPE that had been done within 30 days of admission and an admission IPN which was done on the day of admission.

16. The psychiatric diagnoses were consistent in the medical, behavioral health and psychiatric sections of the record for all the individuals, except Individual #69.

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

Summary: Psychiatric documentation was not submitted to the IDT within the required timeframe for two individuals (indicator 19). An annual ISP observed by the Monitoring Team contained good psychiatrist participation. This was not evident in the written ISP document for the other individuals. It may be that participation is occurring, but is not being captured in the written document. Indicator 21 will remain in active monitoring. Indicator 19 will remain in the category of requiring less oversight and is not in danger of being returned to active monitoring, however, given documentation was not submitted within required timeframe for two individuals (25%), the Center should make sure this is done going forward for all individuals.

#	Indicator	Overall Score	Individuals: 369	152	151	66	403	292	296	2	69
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.										
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	13% 1/8	1/1	0/1	0/1	0/1	0/1	0/1		0/1	0/1

Comments:

19. The CPEs and CPE updates were prepared and submitted to the ISP team in a timely manner at least 10 days prior to the ISP for all of the individuals, except Individual #2 and Individual #69.

21. The ISP met the content requirements for one of the individuals, Individual #369. A consistent finding in the other ISPs was the lack of references to the psychiatrist's participation in the meeting. The Monitoring Team observed Individual #369's ISP on 2/11/19. The facility psychiatrist was an active participant in the meeting. He led the discussion of his psychiatric treatment plan including the risk benefit discussion and future plans regarding the psychotropic medications. Individual #369's mother was also present at the meeting and it was clear that she had a good working relationship with the psychiatrist.

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

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.												
Summary: Signed consent forms were present and met criteria for indicator 28 for all individuals for this review and the last two reviews, too (with one exception at the last review). Given this sustained high performance, indicator 28 will be moved to the category of requiring less oversight. With sustained high performance, the same might occur for indicator 31 after the next review, too. It will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	369	152	151	66	403	292	296	2	69	
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1	
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
30	A risk versus benefit discussion is in the consent documentation.											
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1	
32	HRC review was obtained prior to implementation and annually.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments:												

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.												
Summary: Austin SSLC should focus strongly on obtaining data that are reliable. This sets the foundation for assessment and for making treatment decisions (for behavioral health, psychiatry, etc.). Further, it is a hallmark of applied behavior analytic intervention. As noted below, many behavior occurrences were not recorded at all. Indicator 5 will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	369	152	151	66	403	292	296	2	69
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.										
3	The psychological/behavioral goals/objectives are measurable.										
4	The goals/objectives were based upon the individual's assessments.										
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8	0/1	0/1	0/1	0/1	0/1		0/1	0/1	0/1

Comments:

5. Based upon a review of monthly PBSP progress notes and six months of completed monitoring forms, there was evidence of regular assessment of inter-observer agreement for Individual #403 and Individual #296. Further, although the facility continued to assess data entry every two hours, reporting of data timeliness was either inconsistent or below established levels for all of the individuals.

During the onsite visit, several individuals were observed engaging in identified problem behaviors. A check of their PBSP data revealed the following:

- Individual #69 swore during lunch on 2/12/19, but this was not recorded.
- Individual #374 cleared the table top, hit a staff member, and yelled at 5:05 pm on 2/12/19. Data sheets printed on 2/13/19 did not document these behaviors, while data sheets printed on 2/14/19 did document aggression.
- At the same time, Individual #421 was observed pushing a peer, but this was not documented.
- Individual #296 was observed ripping his shirt at 4:45 pm on 2/13/19, but this was not documented.
- Individual #66 was observed attempting to leave the facility and hitting staff at approximately 5:30 pm on 2/13/19. These behaviors were recorded.
- Individual #15 was observed screaming at 1:25 pm on 2/13/19, but the facility reported that she did not have a PBSP.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.											
Summary: Indicator 10 scored lower, and indicator 12 scored higher, than at the last review. Attention to a few more details of the requirements of both indicators might lead to sustained higher performance. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	369	152	151	66	403	292	296	2	69
10	The individual has a current, and complete annual behavioral health update.	33% 3/9	1/1	1/1	0/1	0/1	1/1	0/1	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.	63% 5/8	1/1	0/1	1/1	0/1	1/1		1/1	0/1	1/1

Comments:
10. All nine individuals had a current behavioral health assessment. However, the assessment was complete for three individuals (Individual #369, Individual #152, Individual #403). For all others, there was no review of his/her physical health over the previous 12 months. Additionally, Individual #296's assessment did not include an evaluation of his cognitive abilities.

12. The functional behavior assessment was considered complete for Individual #369, Individual #151, Individual #403, Individual #296, and Individual #69. Although direct observations were conducted for Individual #152, no problem behaviors were observed. There was no explanation as to why additional observations were not necessary. The consequences that maintained Individual #66's problem behaviors were not identified.

Because Individual #152 had increased his elopement behavior, staff are advised to update his functional behavior assessment. Similarly, the plans for Individual #66 and Individual #2 included monitored behaviors that may not have been present when their assessments were completed. Both of these behaviors, self-induced vomiting and pulling on catheter, respectively, can cause significant harm, therefore, an updated functional behavior assessment was warranted.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.	
Summary: Half of the PBSPs were implemented within the required 14 days of receiving consent. Content of PBSPs continued to improve, though just one PBSP met criteria for all required content. Performance scores for both indicators remained about the same as at the last review and both will remain in active monitoring. Indicator 14 will remain in the category of requiring less oversight. Even so, the Monitoring Team has provided some detailed commentary for this topic, including acknowledging the updated plans put into place for some of the	Individuals:

individuals. In addition, comments regarding fire drill exiting protocols at Austin SSLC are highlighted in a paragraph within indicator 14. This is regarding the handling of fire drills for those individuals who have difficulty complying with exiting when the fire alarm is sounded.											
#	Indicator	Overall Score	369	152	151	66	403	292	296	2	69
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	50% 4/8	1/1	0/1	0/1	1/1	1/1		1/1	0/1	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.	13% 1/8	0/1	1/1	0/1	0/1	0/1		0/1	0/1	0/1

Comments:

13. The facility provided information on approval by the Behavior Support Committee (BSC), the Human Rights Committee (when applicable), and consent. The date that training was completed was also provided. All plans included the date of team approval and/or the finalization date. Based on this information, it was determined that four of the eight plans (Individual #369, Individual #66, Individual #403, Individual #296) had been implemented within 14 days of all necessary consents. Training was completed on Individual #152's plan almost two months after BSC approval; the finalization date in Individual #151's plan was before consent had been obtained and training completed; training was completed 15 days after consent was obtained for Individual #2's plan; and training on Individual #69's plan was completed almost two months prior to the date provided for BSC approval.

14. All of the PBSPs had been developed/implemented within the past 12 months. Individual #296's 2018 PBSP was provided to the Monitoring Team, but an updated plan (January 2019) was found in his I-Book.

Appropriately, four plans had been revised since they were first approved by the IDT. These included the following:

- Individual #151's plan had been revised to address the benefit of engagement in preferred activities.
- Individual #66's plan had been revised several times to ensure that all observed problem behaviors were addressed and additional interventions were included.
- Similarly, several revisions were made to Individual #403's plan to update objectives and communication techniques, as well as adding instructions for how to respond to observed behavior.
- Individual #2's plan had been revised in November 2018 to include staff response to an observed behavior and the addition of grabbing to his aggression definition. Although it was noted in January 2019 that leaving a designated area would be monitored, this change was not yet evident.

Staff are advised to revise the PBSPs for Individual #152 and Individual #296 as these referenced PMAB techniques which had been replaced with Ukeru and Safe Use of Restraint. Additionally, staff reported that since Individual #296 had quit smoking, they no longer used a green card as a cue. Staff are also advised to add elopement to Individual #152's plan as staff had begun collecting data on this frequently observed behavior in August 2018.

While staff addressed problem behaviors identified in the functional behavior assessment, it would be advisable to address other problems/concerns as they arise in IDT meetings.

- Fire drill exiting: For example, Individual #292 was noted to become agitated during fire drills, resulting in difficulty gaining his cooperation to participate. The action taken by his IDT was to put him on the pre-evacuation list. When this list was requested, a total of 21 individuals were included. Also provided in this request were notes for several individuals indicating that their IDTs would meet to determine whether this accommodation remained necessary. Rather than exempting an individual from participation in a fire drill, behavioral health services staff should work with other members of the team to teach the individual to tolerate this required activity (e.g., as a skill acquisition activity perhaps; see Bannerman, Sheldon, & Sherman, 1991, Teaching adults with severe and profound retardation to exit their homes upon hearing the fire alarm, Journal of Applied Behavior Analysis, 24, 571-577).
- Team visit to employment sites: Another example was Individual #421's reported difficulties when working at the Austin State Hospital. To effect successful transitions to off campus environments, behavioral health services staff are advised to make visits to identified sites prior to, early in the transition, and as needed to train staff and ensure appropriate supports are put in place immediately.

15. Although only Individual #152's PBSP was considered complete, all of the other plans included most identified components. These included operational definitions of both targeted problem behaviors and replacement behaviors, antecedent and consequent strategies, the training/reinforcement of functionally equivalent replacement behaviors, sufficient opportunities for replacement behaviors to be trained or reinforced, treatment objectives, and clear, precise interventions. Individual specific feedback is provided below.

- Individual #152's PBSP did not target elopement, although staff had begun recording this behavior in August 2018. It would be advisable to update his plan to include an operational definition of this behavior and strategies to help reduce the same.
- In Individual #2's PBSP, the replacement behaviors were not adequately defined. Both asking for attention and asking for an item/activity included the descriptor of approaching an individual. It was unclear how staff would discriminate whether his approach was an attempt to gain attention or obtain an item/activity.
- While there were indicators that reinforcement schedules had been established for some individuals, these were not outlined in their PBSPs.
    - Individual #369 was to earn a CD each month as long as he did not destroy his personal CD player or radio. It was difficult to determine the efficacy of this intervention as this behavior was included in the targeted problem behavior of property destruction.
    - Individual #69 had a token economy, but this was not included in his PBSP. Further, it was unclear when this reinforcement program had been introduced.
    - Individual #66 had a yellow/red level system and a behavioral contract, but these were not clearly described in her PBSP. Further, there was mention of a token economy in the peer review minutes for Individual #66, but this was not included in her PBSP. Staff are advised to include these in the plan so that direct support professionals can be aware of the importance of reinforcement and can have a clear understanding of how to implement identified strategies.
- The plans for seven of eight individuals noted limited times for formal training of replacement behaviors, but then added that informal training should occur during all waking hours. The exception was Individual #369's plan.
- Several plans referenced behaviors that may be observed prior to targeted problem behaviors. Staff are advised to ensure that

identified precursor behaviors are not the same as those defined in targeted problem behaviors. Examples included swearing behavior exhibited by Individual #66 and Individual #69 (identified as both a precursor and part of verbal aggression), and Individual #403's yelling and sliding to the floor (identified as both a precursor and part of disruptive behavior).

- Individual #66's referenced level system included the use of a safe space which was a room in another building. Because this involved her removal from her home, staff are advised to collect data on its usage.
- Most PBSPs included directions indicating that staff should record problem and replacement behaviors as they occurred or at least every two hours.
    - Individual #369's PBSP, however, noted that if the target and/or replacement behaviors did not occur, staff should enter zero at the end of the shift. This did not comply with data timeliness guidelines.
    - Individual #69's plan noted that staff should record data once they were relieved of 1:1 responsibilities. As this could exceed a two-hour period of time, it did not comply with data timeliness expectations.
- Although not a requirement of the Settlement Agreement, the State policy indicated that the "…PBSP must have a schedule for measurement of accountability of plan implementation." This includes treatment integrity, data integrity, and inter-observer agreement. Only the PBSP for Individual #2 included this information.
- Individual #403's Behavioral Health Assessment from April 2018 noted that the use of a weighted blanket had "…been effective in preventing and managing target behavior." Further, a Habilitation Therapy Note from October 2018 noted that she was wearing a backpack for "…added proprioceptive input." When staff were asked about the use of these two items, it was reported that these were not designed to address her problem behaviors. It would be advisable to ensure that direct support professionals have a clear understanding of all components of Individual #403's PBSP.

During the week of the onsite monitoring visit, Individual #66 ran off the facility grounds on two consecutive evenings. She reportedly was running in traffic with staff trying to ensure her safety. Although she did have a Crisis Intervention Plan, the plan indicated that staff were to utilize restraint if she arrived at the gate of the facility. Staff are advised to review this plan because it may be advisable to intervene earlier in the episode. Similarly, staff are advised to review her current PBSP to ensure that reinforcement is being utilized in a manner likely to result in positive behavior change. Lastly, the IDT is advised to review Individual #66's activity schedule to ensure that she is engaged in meaningful activities that may enhance her motivation and participation.

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

Summary: This was the first time that Austin SSLC scored 100% on both indicators in this outcome. Both will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 369	152	151	66	403	292	296	2	69
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 1/1				1/1					
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 1/1				1/1					

Comments:
24-25. Individual #66 had been receiving counseling services up until the counselor resigned in December 2018. At the time of the

onsite visit, a new counselor had been hired with plans to resume counseling services with Individual #66. When she was receiving counseling services, Individual #66 had a complete treatment plan and progress notes.

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, and that PCPs complete reviews according to these schedules. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.										
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	22% 2/9	0/2	0/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1

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." Interim reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interim reviews will need to occur more frequently.

The IHCPs of three of the individuals reviewed defined the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. These included the IHCPs for:

- Individual #403 – circulatory (three months), and fluid imbalance (three months) - the PCP had not conducted a quarterly review in January 2019;
- Individual #450 – aspiration (six months), and skin integrity (three months) – the PCP conducted quarterly reviews; and
- Individual #212 – respiratory compromise (three months), and constipation/bowel obstruction (three months) – the PCP conducted quarterly reviews.

Outcome 3 – Individuals receive quality routine medical assessments and care.	
Summary: Center staff should continue to improve the quality of the medical assessments with particular focus on thorough plans of care for active medical problems. Indicators a and c will remain in active oversight.	Individuals:

#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	Individual receives quality AMA.	44% 4/9	0/1	0/1	1/1	0/1	1/1	1/1	0/1	1/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	22% 4/18	0/2	0/2	2/2	0/2	0/2	0/2	0/2	2/2	0/2

Comments: a. It was positive that four individuals' AMAs (i.e., Individual #450, Individual #421, Individual #227, and Individual #212) included all of the necessary components, and addressed the selected chronic diagnoses or at-risk conditions with thorough plans of care. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, family history, social/smoking histories, childhood illnesses, past medical histories, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Most, but not all included updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments include thorough plans of care for each active medical problem, when appropriate.

c. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions [i.e., Individual #2 – circulatory, and infections; Individual #403 – circulatory, and fluid imbalance; Individual #450 – aspiration, and skin integrity; Individual #172 – falls, and gastrointestinal (GI) problems; Individual #421 – infections, and falls; Individual #227 – falls, and osteoporosis; Individual #260 – constipation/bowel obstruction, and GI problems; Individual #212 – respiratory compromise, and constipation/bowel obstruction; and Individual #138 – osteoporosis, and fluid imbalance].

As noted above, the ISPs/IHCPs reviewed often did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. For Individual #450 and Individual #212, IHCPs defined the frequency, and the PCPs completed quality interim reviews.

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

Summary: As indicated in the last several reports, overall, much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs. These indicators will continue in active oversight.

Individuals:

#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
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.	6% 1/18	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based	33%	0/2	2/2	2/2	0/2	0/2	0/2	0/2	2/2	0/2

	on current standards of practice, and accepted clinical pathways/guidelines.	6/18										

Comments: a. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions (i.e., Individual #2 – circulatory, and infections; Individual #403 – circulatory, and fluid imbalance; Individual #450 – aspiration, and skin integrity; Individual #172 – falls, and GI problems; Individual #421 – infections, and falls; Individual #227 – falls, and osteoporosis; Individual #260 – constipation/bowel obstruction, and GI problems; Individual #212 – respiratory compromise, and constipation/bowel obstruction; and Individual #138 – osteoporosis, and fluid imbalance).

The following IHCP included action steps to sufficiently address the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations: Individual #450 – skin integrity.

b. As noted above, the ISPs/IHCPs reviewed often did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. On a positive note, the following individuals' ISPs/IHCPs defined the frequency as either every six months or every three months, based on the severity of the individuals' level of risk: Individual #403 – circulatory (three months), and fluid imbalance (three months); Individual #450 – aspiration (six months), and skin integrity (three months); and Individual #212 – respiratory compromise (three months), and constipation/bowel obstruction (three months).

Dental

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

Summary: For this review and the previous two reviews, the Center has sustained high performance with regard to the completion of quality comprehensive annual dental examinations (i.e. Round 12 - 100%, Round 13 – 100% and Round 14 – 100%). As a result, Indicator b will move to the category of less oversight. Indicator a.ii will remain in less oversight, due to the Center's attention to some timeliness problems for dental examinations noted in the two previous reports. The Center had also made improvement in ensuring the timeliness and quality of annual dental summaries. These indicators will remain in active oversight, but might move to less oversight after the next review.

#	Indicator	Overall Score	Individuals: 2	403	450	172	421	227	260	212	138
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									
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									

	ISP meeting.										
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	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.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1

Comments: a. In the last two reports, the Monitoring Team explained concerns related to the timeliness of dental exams, and cautioned Center staff that if the issues were not corrected, Indicator a.ii might return to active oversight. It was good to see during this review that Center staff had largely corrected the problem. For Individual #212, the dentist did not complete the 2018 annual dental exam, dated 10/25/17 (with another completed on 10/2/18), no earlier than 90 days from the ISP meeting. However, for this individual, it appeared that the dentist was correcting the problem for this current ISP cycle (i.e., exam on 2/4/19, for an ISP scheduled on 3/19/19). This indicator will continue in less oversight.

It was positive that all nine of the individuals had an annual dental summary completed no later than ten working days prior to the ISP annual meeting. As noted above, Individual #212's was based on information older than 90 days.

b. All of the comprehensive dental examinations reviewed included each of the required components, including the following:

- A description of the individual's cooperation;
- An oral hygiene rating completed prior to treatment;
- Periodontal condition/type;
- The recall frequency;
- Caries risk;
- Periodontal risk;
- An oral cancer screening;
- Information regarding last x-ray(s) and type of x-ray, including the date;
- Sedation use;
- A summary of the number of teeth present/missing;
- Treatment provided/completed;
- An odontogram;
- A treatment plan; and,
- Periodontal charting, updated within the last year, or a justification for not completing it with a plan to complete it.

c. Individual #212's dental summary was based on information that was more than 90 days, and so it did not meet criterion. It was very good to see that all of the remaining dental summaries reviewed included each of the required components, including the following:

- Effectiveness of pre-treatment sedation;
- Recommendation of need for desensitization or another plan;

- A description of the treatment provided (i.e., treatment completed);
- The number of teeth present/missing;
- Dental care recommendations;
- Dental conditions that could cause systemic health issues or are caused by systemic health issues;
- Treatment plan, including the recall frequency;
- Provision of written oral hygiene instructions. It was nice to see the thoughtful approach with which these recommendations were offered. Many of them identified specific preferences of the individual to increase the likelihood that the individual would engage in home and/or dental office dental care. IDTs could have used some of the recommendations to develop clinically relevant goals/objectives (e.g., brushing teeth after sugary snacks, focus on gum line, ensure all surfaces of teeth are brushed, etc.); and
- Recommendations for the risk level for the IRRF.

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.

Summary: For the nine individuals reviewed, nurses completed timely annual nursing reviews and physical assessments, as well as quarterly nursing record reviews and/or physical assessments. This was good to see. At this time, these indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 2	403	450	172	421	227	260	212	138
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments: a.i. and a.ii. It was positive that for all nine of the individuals reviewed, nurses completed timely annual comprehensive nursing reviews and physical assessments, as well as quarterly nursing record reviews and physical assessments.

Outcome 4 – Individuals have quality nursing assessments to inform care planning.											
Summary: It was positive that for the individuals reviewed, nurses completed annual and quarterly physical assessments that addressed the necessary components. Work is needed to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to their at-risk conditions. In addition, when individuals experience changes of status, nurses need to complete assessments in accordance with current standards of practice. All of these indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	Individual receives a quality annual nursing record review.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual receives quality annual nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual receives a quality quarterly nursing record review.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality quarterly nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

f.	On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
g.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	30% 3/10	0/1	1/1	1/1	0/1	1/1	0/1	0/2	0/1	0/1

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

- Immunizations;
- Consultation summary;
- Lab and diagnostic testing requiring review and/or intervention; and
- Tertiary care.

Most, but not all included, as applicable:

- Active problem and diagnoses list updated at time of annual nursing assessment (ANA); and
- List of medications with dosages at time of ANA.

The components on which Center staff should focus include:

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

b. It was positive that for the nine individuals reviewed, nurses completed annual physical assessments that addressed the necessary components.

c. and f. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #2 – falls, and constipation/bowel obstruction; Individual #403 – falls, and choking; Individual #450 – osteoporosis, and seizures; Individual #172 – falls, and constipation/bowel obstruction; Individual #421 – constipation/bowel obstruction, and infections; Individual #227 – skin integrity, and choking; Individual #260 – GI problems, and cardiac disease; Individual #212 – constipation/bowel obstruction, and choking; and Individual #138 – constipation/bowel obstruction, and fractures).

Overall, none of the annual comprehensive nursing or quarterly assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Nurses often had not included complete status updates in annual and quarterly assessments, including relevant clinical data (i.e., the exceptions were the ANA for Individual #421's infections, and the quarterly assessment for Individual #421's constipation/bowel obstruction, and infection risks); analyzed this information, including comparisons with the previous quarter or year; and/or made recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

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

- Active problem and diagnoses list updated at time of the quarterly assessment;
- List of medications with dosages at the time of the quarterly nursing assessment;
- Immunizations;
- Consultation summary;
- Lab and diagnostic testing requiring review and/or intervention; and
- Tertiary care.

The components on which Center staff should focus include:

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

e. It was positive that for the individuals reviewed, nurses completed quarterly physical assessments that addressed the necessary components.

g. The changes of statuses for which nurses conducted assessments in accordance with relevant nursing guidelines were those for: Individual #403's fall on 9/5/18, Individual #450's seizure activity on 12/24/18, and Individual #421's skin integrity issue (i.e., red and peeling skin to right ear and cheek) on 11/1/18.

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:

- A nursing progress note IPN, dated 11/14/18, at 1:36 p.m., indicated Individual #2 fell to the floor from his wheelchair. Because the IPN did not provide the time of the fall, IView could not be referenced to determine if the nurse assessed his vital signs. The IPN also did not describe where the fall occurred, or the circumstances of the fall. The nurse did not conduct and/or document an assessment of range of motion, pain, or his skin to check for redness or bruising.
- An IPN, dated 8/6/18, at 9:18 a.m., indicated that after Individual #172 fell from his wheelchair to the floor, staff called a 6200. The nurse's assessment noted he was sleepy, but arousable. However, the nurse did not complete and/or document any initial neurological checks or mental status exam. Some of the assessment comments related to the individual's complaints of pain- were cut off in the documents the Center submitted to the Monitoring Team.
- An IPN, dated 1/10/18, at 12:33 p.m., noted that Individual #227 had possible insect bites on her right forearm. The nurse's assessment did not include temperature of the skin, if the area was raised, a pain assessment, or mention of whether or not the skin was checked for additional reddened areas.
- An IPN, dated 8/27/18, at 9:48 p.m., noted that 15 minutes after returning from dinner, Individual #260 vomited 300 milliliters (ml) of greenish-brown emesis. The nurse did not include the time of the emesis in the IPN, and the assessment documentation in IView for the same day, at 6:10 p.m., and 10:10 p.m., stated: "none" for GI symptoms. There was no mention of his mental status or pain assessment, and the IPN indicated that the PCP would be notified if he had "recurrent emesis." Nurses did not take and/or document vital signs every four hours as the initial IPN indicated would occur. No subsequent nursing IPNs were

found for between 8/28/18 through 8/31/18, when at 10:39 a.m., an IPN noted the individual had another episode of emesis. Although nurses documented vital signs on these dates, they did not write IPNs to describe the individual's mental status, activity level, or participation in any activities to provide a picture of his overall status.

- Although nurses documented vital signs daily in IView for Individual #260, there was no indication that nurses notified the PCP of the increasing episodes of high blood pressures he was having in August and September 2018. Also, there was no indication that nurses re-took the blood pressures, as would be the standard of practice when abnormal values are obtained.
- Document #TX- AU-1902- II.P.1-20 indicated that nursing staff administered pro re nata (PRN, or as needed) medications to Individual #212 for constipation on the following dates: 7/3/18, 7/5/18, 7/6/18, 7/9/18, 7/12/18, 7/15/18, 7/20/18, 7/26/18, 7/27/18, 7/29/18, 7/31/18, 8/2/18, 8/4/18, 8/7/18, 8/11/18 (x3), and 11/24/18. The Monitoring team requested documentation regarding whether or not nurses notified the PCP of the number of times the individual received PRN medication for constipation in July and August 2018. Center staff submitted a PCP note indicating that during the morning meeting: "it came to light that [Individual #212] had 3 suppositories this week for constipation." The referenced dates were 7/23/18 through 8/2/18, which did not encompass the full timeframe and/or the number of PRN medications noted above. As a result, it did not appear that nursing staff assessed and communicated the frequency of the individual's episodes of constipation and PRN medication usage to the PCP.

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

Summary: Given that over the last several review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 2	403	450	172	421	227	260	212	138
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.	11% 2/18	0/2	1/2	0/2	0/2	0/2	0/2	1/2	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).	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	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	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of	6%	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2

	monitoring/review of progress.	1/18									
Comments: b. The IHCPs that included preventative measures were for Individual #403 – choking (i.e., assess for distress when eating/drinking/medication administration to evaluate diet texture), and Individual #260 – cardiac disease (i.e., assess vital signs prior to administering blood pressure medication). c., e., and f. The nursing assessment intervention in Individual #260's cardiac disease IHCP also was measurable, and identified specific clinical indicators with a defined frequency. The resulting data would allow the IDT to determine whether the individual's condition remained the same, improved, or regressed.											

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 a Registered Nurse (RN) Post-Hospitalization Review was completed for most of the individuals who needed them, and the PNMT discussed the results. However, problems were noted with IDTs making timely referrals of individuals to the PNMT, and/or the PNMT making self-referrals. In addition, the PNMT should focus on the completion of PNMT reviews and/or comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT reviews and comprehensive assessments. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	25% 1/4	N/A	N/A	0/1	N/A	N/A	1/1	0/1	0/1	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	25% 1/4			0/1			1/1	0/1	0/1	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/1			0/1			N/A	N/A	N/A	
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	25% 1/4			0/1			1/1	0/1	0/1	
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	67% 2/3			1/1			N/A	1/1	0/1	
f.	Individuals receive review/assessment with the collaboration of	0%			0/1			0/1	0/1	0/1	

	disciplines needed to address the identified issue.	0/4									
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/4			0/1			0/1	0/1	0/1	
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/1			0/1			N/A	N/A	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:

- On 9/15/18, Individual #450 was diagnosed with aspiration pneumonia. No evidence was found that her IDT made a referral to the PNMT, or that the PNMT made a self-referral. In addition, on 9/25/18, she had a new feeding tube placed, which should have resulted in a referral, but did not. Of note, back on 1/15/18, this individual was hospitalized and diagnosed with aspiration pneumonia, although Center staff later indicated this was "likely HCAP [healthcare-acquired pneumonia]," and therefore, did not require PNMT review. At that time, a hospital modified barium swallow study (MBSS) showed aspiration of thin liquids, which represented a change of status. The PNMT should have at least conducted a review.
- On 6/30/18, Individual #227 fell. On 7/1/18, she went to the ED and was diagnosed with a fracture of the left humerus. Her IDT made a timely referral to the PNMT, and on 7/3/18, the PNMT OT conducted a review. Given the potential impact on other risk areas, other PNMT members should have participated in the review. The review lacked information about the potential impact on, for example, dining due to the use of hydrocodone. In other instances, it listed risk areas, but the review contained little discussion and/or analysis. For example, it stated that her respiratory risk was impacted due to decreased movement, but offered no plan to address this risk. The only recommendations were to follow the IDT's plan. However, the review did not indicate what that plan was, or provide clinical justification for its sufficiency.
- On 7/27/18, Individual #260 had emesis. On 8/27/18, he had emesis of 300 ml. On 9/19/18, he had emesis after lunch, described as a large amount, and he was started on an antibiotic due to possible aspiration. Again on 9/20/18, he had a large emesis after lunch. The PNMT minutes indicated that he did not meet the PNMT criteria of more than three episodes of emesis in 30 days. However, given his history of respiratory issues, the increased occurrence of emesis, and that it was occurring during/after meals, the PNMT should have at least conducted a review. Although the audit tool provides a list of criteria that requires referral to the PNMT, it qualifies that list by stating: "Appropriate referral for assessment is defined <u>at a minimum</u> according to the following qualifying event/threshold…" (emphasis added). IDTs still need to refer or the PNMT needs to make self-referrals of individuals who otherwise are at significant risk due to PNM issues.
- Individual #212's IDT did not make a referral to the PNMT, and no evidence was found of at least a review in response to two potential aspiration pneumonia diagnoses on 10/15/18 and 10/23/18. She was hospitalized on these dates, and

documentation indicated that her diagnoses included aspiration pneumonia, but other documentation labeled them as right lower lobe (RLL) rhino virus (RV)-associated pneumonia. According to a PCP IPN, dated 10/25/18, while the hospital listed her as having aspiration pneumonia, Center staff felt it was not aspiration-related. However, document #TX-AU-1902-II.P.1-20 listed the 10/15/18 event as aspiration pneumonia. Given that this individual was at high risk for aspiration, and had increased coughing as well as oral secretions just prior to the pneumonia, at least a PNMT review was warranted to review her status, but this did not occur. In addition, in the past year, the individual had in excess of 15 episodes of constipation, with a diagnosis of ileus on 1/6/19.

According to document #TX-AU-1902-II.P.1-20, on 12/9/18, and 1/7/19, Individual #212 had two additional diagnoses of pneumonia that were "under review," but this document indicated that in the last six months, she had not been referred to the PNMT. This was inconsistent with the Tier I documents (i.e., TX-AU-1902-III.12.b) that indicated she was currently on the PNMT caseload, listed the 12/19/18 event as the reason for referral to the PNMT, and identified the qualifying event as aspiration pneumonia and UTI. The documents submitted did not show any PNMT activity (e.g., minutes, PNMT IPNs, ISPAs showing PNMT involvement).

e. It was positive that for two individuals, a RN Post-Hospitalization Review was completed, and the PNMT discussed the results. For Individual #212, no RN Post-Hospitalization Review was found for her hospitalization on 10/23/18, for aspiration pneumonia, RSV, and a pressure sore on her buttock.

h. As noted above, Individual #450 should have had a comprehensive PNMT assessment, but did not.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. The plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps. In addition, many action steps were not measurable. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
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% 0/17	0/2	0/2	0/2	0/2	0/1	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.	11% 2/18	1/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	0% 0/17	0/2	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/18	0/2	2/2	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: Individual #2 - aspiration, and skin integrity; Individual #403 – choking, and falls; Individual #450 – skin integrity, and aspiration; Individual #172 – aspiration, and falls; Individual #421 – falls, and weight; Individual #227 - choking, and falls; Individual #260 – choking, and aspiration; Individual #212 – skin integrity, and aspiration; and Individual #138 – choking, and falls.

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. The plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps (e.g., if behavior was a frequent cause of falls, measurable interventions to address the behaviors should be included; or if an individual was at increased risk of choking due to a fast eating pace or improper positioning during meals, then measurable action steps, including, for example, skill acquisition plans, are needed to address these factors). In addition, many action steps were not measurable (e.g., "encourage [use of] sidewalks," "encourage healthy choices," etc.).

c. All individuals reviewed had PNMPs and/or Dining Plans. Problems varied across the PNMPs and/or Dining Plans reviewed.

- It was positive that all of the PNMPs, as applicable to the individuals' needs included:
  - Photographs;
  - Positioning instructions;
  - Bathing instructions;
  - Toileting/personal care instructions;
  - Handling precautions or moving instructions;
  - Medication administration instructions;
  - Oral hygiene instructions; and
  - Complete communication strategies.
- As applicable to the individuals, most, but not all of these PNMPs were reviewed and/or updated within the last 12 months (i.e., Individual #421's PNMP was not updated to reflect the need for staff to use verbal prompts to ensure she used correct posture during mealtimes), and included complete:
  - Lists of assistive/adaptive equipment;
  - Transfer instructions;
  - Mobility instructions; and

- Mealtime instructions.
- The components of the PNMPs on which the Center should focus on making improvements include:
  - PNMPs/Dining Plans did not include risk levels; and
  - For three individuals, PNM risk areas were not complete (i.e., some were missing), and for Individual #172, the triggers on the PNMP were not consistent with those in the IHCP.

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

e. The IHCPs reviewed that identified the necessary clinical indicators were those for: Individual #2 - aspiration, and Individual #172 – aspiration.

g. Often, the IHCPs reviewed did not include PNMP monitoring, including the frequency. Those that did were for: Individual #403 – choking, and falls.

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	2	403	450	172	421	227	260	212	138
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	N/A	N/A	N/A	N/A	1/1	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/1			0/1					N/A	
Comments: a. and b. Individual #450's IDT did not update her IRRF to reflect the use of a G-tube. Her IDT also did not set forth a plan to track the use of G-tube or ongoing monitoring of meals to detect aspiration early.											

Occupational and Physical Therapy (OT/PT)

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

individuals' needs has varied. The quality of OT/PT assessments continues to be an area on which Center staff should focus. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
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.	78% 7/9	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	78% 7/9	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									

d.	Individual receives quality Comprehensive Assessment.	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. Seven of the nine individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status. The exceptions were for:

- Individual #2, who had two falls from his wheelchair during November 2018. The IDT met on both occasions. For the first fall that occurred on 11/14/18, the IDT attributed the fall to seatbelt security and re-inserviced staff. Another fall, on 11/26/18, resulted from his wheelchair tipping when he grabbed at staff. Habilitation staff attended both ISPA meetings. There was no evidence the IDT considered the need for a wheelchair review to determine if any modifications were potentially needed to address tipping, nor was such a review completed. The Center also did not provide any evidence it had obtained an orientation and mobility (O&M) assessment secondary to his decreased vision.
- Individual #403 fell a number of times. Some falls were due to behavioral issues, but a number were due to a lack of balance. The PT did not conduct an assessment or consult in response to the falls.

d. None of the individuals reviewed required a Comprehensive Assessment.

e. All nine of the individuals received an OT/PT Assessment of Current Status/Evaluation Update. Most, but not all met criteria, as applicable, with regard to:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports; and,
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, 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).

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

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

opportunities) to ensure consistency of implementation among various IDT members.

Of note, as part of the onsite review week, the Monitoring Team appreciated the Habilitation Therapy Director's willingness to conduct an objective review of one individual's OT/PT and communication assessments, review the findings with the State Office Discipline Lead, and then discuss her findings openly with the members of the Monitoring Team and State Office staff. This effort showed Center staff's ability to identify strengths and weaknesses in the assessments, as well as to identify potential solutions to the essential improvements that are needed with regard to the assessments.

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 positive the Center's IDTs continued the high level of performance noted at the last review (i.e., Round 13 – 100%, and Round 14 – 100%) for ensuring the ISPs included strategies, interventions, and programs recommended in OT/PT assessments. If the Center sustains this performance, Indicator c might move the less oversight after the next review. Improvement continued to be needed with regard to the remaining indicators. To move forward, QIDPs and OTs/PTs should work together to make sure IDTs discuss and include information in ISPs related to individuals' functioning from an OT perspective, and hold ISPAs to discuss and approve implementation of OT/PT supports initiated or modified outside of the annual ISP meeting. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 2	403	450	172	421	227	260	212	138
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	44% 4/9	0/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight									
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	When a new 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.	75% 3/4	N/A	1/1	1/1	N/A	N/A	1/1	N/A	N/A	0/1

Comments: a. Five of the nine ISPs reviewed did not include concise but thorough descriptions of individuals' OT/PT functional statuses. Therapists should work with QIDPs to make improvements, including considering whether their assessments facilitate this

process. Of concern, the OT/PT assessments for these individuals did not provide a concise summary description of individuals' functional statuses; instead, information was scattered throughout. This made it difficult to obtain an overall picture of functional status.

c. and d. Overall, it was positive the IDTs ensured that individuals' ISPs/ISPAs included strategies, interventions, and programs as recommended in assessments and/or initiated or modified outside of an annual ISP meeting. The exception was for Individual #138, for whom an ISPA was not held at the time of initiation of his OT mealtime plan of care.

Communication

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

Summary: Individuals reviewed received timely assessments for ISPs and in accordance with their individualized needs related to communication (i.e., they received the type of assessment they needed). Significant work continued to be needed to improve the quality of communication assessments and updates in order to ensure SLPs provide IDTs with clear understandings of individuals' functional communication status; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 2	403	450	172	421	227	260	212	138
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

b.	Individual receives assessment in accordance with their individualized needs related to communication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/2	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/7	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	N/A

Comments: a. and b. Overall, individuals received timely assessments that were in accordance with their individualized needs related to communication.

d. It was positive that the two Comprehensive Communication Assessments met criteria applicable, with regard to:

- 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;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services; and,
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated.

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

- The individual's preferences and strengths are used in the development of communication supports and services;
- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;

- A comparative analysis of current communication function with previous assessments;
- The effectiveness of current supports, including monitoring findings;
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication; and,
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services.

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

- The individual's preferences and strengths are used in the development of communication supports and services;
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;
- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs (including AAC, EC, or language-based) in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services; and,
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

Summary: Improvement was noted with regard to IDT review of individuals' Communication Dictionaries. Additional improvement is needed with regard to the remaining indicators. To move forward, QIDPs and SLPs should work together to make sure IDTs discuss and include information related to individuals' communication supports in ISPs. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 2	403	450	172	421	227	260	212	138
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.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight									
b.	The IDT has reviewed the Communication Dictionary, as appropriate,	86%	1/1	1/1	1/1	N/A	1/1	1/1	0/1	1/1	N/A

	and it comprehensively addresses the individual's non-verbal communication.	6/7									
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: b. It was positive that most IDTs had reviewed the Communication Dictionaries, as appropriate, and they comprehensively addressed the individuals' non-verbal communication. The exception was for Individual #260, whose ISP did not include evidence that the IDT reviewed and approved the Communication Dictionary.

c. Overall, it was positive that individuals' ISPs/ISPAs included strategies, interventions and programs recommended in their respective assessments.

d. For the two individuals who had a new communication service or support initiated outside of an annual ISP meeting, the IDT did not hold an ISPA meeting to discuss and approve implementation.

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: SAPs continued to improve at Austin SSLC. For one individual (i.e., Individual #152) criteria for all three indicators were met for both of his SAPs. Scoring for indicators 3 and 4 remained about the same as the last review. Even though about one-third to one-half of SAPs were based on assessments and/or practical, functional, and meaningful, Austin SSLC was collecting reliable data on most SAPs (indicator 5). This was good to see and will be an important foundation for continued development of the skill acquisition program at the Center. These three indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	369	152	151	66	403	292	296	2	69
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.	50% 12/24	1/3	2/2	2/2	2/3	1/3	2/3	1/3	0/2	1/3

4	SAPs are practical, functional, and meaningful.	38% 9/24	1/3	2/2	0/2	1/3	1/3	2/3	1/3	0/2	1/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	79% 19/24	3/3	2/2	2/2	0/3	3/3	3/3	2/3	2/2	2/3

Comments:
All of the individuals had skill acquisition plans (SAPs). Three SAPs each were reviewed for six of the nine individuals. The exceptions were Individual #152, Individual #151, and Individual #2 each of whom had two SAPs.

3. Twelve of the SAPs were based on assessments and were scored positively for this indicator. These were skills that the individual could not perform based on either the Functional Skills Assessment (FSA) or the baseline probe. These were Individual #369 making a sandwich and storing his CDs, Individual #152 ceasing work when a timer sounded, Individual #151 turning on the television and filling a work jig, Individual #66 identifying a problem and swimming, Individual #403 getting her work, Individual #292 making a sundae and shredding, Individual #296 making an omelet, and Individual #69 knocking on a door before entering.

In other cases, skills had been identified as mastered either in the FSA or in baseline. In at least one case (Individual #69 making coffee), the assessment indicated he could complete most steps of the task analysis. This suggested that with simple exposure he would master the skill. Individual #66's ability to save one dollar was not clearly assessed. The baseline assessments for Individual #403 counting 10 blocks and Individual #296 matching tiles to create art work commented on their inability to sustain attention to the task.

4. Nine of the 24 SAPs were considered practical, functional, and/or meaningful. These were Individual #369 learning to make a sandwich, Individual #151 learning to turn on the television and fill his work jig, Individual #66 learning to swim, Individual #403 learning to get her own work materials, Individual #292 learning to make a sundae and shred papers, Individual #296 learning to make an omelet, and Individual #69 learning to save money.

Other SAPs did not meet criterion with this indicator due to the skill being a compliance issue (e.g., Individual #152 ceasing work, Individual #403 counting 10 blocks, and Individual #69 knocking on doors), a skill that was already mastered (e.g., Individual #2 operating joy music player and bowling), and a skill that reportedly upset the individual when she was asked to complete this with staff other than her counselor (i.e., Individual #66 identifying problems).

5. Of the 24 SAPs reviewed, there was evidence that 19 had been monitored for data reliability. The exceptions were Individual #66's three SAPs, Individual #296's art SAP, and Individual #69's saving money SAP.

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: These assessments were current for all individuals and complete for most. With some additional focus, these indicators could score higher and at some point, move into the category of requiring less oversight. They will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	369	152	151	66	403	292	296	2	69
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.	89% 8/9	1/1	1/1	1/1	0/1	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. All nine individuals had current FSAs, PSIs, and vocational assessments.

11. Based upon the information provided, it was determined that each of these documents was available to the IDT 10 days prior to the ISP meeting for eight of the nine individuals. The exception was the vocational assessment for Individual #66.

12. Recommendations for skill development were evident in both the FSA and vocational assessment for seven of the nine individuals. There were no SAP recommendations in Individual #296's vocational assessment. In Individual #403's vocational assessment, the sole recommendation was to decrease the amount of assistance she required from staff. This did not address acquisition of a new skill.

As discussed with behavioral health services staff, the FSA assesses skills across 13 domains. However, recommendations were consistently limited to just one to two SAPs. When staff reported that the behavior technicians must restrict their recommendations to the five goal areas discussed at the ISP meeting, it was suggested that these lead staff try to identify which domains address leisure, relationship, work/school/day program, independence, and personal outcome goals.

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

This domain contains 39 outcomes and 164 underlying indicators in the areas of clinical services, and implementation of plans by the various clinical disciplines. At the time of the last review, 38 of these indicators, including five entire outcomes, had sustained high performance scores and moved to the category requiring less oversight. Presently, two additional indicators will move to the category of less oversight in the area of pharmacy.

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

Goals/Objectives and Review of Progress

In psychiatry, when Austin SSLC has goals for the decrease and increase of psychiatric indicators, then progress can be determined.

In behavioral health, without reliable data, the Monitoring Team could not make a valid determination 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 generally were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

Acute Illnesses/Occurrences

Overall, the Center continued to show improvements with regard to the provision of timely acute medical care for issues addressed at the Center, as well as for issues for which individuals required transport to the Emergency Department (ED), or hospitalization. The Center is encouraged to continue its efforts in this regard. Of concern, for some individuals who were hospitalized, IDTs did not hold ISPA meetings or did not document the findings of the ISPA meetings in a timely manner. Timely post-hospitalization ISPAs are important to define necessary medical and healthcare supports to reduce risks and allow for early recognition of signs and symptoms of illness, as appropriate.

In psychiatry, when individuals were experiencing psychiatric problems, psychiatry staff and IDTs did not hesitate to intervene and implement changes.

Implementation of Plans

In psychiatry, for psychotropic medication side effects, Austin SSLC continued to struggle with completing all four components related to the MOSES and AIMS. For the most part, the evaluations were completed and done so in a timely manner (i.e., for 75% of the individuals). The problem was in prescriber review.

In behavioral health, based upon the Center's own data, when an individual met his or her goal, a new/revised goal was not developed. When there was no progress being made, actions were not suggested for any of the individuals.

In behavioral health, not all staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individuals' PBSPs. Half of the individuals did not have monthly progress notes that met criteria (indicator 19). Graphic summaries of data had improved, but were missing one very important characteristic: phase lines to show important changes that occurred in the individual's life (e.g., medication, PBSP updates).

For PBSP data collection, Austin SSLC now had a better infrastructure for assessing timeliness, IOA, and treatment integrity than it had in the past. This was good to see.

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.

When the risk to the individual warranted, there often was not evidence to show that IDTs took action to address individuals' healthcare needs.

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 PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate.

It was good to see that all nine individuals reviewed received the preventative care they needed.

It also was positive that for the individuals reviewed, the Center's medical practitioners 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.

Although since Round 12 of monitoring, the indicator related to the timeliness of the PCPs' review of consultation reports has been in less oversight, some issues were noted during this review, placing the indicator at risk of returning to active oversight. Center staff should ensure that such issues are corrected. For the individuals reviewed, with few exceptions, PCPs wrote orders

for agreed-upon recommendations, which was important to see. It was good to see that PCPs referred consultation recommendations to IDTs, when appropriate, and IDTs reviewed the recommendations and documented their decisions and plans in ISPAs.

Problems were noted with regard to IDTs defining measurable suction tooth brushing parameters (i.e., frequency, as well as length of the session), and including this information in individuals' IHCPs. By the time of the next review, IDTs could easily remedy this situation by including the information in ISPs/IHCPs or holding ISPA meetings to add the needed information.

During this and the past few reviews, the Center has shown sustained performance with regard to the quality of Quarterly Drug Regimen Reviews (QDRRs), as well as practitioners implementing agreed-upon recommendations. As a result, the related indicators will move to the category requiring less oversight.

It was positive that most individuals observed who had adaptive equipment had properly fitting adaptive equipment.

Based on observations, there were still numerous instances (32% of 40 observations) in which staff were not implementing individuals' PNMPs correctly. 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, clarity of PNMPs, sufficiency of staffing or other supports, etc.), and address them.

Restraints

The parties indicated that they reached preliminary agreement that Austin SSLC met the requirements of Section C during the interim period since the last onsite review. Pending the parties' fulfillment of the requirements for a Center's release from a substantive provision of the Settlement Agreement (i.e., Section III, paragraph R), the Monitors did not conduct monitoring for Section C of the Settlement Agreement during this round of monitoring.

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

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.												
Summary: Indicator 3 was not relevant to any of the individuals in either Monitoring Team's review group. The Monitor will leave this indicator in active monitoring for potential review at the next onsite visit.			Individuals:									
#	Indicator	Overall Score										
1	If not receiving psychiatric services, a Reiss was conducted.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.											
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A										
Comments: 3. There were no individuals in the review group for whom a Reiss indicated referral to psychiatry was warranted.												

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.												
Summary: When Austin SSLC has goals for the decrease and increase of psychiatric indicators, then progress can be determined. Also, reliable data will be needed (indicator 7). Even so, when individuals were experiencing psychiatric problems, psychiatry staff and IDTs did not hesitate to intervene and implement changes. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	369	152	151	66	403	292	296	2	69
8	The individual is making progress and/or maintaining stability.	0% 0/8	0/2	0/2	0/2	0/2	0/2	0/2		0/2	0/2
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/8	0/2	0/2	0/2	0/2	0/2	0/2		0/2	0/2
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 6/6	1/1	1/1	1/1	1/1				1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 6/6	1/1	1/1	1/1	1/1				1/1	1/1
Comments: 8-9. Given the absence of data shown to be reliable for psychiatric goals/indicators, progress could not be determined for goals for reduction or for increase. That being said, Individual #403 and Individual #292 were considered to be overall stable by the psychiatric												

team. There was no determination by the psychiatric team or the IDT as to whether goals were met.

10. Although it was not reflected in the goals, there was ample evidence in the psychiatric interim notes, as well as the quarterlies, that when an individual's status was deteriorating, the psychiatric team would intervene and make revisions to the individual's treatment.

11. These interventions were routinely implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary:			Individuals:								
#	Indicator	Overall 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, these indicators were moved to the category of requiring less oversight.									
24	The psychiatrist participated in the development of the PBSP.										
Comments:											

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: There were no individuals in the review group to whom these indicators applied. Indicator 26 will remain in active monitoring so that it can be reviewed during the next onsite visit.			Individuals:								
#	Indicator	Overall Score	369	152	151	66	403	292	296	2	69
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.	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:

25. There were no individuals in the review group for whom anticonvulsant medication was described as being used both for seizure control and for psychiatric purposes.

Individual #152, however, was prescribed two psychotropic medications and two seizure medications. None were considered to be for dual use. Even so, there was evidence in the notes of psychiatry and neurology of each prescribers' awareness of the individual's other

	medications.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.												
Summary:			Individuals:									
#	Indicator	Overall Score										
33	Quarterly reviews were completed quarterly.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
34	Quarterly reviews contained required content.											
35	The individual's psychiatric clinic, as observed, included the standard components.											
	Comments:											

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.												
Summary: Austin SSLC continued to struggle with completing all four components of this indicator. For the most part, the evaluations were completed and done so in a timely manner (i.e., for 75% of the individuals). The problem was in prescriber review. The Center might consider some sort of clerical protocol to ensure this aspect of the MOSES/AIMS protocol is completed. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	369	152	151	66	403	292	296	2	69
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	13% 1/8	0/1	0/1	0/1	0/1	0/1	0/1		0/1	1/1
	Comments: 36. The MOSES and AIMS were performed and reviewed in a timely manner for Individual #69. The evaluations were completed on time, but there were deficits in the timely review by the psychiatrists for Individual #369, Individual #152, Individual #151, Individual #403, and Individual #292. There were deficits in both the completion of the evaluations as well as the timely review by the prescriber for Individual #66 and Individual #2.											

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: All four indicators remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	369	152	151	66	403	292	296	2	69
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A									
Comments:											

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

Psychology/behavioral health

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

Summary: Without reliable data, the Monitoring Team could not make a valid determination of progress. Therefore, indicator 6 was scored 0 for all individuals. Based upon the Center's own data, however, when an individual met his or her goal a new/revised goal was not developed for any of the individuals. When there was no progress being made, actions were not suggested for any of the individuals. This level of performance is lower than that seen at the last review. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 369	152	151	66	403	292	296	2	69
6	The individual is making expected progress	0% 0/8	0/1	0/1	0/1	0/1	0/1		0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/4		0/1	0/1		0/1		0/1		
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	0% 0/3			0/1		0/1			0/1	
9	Activity and/or revisions to treatment were implemented.	0% 0/3			0/1		0/1			0/1	

Comments:

6. The graphs provided by the facility suggested that Individual #369, Individual #152, Individual #66, Individual #403, Individual #296, and Individual #69 were making progress on some or all of their objectives. However, this indicator is rated zero for all individuals due to the identified problems with inter-observer agreement and data timeliness (indicator 5).

7. The Center's own established goals for all, or at least one, replacement behaviors had been met for Individual #152, Individual #151, Individual #403, and Individual #296. Similarly, Individual #152's goal for food/drink stealing and Individual #151's goals for aggression and self-injury had been met. There was no evidence that these goals had been revised. (Individual #403's replacement behavior goals had been revised in July 2018, but these were met again in January 2019.)

8-9. Although graphs indicated a lack of progress for at least one problem behavior for Individual #151, Individual #403, and Individual #2, and worsening of Individual #2's use of his replacement behavior, there was no evidence that changes had been made to the PBSP.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.												
Summary: Continued low performance was found for indicator 16, regarding the training of staff on the individual's PBSP. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	369	152	151	66	403	292	296	2	69
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.	13% 1/8	0/1	0/1	0/1	0/1	1/1		0/1	0/1	0/1
17	There was a PBSP summary for float staff.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.										
Comments: 16. There was evidence that over 80% of assigned staff had been trained on Individual #403's plan. For the other seven individuals, documentation provided indicated that between 0% (Individual #151) and 75% (Individual #2) of assigned staff had been trained.												

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.												
Summary: Half of the individuals did not have monthly progress notes that met criteria (indicator 19). For a number of years, these progress notes met criteria and, as such, this indicator was in the category of requiring less oversight. The Monitor will keep the indicator in this category, but the Center should correct this so that it can remain in this category after the next review, too. Graphic summaries of data had improved, but were missing one very important characteristic: phase lines to show important changes that occurred in the individual's life (e.g., medication, PBSP updates). Also, for peer review to be truly meaningful, recommendations that are generated at these meetings should receive some sort of implementation, follow-up, or response. Indicators 20 and 22 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	369	152	151	66	403	292	296	2	69
19	The individual's progress note comments on the progress of the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
20	The graphs are useful for making data based treatment decisions.	0% 0/8	0/1	0/1	0/1	0/1	0/1		0/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

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.	0% 0/2				0/1					0/1
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

19. There was consistent review of an individual's progress in monthly reports for four of the eight individuals (Individual #152, Individual #403, Individual #296, Individual #2). Concerns with the reports of progress for the other four individuals are described below:

- Individual #369's November 2018 and December 2018 reports reflected different frequencies of aggression, self-injury, and disruptive behavior for the month of November 2018.
- Individual #151 did not have a progress note completed in December 2018.
- Individual #66 had progress reports completed in September 2018 and November 2018 only.
- Individual #69 had one progress note, completed in December 2018, although he was admitted to the facility in July 2018 (i.e., a half-year earlier).

Staff are advised to include graphs in all progress reports as these allow for analysis of trends over time.

In the September 2018 progress note for Individual #2, it was noted that protective mechanical restraint was ordered by his primary care physician following eye surgery. It would be helpful to identify the date this was initiated, the frequency of mitten use, and the date this was discontinued.

20. Most of the graphs were simple and easy to interpret, and graphed at acceptable intervals of time. However, due to the lack of phase change lines for significant changes or events, these were not useful for making data-based treatment decisions. Examples include the following:

- None of the graphs noted the date of implementation for the individual's PBSP.
- ISPA minutes from a Root Cause Analysis for Individual #152 noted changes in seizure medications, introduction of a fluid restriction, and the addition of a sensory toolbox. None of these were noted on his graphs.
- At Individual #151's psychiatric clinic, staff discussed the use of medications to treat his migraines. It would be helpful if the date these medications were begun was indicated on the graphs.
- Individual #66's plan referenced a level system, behavioral contract, and safe place, but it was not clear when these were introduced. In an ISPA meeting held in January 2019, it was noted that the behavior contract would be removed from the PBSP; this too should be noted with a phase change line.
- A weighted blanket and backpack had been introduced for Individual #403, apparently in an effort to improve her behavior. These changes were not indicated on her graphs.
- Individual #296's graphs should include phase change lines noting his surgery for a pacemaker, his smoking cessation, and the

introduction of a sensory toolbox.

- Individual #69 had a token economy, but it was not clear when this was introduced. At the Behavior Support Committee meeting, staff also reference a social story, but it was not clear what this addressed or when it was introduced.

In some cases, phase change lines were placed incorrectly. For example, Individual #152's ISP was held in June 2018, but the phase change line indicated November 2018. Similarly, Individual #2 had eye surgery in August 2018, but this was noted to have occurred between November 2018 and December 2018. The vertical axis in Individual #403's graph depicting targeted problem behaviors was labeled frequency, however, it was episodes of these behaviors were being recorded. Individual #66's replacement behaviors graph indicated there were three different behaviors, but there was only one data path. Further the graph depicting aggression, property destruction, and suicidal threat utilized the same symbol for all three behaviors.

22. There was evidence that Individual #66 and Individual #69 had been reviewed by the internal and/or external peer review committees. For neither individual was there evidence that recommendations had resulted in revisions to the PBSP. This included recommendations for staff to assume responsibility for Individual #66's token program, and the introduction of social stories and training to accept "No" for Individual #69.

Outcome 8 – Data are collected correctly and reliably.

Summary: Austin SSLC now had a better infrastructure for assessing timeliness, IOA, and treatment integrity than it had in the past. This was good to see. The ultimate obtaining of data deemed to be reliable is an important aspect of programming (also see indicators 5 and 6). With sustained high performance, indicators 28 and 29 might be moved to the category of requiring less oversight after the next review. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	369	152	151	66	403	292	296	2	69
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	75% 6/8	1/1	1/1	1/1	0/1	0/1		1/1	1/1	1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 8/8	1/1	1/1	1/1	1/1	1/1		1/1	1/1	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 8/8	1/1	1/1	1/1	1/1	1/1		1/1	1/1	1/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 8/8	1/1	1/1	1/1	1/1	1/1		1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/8	0/1	0/1	0/1	0/1	0/1		0/1	0/1	0/1

Comments:

26. For six individuals, the data collection systems identified in their PBSPs were considered adequate in measuring their targeted

problem behaviors. While episodes of aggression were identified in Individual #2's PBSP, duration data were collected and, therefore, this was considered adequate.

The exceptions were Individual #66 and Individual #403. Although the operational definitions of Individual #66's targeted problem behaviors suggested that each occurrence would be documented, the information in the data collection procedures section of her PBSP suggested that episodes of these behaviors were recorded. Similarly, Individual #403's aggressive and self-injurious behaviors were defined as episodes separated by five minutes without the behavior, but were reported as frequency measures.

27. Each of the eight individuals had a PBSP that adequately measured the individual's replacement behaviors.

28-29. The behavioral health services department had developed acceptable systems for assessing data collection timeliness, IOA, and treatment integrity. As noted previously, staff were expected to observe either targeted problem behavior or replacement behavior during monthly IOA and treatment integrity checks. Further, targeted problem behaviors must be observed in at least 20% of their observations each month. Timely recording of data was prompted every two hours and reviewed weekly. Acceptable levels for all three measures was 80%.

30. There was evidence of monthly monitoring of IOA and treatment integrity for Individual #403 and Individual #296, with both measures consistently reported at 100%. For all other individuals, there was no evidence of monthly monitoring of IOA and treatment integrity. Regarding data timeliness, monthly reporting of this measure was provided for Individual #403 and Individual #2. For five of the remaining individuals, when timeliness was reported it was below expected levels. The exception was Individual #296. Data timeliness was above the expected level when it was reported in January 2019.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	11% 2/18	1/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #2 – circulatory, and infections; Individual #403 – circulatory, and fluid imbalance; Individual #450 – aspiration, and skin integrity; Individual #172 – falls, and GI problems; Individual #421 – infections, and falls; Individual #227 – falls, and osteoporosis; Individual #260 – constipation/bowel obstruction, and GI problems; Individual #212 – respiratory compromise, and constipation/bowel obstruction; and Individual #138 – osteoporosis, and fluid imbalance).

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 #2 – infections, and Individual #227 – osteoporosis.

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

Outcome 4 – Individuals receive preventative care.

Summary: It was good to see that all nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, these indicators will continue in active oversight until the Center's quality assurance/improvement mechanisms related to preventative care can be assessed, and are deemed to meet the requirements of the Settlement Agreement. In addition, for the individuals reviewed, the Center's medical practitioners 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. If the Center sustains this progress, after the next review, this indicator might move to the category of less oversight.

Individuals:

#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
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	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1

	iii. Breast cancer screening	100% 4/4	N/A	1/1	1/1	N/A	N/A	1/1	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	N/A	1/1	1/1	1/1	1/1
	vii. Cervical cancer screening	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: a. The individuals reviewed received timely preventive care, which was good to see. b. It was positive that in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, PCPs addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable to the needs of the nine individuals reviewed. In other words, the PCP reviewed the QDRRs, provided an interpretation of the results, and discussed what changes could be made to medications based on this information, or stated if the individual was clinically stable and changes were not indicated.										

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
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.	N/A									
Comments: a. None											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.	
Summary: Overall, the Center continued to show improvements with regard to the provision of timely acute medical care for both issues addressed at the Center, as well as for issues for which individuals required transport to the ED, or	Individuals:

hospitalization. The Center is encouraged to continue its efforts in this regard. Of concern, for some individuals who were hospitalized, IDTs did not hold ISPA meetings or did not document the findings of the ISPA meetings in a timely manner. Timely post-hospitalization ISPAs are important to define necessary follow-up medical and healthcare supports to reduce risks and allow for early recognition of signs and symptoms of illness, as appropriate. The remaining indicators will continue in active oversight.											
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	100% 12/12	2/2	N/A	2/2	1/1	2/2	1/1	1/1	1/1	2/2
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	80% 4/5	1/1		N/A	0/1	2/2	N/A	N/A	1/1	N/A
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, 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.	100% 11/11	N/A	N/A	2/2	2/2	1/1	2/2	1/1	2/2	1/1
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	75% 3/4			N/A	1/1	N/A	0/1	N/A	1/1	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, this indicator moved to the category requiring less oversight.									
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	91% 10/11			2/2	1/2	1/1	2/2	1/1	2/2	1/1
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	33% 1/3			1/2	N/A	N/A	N/A	N/A	0/1	N/A
h.	Upon the individual's return to the Facility, there is evidence the PCP	100%			2/2	N/A	N/A	N/A	N/A	1/1	N/A

	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.	3/3										

Comments: a. For eight of the nine individuals reviewed, the Monitoring Team reviewed 12 acute illnesses addressed at the Center, including: Individual #2 (open blister to ankle on 12/22/18, and conjunctivitis on 12/10/18), Individual #450 (redness of stoma on 12/20/18, and redness of skin on 12/23/18), Individual #172 (left ankle swelling and warmth on 7/19/18), Individual #421 (cellulitis of ear on 11/1/18, and neutropenia on 10/2/18), Individual #227 (fall on 11/20/18), Individual #260 (emesis on 9/19/18), Individual #212 (elevated alkaline phosphatase on 10/11/18), and Individual #138 (left hallux lesion on 10/6/18, and fungal infection on 12/10/18).

It was good to see that PCPs assessed these acute issues according to accepted clinical practice.

b. According to a PCP IPN, dated 7/19/18, a nurse noticed that Individual #172 had left ankle swelling and warmth. The individual had a history of physical therapy and an ankle and foot orthotic (AFO) for lengthening of the Achilles tendon due to tendonitis in 1986. The individual expressed no pain on exam. He had limited flexion at the ankle due to spasticity and atrophy of the calf muscle. The individual could not have non-steroidal anti-inflammatory drugs (NSAIDs) due to a GI bleed. The PCP ordered an x-ray for the next day. Based on the documentation the Center submitted, the PCP did not complete and/or document review of the x-ray and/or conduct follow-up.

c. For seven of the nine individuals reviewed, the Monitoring Team reviewed 11 acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #450 (hospitalization for seizure, aspiration pneumonia, hypothermia, sepsis, corona virus, and G-tube placement on 9/15/18, and hospitalization for respiratory distress, sepsis, UTI, and right lower lobe pneumonia on 12/24/18), Individual #172 (ED visit for a fall on 8/6/18, and ED visit for altered mental status on 11/18/18), Individual #421 (ED visit for nodule on 8/21/18), Individual #227 (ED visit for a fall on 7/1/18, and ED visit for a fall on 7/5/18), Individual #260 (hospitalization for respiratory failure on 9/27/18), Individual #212 [ED visit for abnormal white blood cell count on 11/12/18, and hospitalization for aspiration pneumonia, respiratory syncytial virus (RSV), and pressure ulcer on 10/24/18], and Individual #138 (ED visit for pain in right ankle on 9/4/18).

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

- It was positive to see that the following individuals displaying signs/symptoms of acute illness received timely acute medical care, and follow-up care, as needed: Individual #450 (hospitalization for respiratory distress, sepsis, UTI, and right lower lobe pneumonia on 12/24/18), Individual #172 (ED visit for a fall on 8/6/18, and ED visit for altered mental status on 11/18/18), Individual #421 (ED visit for nodule on 8/21/18), Individual #227 (ED visit for fall on 7/1/18), Individual #260 (hospitalization for respiratory failure on 9/27/18), Individual #212 (ED visit for abnormal white blood cell count on 11/12/18,), and Individual #138 (ED visit for pain in right ankle on 9/4/18).
- For Individual #450, for the hospitalization on 9/15/18, the ISPA was written/entered on 1/22/19, which was after Center staff were given the list of individuals that the Monitoring Team would review. Although the ISPA listed the date of the ISPA meeting as 9/26/18, the ISP technically was not modified until 1/22/19. Given her change of status, requiring, for example, modification to nothing-by-mouth status, the failure to complete a timely ISPA was problematic. It also was concerning to the

Monitoring Team that Center staff submitted this ISPA without noting that it was a late entry (i.e., staff included it in chronological order based on the meeting date without including an explanation), and/or indicating in the document response that they were including information after the cut-off date for documents, which was 1/10/19.

- On 11/18/18, Individual #172 was unresponsive, and had cool skin, oxygen saturations of 82%, a pulse of 54, and respirations of 14. Then, nursing staff noted he felt cold, and they could not feel a pulse. Staff started chest compressions, and the individual awoke. Staff called Emergency Medical Services (EMS), who transported him to the ED. The Monitoring Team member confirmed during the onsite review that documentation was not available to confirm that staff contacted the ED to provide relevant information.
- According to a PCP IPN, dated 7/5/18, at 4:27 p.m., Individual #227 developed new bruising on the right lower quadrant of her abdomen. The note indicated the PCP suspected that she had injured her spleen during a fall. She was sent to the ED. The PCP also noted that her hemoglobin (Hgb) was 14, and on the date of the transfer, it was 11. Although this occurred during normal business hours, the PCP did not complete an exam.
- From 10/15/18 to 10/22/18, Individual #212 was hospitalized for three viral infections. Upon her return to the Center, her increased secretions continued. According to a nursing IPN, dated 10/24/18, at 1:45 a.m., her oxygen saturations were 85% to 90% on room air with tachycardia, and she had congestion with respiratory distress. She was sent to the ED. From 10/24/18 to 10/25/18, she was hospitalized again. Based on the documentation submitted, no evidence was found that the IDT held a post-hospitalization ISPA meeting.

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

Summary: Although since Round 12 of monitoring, Indicator b has been in less oversight, some issues with timeliness of the PCPs' review of consultation reports were noted during this review, placing the indicator at risk of returning to active oversight. Center staff should ensure that such issues are corrected. For the individuals reviewed, with few exceptions, PCPs wrote orders for agreed-upon recommendations, which was important to see. If the Center sustains this progress, after the next review, Indicator d might move to the category of less oversight. It was good to see that PCPs referred consultation recommendations to IDTs, when appropriate, and IDTs reviewed the recommendations and documented their decisions and plans in ISPAs.

Individuals:

#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
b.	PCP completes review within five business days, or sooner if clinically indicated.										
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.	83% 10/12	2/2	1/1	2/2	1/1	N/A	1/2	1/1	1/1	1/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	100% 2/2	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	1/1

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 14 consultations. The consultations reviewed included those for Individual #2 for Ear, Nose, and Throat (ENT) on 7/26/18, and ophthalmology on 10/1/18; Individual #403 for neurology on 9/28/18, and nephrology on 8/20/18; Individual #450 for ENT on 12/13/18, and gastroenterology (GI) on 11/12/18; Individual #172 for podiatry on 7/20/18; Individual #421 for surgery on 8/20/18; Individual #227 for hematology on 8/16/18, and orthopedics on 8/10/18; Individual #360 for GI on 7/23/18; Individual #212 for neurology on 7/27/18; and Individual #138 for hematology/oncology on 7/5/18, and orthopedics on 10/12/18.

b. Although since Round 12 of monitoring, Indicator b has been in less oversight, some issues with timeliness of the PCPs' review of consultation reports were noted during this review (i.e., Individual #2 for ophthalmology on 10/1/18, Individual #403 for neurology on 9/28/18, and Individual #450 for ENT on 12/13/18), placing the indicator at risk of returning to active oversight. Center staff should ensure that such issues are corrected.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, with the exceptions of the following:

- For Individual #227, the orthopedist recommended discontinuation of the sling and swathe, continuation of range-of-motion exercises, and a return to ad lib activities. The Center did not submit documentation to show the PCP wrote corresponding orders.
- For Individual #138, the hematologist/oncologist recommended a repeat of the serum protein electrophoresis (SPEP) blood test in one year, but an order was not found for it. In addition, the consultant recommended re-initiation of a calcium supplement, but calcium was not listed in the current 90/180 day orders.

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.			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	Individual with chronic condition or individual who is at high or	67%	1/2	1/2	2/2	1/2	2/2	2/2	1/2	2/2	0/2

	medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	12/18									

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #2 – circulatory, and infections; Individual #403 – circulatory, and fluid imbalance; Individual #450 – aspiration, and skin integrity; Individual #172 – falls, and GI problems; Individual #421 – infections, and falls; Individual #227 – falls, and osteoporosis; Individual #260 – constipation/bowel obstruction; Individual #212 – respiratory compromise, and constipation/bowel obstruction; and Individual #138 – osteoporosis, and fluid imbalance).

a. For the following individuals' chronic or at-risk conditions, PCPs conducted medical assessment, tests, and evaluations consistent with current standards of care, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #2 – infections; Individual #403 – fluid imbalance; Individual #450 – aspiration, and skin integrity; Individual #172 – falls; Individual #421 – infections, and falls; Individual #227 – falls, and osteoporosis; Individual #260 – constipation/bowel obstruction; and Individual #212 – respiratory compromise, and constipation/bowel obstruction. The following provide examples of concerns noted:

- Individual #2 had a long history of chronic kidney disease, due to hypertension, nephrosclerosis, and hydronephrosis. To sustain his hemoglobin/hematocrit due to his impaired renal function, he required Epoetin injections weekly. He also had a history of slowly worsening persistent hyperkalemia (elevated potassium). On 9/12/17, the PCP ordered Kayexalate twice weekly, which controlled his hyperkalemia. On 1/9/18, this was increased to three times weekly; on 9/4/18, it increased to four times weekly; and, on 10/30/18, the PCP increased it to daily with two days with additional doses at bedtime. He was prescribed a high-calorie renal diet, with the addition of Suplena. The most recently submitted lab data indicated his glomerular filtration rate (GFR) was 44 (for reference: normal GFR is greater than 60, and a GFR of less than15 indicates kidney failure and the need for dialysis or transplant). In the past year, his GFR has been 37 to 48; a cystatin C level from 5/18/18, suggested his GFR was less than 30. The monitoring and treatment of complications of his gradual renal function decline had been timely, with positive clinical impact on his hemoglobin, hematocrit, potassium level, and hydration status.

  However, despite concerns clearly articulated in the Monitoring Team's last report, the PCP and IDT had not documented discussion with his Legally Authorized Representative (LAR)/family members regarding the future plan for his renal disease. It was not evident from submitted documentation that there has been clear communication with the family to determine their wishes on this significant issue. If the plan was for the individual to undergo or have a trial of dialysis, then his self-injurious behaviors, such as biting, pinching, and hitting himself with his hand required improved behavioral supports due to the need for an arteriovenous shunt. He also would need to be able to sit still in a dialysis chair for three hours several times a week, which would require the implementation of plans to modify his current daily routine for which he had strong preferences. Given this individual's history, changing his behavior and routine will require months to years of integrated behavioral health interventions. Therefore, the IDT would need to immediately engage in interdisciplinary planning and concerted efforts to implement plans to address the needed changes. Such efforts and documentation of progress or lack thereof are necessary to determine whether or not he is a candidate for this life-changing treatment, and/or to allow the LAR and IDT to justify not offering this aggressive treatment alternative. Based on the documentation submitted, the IDT with the leadership of the PCP had not engaged in this level of decision-making, planning, and implementation of plans to meet his needs. It was concerning that since the Monitoring Team's last review, nine months earlier, Individual #2's risk had increased, but the IDT had not addressed the concerns articulated in the Monitoring Team's last report or provided clinical justification for not addressing

them.

In its comments on the draft report, the State provided the following in way of clarification: "With regards to individual #2, considering that his GFR has remained mostly above 40 since November 2017, again we do not anticipate the need for renal replacement therapy over the next several years as long as supports are in place to preserve kidney function for as long as possible. Hence, no planning for AV shunt has been done at this time…" Although it was fortunate that Individual #2 did not currently require renal replacement therapy, the Monitoring Team's point in this report, as well as it previous report was that the IDT should begin planning now for the probable need for it in the future. If the IDT were to wait until it was imminently needed, it would likely be too late to effectuate the needed behavioral changes. Given Individual #2's behavioral profile, efforts to increase his tolerance for such procedures potentially could take several years. Again, if the plan is to try dialysis should he need it, then the PCP and IDT should take advantage of his current status to develop and implement a plan to assist him in cooperating with the procedures in the future.

- For Individual #403, by 2010, her renal function had dropped to a GFR of 30 to 40. A nephrologist followed her. On 11/12/13, her GFR dropped to 32, and on 4/21/17, it was 24. It was believed she had worsening renal function due to a dehydration effect from her diabetes insipidus and water was offered liberally. She was offered up to 7400 ml per day, and the PCP increased desmopressin acetate (DDAVP), with stabilization of her GFR in the 26 to 32 range. On 10/22/17, she was hospitalized for a UTI, associated with worsening renal function (creatinine 2.5). The PCP added cranberry juice to her diet to minimize recurrent UTIs. A computed tomography (CT) scan of the abdomen indicated no structural abnormalities of the renal system nor stone formation. Nephrology recommended continuation of the current treatment at that time. Her renal function slowly improved. On 11/30/17, her creatinine dropped to 1.46, and the GFR had increased to 40, with a potassium of 4.8. She was allowed to drink 6000 to 9000 ml per day in order to quench her thirst. An attempt was made to decrease her fluid intake from 12 to 10 ounces per hour, but this reverted to 12 ounces per hour, because her behaviors increased. On 12/10/17, the PCP added cephalexin for UTI prophylaxis. A nephrology consult, dated 8/21/18, indicated her blood pressure was under good control without blood pressure medications. Parameters were set for when to restart Procrit to prevent anemia. Based on the submitted documents, on 10/16/18, the most recent value of the GFR was 29. On 1/11/19, and 2/8/19, the PCP communicated with the nephrologist, reviewing lab data and changes in her medication regimen to optimize her medication management. The submitted documentation indicated appropriate monitoring of renal function, hydration, and prevention of UTIs.

  However, similar to Individual #2, it was less clear that the PCP had had a discussion with family/LAR concerning plans as the individual's renal function declined. If dialysis were indicated, then behavioral health services needed to evaluate her self-injurious behaviors, with development and implementation of a plan so she would eventually tolerate an arteriovenous fistula. Again, the acceptance of a fistula, as well as tolerance for sitting for dialysis for three-hour periods three times weekly might take months to years for her to accept and cooperate. Such efforts and documentation of progress or lack thereof are necessary to determine whether or not she is a candidate for dialysis in the future, and/or to allow the LAR/family and IDT to justify not offering this aggressive treatment alternative at the time it would be clinically indicated. Based on the documentation submitted, the IDT with the leadership of the PCP had not engaged in this level of planning and implementation of plans to meet her needs. Additionally, the IDT should discuss whether she would cooperate with preoperative, and postoperative renal

transplantation as a future long-range alternate option to dialysis, as this would both correct the kidney failure as well as potentially the significant side effects (excessive thirst) and complications (dehydration) associated with the nephrogenic component/etiology of her diabetes insipidus. This option would take considerable communication and coordination with a transplant center.

In its response to the draft report, the State offered clarifications, and stated: "…the main goal in managing individual #403 at this time has been to minimize the progression of chronic kidney disease to preserve kidney function as long as possible without needing renal replacement therapy… the glomerular filtration rate (GFR) has trended upwards with these supports in place. The last measured GFR was 35. Further, the Society for Vascular Surgery guidelines indicate that the time for referral and planning for AV Shunt is when GFR drops below 20-25. Due to individual's improving renal function, the IDT did not consider behavioral planning for placement of an AV fistula at this time as it could take several years for her GFR to reach below 20-25…" The Monitoring Team's response to these comments are the same as for Individual #2. Moreover, for Individual #403, the submitted data indicated that her renal function could change (improve or worsen) over a brief period of time. Again, the IDT should consider taking advantage of this period of time when she does not require dialysis to proactively address the behaviors that might prevent its successful implementation in the future.

The Monitoring Team appreciates the State's commitment to: "have IDT meetings to discuss both of these invididual's [sic] [i.e., Individual #2 and Individual #403's] chronic kidney disease as well as had further discussions with the guardians/LAR regarding the future need for renal replacement therapy. This will be documented in an ISPA." The Monitoring Team would encourage the PCPs and IDTs to discuss the potential advantages of starting early to proactively assist these individuals to tolerate the procedures that might become a necessary part of their routine (e.g., sitting for a period of time, having a something attached to their arms, etc.), as well as the risks of not doing so.

- Individual #172 had a long history of gastritis/esophagitis. In 1992, he had recurrent iron deficiency anemia. Stool for occult blood was positive. An esophagogastroduodenoscopy (EGD) found gastritis. An upper gastrointestinal series (UGI) noted changes of peptic ulcer disease. He was treated with Zantac and his blood count improved with iron supplementation. Later that same year, he required a blood transfusion, and an EGD showed a gastric ulcer. In July 1998, an EGD found acute and chronic gastritis and H pylori infection, which was treated. In February 1999, a video esophagram showed severe spontaneous gastroesophageal reflux disease (GERD) and normal swallowing. The PCP ordered medication and anti-reflux measures. A March 2000 video esophagram showed GERD and esophagitis. The PCP changed the H2 receptor blocker to a proton pump inhibitor (PPI). In June 2004, a video esophagram showed GERD to the upper level of the esophagus. On 1/28/09, a video esophagram showed trace aspiration and reflux the entire length of the esophagus. In July 2011, he was hospitalized for an acute GI bleed due to esophageal ulceration. On 5/10/14, the bleeding recurred and an EGD showed severe ulcerative esophagitis with bleeding, as well as gastritis. From then until July 2018, there was little information submitted related to his GI health.

  Most recently, he had occasional emesis (i.e., 11/14/18, 12/13/18, 12/17/18, and 12/18/18). The recent AMA, dated 1/15/19, stated his anemia was stable, with lab testing every six months. A 2/2/18 Hgb was 14, at which time his iron and ascorbic acid were discontinued. A follow-up Hgb/hematocrit (Hct), of 5/21/18, was 12.7/37.6, and a Hgb/Hct, of 11/6/18,

was 12.2/38.1, which might be interpreted as a slow decrease from the 2/2/18 values. He was to continue the PPI twice daily. To address the recurrent emesis, the PCP ordered Zofran three times daily. However, this treated symptoms and not the underlying disease process. During onsite discussion with the PCP, it was not clear whether there was a well-defined plan for identifying threshold signs/symptoms, or when to refer him back to GI, given his history of severe GERD associated with GI bleeding. The recent increase in emesis was a potential concern. Although he had a history of severe GERD the entire length of the esophagus, the submitted documents did not discuss whether he was at risk for Barrett's esophagus or whether this had been ruled out (the date of the last EGD was 2014, and if there was a more recent EGD, it was not recorded/submitted). Whether his severe GERD was adequately treated or would benefit from further/supplemental medical or surgical intervention (fundoplication) could not be determined.

- Individual #260 had a diagnosis of GERD, and was prescribed Nexium. The submitted documentation did not include evidence to support this diagnosis. On 2/22/95, a video esophagram found no aspiration and no reflux, but marked aerophagia. A 5/22/00 video esophagram found no aspiration or reflux. An EGD, on 2/10/15, was completed for a possible esophageal stricture, but the exam was normal. The July 2018-monthly nursing record review indicated he had dysphagia. On 7/27/18, he had emesis. On 8/27/18, he had emesis of 300 ml. On 9/19/18, he had emesis after lunch, described as a large amount, and he was started on an antibiotic due to possible aspiration. Again on 9/20/18, he had a large emesis after lunch. On 9/27/18, he developed hypoxia and was hospitalized, but did not survive this acute illness.

  The submitted documentation did not confirm a diagnosis of GERD, although most recently there were episodes of emesis after eating, with potential aspiration. There was no information to indicate further evaluation or a plan for evaluation of his recent emesis episodes (i.e., 7/27/18, 8/27/18, 9/19/18, and 9/20/18). On 9/27/18, a nursing IPN stated that he developed respiratory failure/hypoxia unrelated to eating or emesis and was transferred to the hospital after hours. However, evaluation of the original diagnosis of GERD was incomplete. Additionally, the more recent significant episodes of emesis did not trigger further evaluation and treatment.

- Individual #138 had spastic quadriplegia and scoliosis, associated with foot deformities. He had poor balance and functional weakness. He also had cataracts, along with hyperopia and astigmatism. In 2003, he was diagnosed with osteoporosis, and on 1/17/15, he was found to have a low vitamin D level. His hypovitaminosis D had been resolved. A surgeon was consulted concerning his scoliosis, but he did not have clinical indications (i.e., cardiopulmonary compromise, gluteal breakdown) for surgical intervention. In 2011, he had a traumatic hemarthrosis of his left knee, which was tapped. He had a history of monoclonal gammopathy of undetermined significance (MGUS), for which hematology followed him. In 2013, a skeletal survey indicated two lucencies of the distal right femoral shaft compatible with myeloma, but a subsequent aspiration and biopsy were negative for this. Calcium and Vitamin D supplements were discontinued as it was believed the MGUS was the etiology of hypercalcemia at that time. In December 2014, he developed bilateral knee swelling and pain. Evaluation included x-rays, which were negative for acute findings. An orthopedist was consulted for the bilateral knee pain, and he was to use a short knee brace on the left knee with transfers. A DEXA scan, on 11/9/16, showed a T score of -3.8. He already had been on Reclast yearly. A testosterone level ruled out hypogonadism as an additional/potential cause of osteoporosis. The chronic knee pain improved on NSAIDs. Again, on 7/6/18, he had right knee pain and was seen in the orthopedic clinic and noted to have decreased ROM due to spasticity, but no instability. Treatment was symptomatic, with compressive wrap and analgesics. He

was to return as needed. Habilitation Therapy provided a knee sleeve, which resolved the discomfort. On 7/6/18, a one-year follow-up with the hematologist for his MGUS was completed. He was considered stable for this condition, and it was recommended that he restart his calcium supplementation, as the calcium level had normalized in 2018.

On 9/1/18, he was noted to have bruises to his hip/left thigh compatible with a bump during a transfer. On 9/3/18, he complained of left knee pain, but there were no clinical findings. On 9/4/18, he complained of right ankle pain. There was swelling and bruising, and an x-ray showed a right medial malleolus fracture. A fracture boot and compression hosiery/wrap were recommended. Orthopedic specialists followed him until the fracture healed. The etiology of the fracture was unknown, but it might have been associated with a family member transferring him in and out of the car during an off-campus visit. The IDT agreed to have Austin SSLC staff provide transportation and staffing for weekend family visits. The guardian agreed with this decision. This individual has several systemic and skeletal system challenges (i.e., osteoporosis, MGUS, contractures, spastic quadriparesis, scoliosis, fractures, and recurrent knee pain), but there was appropriate evaluation of each condition. However, the submitted documentation did not show resumption of calcium following the 7/6/18 hematology consult, indicating further review was needed of treatment.

- Individual #138 had a history of electrolyte imbalance, specifically hyponatremia. In the AMA, the history indicated that in 2014, lab results showed a decrease in his sodium level, when it dropped from 137 to 129 despite a fluid restriction. Despite intravenous (IV) normal saline (NS), Lasix, and demeclocycline, the sodium continued to drop to 121, at which time he was hospitalized. A nephrologist was consulted and indicated the need to restrict him to one liter per day of fluids, but to avoid NS unless volume depleted. It was determined that the diagnosis was spontaneous idiopathic antidiuretic hormone (SIADH) with a fixed antidiuretic hormone (ADH) secretion, which was not due to medications. Despite this, the Active Problem List (APL) in the AMA indicated: "hyponatremia secondary to SIADH due to needed medication." It appeared this was not corrected or there was other information not submitted for review, which would provide evidence for continuation of the ''medication effect" of his IADH. It was noted that he did not have symptoms of his hyponatremia. Pedialyte was offered instead of water, and salt supplements were gradually increased from ¼ teaspoon to ½ teaspoon per meal. Pedialyte supplementation was subsequently discontinued. An IPN, dated 8/17/18, indicated his sodium was stable at 133.

  In 2014, he also had lower extremity edema, which was successfully treated with compression stockings. A fluid restriction of 1000 ml every 24 hours was changed on 10/15/18, to 1180 ml per day in order to allow administration of one packet of Juven with his medication pass to support healing. During the temporary change in fluid restriction, sodium chloride (NaCl) supplementation was increased to 1000 milligrams (mg) three times a day. On 10/19/18, the Juven supplement was discontinued, and he then reverted to his prior schedule of 1000 ml fluid restriction per day. His sodium level had remained stable during and after that time. His evaluation and treatment were appropriate to meet his needs, but the documentation of evaluation/diagnosis needs clarification in the APL.

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 generally found to show implementation of those few action steps assigned to the PCPs that IDTs had	Individuals:

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	2	403	450	172	421	227	260	212	138
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	82% 9/11	N/A	0/2	2/2	N/A	2/2	1/1	N/A	2/2	2/2
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, the action steps assigned to the PCPs were implemented for the following: Individual #450 – aspiration, and skin integrity; Individual #421 – infections, and falls; Individual #227 – osteoporosis; Individual #212 – respiratory compromise, and constipation/bowel obstruction; and Individual #138 – osteoporosis, and fluid imbalance.											

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; recommendations are made about any necessary additional laboratory testing regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.											
Summary: N/R			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	Not rated (N/R)									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: a. and b. The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.											

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.	
Summary: Given that for the past two reviews and this review, for the individuals reviewed, the Clinical Pharmacist generally addressed laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and made recommendations to the prescribers in relation to: • Laboratory results, including sub-therapeutic medication values (i.e.,	

• Round 12 – 94%, Round – 100%, and Round – 100%); • Benzodiazepine use (i.e., Round 12 – 93%, Round – 100%, and Round – 100%); • Medication polypharmacy (i.e., Round 12 – 100%, Round – 100%, and Round – 100%); • New generation antipsychotic use (i.e., Round 12 – 100%, Round – 100%, and Round – 100%); and • Anticholinergic burden (i.e., Round 12 – 82%, Round – 100%, and Round – 100%); Indicator b will be placed in the category requiring less oversight. In addition, given that for the past two reviews and this review, for the individuals reviewed, prescribers generally implemented the recommendations agreed upon from QDRRs (i.e., Round 12 – 100%, Round – 100%, and Round – 88%), Indicator d will move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	QDRRs are completed quarterly by the pharmacist.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	ii. Benzodiazepine use;	100% 10/10	2/2	N/A	2/2	N/A	2/2	N/A	2/2	N/A	2/2
	iii. Medication polypharmacy;	100% 14/14	2/2	N/A	2/2	2/2	2/2	N/A	2/2	2/2	2/2
	iv. New generation antipsychotic use; and	100% 6/6	2/2	2/2	N/A	N/A	2/2	N/A	N/A	N/A	N/A
	v. Anticholinergic burden.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									

	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	88% 7/8	1/1	N/A	1/2	N/A	1/1	2/2	N/A	1/1	1/1
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	N/R									

Comments: b. It was good to see that for the individuals reviewed, the Clinical Pharmacist completed QDRRs that noted any irregularities, the significance of the irregularities, and made recommendations to the prescribers with regard to laboratory results, benzodiazepine use, medication polypharmacy, new generation antipsychotic uses, and anticholinergic burden, as applicable to the individual.

d. When prescribers agreed to recommendations for the individuals reviewed, documentation generally was presented to show they implemented them. The exception was for Individual #450 for whom the Pharmacist noted a drug-drug interaction risk and recommended the PCP change the calcium carbonate dosing time to 7:00 p.m. to improve the absorption of levothyroxine. When the Pharmacist made the recommendation, the individual was in the hospital. She returned with a G-tube, and the PCP changed the route for all medications to the G-tube. On 9/27/18, the order for calcium was for 7:00 a.m., and the levothyroxine was also at 7:00 a.m. These were listed in the Orders, and on the Medication Patient Profile (Medication List) to be given at 7:00 a.m.

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

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

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

Comments: a. and b. The Monitoring Team reviewed four individuals with medium or high dental risk ratings. None of the four had clinically relevant, achievable, and measurable goals/objectives related to dental. For the remaining five individuals, the IDTs indicated the dental risk was low, but all of them had one or more risk that should have resulted in either medium or high risk ratings (e.g., use of suction tooth brushing, periodontal disease Type II to IV, and/or the need for general anesthesia/TIVA for routine and/or invasive procedures).

The Monitoring Team will be working with State Office on this issue so that State Office can provide more guidance to the Centers. A good way to think about it, though, is: "what would the dentist tell the individual he/she or staff should work on between now and the next visit?" For different individuals, the causes of their dental problems are different, and so the solution or goal should be tailored to the problem. For example, should an individual reduce the amounts of sugary snacks he/she consumes, should an individual brush his/her teeth twice a day for two minutes instead of once a day, should a goal revolve around the individual tolerating tooth brushing for 30 seconds leading up to an eventual two minutes? These are the type of questions IDTs should be asking themselves when deciding upon a goal.

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

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	N/R									

Comments: a. As indicated in the dental audit tool, this indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will be marked "N/R." At the time of the review, State Office had not yet developed and implemented a

process to ensure inter-rater reliability with the Centers.

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
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.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.										
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.										
e.	If the individual has need for restorative work, it is completed in a timely manner.										
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.										
Comments: a. through f. None.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
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, these indicators 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: a. through c. None.											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: Problems were noted with regard to IDTs defining measurable suction tooth brushing parameters (i.e., frequency, as well as length of the session), and including this information in individuals' IHCPs. By the time of the next review, IDTs could easily remedy this situation by including the information in ISPs/IHCPs or holding ISPA meetings to add the needed information. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	0% 0/4	N/A	N/A	0/1	N/A	N/A	N/A	0/1	0/1	0/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/4	N/A	N/A	0/1	N/A	N/A	N/A	0/1	0/1	0/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	25% 1/4	N/A	N/A	0/1	N/A	N/A	N/A	0/1	0/1	1/1
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/4	N/A	N/A	0/1	N/A	N/A	N/A	0/1	0/1	0/1

Comments: a. The IDTs did not include suction tooth brushing strategies/action plans in the ISPs/IHCPs for the four applicable individuals. IDTs placed the frequency in the Integrated Risk Rating Forms (IRRFs), but did not transfer them to the ISP or IHCP (i.e., which are the vehicles IDTs use to make sure that needed supports are delivered), and IDTs did not define the length of time for each session.

b. The Center submitted data for suction tooth brushing that each of these individuals had received, but without a specific action plan for frequency and duration, it was not possible to determine if this was consistent with their individual needs.

c. Although it appeared that Dental Department staff conducted some monitoring of staff's implementation of suction tooth brushing for quality, as well as safety, ISP action plans did not define the frequency expected to meet the needs of three of the four individuals. As a result, the Monitoring Team could not determine whether or not the frequency was sufficient. For Individual #138, the current ISP did define twice-yearly annual monitoring and the Center had completed the first of the two monitorings, with one pending but not yet due.

Since the inception of the Dental Audit Tool, in January 2015, the interpretive guidelines for this indicator have read: "Frequency of monitoring should be identified in the individual's ISP/IHCP, and should reflect the clinical intensity necessary to reduce the individual's risk to the extent possible." As indicated in the previous report, IDTs still needed to ensure that individuals with suction tooth brushing have IHCPs that define the frequency of monitoring and it is implemented according to the schedule.

d. ISP monthly reviews did not include specific data reflective of the measurable goal/objective related to suction tooth brushing. Specific suction tooth brushing data is needed to summarize the frequency of sessions completed in comparison with the number anticipated (e.g., 60 out of 62 sessions). While QIDP monthly reviews for the four individuals sometimes included data with regard to the number of suction tooth brushing sessions, only one (for Individual #450) also included the number anticipated. Additionally, a second data subset is needed on the number of such events during which the individual completed the expected duration of suction tooth brushing (e.g., of the 60 completed sessions, in 12 sessions the individual completed two minutes of suction tooth brushing). None of the monthly reviews included this information.

Outcome 9 – Individuals who need them have dentures.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	Due to the Center's sustained performance, this indicator moved to the category of requiring less oversight									
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: b. None of the individuals with missing teeth reviewed had a recommendation for dentures.											

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: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
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	0%									

	assessments.										
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	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. In the months prior to the review, State Office provided training to all of the Centers on the development of acute care plans. During this round of reviews, the Monitoring Team is working with State Office on ensuring Centers provide the correct documentation for review of acute care plans. Given the timing of the Austin SSLC review, the Center was in the initial stages of implementing the revised acute care plan template/process. It was decided that the Monitoring Team would not search for needed acute care plans that might not exist throughout the preceding six months. However, as a result of the ongoing systems issue since the implementation of IRIS, these indicators do not meet criteria. Center staff should continue to work with State Office to correct the issues. By the time of the next review, the Monitoring Team plans to conduct a full review of acute care plans.											

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
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.	6% 1/18	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #2 – falls, and constipation/bowel obstruction; Individual #403 – falls, and choking; Individual #450 – osteoporosis, and seizures; Individual #172 – falls, and constipation/bowel obstruction; Individual #421 – constipation/bowel obstruction, and infections; Individual #227 – skin integrity, and choking; Individual #260 – GI problems, and cardiac disease; Individual #212 – constipation/bowel obstruction, and choking; and Individual #138 – constipation/bowel obstruction, and fractures).											

None of the goals/objectives reviewed were clinically relevant and achievable.

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #403 – choking.

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

Outcome 6 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.

Summary: Nurses often did not include interventions in IHCPs to address individuals' at-risk conditions, and even for those included in the IHCPs, documentation often was not present to show nurses implemented them. In addition, IDTs often did not collect and analyze information, and develop and implement plans to address the underlying etiology(ies) of individuals' risks. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 2	403	450	172	421	227	260	212	138
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	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	8% 1/12	0/1	0/1	0/2	0/1	1/2	0/1	0/2	0/1	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. and c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, or that nursing interventions were implemented thoroughly. For Individual #260, records showed that nurses documented vital signs daily, but nurses did not re-take vital signs when abnormal values

were noted.

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

- Although the ISPAs, dated 11/14/18 and 11/26/18, noted that Individual #2's IDT meet in response to falls on these same dates (i.e., on 11/14/18, he fell out of his wheelchair, and on 11/26/18, his wheelchair tipped forward with him in it), there was no indication that the IDT met to discuss issues regarding his anemia, loss of vision and surgery to remove his right eye, chronic urinary tract infections (UTIs), kidney failure, episodes of elevated potassium, changes in medications, incidents of him pulling out his suprapubic catheter, and/or the effects of the use of pain medications on his overall health and behavior. Symptoms of many of these issues can have an impact on fatigue and weakness, as well as behavior.
- Of concern, there were discrepancies in the IPNs regarding Individual #403's falls versus controlled sitting on the ground. For example, the IPNs, dated 10/9/18, and 10/10/18, indicated that the individual sat on the floor, but staff's review of the video showed that she fell. Although it was positive that staff reviewed these episodes via the video, it also identified a need for staff to accurately report falls, and potentially receive additional training. Also, of concern, Document #TX- AU-1902- II.P.1-20 indicated that she had no falls over the previous six months, but the ISPA, dated 1/5/19, indicated she fell on 10/5/18, 10/9/18, 10/10/18, 11/26/18, and 12/4/18. Although the ISPAs showed that the IDT met frequently to review each fall, based on the documentation provided, the IDT had not conducted a comprehensive assessment and analysis to identify underlying causes of why she was falling in order to develop interventions to prevent them to the extent possible.
- After being seizure-free since March 2009, on 8/7/18, Individual #450 began having seizures. According to the AMA and Document #TX-AU-1902-II.P.1-20, on 8/17/18, 9/15/18, and 12/24/18, she had additional seizures.

  In addition, the ISPA, dated 3/16/18, noted that she had not had an episode of hypothermia since 10/3/16, and the IDT decided to take her name off the hypothermia precautions list. However, the ISPA, dated 1/16/19, indicated that on 8/16/18, the IDT "re-implemented" these precautions due to hypothermia episodes. The ISPA stated: "In 2018 [Individual #450] had 7 documented days of low body temperatures and 1 so far in 2019. On 1/3/18, 1/15/18, 2/17/18, 2/22/18 and 2/23/18 low temp of 35.4 to 36.4 Celsius were documented. Blankets were added and tucked around her. On 10/9/18 an electric blanket was used. On 12/23/18 and 1/14/19 a Bear Hugger was used to bring her body temperature back up." (Of note, the dates included in this ISPA reflected eight, as opposed to seven episodes of hypothermia). The ISPA, dated 1/16/19, did not explain why on 3/16/18, when the IDT decided to remove her from the list of individuals on hypothermia precautions, the IDT was not aware of her episodes of hypothermia in January and February 2018.

  Some of the additional health issues that were occurring for Individual #450 included:
  - On 1/15/18, 9/15/18, 12/24/18, and 1/5/19, she was hospitalized for pneumonia/aspiration pneumonias.
  - On 9/25/18, she had a percutaneous endoscopic gastrostomy tube (PEG) tube placement.
  - From September through October 2018, she had a pressure ulcer Stage 2 to her right heel and an unstageable ulcer to the right ankle, and perineal and buttocks rash.
  - According to her AMA, in October/November 2018, she had elevated residuals ranging from 150 to 300 cubic

centimeters (cc) and impaired gastric motility with both PEG feedings and oral intake.
  - On 12/4/18, during a pelvic ultrasound, a left pelvic renal stone (large) was found.
  - Her AMA noted: "would benefit from increased fluid intake," and an ISPA, dated 12/13/18, indicated her PCP stated that she "seemed dehydrated as determined by high BUN [blood urea nitrogen] and higher than usual BUN/Creatinine ratio." Her fluid intake was to increase via gastrostomy tube (G-tube) to "close to 2000 ml daily."
  - Enteral Feeding Records, for 12/13/18 through 1/15/19, reflected various totals of enteral intake ranging from 2500 ml (i.e., on 12/11/18, 12/12/18, and 12/13/18) to 898 (i.e., on 1/13/19). It was not clear if or how staff were documenting any oral intake, and including this information in the 24-hour totals.
  - According to the ISPA, dated 1/16/19, she had been exposed to infectious illness and her home had been placed on droplet precautions "at least 4 different times" (no dates provided). This ISPA indicated that staff did not wear the appropriate personal protective equipment (PPE) or dispose of it in the proper receptacles, some staff had not been vaccinated for influenza, and standardized protocols were lacking for cleaning shared items in the home and possibly at the day programs. (The Center only recently filled the two infection control positions and was in the beginning stages of resurrecting the Infection Control Committee.)
  - In August 2018, Individual #450 had an elevated thyroid stimulating hormone (TSH) (i.e., 8.34 international units per liter in comparison with the normal range of 0.026 to 5.1). Hypothyroidism can cause high cholesterol, a puffy face, weight gain, sensitivity to cold, and fatigue.

As illustrated above, during the past year, this individual's status significantly changed. However, the IDT had not conducted a comprehensive review of her issues, until on 1/16/19, the IDT initiated a "root cause analysis" (RCA). Unfortunately, the IDT did not include in the RCA data related to all of her health issues, monitoring data for PNMP compliance and oral intake sessions, or a timeline to identify possible trends. As a result, the IDT did not have the data or analysis of the data to support its conclusion that: "Placement of the enteral feeding tube during her September hospitalization is felt to be the primary factor in the recurrence of hospitalizations in December 2018 and January 2019."

- After Individual #172 fell on 7/20/18, it was positive that the IDT reviewed the video tape, and identified the cause of his fall as an incorrect stand pivot transfer procedure. However, based on the ISPA dated 7/23/18, it was concerning that the IDT did not initiate regular monitoring to ensure staff were correctly executing transfer procedures.
- Individual #421 had an incision and drainage procedure performed, and the culture showed the wound was positive for Methicillin-resistant Staphylococcus aureus (MRSA). Based on the IPNs submitted, upon her admission to the Infirmary following this procedure, nursing staff did not implement no-contact precautions. There was no indication that infection control staff were involved to ensure staff and the individual followed the practices necessary to promote healing and prevent the spread of the contagious infection. In the IPNs, staff noted that the individual would take off the dressing and take out the packing from the wound. However, the notes did not describe steps staff were taking with the individual to ensure that she was not spreading the infection to other areas of her body. This was particularly important given that she had cellulitis on her right ear lobe (pinna) and on her left cheek and earlobe, as well as the MRSA infection under her right arm. Her ISP, dated 7/10/18, noted that she communicated effectively both verbally and nonverbally and required minimal cueing to communicate her wants, needs, and emotions. The ISP listed a number of communication strategies, such as "get her attention by saying her name and making eye contact before talking to her or giving her directions," and "give only one step of directions at a time and wait for her to complete that step before giving another step." However, her ISP also indicated that she had issues regarding

her ability to maintain focus and attention, and stated that she might require many prompts. The documentation provided did not indicate that that staff were implementing these strategies with regard to handwashing, or the implementation of other strategies to prevent her from removing her wound dressing and packing. Also, there was no mention of this episode of MRSA in the minutes of the Infection Control Committee meeting, dated 12/28/18, so it was not clear that the Committee was aware of the it.

- For Individual #260, based on the documentation submitted, the IDT did not meet to address emesis episodes on 7/27/18, 8/27/18, 8/31/18, and 9/19/18. There were significant gaps in nursing IPNs surrounding these episodes of emesis (e.g., nurses did not enter any IPNs for the following dates: 7/6/18 to 7/16/18, 7/18/18 to 7/26/18, 8/3/18 to 8/26/18, 8/28/18 to 8/30/18, 9/1/18 to 9/6/18, and 9/8/18 to 9/18/18). The PCP IPN, dated 9/19/18, at 3:55 p.m., noted: "snoring, apnea, gasps" that the home nurse reported "to be his baseline." However, based on review of IView and the IPNs, these issues were not documented as the individual's baseline. The nursing annual physical assessment, dated 4/12/18, and the quarterly physical assessment, dated 7/5/18, only noted "sleeps most of the night." Nursing staff did not enter IPNs from 9/21/18 until 9/27/18, at 9:23 p.m., at which time he was "unable to arouse while taking VS [vital signs]," had an oxygen (O2) level of "66-77%," and was transported to the hospital. Moreover, IView entries for the following dates showed abnormal values for which it did not appear that the blood pressure, temperature, or oxygen saturations were retaken. As noted above, for many of these days, there were gaps in the nursing IPNs. It also was not clear that the PCP and the IDT were aware of these variations in values:
    - 7/21/18: blood pressure - 141/88 high (H) and O2 saturation - 89 low (L);
    - 7/30/18: blood pressure - 141/89 (H);
    - 8/4/18: blood pressure - 141/88 (H);
    - 8/5/18: O2 - 89 (L);
    - 8/9/18: blood pressure - 142/89 (H);
    - 8/15/18: O2 - 89 (L);
    - 8/16/18: blood pressure - 157/87 (H);
    - 8/17/18: blood pressure - 154/94 (H);
    - 8/18/18: blood pressure - 148/94 (H);
    - 8/19/18: blood pressure - 145/92 (H);
    - 8/20/18: blood pressure - 142/90 (H);
    - 8/23/18: temperature - 36.4 (L);
    - 8/24/18: blood pressure - 161/86 (H);
    - 8/25/18: blood pressure - 142/92 (H);
    - 8/26/18: blood pressure - 141/86 (H);
    - 8/26/18: blood pressure - 143/84 (H);
    - 8/27/18: blood pressure - 145/86 (H);
    - 8/28/18: blood pressure - 142/80 (H);
    - 8/29/18: blood pressure - 143/91 (H)
    - 8/30/18: blood pressure - 143/92 (H);
    - 8/31/18: blood pressure - 144/89 (H);
    - 9/2/18: temperature - 36.3 (L), and blood pressure - 143/89 (H);
    - 9/5/18: blood pressure - 142/82 (H);

- 9/6/18: O2 - 89 (L);
- 9/7/18: blood pressure - 146/89 (H);
- 9/11/18: O2 - 89 (L);
- 9/13/18: blood pressure - 141/90 (H);
- 9/17/18: blood pressure - 141/89 (H);
- 9/19/18: O2 - 89 (L);
- 9/19/18: blood pressure - 146/81 (H);
- 9/21/18: blood pressure - 141/90 (H);
- 9/23/18: blood pressure - 157/87 (H);
- 9/23/18: blood pressure - 142/80 (H); and
- 9/24/18: blood pressure - 159/89 (H), and O2 - 89 (L).

On 9/27/18, Individual #260 was hospitalized with diagnoses of acute on chronic respiratory failure with central hypoventilation and aspiration pneumonia. On 10/5/18, the individual died with causes of death listed as acute on chronic respiratory failure, recurrent aspiration pneumonia, and chronic hypoventilation. Of note, the Quality Assurance Death Review of Clinical Services did not discuss the issues related to nursing supports and/or the lack IDT involvement highlighted above.

- Document #TX-AU-1902- II.P.1-20 indicated that nursing staff administered PRN medications to Individual #212 for constipation on the following dates: 7/3/18, 7/5/18, 7/6/18, 7/9/18, 7/12/18, 7/15/18, 7/20/18, 7/26/18, 7/27/18, 7/29/18, 7/31/18, 8/2/18, 8/4/18, 8/7/18, 8/11/18 (x3), and 11/24/18. As illustrated below, the IDT did not take needed steps to address this individual's constipation, which resulted in significant use of PRN medications, impaction, and ileus.
  - The nursing quarterly assessment, dated 7/1/18 through 9/30/18, did not include an update addressing the individual's constipation or the significant number of PRN medications she required during this time. This lack of tracking and analysis was a significant concern, because the individual received eight PRN medication in June 2018, 11 in July 2018, six in August 2018, and had an impaction in November 2018, and an ileus in January 2019.
  - The Monitoring team requested documentation regarding whether or not nurses notified the PCP of the number of times the individual received PRN medication for constipation in July and August 2018. Center staff submitted a PCP note indicating that during the morning meeting: "it came to light that [Individual #212] had 3 suppositories this week for constipation." The referenced dates were 7/23/18 through 8/2/18, which did not encompass the full timeframe and/or the number of PRN medications noted above. As a result, it did not appear that nursing staff assessed and communicated the frequency of the individual's episodes of constipation and PRN medication usage to the PCP. The IPN indicated that according to the Pharmacist, her regular bowel regimen changed since the MiraLAX was discontinued in April 2018 due to lose stools, and that "it looks like her prn Bisacodyl and Fleets enema use has increased since the MiraLAX was discontinued." The note indicated that the MiraLAX was to be restarted at a lower dose than it was at previously.
  - In the documents submitted, no ISPAs were found to show that the IDT addressed the individual's significant constipation until 11/14/18, when the IDT met to discuss her hospitalization due to an impaction. This was despite the fact that on 8/3/18, during the morning meeting "it came to light" that she received three PRN medications. Even this review on 8/3/18, was a limited review, and the IDT did not review data over time to show that since at least June 2018, she received numerous PRN medications for constipation.

- The IHCP did not include assessments and interventions consistent with her level of risk that were aimed at preventing constipation. The ISPA, dated 11/14/18, after she was hospitalized due to a fecal impaction, noted: "No change to IHCP at this time."
- The ISPA, dated 1/22/19, indicated that from 1/7/19 through 1/16/19, Individual #212 was hospitalized for aspiration pneumonia, hypoxia, abdominal distention, and ileus. Unfortunately, the documentation did not reflect a comprehensive review of her health issues prior to her hospitalization to determine if care and interventions were sufficient to meet her needs, and if not, what the IDT needed to implement to prevent health issues, especially ileus. However, the ISPA again indicated that "no changes" were needed to the PNMP, IRRF, PBSP, or the IHCP.

- The ISPA, dated 9/5/18, regarding a discovered fracture to Individual #138's right ankle noted that the IDT "was of the opinion that the fracture probably happened during transfers." It was concerning that the ISPA indicated that the IDT had been aware that the individual's brother, who visited him every Sunday, was not following PNMP instructions for proper transfers and transporting, but the IDT did not intervene. In addition, the IDT did not put into place regular monitoring of transfers to ensure that staff were following all procedures correctly.

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

Summary: For at least the two previous reviews, as well as this review, the Center did well with the indicators related to: 1) nurses administering medications according to the nine rights; 2) nurses following individuals' PNMPs while administering medications; and 3) nurses adhering to infection control procedures while administering medications. However, given the importance of these indicators to individuals' health and safety, these indicators will continue in active oversight until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will continue in active oversight as well.

#	Indicator	Overall Score	Individuals: 2	403	450	172	421	227	260	212	138
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	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A

	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.	1/1									
	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.	33% 1/3	N/A	N/A	0/2	N/A	N/A	N/A	N/A	1/1	N/A
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		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 #2, Individual #403, Individual #450, Individual #172, Individual #421, Individual #227, Individual #212, and Individual #138.

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.

Although the nurse for Individual #172 followed correct procedures for medication administration, the process took close to an hour to complete. Based on conversations with staff, this was not typical, but appeared to be due to the medication nurse presenting and/or modifying procedures because the Monitoring Team member was observing. This was concerning, because the individual should be the nurse's focus during any medication pass.

d. The following concerns were noted:

- The medication nurse did not assess Individual #450's posterior lung sounds correctly. It was good to see that the Center's nurse auditor identified the issue, spoke with the medication nurse about it, and promptly arranged for re-training and additional observations. This individual's IHCPs and/or ACPs did not describe needed respiratory assessments.

f. During the eight observations, medication nurses followed the individuals' PNMPs, including checking the position of the individuals prior to medication administration.

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: Overall, IDTs and/or the PNMT did not have a way to measure clinically relevant outcomes related to individuals' physical and nutritional management at-risk conditions. Concerns also were noted with regard to individuals' IDTs referring them to the PNMT, when needed, and/or the PNMT making self-referrals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
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	0% 0/14	0/2	0/2	0/1	0/2	0/2	0/1	0/1	0/1	0/2

	interventions;										
	ii. Individual has a measurable goal/objective, including timeframes for completion;	7% 1/14	0/2	1/2	0/1	0/2	0/2	0/1	0/1	0/1	0/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/14	0/2	0/2	0/1	0/2	0/2	0/1	0/1	0/1	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/14	0/2	0/2	0/1	0/2	0/2	0/1	0/1	0/1	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/14	0/2	0/2	0/1	0/2	0/2	0/1	0/1	0/1	0/2
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	25% 1/4	N/A	N/A	0/1	N/A	N/A	1/1	0/1	0/1	N/A
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/4			0/1			0/1	0/1	0/1	
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/4			0/1			0/1	0/1	0/1	
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/4			0/1			0/1	0/1	0/1	
	v. Individual has made progress on his/her goal/objective; and	0% 0/4			0/1			0/1	0/1	0/1	
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/4			0/1			0/1	0/1	0/1	

Comments: The Monitoring Team reviewed 14 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: Individual #2 - aspiration, and skin integrity; Individual #403 – choking, and falls; Individual #450 – skin integrity; Individual #172 – aspiration, and falls; Individual #421 – falls, and weight; Individual #227 - choking; Individual #260 – choking; Individual #212 – skin integrity; and Individual #138 – choking, and falls.

a.i. and a.ii. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #403 – choking.

b.i. The Monitoring Team reviewed four areas of need for four individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goals/objectives were included. These areas of need included for: Individual #450 - aspiration, Individual #227 - falls, Individual #260 - aspiration, and

Individual #212 - aspiration.

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

- On 9/15/18, Individual #450 was diagnosed with aspiration pneumonia. No evidence was found that her IDT made a referral to the PNMT, or that the PNMT made a self-referral. In addition, on 9/25/18, she had a new feeding tube placed, which should have resulted in a referral, but did not. Of note, back on 1/15/18, this individual was hospitalized and diagnosed with aspiration pneumonia, although Center staff later indicated this was "likely HCAP [healthcare-acquired pneumonia]," and therefore, did not require PNMT review. At that time, a hospital MBSS showed aspiration of thin liquids, which represented a change of status. The PNMT should have at least conducted a review.
- On 7/27/18, Individual #260 had emesis. On 8/27/18, he had emesis of 300 ml. On 9/19/18, he had emesis after lunch, described as a large amount, and he was started on an antibiotic due to possible aspiration. Again on 9/20/18, he had a large emesis after lunch. The PNMT minutes indicated that he did not meet the PNMT criteria of more than three episodes of emesis in 30 days. However, given his history of respiratory issues, the increased occurrence of emesis, and that it was occurring after meals, the PNMT should have at least conducted a review. Although the audit tool provides a list of criteria that requires referral to the PNMT, it qualifies that list by stating: "Appropriate referral for assessment is defined <u>at a minimum</u> according to the following qualifying event/threshold…" (emphasis added). IDTs still need to refer or the PNMT needs to make self-referrals of individuals who otherwise are at significant risk due to PNM issues.
- Individual #212's IDT did not make a referral to the PNMT, and no evidence was found of at least a review in response to two potential aspiration pneumonia diagnoses on 10/15/18 and 10/23/18. She was hospitalized on these dates, and documentation indicated that her diagnoses included aspiration pneumonia, but other documentation labeled them as RLL RV-associated pneumonia. According to a PCP IPN, dated 10/25/18, while the hospital listed her as having aspiration pneumonia, Center staff felt it was not aspiration-related. Given that this individual was at high risk for aspiration, and had increased coughing as well as oral secretions, at least a PNMT review was warranted to review her status, but this did not occur.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT did not develop clinically relevant, achievable, and measurable goals/objectives for these individuals.

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

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.	
Summary: None of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Many of the PNM action steps that were included were not measurable, making it difficult to collect specific data. Substantially more work is needed to document that individuals receive the PNM supports they require. In	Individuals:

about half of the instances reviewed, IDTs did not take needed action, when individuals' PNM risk increased or they experienced changes of status. Although some examples were seen of prompt and thorough action, more work is needed to meet individuals' needs, and reduce their risk to the extent possible. At this time, these indicators will remain in active oversight.											
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
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.	28% 5/18	0/2	0/2	2/2	0/2	2/2	1/2	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.	42% 5/12	1/1	0/1	1/2	1/2	0/1	0/1	0/1	1/2	1/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	N/A									

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, the IHCPs for which documentation was found to confirm the implementation of the PNM action steps that were included were for: Individual #450 – skin integrity, and aspiration; Individual #421 – falls, and weight; and Individual #227 - falls. Monthly integrated reviews often did not provide specific information or data about the status of the implementation of the action steps.

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

- After Individual #2's eye surgery, the IDT noted an increase in skin injuries (e.g., scratches, bruises), and so they increased his supports to address his uptick in agitation.
- When Individual #450 had issues with skin breakdown, on 1/30/18, and 9/29/18, the IDT promptly requested PT consultations.
- Individual #421's annual OT/PT assessment noted poor safety awareness and poor scanning, placing her at risk for injuries from falls. It also noted decreased balance, but offered no plan/program to address these concerns or rationale regarding why they would not be addressed
- Based on the ISPA, dated 9/5/18, Individual #138's IDT reviewed his right ankle fracture. The IDT made multiple changes to the PNMP as a result. These included changes to daytime bed positioning, as well as transfer methods. After the IPSA meeting, the PT/OT conducted multiple consultations to check on the status of the fractured ankle.

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

- Based on documents requested, from January 2018 to July 2018, Individual #403 had no sit-downs or falls. However, after her walker was removed, and the IDT implemented sighted-guide techniques, sit-downs and falls began to occur. While the IDT met, no evidence was found in ISPAs that the IDT discussed and/or addressed this change of status in relation to the change in

mobility assistance. The PT continued to state that the individual had no balance issues, but someone who has good balance should not fall when turning with or without the use of a backpack.

- On 8/15/18, 8/17/18, and 8/30/18, Individual #450 had coughing episodes during meals, but no consultation was found.
- For Individual #172, no evidence was found of increased monitoring outside of transfers, even though falls occurred during other types of events.
- After Individual #227 fell on 6/30/18, the OT completed a timely observation, and concluded that the individual was no longer raising her head to look around. However, the OT provided no recommendations to work on improving this skill in order to reduce the risk of the individual falling again.
- After Individual #260 had episodes of emesis on 6/3/18, 7/27/18, and 8/27/18, Habilitation Therapy staff did not conduct a review of positioning and/or mealtime techniques.
- On 10/15/18 and 10/23/18, Individual #212 was hospitalized. Some documentation indicated that her diagnoses included aspiration pneumonia, but other documentation labeled them as RLL RV-associated pneumonia. Regardless, based on documentation submitted, her IDT did not hold a post-hospitalization ISPA meeting until 11/14/18. Despite reports of emesis in bed, the Habilitation Therapies staff did not conduct a head-of-bed-elevation (HOBE) evaluation, nor was a review of her positioning schedule found.

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

Summary: Based on observations, staff completed transfers correctly. However, efforts are needed to continue to improve Dining Plan implementation, and positioning. Often, the errors that occurred (e.g., taking large bites, and/or eating at an unsafe rate) placed individuals at significant risk of harm. Implementation of PNMPs is non-negotiable. The Center, including Habilitation Therapies, as well as Residential and Day Program/Vocational staff, and Skill Acquisition/Behavioral Health staff should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them. These indicators will continue in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	68% 27/40	
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	75% 3/4	

Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 12 out of 17 observations (71%). Staff followed individuals' dining plans during 11 out of 19 mealtime observations (58%). Staff completed transfers correctly during four out of four observations (100%).

The following provides more specifics about the problems noted:

- With regard to Dining Plan implementation, the great majority of the errors related to staff not using correct techniques (e.g., cues for slowing, offering drinks/sips throughout the meal, prompting, etc.). Individuals were at increased risk due to staff's failure, for example, to intervene when they took large unsafe bites, ate at too fast a rate, or staff did not provide liquids in between bites. It was good to see that during all mealtime observations, texture/consistency was correct, adaptive equipment was correct, and staff and the individuals observed were positioned correctly at mealtime.
- With regard to positioning, the most common problem was that individuals were not positioned correctly, according to the PNMP (e.g., slid down in wheelchair, leaning to the side, hips out of alignment, etc.). It was positive that adaptive supports for positioning were present, and with one exception, staff used the equipment correctly.

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	2	403	450	172	421	227	260	212	138
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.	0% 0/1			0/1					N/A	
Comments: a. As noted above, Individual #450's IDT had not set forth a plan to track the use of her G-tube or ongoing monitoring of meals (i.e., she was eating some by mouth) to detect aspiration early.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.										
Summary: Most individuals reviewed did not have clinically relevant, and measurable goals/objectives to address their needs for formal OT/PT services. In addition, QIDP interim reviews often did not include data related to existing goals/objectives. As a result, IDTs did not have information in an integrated format related to individuals' progress or lack thereof. These indicators will remain in active oversight.		Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant	14%	0/1	N/A	0/1	0/1	0/1	0/1	N/A	0/1	1/1

	and achievable to measure the efficacy of interventions.	1/7									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	29% 2/7	0/1		1/1	0/1	0/1	0/1		0/1	1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/7	0/1		0/1	0/1	0/1	0/1		0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/7	0/1		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% 0/7	0/1		0/1	0/1	0/1	0/1		0/1	0/1

Comments: a. and b. Individual #403 and Individual #260 did not require formal OT/PT services and supports. For the remaining seven individuals, only Individual #138 had a goal that was both clinically relevant and measurable (i.e., independently placing his spoon over his food with 75% accuracy). Individual #450's goal/objective (i.e., roll a bowling ball down a ramp) was measurable, but was not clinically relevant, because it was not clear she could understand the directive on which the goal was based.

c. through e. Although data were submitted to show Individual #138's goal/objective to independently place his spoon over his food with 75% accuracy was implemented, no evidence was found to show the PT worked with the QIDP to analyze the data and include it in the monthly integrated reviews for the IDT's consideration.

Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. The Monitoring Team conducted full reviews for all nine individuals, including Individual #403 and Individual #260 who were both part of the core group.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: Overall, it was positive that evidence was found in ISP integrated reviews to show that OT/PT supports, other than PNM supports reviewed elsewhere, were implemented. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	100% 3/3	N/A	N/A	1/1	N/A	N/A	1/1	N/A	N/A	1/1
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.	80% 4/5	N/A	1/1	1/1	N/A	N/A	1/1	N/A	1/1	0/1

Comments: a. For OT/PT supports, it was positive ISP integrated reviews included evidence that the measurable strategies and action plans included in the ISPs/ISPAs were implemented. This finding did not address PNM supports that are reviewed elsewhere in this report.

b. It was positive that for most OT/PT services or supports for which termination was recommended, the respective IDTs met to discuss and approve the changes. The exception was for Individual #138, who did not have an ISPA related to the termination of his OT plan of care.

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

Summary: The Center continued to steadily improve its performance in ensuring the proper fit of individuals' assistive/adaptive equipment (Round 12 – 87%, Round 13 – 90%, and Round 14 - 94%). Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators.

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

#	Indicator	Overall Score	Individuals: 433	91	224	338	63	181	84	403	353
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance, these indicators 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.	94% 33/35	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		15	351	265	22	16	31	310	268	450
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		394	118	57	365	138	290	152	227	27

c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		450	151	172	2	370	153	307	401	
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
Comments: c. The Monitoring Team conducted observations of 35 pieces of adaptive equipment. The individuals the Monitoring Team observed generally had adaptive equipment that appeared to be the proper fit, which was good to see. Based on observation, the exceptions were for Individual #433 and Individual #91. Individual #433 was positioned in a wheelchair at her home that should only have been used for transport on long distances. The back of the wheelchair was also collapsed due to a backpack hanging there, negatively impacting support. Individual #91 had slid down in her wheelchair, with her hips pushed forward and trunk collapsed. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.										

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

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

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

In ISPs, one goal was rated as making progress. Problems with implementation, collection of reliable data, and modifications when no progress was seen competed with individuals making progress towards achieving their personal goals.

Staff for two-thirds of the individuals were knowledgeable about individuals' preferences and supports. And, they were very respectful and supportive in their interactions with individuals.

For the most part, QIDP ISP monthly reviews were routinely submitted on time and included a cursory review of all services. The consistent completion of the QIDP monthly reviews was good to see, however, they included little meaningful information regarding progress towards goals and efficacy of supports.

More SAPs contained more components than at the last review, though no SAPs contained all of the required 10 components.

Austin SSLC was working on ensuring that SAPs were implemented correctly. This was evidenced, in part, by the high percentage of SAPs that met criterion for regular integrity checks (indicator 15). Monitoring Team observations found that few SAPs were indeed fully implemented correctly, though almost all SAP implementations had some aspects implemented correctly.

Austin SSLC showed a continuing improving trend for the conduct of SAP monthly reviews over this and the previous two reviews. All but one SAP had a graphic summary. Some individuals were progressing on some SAPs and actions were taken for just a few of those SAPs that were not progressing.

About half of the individuals were regularly engaged in activities when directly observed by the Monitoring Team. This is about the same amount as observed during the previous two reviews, too. All sites at Austin SSLC had goals for engagement and those goals were met for all of these individuals

It was good to see homes in which all or most individuals had their own bedrooms. However, as Center Administration recognized, other homes were somewhat chaotic due to the number of active individuals living in one home, or the number of individuals sharing bedrooms who needed adaptive equipment.

It was also positive to observe an individual with significant arthritis participating in the Aquadome to continue to work on range of motion.

The Center should continue to focus on ensuring individuals have their AAC devices with them. Most importantly, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their augmentative and alternative communication (AAC) devices in a functional manner.

ISPs

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

Summary: One goal was rated as making progress. Problems with implementation, collection of reliable data, and modifications when no progress was seen competed with individuals making progress towards achieving their personal goals. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	403	2	152	369	421	227			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	1/6	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. For personal goals that did not meet criterion as described above, there was no basis for assessing progress in these areas.

For the nine 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 eight of the nine goals (i.e., indicator 3). Therefore, progress could not be determined.

For the one goal that had reliable data, Individual #403 was making progress towards her goal to wash her clothes.

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

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

Summary: Staff for two-thirds of the individuals were knowledgeable about individuals' preferences and supports. And, they were very respectful and supportive in their interactions with individuals. The zero score for indicator 40 again points to the need for the Center to ensure that action plans, developed by the IDT through the detailed ISP creation process, are implemented. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 403	2	152	369	421	227			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	67% 4/6	0/1	1/1	1/1	1/1	1/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

39. For the most part, direct support professional staff interviewed and observed throughout the week were knowledgeable about individual's preferences and support needs and very respectful and supportive to each individual in their interactions.

The staff for two individuals, however, were not found to exhibit a level of competence to ensure implementation of the ISP. These were staff supporting Individual #403 and Individual #227. For the most part, this could be attributed to the lack of clear staff instructions for carrying out the supports included in the ISP. Staff were not fully implementing ISPs, so it was difficult to verify that they could exhibit competence in implementing support plans. ISPs rarely included detailed instructions to guide staff when implementing the ISP. As noted throughout this section of the report, ISPs often included service objectives that did not have specific implementation methodologies and this contributed to the lack of implementation.

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

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

Skill Acquisition and Engagement

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

Summary: Some individuals were progressing on some SAPs and actions were taken for just of few of those SAPs that were not progressing. Overall performance scores were about the same as at the last review. Responding to the data (which were for the most part reliable, see indicator 5) and making changes as necessary can set the occasion for performance to improve on these three indicators, all of which will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 369	152	151	66	403	292	296	2	69
6	The individual is progressing on his/her SAPs.	27% 6/22	0/3	0/2	1/2	2/3	0/3	2/3	0/2	1/2	0/2
7	If the goal/objective was met, a new or updated goal/objective was introduced.	50% 1/2			1/1					0/1	
8	If the individual was not making progress, actions were taken.	20% 3/15	1/3	1/2	0/1	1/1	0/3	0/1	0/2		0/2
9	(No longer scored)										

Comments:

6. Based upon a review of the data present in the Client SAP Training Progress Note, it was determined that progress was being made on six of the 22 SAPs. Two SAPs were excluded from this analysis due to a lack of data (Individual #296 creating art work) or only one data point (Individual #69 saving money). SAPs in which progress was evident were the following: Individual #151 turning on the television; Individual #66 identifying the problem and putting aside one dollar to save; Individual #292 making a sundae and shredding papers; and Individual #2 operating his music.

7. Two individuals had met the goal for one of their SAPs. Individual #151 had met the goal of using an adaptive switch to turn on the television. It was noted that the SAP would be revised for him to perform this skill with a model or gestural prompt. Individual #2 had mastered step 3 of his bowling SAP in October 2018. Although the plan was to move him to step 4, in December 2018 the graph still reflected his performance on step 3.

8. Action was taken to address the individuals lack of progress in three cases. The IDTs had met and decided to discontinue the shredding SAP for Individual #369 and the swimming SAP for Individual #66 due to their lack of progress or disinterest, respectively. During the onsite visit, behavioral health services staff reported that Individual #152's stopping work in response to a timer SAP had been revised due to his lack of progress.

Outcome 4- All individuals have SAPs that contain the required components.												
Summary: More SAPs contained more components than at the last review, though no SAPs contained all of the required 10 components. Additional feedback is provided to the Center below. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	369	152	151	66	403	292	296	2	69
13	The individual's SAPs are complete.	0% 0/24	0/3 17/30	0/2 9/19	0/2 14/19	0/3 17/30	0/3 14/27	0/3 19/29	0/3 24/29	0/2 14/20	0/3 17/28

Comments:

13. Although none of the SAPs were considered complete, better than 80% of the SAPs included the following elements:
    - a task analysis where appropriate, a behavioral objective, a relevant discriminative stimulus, plans for maintenance and generalization, and documentation methodology.

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

Missing from most SAPs were specific instructions for teaching the skill and a teaching schedule that allowed for multiple trials, when appropriate, on identified training days. It was good to find photos and drawings in some SAP instructions (e.g., Individual #151 learning to turn on the television) because these tended to offer greater clarity for plan implementation. Staff are advised to consider the use of identified preferences when reinforcing correct responding as praise may not always be meaningful to the individual.

Feedback on a few individual SAPs is provided below.

- Individual #369's shredding SAP indicated he was turning on the shredder, but baseline information suggested he had this skill. The instructions did not address the task of shredding.
- The preferences, strengths, and needs/barriers section of Individual #152's street crossing SAP did not relate to the skill.
- It would be advisable to expand the instructions for Individual #151's work SAP to include a description of how to set up work materials as well as noting a dominant or preferred hand. While the SAP indicated that he will fill a jig with toothbrushes or binders, it may be helpful to teach one task first and then generalize to the second task. As discussed with behavioral health services staff, ensure that materials fit readily into the jigs being used.
- Individual #66 was learning to save money, however, the SAP included a statement that if she didn't want to save, she didn't have to. It would be advisable to consider another SAP that may be more meaningful to her.
- Individual #292's television SAP indicated he will change channels. However, the instructions indicated that he would learn to put the remote on the table after he pressed the "on" button.
- Baseline assessment of Individual #296's hand washing indicated he had mastered the current step he was working on.
- It would be advisable to schedule a consultation with the orientation and mobility specialists to determine whether additional supports/strategies are needed since Individual #2 had his right eye surgically removed.

Outcome 5- SAPs are implemented with integrity.

Summary: Austin SSLC was working on ensuring that SAPs were implemented correctly. This was evidenced, in part, by the high percentage of SAPs that met criterion for regular integrity checks (indicator 15). Monitoring Team observations found that few SAPs were indeed fully implemented correctly, though almost all SAP implementations had some aspects implemented correctly. The SAP managers might use the comments below in indicator 14 as a model for the type of detail that an integrity observer should be doing, too. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 369	152	151	66	403	292	296	2	69
14	SAPs are implemented as written.	29% 2/7	1/1	Attempted	0/1	0/1	0/1	0/1	1/1	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.	83% 20/24	3/3	2/2	2/2	1/3	3/3	/3	2/3	2/2	2/3

Comments:

14. During the onsite visit, an observation of training on one SAP was scheduled for each of the nine individuals. Individual #152 left the workshop before the SAP training could be conducted and Individual #2 repeatedly moved away from the bowling apparatus that was set up in the recreation center. For the seven SAP observations that were completed, two were implemented as written (Individual #369, Individual #296). Individual specific feedback is provided below.

- The staff member used hand underhand prompts to show Individual #369 where the materials were before beginning instruction. As discussed with the behavioral health services staff, it would be appropriate to work with the dietician to identify an alternative to rice cakes because these can break easily when one tries to cover these with peanut butter. It would also be helpful to put peanut butter and jelly in larger containers that are easier to use/manipulate particularly for someone with a visual impairment.
- The staff member set up the materials as described in the Picasso art SAP for Individual #296. She also delivered the Sd (i.e., cue/instruction) and praise as indicated. During this observation, it was evident to everyone present that Individual #296 had difficulty completing this tile pattern because the model was smaller than the actual tiles used (he prefers to set the tiles on top of the photo because he matches to sample). This SAP was written to have him complete one model only. It may be more meaningful if he were to choose from an array of patterns and then find the necessary tiles in the box. Staff may also want to consider teaching him to create art work that he could keep in a portfolio, display on his wall, etc.
- The staff member working with Individual #151 did a nice job setting up the training session. However, she repeated the initial instruction three times before using a more intrusive prompt to help him successfully turn on the television.
- The staff person did not use the problem-solving cards as indicated in the SAP for Individual #66. Although the behavioral health services staff explained that the cards had been lost, these should have been replaced as soon as this was discovered.
- The staff member sat in a chair near Individual #403's bed as instructed in the SAP. She then introduced herself, established

joint attention, and delivered the initial discriminative stimulus. However, she did not use the identified verbal prompt, rather she repeated the discriminative stimulus while also providing the sign for blanket (an appropriate alternative). Individual #403's refusal was appropriately honored.

- The discriminative stimulus provided did not match Individual #292's SAP (i.e., make your ice cream versus make a sundae). Individual #292 did not chop the banana or use the scooper to scoop whipped cream onto the ice cream. Individual #292 readily squeezed the syrup as indicated. One of the home staff members described the manner in which Individual #292 often completed the SAP (i.e., turning over the bowls of bananas and whipped cream onto the ice cream). Behavioral health services staff may want to consider revising the SAP to match this preferred method. Staff may also want to use a different sized/colored bowl to hold the sundae to enhance the discrimination of materials. Lastly, it may be appropriate to probe the terminal objective to determine whether the skill has been acquired.
- The staff person told Individual #69 to knock on the door, but she did not block the entrance to the office as indicated in the SAP (it was noted that this was no longer necessary). Individual #69 actually performed the skill quite well. He demonstrated mastery of this skill by waiting and announcing his presence when the knock did not get a response. He entered the office only after the door was opened. The SAP supervisor (BCBA) noted that the SAP should be changed to remove verbal instruction and simply have closed doors serve as the discriminative stimulus.

15. Per state policy, SAP integrity should be assessed at a minimum of twice annually. Goal levels were established at 80% or better. Based upon the documentation provided, it was determined that 20 of the 24 SAPs had been monitored at least once over the previous six-month period. The exceptions were Individual #66's swimming and sorting money SAPs, Individual #296's making Picasso art SAP, and Individual #69's saving money SAP. Note, however, that these last two SAPs had just been implemented in January 2019 and December 2018, respectively.

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

Summary: Austin SSLC showed a continuing improving trend for the conduct of SAP monthly reviews over this and the previous two reviews. All but one SAP had a graphic summary. With sustained high performance, this graph-related indicator (17) might be moved to the category of requiring less oversight. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 369	152	151	66	403	292	296	2	69
16	There is evidence that SAPs are reviewed monthly.	57% 13/23	3/3	2/2	1/2	0/3	3/3	3/3	0/2	0/2	1/3
17	SAP outcomes are graphed.	96% 22/23	3/3	2/2	2/2	3/3	3/3	3/3	1/2	2/2	3/3

Comments:

16. There was evidence that 13 of 23 SAPs were reviewed monthly in the QIDP Monthly Report. Individual #296's making Picasso art SAP was excluded from this analysis because it had just been implemented in January 2019. Data-based monthly reviews were found for all of the identified SAPs for Individual #369, Individual #152, Individual #403, and Individual #292. Others included the turn on

television SAP for Individual #151 and the save money SAP for Individual #69. All other SAPs were either not reviewed each month and/or lacked data to determine progress.

17. Graphs were provided for 22 of 23 SAPs. Again, Individual #296's Picasso art SAP was excluded as it had just recently been implemented. The exception was the graph for Individual #296's making an omelet SAP because it did not indicate what step he was working on.

Note: It was noteworthy that the behavior technician had been conducting the SAP training for three months with Individual #66 (saving money), Individual #292 (make sundae), and Individual #69 (make coffee). This affords the behavioral health services staff direct opportunities to identify problems early on. When the individual's performance is poor for consecutive months, the technician is advised to seek advice/assistance from a SAP supervisor before having direct support staff assume responsibility for training.

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

Summary: About half of the individuals were regularly engaged in activities when directly observed by the Monitoring Team. This is about the same amount as observed during the previous two reviews, too. All sites at Austin SSLC had goals for engagement and those goals were met for all of these individuals. This latter point has been the case for all individuals for this and the last two reviews, too (with one exception at the last review). Therefore, indicator 21 will be moved to the category of requiring less oversight. Indicators 18 and 20 will remain in active monitoring. With sustained high performance, indicator 20 might be moved to the category of requiring less oversight after the next review.

#	Indicator	Overall Score	Individuals: 369	152	151	66	403	292	296	2	69
18	The individual is meaningfully engaged in residential and treatment sites.	56% 5/9	0/1	0/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
18. During the onsite visit, individuals were observed in their work sites, day programs, and/or home environments. Individual #403 and Individual #151 were only observed in their homes because participation in their vocational and day programs was restricted due to a recent illness. Five of the nine individuals were considered to be meaningfully engaged. These were Individual #66, Individual #292, Individual #296, Individual #2, and Individual #69. Although Individual #369 was consistently engaged in his workshop, he was

not observed to be meaningfully engaged either at home or in the recreation center. Individual #152 was often observed running from his work site.

Individual #66 had expressed an interest in attending school. The IDT noted that she was no longer eligible to attend public school, yet there was no discussion of exploring adult education classes in the community.
In the ISP completed in May 2018 for Individual #292, it was recommended that his QIDP explore possible events with the local Jewish Community Center. When a request was submitted for an update on this matter, minutes were provided from his ISP preparation meeting held in January 2019 along with several e-mails sent later in January 2019 and February 2019. It is recommended that staff be more attentive to plans outlined in the individual's ISP to ensure that these are addressed in a timely manner.

20. The facility policy indicated that all homes were monitored for engagement during all odd numbered months of the year. Similarly, all day program/vocational sites are monitored during all even numbered months of the year. Engagement goals were established at 80% across all settings.

21. Engagement goal frequencies and levels were achieved in all homes and work/day program sites for all nine individuals.

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

Summary: Goal frequencies for community outings were in place for seven of the individuals and should be easy to put into place for all individuals. There were no frequency goals related to SAP implementation in the community and actions to address this were not developed. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 369	152	151	66	403	292	296	2	69
22	For the individual, goal frequencies of community recreational activities are established and achieved.	78% 7/9	1/1	1/1	1/1	1/1	0/1	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. All of the individuals had identified goal frequencies for community recreational activities. These goals were met for everyone, but Individual #403 and Individual #292.

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

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

or community-based SAP training.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.												
Summary: There were no individuals who were entitled to, or received, educational services. This indicator will remain in active monitoring, so that it can be assessed if applicable at the next review.			Individuals:									
#	Indicator	Overall Score										
25	The student receives educational services that are integrated with the ISP.	N/A										
Comments: 25. At the time of the onsite visit, there were no school-aged individuals in residence at the facility.												

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	2	403	450	172	421	227	260	212	138
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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									
a. through d. Based on the documentation provided, during the six months prior to the review, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed refused dental care.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Significant work is still needed to improve the clinical relevance and measurability of goals/objectives. It also will be important for SLPs to work with QIDPs to include data and analysis of data on communication goals/objectives in the QIDP integrated reviews. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	20% 2/10	1/1	0/2	1/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	30% 3/10	0/1	2/2	0/1	0/1	0/1	0/1	0/1	1/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	10% 1/10	0/1	0/2	0/1	0/1	0/1	0/1	0/1	1/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/10	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/10	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. None of the nine individuals had needed communication goals that were also both clinically relevant and measurable. The goal/objective for Individual #450 (i.e., toss the ball into the plastic bin) was clinically relevant, but not measurable. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #403 (i.e., verbally name target items/activities, and use signs to name a target item/activity), and Individual #212 (i.e., press adaptive switch to activate a radio.) c. through e. The QIDP integrated monthly review included specific data only for Individual #212 (i.e., press adaptive switch to activate a radio), but the goal that was not clinically relevant. The Monitoring Team completed full reviews for all nine individuals 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: To move forward, QIDPs and SLPs should work together to make sure QIDP integrated monthly reviews include data, and analysis of data, related to the implementation of communication strategies and SAPs. These indicators will	Individuals:

remain in active oversight.											
#	Indicator	Overall Score	2	403	450	172	421	227	260	212	138
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	83% 5/6	0/1	2/2	1/1	N/A	N/A	N/A	1/1	1/1	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	0% 0/3	0/1	0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. Examples of concerns included: • For Individual #2, ISP integrated monthly reviews did not reflect implementation data past July 2018. In addition, on 1/30/19, the IDT discontinued the use of the AAC device (go talk), reportedly because the individual was not using it. As discussed during the Monitoring Team's last review, the device was not readily available to the individual, so it would be difficult for the individual to use it. No SLP consultation was found to support discontinuation of the device, nor did the IDT hold an ISPA meeting, based on the documentation submitted. • For Individual #403, the Center provided no evidence that an ISPA meeting had been held to discuss discharge from direct speech therapy.										

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
Summary: The Center should continue to focus on ensuring individuals have their AAC devices with them. Most importantly, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	152	394	57	2	450	268	22	403	307
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	63% 5/8	1/1	0/1	0/1	1/1	1/1	1/1	1/1	N/A	0/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	44% 4/9	0/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	33% 1/3									
Comments: a. and b. It was concerning that individuals' AAC devices were not consistently 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. At this time, none will move to the category requiring less oversight.

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

It is essential for the Center to be able to objectively verify provider staff competence to implement all important health and safety supports prior to individuals' moves to the community. Pre-move training supports should address the content of training provider staff would need, as well as describe the staff to be trained, the training methodologies to be used, and the competency criteria. The Center must also describe how it will verify provider staff have the knowledge and competence to provide each individual's unique set of needed supports prior to relinquishing day-to-day responsibility for his or her health and safety. The Center should focus on defining specific competency criteria, and then on ensuring the tools for measuring those competencies are thorough and appropriate to the need.

Center staff are encouraged to continue making improvements in the development of a comprehensive set of supports, with particular emphasis on identifying supports to address all important requirements with regard to pre-move training for provider staff and for behavioral, safety, healthcare, therapeutic and supervision needs.

It was good to see that the Post-Move Monitor conducted timely monitoring. However, the quality of post-move monitoring required improvements. Some of the areas in which continued efforts were needed related to the PMM consistently gathering reliable and valid data upon which to make accurate judgements about the presence of needed supports and the PMM correctly scoring the presence or absence supports based on the evidence.

While the IDT met as needed to discuss the potentially disrupted community transition (PDCT) event experienced by one of the two individuals in this review (i.e., the individual died), improvements are needed to ensure this process includes a thorough critical analysis that supports the identification of process improvements that might help to avoid any similar issues for individuals moving to the community in the future. It was positive to see the IDT and transition staff taking a proactive approach to address emerging concerns for the other recently-transitioned individual, including providing additional monitoring, arranging to meet with the IDT and planning to offer additional provider training.

Transition staff had identified the need to improve the quality and content of transition assessments, and had scheduled an upcoming training with discipline leads to move this forward. This initiative should greatly assist with the areas for improvement identified during this monitoring visit, including the completion of all needed assessments and the inclusion of comprehensive and community-appropriate recommendations. Although Center staff provided training to community provider staff, the CLDPs did not define the training thoroughly, and Center staff still were not able to confirm that community provider staff were competent to meet individuals' needs at the time of transition. It was positive, though, that the Center was involving direct support professional participation throughout transition activities, as well as using staff shadowing as a training methodology.

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

Summary: It is essential for the Center to be able to objectively verify provider staff competence to implement all important health and safety supports prior to individuals' moves to the community. Pre-move training supports should address the content of training provider staff would need, as well as describe the staff to be trained, the training methodologies to be used, and the competency criteria. The Center must also describe how it will verify provider staff have the knowledge and competence to provide each individual's unique set of needed supports prior to relinquishing day-to-day responsibility for his or her health and safety. The Center should focus on defining specific competency criteria, and then on ensuring the tools for measuring those competencies are thorough and appropriate to the need.

Center staff are encouraged to continue making improvements in the development of a comprehensive set of supports, with particular emphasis on identifying supports to address all important requirements with regard to pre-move training for provider staff, and for behavioral, safety, healthcare, therapeutic and supervision needs.

#	Indicator	Overall Score	Individuals: 405	312							
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1							
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1							

Comments: The Monitoring Team reviewed transitions for two individuals (i.e., Individual #405, and Individual #312) who had moved from Austin SSLC to the community. Both individuals transitioned to a community group home operated under the State's Home and Community-based (HCS) program. The Monitoring Team reviewed these two transitions and discussed them in detail with the Austin

SSLC Admissions and Placement staff.

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

- Pre-move supports: The respective IDTs developed 14 pre-move supports for Individual #405, and 18 pre-move supports for Individual #312.
    - For Individual #405, eleven pre-move supports addressed the availability of furnishings, environmental preparations, and the completion of several medical appointments prior to transition. Most of these met criterion for measurability. One exception was a pre-move support that required the provider to modify the bathroom in the home per the OT recommendations related to her rolling shower chair, but the support did not describe the required modifications.
    - For Individual #312, ten pre-move supports addressed the availability of adaptive equipment as well as needed materials, the completion of health care supports (i.e., an optometry appointment and needed lab work), and, arranging for contact with his family with regard to the transition. These met criteria for measurability.
    - The remaining pre-move supports for these individuals addressed pre-move training needs, but these did not meet criterion for measurability. It is essential for the Center to be able to objectively verify provider staff competence to implement all important health and safety supports prior to individuals' moves to the community. To achieve compliance, pre-move training supports should address the content of training that provider staff would need, as well as describe the staff to be trained, the training methodologies to be used, and the competency criteria. The Center should also describe how it will verify provider staff have the knowledge and competence to provide each individual's unique set of needed supports prior to relinquishing day-to-day responsibility for his or her health and safety. To continue to move toward compliance, the Center should continue to focus on defining specific competency criteria, and ensuring the tools for measuring those competencies are thorough and appropriate to the need. Additional findings included:
        - Pre-move training supports provided a list of topics as the content to be covered under each broad area of training, but only a few of the lists of topics indicated the specific knowledge provider staff would be required to know by the time of the transition. Most did not provide specific criteria by which competency could be measured.
        - The written quizzes provided for review did not test competency in a comprehensive manner for either individual. Testing needed to be constructed to measure the specific criteria that would demonstrate staff were competent to provide supports as required. The written tests reviewed for these two CLDPs did not include questions for many of the topics and/or competencies listed as needed under each support, so there was no corresponding measurable evidence of related staff knowledge. For example:
            - For Individual #405, the pre-move support for communication strategies did not reference competency criteria, but the post-move support did provide considerably more information about what provider staff needed to know. The corresponding test asked only how she communicated

discomfort or that she was finished eating, and did not otherwise address the competency criteria defined in the post-move support.
    - For Individual #312, the competency test regarding his diagnosis of phenylketonuria (PKU) was comprised of seven questions. Without competency criteria, the Monitoring Team was not able to discern if these were the needed questions to confirm staff knowledge. For example, one question asked whether individuals with PKU needed supplements and required a yes/no answer. To test competency of the direct support professionals (DSPs) regarding how to meet Individual #312's individual needs, it would have been more appropriate to ask questions such as how often he needed supplements, and/or what supplements he required.
- Post-Move: The respective IDTs developed 36 post-move supports for Individual #405, and 52 post-move supports for Individual #312. Many post-move supports were measurable, including those that described most medical and health care appointments. Examples of post-move supports that did not meet criterion included:
    - For Individual #405:
        - IDTs should refrain from using language that is too broad or equivocal. For example, Individual #405's CLDP included a post-move support for staff to offer her an opportunity to participate in Hispanic cultural and music events "when available" or at least quarterly. It would not be possible for the Post-Move Monitor to ascertain when events might have been available. In another example, a post-move support called for the community primary care practitioner (PCP) to see her within 60 days for prescription renewals and routine, annual, and as needed medical care as well as appropriate labs, referrals for consultants and procedures that might be needed on an as-needed basis. This support was very broad and did not define specific expectations about her medical care.
    - For Individual #312:
        - The IDT developed a post-move support to take him to the library and listen to audiobooks about animals or to be read to by staff. The support stated this should be "ongoing" and due by the first visit. The use of the terminology "ongoing" did not provide any clear expectation as to how often these events should occur (e.g., daily, weekly, monthly or quarterly).

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

- Past history, and recent and current behavioral and psychiatric problems: The CLDPs did not include supports that comprehensively addressed past history, and recent and current behavioral and psychiatric problems. To meet criterion, the IDTs should continue to make improvement toward developing comprehensive supports that address behavioral and psychiatric history, including how the provider could recognize re-emerging concerns and address then proactively. Findings included:
    - Individual #405 did not have significant behavioral health needs at the time of transition, but did have historical behaviors of rectal digging and shredding her brief. The IDT should have considered ensuring the provider had knowledge of these behaviors, but did not.

- Per Individual #312's social assessment, dated 12/7/18, he had an extensive history of self-abusive behaviors, including biting and hitting himself, banging his head, and hitting his arms together. The assessment further indicated that on 3/26/17, Center staff implemented a positive behavior support plan (PBSP) with replacement behaviors and, per the Behavioral Health Assessment (BHA), in June 2017, it was later discontinued because the behaviors were not causing injury. The CLDP did not include a pre-move training support for staff knowledge of these behaviors and how to address them, whether or not they resulted in injury.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The respective IDTs developed supports in some areas related to safety, medical, healthcare, therapeutic and risk needs, such as for scheduling of health care appointments. To meet criteria, the IDTs still needed to develop clear and comprehensive supports in this area. Examples included, but were not limited to:
  - For Individual #405:
    - Documentation, such as the 14-Day ISPA and the Integrated Risk Rating Form (IRRF), indicated nursing staff needed to perform a head-to-toe assessment, with vital signs, on a weekly basis to monitor for changes in status related to her elevated risks for gastrointestinal, cardiac, osteoporosis, falls, and skin integrity. The CLDP did not include specific post-move supports with regard to this requirement.
    - Shortly before her transition, her IDT met to discuss the development of skin breakdown that had caused a delay in her transition date. The IDT discussed supports and services in place to assist with preventing skin breakdown in the future, including having the Registered Nurse (RN) check the area each shift in addition to the check and change every two hours with additional barrier cream. The IDT further agreed to modify her physical and nutritional management plan (PNMP) to require that check and change occur whether the brief was soiled or not, and to change the "check and change" language to "change, clean and reposition every two hours." The final support in the CLDP did not include this language.
    - Per her 14-day ISPA, Individual #405 needed 24-hour awake staff for check and change every two hours and for repositioning. It further indicated she required a two-person manual transfer and that staff must be specifically trained to transfer her. Per a 3/29/18 ISPA, the eventual provider could not provide two staff for transfer in the home, but indicated it might be able to use three staff during day habilitation. The CLDP did not include a specific support for staffing levels, or provide a justification as to why two staff would no longer be needed at home.
    - The 14-day ISPA stated she required earplugs for all bathing and water activities, to be thrown away after using one time, but the CLDP did not include a related support.
  - For Individual #312:
    - The CLDP Profile stated he would likely need pre-treatment sedation (PTS) for various health care and medical appointments, including ENT, eye exams, Reclast administration, audiology and ear cleaning, as well as off-campus medical appointments and procedures. It indicated he was very unlikely to be able to cooperate or stay still long enough for the needed exams or procedures to occur. It further indicated that not using PTS was very likely to create significant stress and anxiety and increase the need for physical restraints associated with attempting the procedure without sedation. The IDT did not develop a comprehensive support that clearly stated the scope of this need. Instead, supports typically indicated he "may" require the use of PTS for appointments such as ENT, optometry, or any invasive appointments.

- The nursing assessment recommended close nursing oversight on administration of medication and his PKU supplements, to include possibly trialing other supplements that might be more palatable, during first six months. The IDT developed a related support for the nurse to monitor health issues, including scheduling medical appointments; weight monitoring; bowel movement monitoring; blood pressure monitoring; ordering labs; ensuring side effects monitoring; and, an assessment for self-administration of medication to be completed in a timely manner. The support did not adequately convey the extent of the recommendation. It did not describe what "close" monitoring should entail (e.g., with what frequency), nor did it state that the monitoring needed to extend through the first six months.

- What was important to the individual: The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. Neither CLDP assertively addressed these outcomes. Findings included:
  - For Individual #405, the CLDP identified the following to be her important outcomes: opportunities to attend Hispanic cultural and musical events; go out to eat at Mexican restaurants; sit outside at her home, and bring her adaptive/assistive equipment with her. It was concerning that the CLDP supports only addressed preferred community activities on a limited basis, including monthly opportunities to eat out and "at least quarterly" opportunities to attend the preferred events. The IDT needed to consider expanding its expectations for allowing individuals to experience community living in a more meaningful and frequent way. For example, Individual #405's PSI indicated she would enjoy music recitals at local colleges, which could have provided more frequent opportunities for participation. The CLDP included a support for attending music events, but again only on a quarterly basis.
  - For Individual #312, the CLDP described his important outcomes as attending the public library, sitting outside and going to a day program, and also referenced access to his assistive and adaptive equipment. It was concerning that the IDT did not document a clear discussion about his enjoyment of swimming and music. For example, his ISP, dated 12/3/18, listed going to the pool and getting in the water as one of his strong preferences that also helped him to relax. This was confirmed in the PSI and several assessments. So, it was unclear why the CLDP indicated that he was not interested just a few weeks after the ISP annual meeting. Per transition staff who attended the CLDP meeting, they also found this puzzling.
- Need/desire for employment, and/or other meaningful day activities: Neither CLDP met criterion. Neither CLDP specified supports for how the individual would spend their day, but both did attend day habilitation programs in the community after their transitions. Both CLDPs provided minimal supports for meaningful day activities in integrated community environments. The CLDPs only included participation in community outings or activities on a monthly basis at most; some were only quarterly. The Monitoring Team was concerned that individuals were transitioning to the community, but IDTs were setting only minimal expectations for community participation and integration.
- Positive reinforcement, incentives, and/or other motivating components to an individual's success:
  - For Individual #405, documentation indicated she preferred Spanish-speaking staff and exhibited less self-stimulatory behavior when listening to Spanish and/or to Tejano music. The provider said they could try to offer a Spanish-speaking staff, when and if available, but the IDT did not develop any supports related to this expectation.
  - For Individual #312, per audiology and day program assessments, he should have his iPod and headphones available at all times, but the CLDP did not include this support.
- Teaching, maintenance, participation, and acquisition of specific skills:

- For Individual #405, CLDP supports indicated only that within the first 30 days after transition, the provider would assess her self-care and home living skills and determine the appropriate supports and needs. It did not provide any expectation that supports would be implemented. Per the PMM documentation, the provider completed the assessment and concluded she did not have notable skills or abilities, and indicated no plan to develop any training programs.
- For Individual #312, the CLDP included a support for a training program for pulling his shirt down, but did not address a final recommendation from the day program assessment to work on a training objective to choose between two preferred activities through eye gaze.

- All recommendations from assessments are included, or if not, there is a rationale provided: Austin SSLC had a process in place for documenting in the CLDP the IDT's discussion of assessments and recommendations, including the IDT's rationale for any changes to, or additional recommendations. The Center also had a process for reviewing the discipline assessments for thoroughness. For this review, the IDTs did not yet address all recommendations with supports or otherwise provide a justification, as described throughout the discussion about this indicator.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.											
Summary: Post-move monitoring required improvements. Some of the areas in which continued efforts were needed related to the PMM consistently gathering reliable and valid data upon which to make accurate judgements about the presence of needed supports, and the PMM correctly scoring the presence or absence supports based on the evidence. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	405	312							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	100% 2/2	1/1	1/1							
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1							
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1							
6	The PMM's scoring is correct based on the evidence.	0% 0/2	0/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, the IDT/Facility implemented corrective actions in a timely manner.	0% 0/2	0/1	0/1							

8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A	N/A	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A	N/A	N/A							

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

4. PMM Checklists did not yet consistently provide valid and reliable data. To continue to move toward compliance, the Center should continue to focus on improving overall clarity and measurability of supports that provide guidance to the PMM as to what criteria would constitute the presence of various supports, as well as ensuring that PMM documentation addresses all requirements of supports and corresponding evidence. Findings included:

- In some instances, it was positive the PMM provided comments with sufficient detail that evidenced provider staff were knowledgeable of individuals' needs or that supports had been provided as required. For example, the PMM Checklist for Individual #405 provided many very thorough comments that touched on all the required evidence.
- For both individuals, it was also positive the PMM often made a practice of confirming supervisory staff knowledge of supports that were not yet due.
- In other instances, the evidence provided was not complete, valid and/or reliable. For example:
    - For Individual #405, the PMM did not consistently confirm provider staff knowledge of supports. In some instances, the PMM noted that direct support professionals were expected to have knowledge of certain supports (e.g., signs and symptoms of choking, falls/fractures, skin integrity), but only documented interviewing supervisory staff.
    - Also, for Individual #405, the PMM sometimes only reviewed documentation for some supports (e.g. medication administration, seizures and check and change logs), when staff interviews were also required.
    - For Individual #312, the CLDP included a post-move support to continue his current diet texture. The evidence required included staff interviews, but the PMM only documented interviewing provider supervisors who said staff had been trained. It is essential that the PMM interview staff who are responsible for carrying out supports to evaluate their knowledge and competence, rather than relying on a statement that they had been trained. This was a concern with some other supports as well.

5. Based on information the Post Move Monitor collected, both individuals had frequently received supports as listed and/or described in the CLDP, but this was not yet consistent. As described above, the Monitoring Team sometimes could not evaluate or confirm whether individuals had received supports due to the lack clarity and measurability of the supports as written and/or a lack of reliable and valid evidence that demonstrated a support was in place as required. Other examples of supports not in place as required included the following:

- For Individual #405, the PMM identified the following supports as not being in place:
    - The provider had not yet initiated the guardianship process at the time of the 45 and 90-day PMM visits.
    - At the time of the 90-day PMM visit, the PMM documented Individual #405 had a mark on her arm and that the

provider was to follow up to confirm whether an injury report had been completed, which was a requirement of the support. The PMM marked this support for skin integrity in place, but the evidence appeared to indicate otherwise.

- For Individual #312, the PMM identified the following supports as not being in place at the time of the seven-day PMM visit:
  - The home had not maintained the daily bowel log. The PMM indicated the day habilitation bowel log was in place, but further stated it did not document barrier cream application. This should have spurred the PMM to mark the support as not fully in place.
  - The training objective for dressing had not yet started as required.
  - His nails had not been trimmed and were observed to be jagged. The required daily log for nail checks had not been implemented.
  - The provider had not implemented the required seizure log.

6. Based on the supports defined in the CLDP, the Post-Move Monitor's scoring was not consistently correct. In some instances, the PMM still marked supports as in place without having documented obtaining the required evidence that would confirm this evaluation. In addition to those examples described in relation to Indicator #4 above and Indicator 5 below, some other concerns included:

- For Individual #405:
  - At the time of the 45-day PMM visit, the documentation for a support for bedtime positioning was incomplete, but the PMM marked it as in place.
  - At the time of the 90-day PMM visit, the PMM marked as in place a support for having the opportunity to eat out in the community, but the evidence provided only indicated she had limited food options when she went out to eat and that the provider offered alternate activities during cookouts.
- For Individual #312:
  - Per the CLDP supports, he was to receive a supplement three times a day. Per the PMM comments, provider staff were having trouble getting him to drink and had been trying a syringe. Documentation did not clearly reflect how much he was consuming. Similarly, another support required that he have PKU meals three times a day. The PMM found a lack of clear documentation about how much he was consuming, and correctly addressed the need for a log. The PMM marked both supports as in place, but should have indicated they were not fully in place and flagged them for follow-up with the IDT, especially given his previous history with refusals and weight loss.

7. through 8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed up through to resolution. Whether follow-up is completed as needed relies heavily on the accuracy of the PMM's assessment of whether supports were, or were not, in place. As described in the previous indicators, the PMM did not always document the evidence needed to confirm presence or absence of a support. Other findings included:

- For Individual #405, the Center did not consistently document corrective action and resolution, when needed. Examples included, but were not limited to:
  - The PMM marked a standard support for remaining free from injury as not in place, as described above with regard to Indicator 5. The PMM listed this as an area of concern, but the PMM Checklist did not document any additional follow-up completed.
  - At the time of the 90-day PMM visit, which took place approximately six days before the conclusion of the first 90 days, the provider had not obtained the required occupational therapy/physical therapy (OT/PT) assessment. The PMM

marked this in place because the full 90 days had not yet elapsed, and further indicated this would be reviewed at the 180-day PMM visit. It was not reasonable to wait another three months before ensuring this important support had been fulfilled. This should have been noted as not in place at the time of the 90-day visit, and the PMM should have made a specific plan to ensure it was resolved on a timelier basis than three months hence.
    - At the time of the 45-day, PMM visit, the community PCP changed her vitamin D dosage from 50,000 IU monthly to that same amount weekly. The documentation provided no rationale, such as a report of the vitamin D level, nor was there any evidence of IDT review.
- For Individual #312, the PMM Checklist listed no unmet needs or areas of concern, but the PMM should have informed the IDT about the missing bowel management and seizure logs, and engaged them about the concerning issues with intake. It was of note these issues had continued following the seven-day PMM visit to the point of the provider asking for additional training. It was positive the Center had responded with additional monitoring and a plan to hold an ISPA meeting to address the ongoing concerns.

9. through 10. Post-move monitoring did not take place during the onsite monitoring visit, so this indicator was not rated.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of preventable negative events following transition into the community.

Summary: While the IDT met as needed to discuss the potentially disrupted community transition (PDCT) event experienced by one of the two individuals in this review, improvements are needed to ensure this process includes a thorough critical analysis that supports the identification of process improvements that might help to avoid any similar issues for individuals moving to the community in the future. It was positive to see the IDT and transition staff taking a proactive approach to address emerging concerns for the other recently-transitioned individual, including providing additional monitoring, arranging to meet with the IDT and planning to offer additional provider training.

#	Indicator	Overall Score	Individuals: 405	312							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	50% 1/2	0/1	1/1							

Comments: 11. Individual #312 had not had any reported PDCT events, but Individual #405 died from a cardiac event within 90 days of her transition. Findings included:

- Per the PDCT documentation, on 7/17/18, Individual #405 was found unresponsive in her wheelchair at the day program following breakfast. She was revived and taken to the emergency department (ED), where she had a "massive cardiac event" and was pronounced dead.

- On 7/27/18, the IDT met to discuss this PDCT.
  - Per the documentation, Individual #405 had not had any prior signs or symptoms related to a possible cardiac event, and on 7/15/18, her vital signs had been taken and were normal.
  - In discussing whether the event could have been anticipated, the IDT concluded it could not have been. As rationale, the IDT referenced her low cardiac risk as documented in the IRRF, which further indicated her cholesterol was within normal limits, and her high triglycerides were being treated with medication (i.e., Lovaza). The documentation further indicated one of her nursing supports consisted of weekly assessments with vital signs completed by the home nurse.
  - Overall, the IDT concluded nothing could have been done differently, but made a recommendation for familiar staff to attend PMM visits, at least on the seven and 45-day visits, to see if anything looked out of the ordinary, particularly for individuals from homes serving those who were medically involved. This was a thoughtful recommendation.
- It is important for the IDT to critically assess all circumstances that might have contributed to any PDCT. In this case, some of the other things the IDT should have considered included:
  - Individual #405 did have at least one known risk factor (i.e., high triglycerides) for cardiac disease, and the IDT decided to treat it conservatively due to other risk factors that might come with more aggressive medication. This might well have been the appropriate decision, based on their knowledge of all her related needs, but it was not clear that a low risk rating was correct.
  - She had not had labs completed before her transition to confirm her cholesterol levels, but the previous levels indicated the only concern was high triglycerides, with all other lipid panel findings being within normal limits. The CLDP included a support to have labs drawn within 60-90 days of transition. Per other documentation provided, on 4/28/18, she did have labs drawn in the community, shortly after her transition, that indicated her total cholesterol, triglycerides, and low density lipoprotein (LDL) cholesterol were high, while her protective HDL cholesterol was low. These results were significantly different from those the Center had last reported. While this is not necessarily implicated in the cause of the cardiac event, it should have prompted the IDT to discuss whether post-move monitoring had sufficiently gathered needed information. For example, the CLDP included a support to have labs drawn within 60-90 days of transition, but the PMM documentation only indicated that a lipid panel was completed. It did not provide the results; if these had been brought to the IDT, it might have caused them to reconsider the risk rating and the recommended treatment.
  - It was also concerning that the PDCT ISPA indicated one of her nursing supports included weekly vital signs to be completed by the home nurse, but the CLDP did not specify such a support. The ISPA further indicated Individual #405's vital signs had been normal on 7/15/18, and the IDT appeared to deduce that this meant they were routinely in normal range. The IDT should have probed further to determine if weekly vital sign data were available and reviewed them to make an accurate conclusion.

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: Transition staff had identified the need to improve the quality and content of transition assessments and had scheduled an upcoming training with discipline leads to move this forward. This initiative should greatly assist with the areas for improvement identified during this monitoring visit, including the completion of all needed assessments and the inclusion of comprehensive and community-appropriate recommendations. Although Center staff provided training to community provider staff, the CLDPs did not define the training thoroughly, and	Individuals:

Center staff still were not able to confirm that community provider staff were competent to meet individuals' needs at the time of transition. It was positive, though, that the Center was involving direct support professional participation throughout transition activities, as well as using staff shadowing as a training methodology. These indicators will continue in active oversight.											
#	Indicator	Overall Score	405	312							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	100% 2/2	1/1	1/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	50% 1/2	0/1	1/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	100% 2/2	1/1	1/1							
18	The APC and transition department staff collaborates with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition.	100% 2/2	1/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							
Comments: 12. Assessments did not consistently meet criterion for this indicator. It was positive transition staff were planning training for discipline leads on the expectations for transition assessments. The Monitoring Team considers the following four sub-											

indicators when evaluating compliance:

- Assessments updated with 45 Days of transition: Most assessments provided for review met criterion for timeliness. Examples of assessment that did not meet criterion included:
    - It was good to see a detailed review of both the IRRF and the Quarterly Drug Regimen Review (QDRR) included in Individual #312's CLDP.
    - For Individual #405, the last comprehensive communication assessment was dated 7/12/11, and no comprehensive assessment had been completed since her dementia diagnosis. These circumstances, including the fact that she was moving to a new environment with unfamiliar staff, merited a new comprehensive assessment. It was also concerning that her communication dictionary included only three items, particularly since she had lived at the Center for almost 70 years.
    - Also, for Individual #405, the Center did not provide a Functional Skills Assessment (FSA).
    - For Individual #312, the nursing and FSA were not updated within 45 days.
- Assessments provided a summary of relevant facts of the individual's stay at the Center: Some disciplines provided a summary of relevant facts in the available assessments, but this was not consistent. For example, Individual #312's medical assessment noted in the interval history that he underwent an esophagogastroduodenoscopy (EGD) on 11/14/18. That procedure indicated diagnoses of reflux esophagitis, short segment Barrett's Esophagus, and hiatal hernia. Per the documentation, pathology results were pending before determining whether to treat these conditions with medication. The medical transition update, on 12/7/18, and again on 12/17/18, did not document resolution of the pending pathology report or make any recommendation for follow-up, nor did the CLDP. In addition to the lack of updated content in Individual #312's medical update related to his EGD results, his behavioral assessment did not provide a thorough history of his behavioral needs and how they had been successfully addressed in the past.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments did not yet thoroughly provide recommendations to support transition.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not fully address/focus on the new community home and day/work settings. Currently, assessments did not consistently meet criterion in this area. On a positive note, Individual #312's BHA update included a set of recommendations for how to choose items for engagement. These provided a good foundation for describing supports for use by community provider staff. It was unfortunate the CLDP did not include this information in any related supports or provider staff training.

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

14. Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff

to be trained and method of training required: Training provided to community provider staff did not yet meet criterion for these two CLDPs, as described below and with regard to Indicator 1 above. Findings included:

- As described with regard to Indicator 1 above, the CLDPs did not always include pre-move training supports in important areas, nor did they consistently identify the expected provider staff knowledge or competencies that needed to be demonstrated.
- To continue to move towards compliance, the Center should ensure the written exams it relies on to demonstrate competency are constructed to cover all essential knowledge. The testing materials the Monitoring Team reviewed fell short of this mark. Competency testing did not clearly document provider staff had knowledge of all essential supports based on each individual's needs.
- It was positive, though, that the Center had included having provider staff shadow their Center counterparts prior to transition as a training technique for both these individuals. The Center should continue to expand upon the value of this training methodology by clearly indicating the competencies to be learned in the process as well as how those competencies would be demonstrated by provider staff.

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

- For Individual #405, the 14-day ISPA indicated PCP-to-PCP collaboration was needed, but the CLDP indicated no such collaboration was needed. The IDT did not provide a rationale for this change in recommendation, but should have. It was positive, though, that the CLDP indicated the provider RN shadowed staff at the Center, which is a valuable form of collaboration.
- For Individual #312, the CLDP stated the IDT did not feel collaboration between PCPs was necessary, but did not provide any rationale. The CLDP further indicated the Registered Nurse Case manager (RNCM) completed an in-service with the provider RNs, which gave them an opportunity to answer any questions, but this indicator calls for the IDT to make a judgement about whether specific collaboration is needed, based on individualized needs. The IDT did not specify what needed to be communicated.

16. SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs: The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. One of two CLDPs met criterion. For both individuals, the IDTs determined the occupational therapist (OT) needed to complete a setting assessment based on their needs for adaptive and assistive equipment and potential home modifications. Both also provided documentation that assessments were completed. However, for Individual #405, the IDT did not provide resolution about her need for having two staff available for transferring in her home environment. Given the previously-stated requirements for two-person transfers, the IDT should have determined whether the home had adaptations, equipment, or other factors that made it feasible and/or safe for one person to facilitate transfers that might be needed, such as in the case of a fire or other emergency.

17. Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual: The CLDP should include a specific statement of IDT considerations of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results. Examples

include provider direct support staff spending time at the Center, Center direct support staff spending time with the individual in the community, and Center and provider direct support staff meeting to discuss the individual's needs. Both CLDPs provided a clear statement describing the IDT's consideration in this regard. It was positive that DSPs participated in both transitions.

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

19. The pre-move site reviews (PMSRs) for both individuals were completed prior to the transition date as required. It is essential the Center can directly affirm provider staff competency to ensure an individual's health and safety prior to relinquishing day-to-day responsibility, but neither of these two PMSRs accomplished this, as described above with regard to Indicator 1 and Indicator 14.

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary: This indicator will continue in active oversight.			Individuals:									
#	Indicator	Overall Score	405	312								
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	100% 2/2	1/1	1/1								

Comments: 20. Both CLDPs met criterion for this indicator.

- Individual #405 was referred on 9/1/16, and transitioned on 3/28/18. This exceeded 180 days, but the transition log documented ongoing community exploration and transition activity. One delay resulted from a respective delay in funding for a needed home modification, and another occurred due to an episode of skin breakdown in March 2018. It was positive the IDT continued to work toward transition during these times.
- Individual #312 was referred on 9/13/16, and transitioned on 7/24/18. This transition also exceeded 180 days, but the transition log documented considerable and ongoing work to locate a community setting that could meet his health care and physical/nutritional management needs.

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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