United States v. State of Texas

Monitoring Team Report

Austin State Supported Living Center

Dates of Remote Review: July 26th to 29th, 2021

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Background

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

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

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

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

Methodology

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

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

b. **Onsite review** – Due to the COVID-19 pandemic and resultant safety precautions and restrictions, the Monitoring Teams did not visit the campus in person. Instead, the Monitoring Teams collaborated with the Parties to create a remote virtual review protocol that allowed for the monitoring of all of the outcomes and indicators.
    1. Review of documents – Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some Center-wide documents. During the week of the remote review, the Monitoring Team requested and reviewed additional documents.
    2. Attending meetings – The Monitoring Team attended various regularly occurring meetings at the Center by calling in to a teleconference, or utilizing a video meeting platform (Microsoft Teams). Examples included daily morning medical meeting, daily incident management review team, physical nutritional management team, ISPs annual and preparation meetings, and QAQI Council.
    3. Interviews – The Monitoring Team conducted interviews of staff, managers, clinicians, individuals, and others by calling in to a teleconference, or utilizing a video meeting platform (Microsoft Teams).
    4. Observations – The Monitoring Team conducted observations of individuals and staff engaged in various activities with the usage of a video platform (Microsoft Teams). The Center assigned a staff member to host each observation. That staff member used a portable mobile device (e.g., iPhone) to show the individual and staff. Activities included administration of medication, implementation of skill acquisition plans, and engagement in activities at home.
c. **Monitoring Report** – The monitoring report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. A summary paragraph is also provided for each outcome. In this paragraph, the Monitor provides some details about the indicators that comprise the outcome, including a determination of whether any indicators will move to the category of requiring less oversight. At the next review, indicators that move to this category will not be rated, but may return to active oversight at future reviews if the Monitor has concerns about the Center's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the Center's plans for continued quality assurance and improvement. In this report, any indicators that were moved to the category of less oversight during previous reviews are shown as shaded and no scores are provided. The Monitor may, however, include comments regarding these indicators.

Organization of Report

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

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

Executive Summary

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

Austin SSLC met and maintained substantial compliance with section K of the Settlement Agreement (Psychological Care and Services) and is now exited from the monitoring of this section.

With regard to Section L on medical care:

- Section L.1 – As indicated in the final report for the last review, dated 12/23/20, the Center generally met the standards for the provision of routine medical care, but needed to show sustained compliance in this area for another review, as per paragraph III.J of the Settlement Agreement. Based on the results of current review, the Center sustained its progress in this area.

  During this review and previous reviews, the Center also has done well with many of the indicators related to acute care, as well as preventative care.

  In recent weeks, the parties reached agreement and the Court approved the Amended Settlement Agreement that allows exit by provision. The parties and the Monitors are working through a process to begin implementation of the revised Agreement. Once this occurs, Austin SSLC will exit Section L.1.
- Section L.2 and L.3 – As indicated in the final report from the last review: "At the bottom of the medical audit tool, the Monitor stated: '**Sections L.2 and L.3:** The Monitor is recommending the parties discuss the auditing of Sections L.2 and L.3. They both relate to quality assurance mechanisms (i.e., L.2 to non-Facility physician review, and L.3 to the Facility's medical QI program). Consideration should be given to incorporating these with Section E, and/or the process previously discussed in which the State would adopt the Monitoring Team's tools, and establish inter-rater reliability.' To the Monitor's knowledge, the parties never addressed these outstanding provisions of the Settlement Agreement that did not fit within the Quality Service Review (QSR) monitoring model. The Lead Monitor is willing to work with the parties between now and the next review to determine how Austin SSLC will demonstrate that it meets these requirements of Section L."

  On 12/10/20, the Lead Monitors met with the parties, and based on the current status of the system, proposed that the State hire a technical assistance consultant to work with staff on their development of quality assurance/improvement processes. The Monitors specifically identified as priority areas these medical quality assurance/improvement initiatives as well as protection from harm issues. The consultant is now in place, and the Monitors continue to recommend that the State use this resource to assist them in developing a set of valid and reliable measures for medical services and supports for use at Austin SSLC as well as the other Centers. The Amended Agreement also sets forth expectations for the establishment of inter-rater agreement between State Reviewers and the Monitoring Team.
- Section L.4 – In the Amended Settlement Agreement, the parties deleted this provision.

In a letter, dated 8/23/21, the Monitor notified the parties that the Center achieved substantial compliance with most of the requirements of Section Q of the Settlement Agreement. The exceptions are: 1) implementation of a policy/clinical guideline that is consistent with current generally accepted standards of care on perioperative assessment and management of individuals needing TIVA/general anesthesia for dental work, which the Monitoring Team will continue to assess and apply the findings to paragraph H.7; and 2) personal goals/objectives for individuals who are at risk for dental problems, as well as the development and implementation of plans for individuals who require suction tooth brushing, which the Monitoring Team will assess as part of Section F. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Austin SSLC exited from the other requirements of Section Q of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the related outcomes and indicators.

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

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

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

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

At the time of the last review, this Domain contained five outcomes, and 18 underlying indicators. After the last review, four indicators were moved to, or were already in, the category of less oversight. Presently, no additional indicators will move to the category of less oversight.

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

Other

For three of four individuals, the IDTs determined that, based on the procedures for which pretreatment sedation (PTS) was used, that intervention strategies were not needed. For the fourth individual, a new admission, PTS was used for dental surgery with no IDT review, ISPA completion, or consent from the LAR.

Restraint

Austin SSLC met the substantial compliance requirements of section C of the Settlement Agreement and was exited from monitoring. Thus, the Monitors did not conduct monitoring of this area.

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

Austin SSLC met the substantial compliance requirements of section D of the Settlement Agreement and was exited from monitoring. Thus, the Monitors did not conduct monitoring of this area.

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

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	225	429	355	394	357	378	148	16	50
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/3	0/1	N/A	0/1	N/A	N/A	N/A	N/A	0/1	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. The Monitoring Team reviewed the uses of TIVA for the following individuals who met criteria for its use: Individual #225 on 6/2/21, Individual #355 on 3/4/21, and Individual #16 on 3/4/21.

Center staff obtained informed consent, ensured the individuals had nothing-by-mouth prior to the procedures, and wrote operative notes describing the assessment and procedures completed. In addition, nursing staff completed post-operative vital signs according to the required schedule.

As discussed in previous reports, the Center's policy related to perioperative assessment and management needed to be expanded and improved. Dental surgery is considered a low-risk procedure; however, an individual might 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, for example, information on perioperative management of the individual's routine medications.

The Center submitted an undated document entitled: "Medical Clearance Guidelines for IV Sedations/General Anesthesia." As its title indicated, it largely addressed medical clearance, as opposed to perioperative risk assessment.

A number of well-known organizations provide guidance on the completion of perioperative evaluations for non-cardiac surgery. The following provides one example of guidance that might be helpful to State Office as it revises/develops a guideline consistent with current generally accepted standards: https://www.icsi.org/guideline/perioperative-guideline/. Given the risks involved with TIVA, it is essential that such guidelines be revised/developed and implemented. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures.

b. Based on the documentation provided, during the six months prior to the review, none of the nine individuals in the physical health review group received 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	225	429	355	394	357	378	148	16	50
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	25% 1/4	N/A	1/3	N/A	0/1	N/A	N/A	N/A	N/A	N/A

Comments: a. In the six months prior to the review, the following individuals in the physical health review group required the use of pre-treatment sedation: Individual #429 for an abdominal ultrasound on 4/5/21, general anesthesia for an esophagogastroduodenoscopy (EGD) on 4/12/21, and a catherization for a urine specimen on 5/7/21; and Individual #394 for an audiology appointment on 5/11/21.

For Individual #429:

- It was positive that the ISP showed discussion of the need for the use of pre-treatment sedation, as well as the IDT's agreement on the use of Ativan and a dosage range.
- For the uses of pre-treatment sedation for an abdominal ultrasound on 4/5/21, and for a catherization for a urine specimen on 5/7/21, the Center director signed consent forms. However, the forms did not specify the procedures. In addition, the forms referenced the use of Ativan, but not list the dose or dosage range, nor the route of administration.
- For each of the instances reviewed for this individual, nurses assessed pre-procedure vital signs in alignment with the nursing guidelines.
- For the sedation uses on 4/12/21, and 5/7/21, nurses also completed post-procedure vital sign assessments in alignment with the relevant guidelines. However, for the use on 4/5/21, vital signs were missing for the day shift on 4/6/21.

For Individual #394:

- The ISP listed procedures for which pre-treatment sedation was needed, but the IDT did not indicate which medication and/or a dosage range.
- With regard to informed consent, on 8/5/20, the legally authorized representative (LAR) signed a form entitled "Consent for medical or dental care" for Vistaril (Hydroxyzine). The form reviewed the potential side effects, and listed medical procedures and exams for which the individual needed pre-treatment sedation. However, the form did not list the dosage or dosage range nor the route of administration of the medication.
- It was positive that nurses completed pre- and post-procedure vital signs assessments in alignment with the relevant 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: For three of the four individuals to whom this outcome applied, the IDT met the requirements for content review. The IDTs determined that, based on the	Individuals:

procedures for which PTS was used, that intervention strategies were not needed. For the fourth individual, a new admission, PTS was used for dental surgery with no IDT review, ISPA completion, or consent from LAR. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	162	263	429	457	127	329	57	225	425
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	75% 3/4		1/1	1/1					0/1	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	N/A									
4	Action plans were implemented.	N/A									
5	If implemented, progress was monitored.	N/A									
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A									

Comments:
1-6. Based upon the documentation provided, it was determined that four of the individuals had required pretreatment sedation (PTS) or anesthesia over the previous 12-month period. Individual #263, Individual #429, Individual #225, and Individual #425 had required sedation for at least one medical procedure. For everyone, but Individual #225, 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 sedation, and identification of this need in the rights restriction section of their ISPs. Current guardian consent forms were provided for Individual #263 and Individual #425, while the facility director provided consent for Individual #429.

For these three individuals, their IDTs determined that they were not candidates for desensitization plans and identified no other actions needed to reduce the use of sedation in the future.

Individual #225 required anesthesia for the extraction of her wisdom teeth. It was noted at her ISP meeting that she had not required PTS prior to admission to the facility and that consent would not be sought at that time. There were no ISPA minutes provided regarding this dental surgery appointment, nor was there evidence of informed consent from her guardian.

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	131	265	314	87					
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 4/4	1/1	1/1	1/1	1/1					
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1					

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

- On 10/28/20, Individual #178 died at the age of 69 with cause of death listed as COVID-19 pneumonia.
- On 11/11/20, Individual #131 died at the age of 59 with causes of death listed as bilateral pulmonary thromboembolism, and deep vein thrombosis.
- On 11/13/20, Individual #265 died at the age of 74 with causes of death listed as acute hypoxic respiratory failure, aspiration pneumonia, oropharyngeal dysphagia, and neurologic disease.
- On 11/16/20, Individual #307 died at the age of 70 with cause of death listed as atherosclerotic and hypertensive cardiac disease.
- On 1/7/21, Individual #314 died at the age of 70 with causes of death listed as acute hypoxic hypercarbic respiratory failure.
- On 2/17/21, Individual #87 died at the age of 69 with causes of death listed as sudden cardiac arrest, hypertension, chronic kidney disease, and "Type 2 diabetes Pre-Diabetes."
- On 4/11/21, Individual #23 died at the age of 74 with cause of death listed as Stage IV undifferentiated sarcoma.
- On 4/25/21, Individual #365 died at the age of 83 with cause of death listed as dysphagia due to cerebral infarction.

- On 5/28/21, Individual #148 died at the age of 61 with cause of death listed as intracerebral hemorrhage.

b. through d. The Center completed death reviews for each of the four individuals. These reviews identified concerns, and resulted in some important recommendations.

- Overall, the Medical Director's reviews of deaths identified relevant concerns and resulted in a number of necessary recommendations. These recommendations generally were pulled forward into the administrative and/or clinical death reviews for discussion and approval.
- Similarly, the nursing reviews identified some relevant concerns, as well as some patterns of problems with the provision of nursing care.

However, at times, evidence was not submitted to show that Center staff fully identified concerns impacting the delivery of healthcare supports and/or followed through with the findings from the reviews to ensure that recommendations were made, and action was taken to address the findings. For example:

- For Individual #87 and Individual #314, the Center's nurse reviewers identified a series of recommendations, and stated: "Over the last 6 death reviews a trend has been recognized regarding lack of nursing documentation, following PCP orders and ACP/IHCP interventions. During clinical death reviews held on 5/6/2020, 5/15/2020, 9/8/2020, and 11/17/20, 12/1/2020 and 12/7/2020 these trends were discussed at length and recognized as an issue and the recommendations given by quality assurance RN were agreed upon by the committee…" The reviews then listed the dates on which various steps were taken to implement the recommendations. The reviewers then made a statements such as: "Upon completion of the CDR [clinical death review] on [Individual #314], there are not any discrepancies or anomalies specifically related to her death review, however, the same trend of [not] following PCP orders, CMO [care management orders] and weak IHCP [Integrated Healthcare Plans] interventions by RNCM [Registered Nurse Case Managers] are noted."

  It was positive that nursing staff identified these overall trends, and the mortality review committees approved recommendations to address them. However, from the information presented, these trends continued over at least a seven-month period of time. This raised the question of whether or not the recommendations were sufficient to effectively address the problems.
- As the Monitoring Team's report illustrates, problems persisted with other aspects of clinical assessment, planning, and care. For example, in addition to problems with the nursing aspects of IHCPs, the plans did not include thorough plans to address individuals' needs for medical, and/or physical and nutritional management supports and services. As a result, IDTs did not have a way to determine whether or not supports were provided as needed, and/or that they effectively addressed individuals' healthcare concerns. A nursing recommendation for Individual #265 addressed problems with the quality of the nursing interventions included in IHCPs. Generally, though, the Center's mortality reviews and the resulting recommendations did not address these concerns for other disciplines.

e. It was good to see that most of the recommendations were written in a way that helped to ensure that Center practice improved. For example, a recommendation that read: "In-service all PCPs on the state office diabetic guidelines with special focus on monitoring & prevention of diabetic complications…" resulted in an in-service training. The Administrative Death Review Committee also

appropriately required the Medical Director/Compliance RN to monitor all individuals with diabetes to ensure they received the necessary monitoring and preventive care (e.g., labs, blood pressure monitoring, annual eye exams, annual diabetic foot exams, etc.).

In some cases, Center staff did not submit documentation to show action taken to implement the recommendations. For example, for Individual 314, no information was submitted with regard to five of the six recommendations. In addition, often documentation was not submitted to show the implementation of the monitoring plans that were part of the recommendations.

The documentation the Center provided made it difficult to determine whether or not, and when a Clinical death review recommendation was considered closed. Specifically, the charts that listed the recommendations did not include a column to indicate the date on which the recommendation was initiated and a date on which it was closed, or to provide a "pending" status update.

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

Quality Assurance

After Round 14, based on the Center's scores over the past three monitoring cycles, DOJ and the State agreed that the Center achieved substantial compliance with most of the requirements of Section N of the Settlement Agreement. The exceptions are Section N.6 related to adverse drug reactions (i.e., see below), and Section N.8 related to medication variances that the Monitoring Team will review as part of Section E, and Section N.5 related to quarterly monitoring for tardive dyskinesia that will be measured through Section J.12. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Austin SSLC exited from the other requirements of Section N of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the outcomes and indicators related to the exited provisions of the Settlement Agreement.

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: None of the ADRs reviewed were reportable to MedWatch.			Individuals:								
#	Indicator	Overall Score	225	429	355	394	357	378	148	16	50
a.	ADRs are reported immediately.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
b.	Clinical follow-up action is completed, as necessary, with the individual.										
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.										

d.	Reportable ADRs are sent to MedWatch.	N/A	N/A	N/A					N/A		
Comments: d. For the nine individuals in the review group, Center staff reported four potential adverse drug reactions, including two for Individual #225 (i.e., on 2/6/21, and 3/12/21), one for Individual #429 (i.e., on 2/25/21), and one for Individual #148 (i.e., on 4/22/21). None of these were reportable to MedWatch.											

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.

In a letter, dated 8/23/21, the Monitor notified the parties that the Center achieved substantial compliance with most of the requirements of Section Q of the Settlement Agreement. The exceptions are: 1) implementation of a policy/clinical guideline that is consistent with current generally accepted standards of care on perioperative assessment and management of individuals needing TIVA/general anesthesia for dental work, which the Monitoring Team will continue to assess and apply the findings to paragraph H.7 of the Settlement Agreement; and 2) personal goals/objectives for individuals who are at risk for dental problems, as well as the development and implementation of plans for individuals who require suction tooth brushing, which the Monitoring Team will assess as part of Section F. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Austin SSLC exited from the other requirements of Section Q of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the related outcomes and indicators. As a result, this Domain contains one less outcome, and five fewer indicators.

Currently, this Domain contains 28 outcomes and 125 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, and OT/PT.

As of this review, Austin SSLC met and maintained substantial compliance with section K of the Settlement Agreement (Psychological Care and Services) and is now exited from the monitoring of this section and the outcomes and indicators under this domain: 4 outcomes, 13 indicators.

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

<u>Assessments</u>
The team arranged for and obtained the needed, relevant assessments prior to the IDT meetings for all but one individual in the review group.

In behavioral health, in the functional assessment, for about half of the individuals, the identified consequences were those outlined in their PBSPs rather than those hypothesized to be maintaining the problem behaviors. Re-training of relevant BHS staff was done.

More SAPs were based on assessment results and were practical, functional, and meaningful than at previous reviews.

In order to assign accurate risk ratings, IDTs need to continue to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings and update the IRRFs within no more than five days.

Since the previous review, Medical Department staff continued their efforts to improve the quality of the annual medical assessments (AMAs), as well as the interval medical reviews (IMRs). For the nine individuals in the review group, the AMAs met the quality criteria, and most of the IMRs also met criteria.

Since the previous review, improvement was noted with primary care providers' (PCPs') completion of IMRs on a quarterly basis (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable").

For the one applicable individual, nurses completed a timely new-admission nursing record review and physical assessment. For three of the six individuals in the review group, problems were noted with regard to nurses' timely completion of quarterly nursing record reviews and/or physical assessments. Due to problems with the timeliness of physical assessments, as well as signature and entry dates on annual record reviews, the related indicator is at risk of returning to active oversight.

Overall, considerable improvement is needed with the content of the new-admission, and annual and quarterly nursing record reviews. 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 60% of the examples reviewed of exacerbations of individuals' chronic conditions, nurses completed assessments in accordance with current standards of practice.

Similar to the last review, the scores during this review showed timely referral of individuals to the Physical and Nutritional Management Team (PNMT), timely completion of PNMT reviews, and completion of the correct type of assessment (i.e., review or comprehensive assessment). For the one individual in the review group who required a PNMT comprehensive assessment, the PNMT completed an assessment that met most of the criteria for quality. Center staff should continue its progress in all of these areas, and focus on the completion of post-hospital PNMT nurse reviews, as well as the quality of PNMT reviews.

It was positive that half of the Occupational Therapy/Physical Therapy (OT/PT) assessments reviewed met the criteria for quality, and that the remaining assessments showed concerns with between only one and three of the sub-indicators. With minimal efforts, Center staff could make continued improvements to the OT/PT assessments.

Significant work continued to be needed to improve the quality of communication assessments in order to ensure that Speech Language Pathologists (SLPs) provide IDTs with clear understandings of individuals' functional communication status; alternative and augmentative communication (AAC) options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports is objectively evaluated.

Individual Support Plans (ISPs)

In the ISPs, one individual's goals met criteria for all five personal goal areas. Moreover, across the six individuals, personal goals met criteria in from one to five areas for a total of 20 goals that met criteria, about the same as at the last review. More work is needed regarding health goals (i.e., the IHCP).

In the ISPs, just under half of the goals were written in measurable terminology. ISP action plans supported the individual's overall enhanced independence.

In the ISPs, few of the goals had reliable data. There were sufficient reliable data to assess progress on two goals; one was progressing.

QIDPs were knowledgeable of the goals, strengths, and support needs of the individuals on their caseloads, but for four individuals did not ensure that the individual received required monitoring, review, and revision of treatments, services, and supports. Similarly, QIDPs were doing a better job of reviewing all goals and including data in the QIDP monthly review when available, but did not generally include an analysis of data or summary of progress towards goals based on data submitted. When progress was not made, action plans were not revised to ensure progress.

Staff were generally knowledgeable regarding specific risks and supports needed and implementation of ISP action plans. Action steps in the ISP were consistently implemented for about half of the individuals.

In behavioral health, inter-observer agreement (IOA) and data collection timeliness (DCT) were assessed regularly and the Center had a good protocol for both. IOA scores were acceptable for all individuals. DCT scores were acceptable for one of the seven individuals, however, as noted in the comments below, BHS staff were working with DSPs on improving DCT, the Center and State Office were working with the IRIS system, and other methods of assessing DCT were in place. Also, the Monitoring Team observed one exhibition of target behavior during the remote review; it was recorded on the data sheet by BHS staff.

It was very positive to see that all PBSPs again met criteria for content and quality. Some PBSPs were implemented before consents were obtained, and one was implemented about 10 days late.

Fewer SAPs had reliable data available that report/summarize the individual's status and progress.

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.

Six out of eight Physical and Nutritional Management Plans (PNMPs) reviewed met the requirements for quality. One individual who should have had a PNMP did not. Given that during the previous review, the Center's score was 89%, and problems noted during that review as well as this review were minimal, if the Center makes needed improvements, and sustains its progress overall, after the next review, the related indicator might move to the category requiring less oversight.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.	
Summary: None of the individuals had goals that met criteria for indicator 1 in all six ISP areas, however, one individual's goals met criteria for all five personal goal areas. Moreover, across the six individuals, personal goals met criteria in from one to five areas for a total of 20 goals that met criteria, about the same as at the last review. More work is needed regarding health goals (i.e., the IHCP). The Monitor has provided additional calculations to assist the Center in identifying progress as well as areas in need of improvement. For indicator 1, the data boxes below separate performance for the five personal goal areas from the health-IHCP goals. Both types of goals need to meet criteria, however, the State has reported that it is working towards improving both types of goals with two concurrent support and training programs. Indicator 2 shows performance regarding the writing of goals in measurable terminology. None of the individuals had a full set of goals that were written in measurable terminology, but overall, just under half of the goals were written in measurable terminology. Indicator 3 shows that few of the goals had reliable data. These three indicators will remain in active monitoring.	Individuals:

#	Indicator		Overall Score	429	457	225	127	355	50			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	Personal goals	17% 1/6 67% 20/30	1/5	4/5	5/5	4/5	3/5	3/5			
		Health goals	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
2	The personal goals are measurable.		0% 0/6 47% 14/30 40% 8/20	3/5 1/1	2/5 1/4	4/5 4/5	2/5 1/4	2/5 1/3	1/5 0/3			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.		0% 0/6	1/6	0/6	0/6	0/6	1/6	0/4			

Comments: The Monitoring Team reviewed the ISP process for six individuals at the Austin State Supported Living Center: Individual #429, Individual #225, Individual #127, Individual #457, Individual #355, and Individual #50. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed staff, including DSPs and QIDPs, and directly observed individuals on the Austin SSLC facility.

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

- the leisure goal for Individual #225, Individual #127, Individual #457, Individual #355, and Individual #50.
- the relationship goal for Individual #225, Individual #127, Individual #457, Individual #355, and Individual #50.
- the work/day/school goal for Individual #225, Individual #127, Individual #457, and Individual #355.
- the independence goal for Individual #225, Individual #127, Individual #457, and Individual #50.
- the living options goal for Individual #429 and Individual #225.

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

- Individual #225's greater independence goal to independently make a homemade dinner for peers of her choosing.
- Individual #429's living option goal to live in a low noise home at Austin SSLC.
- Individual #127' s work/day goal to work at Chili's packaging and sorting silverware.
- Individual #457's work/day goal to independently plan Old Maid with her peers at the day program weekly.
- Individual #355's leisure goal to make food for him and his peers on Super Bowl Sunday annually.
- Individual #50's relationship goal to visit her former housemates.

Some goals did not meet criterion for the indicator because they did not reflect the individual's specific preferences, strengths, and needs or did not provide opportunities to try new activities and learn new skills. For instance:

- Individual #429 had a work/day goal to perform day program activities three times weekly. Her goal did not identify her preferred activities, strengths, or needs.
- Individual #429's recreation/leisure goal was based on her preferences and might lead to greater independence, but did not offer exposure to new activities or opportunities to build new recreation/leisure skills. According to staff, she spent much of her time in her room listening to music or her sound machine. Her previous goal was to independently turn on her music using a switch. She mastered her goal, and it was revised to turn on her sound machine using a switch. While expanding her ability to use a switch to have more control over her environment was a prioritized need, it was unlikely to expand her recreation/leisure skills.
- Individual #127, Individual #457, Individual #355, and Individual #50 had living option goals to live at Austin SSLC. These goals were not aspirational because they were living at Austin SSLC. Individual #127's PSI indicated that she would like to live in a small house with her own bedroom in an area where she could walk through her neighborhood safely.

While goals were based on known preferences and strengths, individuals had few opportunities to explore new activities that might lead towards identifying new preferences. For the most part goals were based on what individuals were already doing without adequately assessing new interests or skills needed to participate in a wider variety of activities.

When an IDT applies the same goal to more than one of the five goal areas, the numerator and the denominator in the individual scoring boxes includes both goal areas.

2. Of the 20 personal goals that met criterion for indicator 1, eight also met criterion for measurability. Five others that did not meet criteria for indicator 1 were measurable. Those that were measurable:

- Recreation/Leisure: Individual #225
- Relationship: none
- Job/School/Day: Individual #225, Individual #127, Individual #457, and Individual #355
- Greater Independence: Individual #429 and Individual #225
- Living Option: all six.

For goals that were not measurable, the goal was not written in observable, measurable terms (i.e., will host, will plan, will be independent with the management of, will perform), did not indicate what the individual was expected to do, or how many times they were expected to complete tasks/activities. Those included:

- Recreation/leisure: Individual #127, Individual #457, Individual #355, Individual #429, and Individual #50
- Relationship: all six
- Job/School/Day: Individual #429 and Individual #50
- Greater Independence: Individual #457, Individual #355, and Individual #50

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

- According to documentation, Individual #429 had met her living option goal to move to a low noise home at Austin SSLC.
- There were data related to Individual #355's action plan to tie a knot in his recycling bag. He was not making progress and the action plan was revised.

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

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

When an IDT applies the same goal to more than one of the five goal areas, the numerator and the denominator in the individual scoring boxes includes both goal areas.

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

Summary: There were sufficient reliable data to assess progress on two goals. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 429	457	225	127	355	50			
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	0/4			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/1								
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/5	0/6	0/6	0/6	1/6	0/4			
7	Activity and/or revisions to supports were implemented.	N/A									

Comments:

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

- According to documentation, Individual #429 had met her living option goal to move to a low noise home at Austin SSLC.
- There were data related to Individual #355's action plan tie a knot in his recycling bag. He was not making progress and the action plan was revised.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.												
Summary: Performance was about the same as at the last review. Five indicators scored slightly higher than at the last review, though the scores were still low. On the positive, indicator 11 showed sustained high performance and will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.				Individuals:								
#	Indicator		Overall Score	429	457	225	127	355	50			
8	ISP action plans support the individual's personal goals.		0% 0/6 25% 5/20	0/1	0/4	1/5	1/4	2/3	1/3			
9	ISP action plans integrated individual preferences and opportunities for choice.	Individual preferences	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
		Opportunities for choice	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.		33% 2/6	0/1	0/1	1/1	1/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.		100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
12	ISP action plans integrated strategies to minimize risks.		17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.		17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.		0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.		67% 4/6	0/1	0/1	1/1	1/1	1/1	1/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.		17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			

17	ISP action plans were developed to address any identified barriers to achieving goals.	17% 1/6	0/1	0/1	1/1	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 13% 4/30	0/6	0/6	0/6	1/6	2/6	1/6			

Comments:

8. For the 20 goals that met criterion for being personal and individualized, five had corresponding action plans that were supportive of goal-achievement. Goals that had action plans that were likely to lead to achievement of goals were:

- Individual #225's living option goal.
- Individual #127's greater independence goal.
- Individual #355's recreation/leisure goal and relationship goal.
- Individual #50's greater independence goal.

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

- Individual #429 did not have action plans related to her goal to live in a home with full walls at Austin SSLC t will better meet her needs and preferences. The IDT should have developed action plans that assigned responsibility to staff that would facilitate her move and outline supports needed and steps to a successful transition.
- For Individual #225:
    - She had one action plan related to her completing a swimming event at the Special Olympics. Her action plan stated that she would visit the recreation center once a week.
    - Action plans to support her goal to host a dance party were to ride her bike weekly and greet staff and peers at the workshop.
    - She had one action plan to support her goal to work in a custodial job off-campus. Her action plan to clean her workstation did not identify related training or supports needed or address how she would be supported to find a job in the community.
    - Action plans related to her goal to make a dinner for peers did include some of the steps necessary to reach her goal, such as learning to cook and hygiene related tasks, however, none of the action plans included supporting her to cook for her peers. According to Individual #225 and her staff, she could independently cook some foods, but had not had the opportunity to prepare a meal for her peers.
- For Individual #127:
    - She had a SAP to invite a friend related to her leisure and relationship goals for planning a trip to movies with her peer. Action plans did not include any other related actions or supports for planning her trip.
    - She had one SAP to sort silverware for her goal to work part-time at Chili's packaging and sorting silverware. The IDT did not develop action plans that assigned staff to facilitate getting a job or address any other barriers to working in the community.
- For Individual #457:

    - She had a recreation/leisure goal and relationship goal to host a dance party for her peers. She two related action plans to turn the CD player on and select her preferred CDs to play during the dance party. She had been working on these action plans since 2018 and had not made progress. Her IDT had not addressed barriers to hosting a party through her action plans. Other necessary action steps to host a party were not addressed.
    - She had one SAP to match cards related to her goal to play Old Maid with her peers. She had been working on this SAP since 2018 and had not achieved progress on her goal. Action plans did not address barriers to progress, address needed supports, or offer her opportunities to actually participate in card games with her peers.
- Individual #355 had related action plans for skill building related to his goal to obtain a part-time job in the community at a local shredding company, however, the IDT did not develop action plans to support him to obtain a job in the community. Without assigning a specific staff and a timeline to secure a job, it was unlikely that he would achieve his goal.
- For Individual #50:
    - Her leisure goal was to request her beauty treatment during beauty hour by using eye gaze. She had two related action plans to choose a beauty item in the community quarterly using eye gaze and go on at least four outings over the next year. Expectations for mastery of her goal were not clear, so it was difficult to determine if the action plans supported achievement of her goal.
    - Her relationship goal was to visit her former housemates to host a beauty treatment session. There were no related action plans.

9. One of the ISPs had action plans that integrated preferences and opportunities for choice. All individuals had action plans related to their known preferences. This indicator also specifically looks at action plans related to opportunities to make choices. For four individuals, although ISPs noted that they had opportunities to make choices, action plans did not integrate opportunities to make choices.

- Individual #50's action plans to choose a beauty item, choose a preferred tactile item, and choose an item to purchase were good examples of training that provided opportunities to make choices.

10. Two of the six individuals had ISPs that met criterion for the indicator. In general, Capacity Assessments identified deficit areas and an individual's inability to make informed decisions.

- Individual #127 and Individual #225 had training related to money management skills.

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

12. One of the ISPs met criterion for the indicator (Individual #225). While some risks were addressed through the individuals' PBSPs, IRRFs, and IHCPs, supports were not typically integrated into their ISP action plans to mitigate risks presented or to offer guidance to staff who were implementing action plans when relevant. For example:

- Individual #225's action plans to ride her bike to work and make a smoothie integrated recommendations to address her risks in the areas of weight, cardiac health, and GI issues.

- Individual #355 had an action plan to purchase healthy snacks that did not integrate recommendations from his nutritional assessment. He had another action plan to cook pizza rolls that did not adhere to dietician recommendations to mitigate his healthcare risks.
- Individual #127 had numerous falls over the past year. Two resulted in fractures. During recovery, action plans were placed on hold without implementing supplemental action plans that included support strategies to minimize her risks and provide staff instructions for supports needed.

13. One of the six ISPs met criterion for the indicator.
    - Individual #429's action plans integrated habilitation therapy recommendations for learning to use an environmental switch and implementation of a walking program. Her living option goal integrated behavioral support recommendations to move to a quieter environment.

Examples where support needs described in ancillary plans were not integrated into action plan included:
- Individual #355 had recommendations to use a picture communication board to expand his ability to communicate his wants and needs. Use of the picture communication system was not integrated into action plans that supported his goal.
- Habilitation therapy identified Individual #225's lack of stability and safety awareness as contributing factors to her falls. Support strategies were not integrated into action plans.
- Individual #50 had numerous therapy recommendations related to positioning. Recommendations were not integrated into training opportunities.

14. The ISP should include individualized action plans that support community participation and integration. None of the ISPs included action plans to support meaningful integration into the community. Most individuals had broad statements in the ISP regarding opportunities for participation in outings (shopping, going to parks, going out to eat), but not for integration which usually requires membership or establishing relationships with people who do not have disabilities. (gym, banking, volunteering, playing on a local sports team) or receiving supports in the community (counseling, classes at community colleges, school). Rarely were action plans developed to address barriers or supports needed to allow the individual to fully participate in the community.
- Individual #225 had goals to participate in Special Olympics, work, and live in the community. Her action plans did not include opportunities for training in the community and did not support achievement of her goals.
- Similarly, Individual #127 had one action plan related to her goal to work in the community to sort silverware. Although it was good to see that the IDT had considered community employment, action plans were unlikely to lead towards accomplishment of her goal to work in the community.

In a comment on the draft version of this report, the State wrote "It is unclear what the expectation is regarding plans to encourage community integration if activities off the home are suspended as precaution due to COVID." The Monitoring Team understands that implementation of plans and activities may be suspended due to COVID. The ISP, however, should still reflect community integration plans for when restrictions are no longer in place, whenever that might be.

15. Four ISPs included action plans to support opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.

- Individual #429 and Individual #457's ISPs noted that they could attend day programs in the community that offered programming based on their preferences. Action plans did not support exploration of these programs and barriers to attending programming in the community were not identified.

16. Five ISPs did not support substantial opportunities for functional engagement described with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Many action plans were on hold due to Covid-19 restrictions. IDTs had not met to modify training that could be implemented at the home. Overall, 24 action plans were being consistently implemented across the six ISPs. Individuals had limited opportunities to participate in training that might enrich their lives and lead to opportunities to fully participate in the community.

- Individual #429 had two skill acquisition plans to turn on her sound machine and choose the symbol for a water activity. Individual #429's action plans were all on hold. Over five observations on varying days and times, she was in bed for three and in her room not engaged in functional activities for two.
- Individual #127 had one work related skill acquisition plan to sort silverware. Documentation indicated that she did not seem to be interested in this task. Other training opportunities that might lead to meaningful employment had not been identified.
- Individual #457 had one SAP for day programming to match cards. During observations on various days and times, she was not engaged in functional activities other than her matching a card activity, which took just a few minutes. She had been working on matching cards since 2018 and had not made significant progress towards her goal to play cards with her peers.
- Individual #225 had skill acquisition plans to clean her workstation and make a smoothie. Per observations, she was able to complete both independently. She was attending work daily, however, the IDT had not identified skill building opportunities that might lead towards working in a less restrictive environment.
- Individual #50's ISP had three SAPs to make a choice using eye gaze. In May 2021, the IDT documented that it was difficult to determine which items she was focused on. The IDT agreed that her SAPs would be revised to identify her preference through facial expression. Her communication assessment indicated that staff were able to determine her preference through facial expression. Her direct support staff confirmed that they were able to determine her preferences by watching her facial expressions. She did not have other training opportunities.

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

Individual #225 was a new admission. A number of assessments had not been completed at the time of her initial ISP meeting, so barriers had not been identified. The IDT agreed to complete assessments relevant to her goals prior to developing action plans in order for the IDT to determine what training she would need to achieve her goals.

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

- Action plans that supported Individual #127's goal to independently dress herself every morning met criteria. A skill acquisition plan was developed that included specific training instructions and described data to be collected for putting on her shoes.
- Action plans that supported Individual #355's recreation/leisure and relationship goals met criteria. A skill acquisition plan to make pizza rolls in the microwave was developed that included specific training instructions and described data to be collected.
- Action plans that supported Individual #50's greater independence goal met criteria. A skill acquisition plan to make a choice between two items using eye gaze was developed that included specific training instructions and described data to be collected.

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

- Individual #225 had one action plan to support her goal to complete a 25m swimming event at the Special Olympics. Her action plan to visit the recreation center weekly did not include enough detail to ensure consistent implementation or documentation.
- Individual #225's work/day goal to obtain a custodial job off-campus had one supporting action plan to clean her workstation at the workshop daily. The action plan did not include what supports were needed, what steps she would complete, or what staff should document.
- Individual #429's action plans to support her work/day program goal did not include detailed information for implementation and documentation. Related action plans included:
  - Will attend day program from 2:00-2:30 for at least 15 minutes on Tuesday and Thursdays.
  - Will attend day program from 8:30-9:00 for at least 15 minutes on Tuesdays and Thursdays.
  - Will visit the on-campus Thinkery one time weekly.
- One of Individual #355's action plans to support his work goal included detailed information for implementation and documentation. Related action plans that did not meet criteria included:
  - Will clean his work area.
  - Will visit a recycling center in the community once a quarter.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.

Summary: Due to sustained high performance, indicators 21 and 25 will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 429	457	225	127	355	50			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			

20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	0% 0/1		0/1							
21	The ISP included the opinions and recommendation of the IDT's staff members.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
23	The determination was based on a thorough examination of living options.	40% 2/5		0/1	1/1	0/1	0/1	1/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	100% 1/1		1/1							
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.	N/A									

Comments:

19. Six ISPs included a description of the individuals' preferences for where to live and how their preferences were determined.

20. Individual #457's annual ISP meeting was observed. The IDT did not discuss her environmental preferences or what type of living situation might match her known preferences. All IDT members agreed that she could live in the community, but did not discuss what type of living option could match with her preferences.

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

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

- Individual #429's ISP included LAR choice as a determination for living options noting that the LAR had been provided information and opportunity for exposure to alternate living options, but was not interested. Per documentation from the CLOIP, the LAR was interested in placement at Rock House in the community or Austin SSLC.

23. Two of the individuals had a thorough examination of living options based upon preferences, needs, and strengths (Individual #225, Individual #50). The other individuals had limited exposure to community living options, and it was not evident that their IDTs thoroughly discussed potential placements in the community.

24. Six 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.

25. Individual #457's annual ISP meeting was observed. The IDT discussed obstacles to referral.

26. The indicator was not met for any of the six individuals. None of their ISPs contained individualized, measurable action plans to address their obstacles to community referral.

27. For Individual #457's annual ISP meeting, the IDT did not developed plans to address/overcome the identified obstacles to referral.

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

29. None of the individuals had been referred for community placement.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
Summary: With sustained high performance, indicator 32 might be moved to the category of requiring less oversight after the next review. Indicator 33 will remain in this category, however, comments are provided below that point to the need for improvement in order for this indicator to remain in this category after the next review. Indicators 32 and 34 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	429	457	225	127	355	50			
30	The ISP was revised at least annually.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.										
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	83% 5/6	1/1	1/1	0/1	1/1	1/1	1/1			

33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

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

- Individual #225's ISP was developed on 2/24/21. The IDT agreed to meet within 14 days to develop action plans to support her goals. Action plans were not developed until May 2021. Some action plans were not implemented until July 2021.

33. Two individuals attended their ISP meetings (Individual #225, Individual #127). ISPs did not reflect the individuals' involvement in the process. ISPs generally noted that the QIDP reviewed goals and action plans prior to the ISP meeting but did not describe the individual's response or how input was obtained. Two individuals (Individual #355, Individual #50) did not attend their meetings because the time conflicted with other activities (work and PNMP downtime). The ISP did not document that the IDT had considered alternate times that might be more conducive to their schedules.

Individual #457's annual ISP meeting was observed. Individual #457 did not attend her meeting. The IDT did not discuss individualized efforts made to encourage her participation.

34. None of the six individuals had appropriately constituted IDTs, based on their strengths, needs and preferences, who participated in the planning process. Findings included:

- Individual #429's DSP did not attend her meeting. It was noted throughout her ISP that she was closest to her DSPs, and they were familiar with her preferences and support needs.
- For Individual #225, her LAR did not attend her meeting. She was recently admitted to the facility and the IDT did not know many of her strengths, needs, and preference.
- For Individual #127, her LAR did not attend her meeting.
- Individual #457's DSP did not attend her meeting.
- Individual #355's LAR and DSP did not attend his meeting.
- Individual #50 had extensive communication and physical therapy needs and supports. Her SLP and PT did not attend her meeting.

Outcome 6: ISP assessments are completed as per the individuals' needs.	
Summary: With sustained high performance, indicator 36 might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	429	457	225	127	355	50			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	83% 5/6	1/1	1/1	0/1	1/1	1/1	1/1			

Comments:
36. The indicator was met for five of the six individuals. Individual #225's PSI, capacity assessment and vocational assessment were not submitted prior to the ISP meeting.

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

Summary: QIDPs were knowledgeable of the goals, strengths, and support needs of the individuals on their caseloads. It was not evident that QIDPs for four individuals ensured that the individual received required monitoring, review, and revision of treatments, services, and supports. QIDPs were doing a better job of reviewing all goals and including data in the QIDP monthly review when available. But, QIDPs did not generally include an analysis of data or summary of progress towards goals based on data submitted. When progress was not made, action plans were not revised to ensure progress. The indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	429	457	225	127	355	50			
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.	33% 2/6	0/1	0/1	0/1	0/1	1/1	1/1			

Comments:
37. None of the ISPs met criterion for the indicator. In general, IDTs met to review ISP action plans, but did not revise action plans that were on hold due to COVID-19. IDTs typically met to discuss changes in health status, behavioral challenges, and incidents and injuries. When warranted, new assessments were completed. This was good to see, however, when supports were revised, the IDTs rarely followed-up to determine the efficacy of those supports.

Individuals were not making progress towards goals. Many of the action plans had been in place for two (or more) years and had not led towards progress towards goals.

It was good to see that some IDTs had met recently to discuss the lack of progress and implemented some revisions of action plans, however, it was still not evident that individuals were making progress towards their goals. Comments are below:

- Individual #429's IDT met frequently to review her progress towards goals and revised action plans as needed. They also met to discuss any health issues or other incidents. They did not meet to discuss her transition to a new home. It was not clear when she moved or what supports were put into place to ensure a successful transition.
- Individual #225's IDT agreed that further assessments were needed to develop action plans to support her goals. The requested assessments were completed in March 2021. The IDT did not meet until May 2021 to implement action plans to support her goals.
- Individual #127's IDT met to place action plans on hold after she fractured both arms. They did not develop plans for needed supports during her recovery. Her SAP related to her relationship goal was never implemented. The IDT met after eight months to place her SAP on hold due to building renovations, however, they did not discuss alternate training that could occur in other locations. Her SO to call her aunt was also not implemented over an eight-month period. Her monthly review indicated that she was unable to contact her aunt. Barriers to implementation were not addressed.
- Individual #457 had been working on her SAP to turn on her CD player since 2016. There was no indication that barriers to progress had been addressed during that time. The IDT agreed to continue her SAP for another year without revision at her annual ISP meeting. The IDT was unable to determine what specific progress had been made or what the barriers to progress might be. Similarly, she had been working on her SAP to match cards for at least three years. The IDT also agreed to continue training at her ISP meeting that was observed without determining what specific progress she had made or consideration of other training that might lead towards mastery of her goal.
- Individual #355's SAPs to make pizza rolls and tie a knot in a bag were carried over from his previous ISP. His ISP preparation documentation did not include a summary of data or barriers to progress.
- All of Individual #50's SAPs were carried over from her previous ISP without reviewing data or revising supports to address barriers to progress during her ISP Preparation meeting. Her IDT did meet recently to revise supports. Revisions were not based on assessment results.

38. QIDPs were knowledgeable of the goals, strengths, and support needs of the individuals on their caseloads. It was not evident that QIDPs for four individuals ensured that the individual received required monitoring, review, and revision of treatments, services, and supports. QIDPs were doing a better job of reviewing all goals and including data in the QIDP monthly review when available. But, QIDPs did not generally include an analysis of data or summary of progress towards goals based on data submitted. When progress was not made, action plans were not revised to ensure progress. Findings included:

- Individual #355 met criteria for his indicator. His IDT recently met to discuss his lack of progress towards goals and agreed to retrain staff and revise training strategies. They also met numerous times to address incidents including falls, peer-to-peer incidents, weight loss, and a hospitalization. His PNMP was revised and a PBSP was developed to address identified risks.
- Individual #50 met criteria for this indicator. Her IDT met as required and revised her action plans to address her lack of progress.
- Individual #429's QIDP was documenting how many times she had walked the length of the hallway monthly and how many times she had refused, but did not comment on how far she walked, what supports were needed, or indicated what progress she had made.

- Individual #225's QIDP recorded the number of times that she visited the recreation center, but did not comment on activities that she participated in or her response to those activities. Her QIDP monthly review noted that she attended cooking class twice in May 2021. There was no summary of how she participated, what training was provided, or what supports she needed. There were no data related to riding her bicycle weekly. The QIDP did not document action taken to ensure implementation.
- Individual #127's QIDP monthly review noted that she had been participating in cooking classes regularly. There was no summary of how she participated, training provided, or supports needed. All of her skill acquisitions plans were placed on hold when she fractured both arms. There was no documentation that the IDT considered other training that she might be able to participate in to support her goals.
- Individual #457 had made little progress on her action plans to support goals, and supports were not revised. She had been working on most of her action plans since at least 2018 with little progress or revision to supports. Her QIDP monthly reviews included implementation data for some service objectives but no summary of progress or supports needed. This included her service objective for sanitizing her hands, walking from her bedroom to dining room, and participating in beauty hour on her home.

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

Summary: With sustained high performance, indicator 39 might be moved to the category of requiring less oversight after the next review. Staff were generally knowledgeable regarding specific risks and supports needed and implementation of ISP action plans. Of the 45 action steps that could have been implemented, 24 were implemented (53%). Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 429	457	225	127	355	50			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	100% 5/5	1/1	1/1	1/1	1/1	1/1				
40	Action steps in the ISP were consistently implemented.	50% 3/6	1/1	0/1	0/1	0/1	1/1	1/1			

Comments:

39. Staff were generally knowledgeable regarding specific risks and supports needed and implementation of ISP action plans. This indicator was not scored for Individual #50. The Monitoring Team was unable to confirm that staff were able to implement her ISP due to limited observations. Access to her home was restricted due to COVID-19 precautions.

40. Across all six individuals, there was a total of 73 action steps evaluated, 24 of which had been consistently implemented. Of the 49 remaining action steps that were not implemented, 28 could not be implemented due to COVID-19 community and gathering restrictions. Thus, of the 45 that could have been implemented, 24 were implemented (53%).

Individual	# of Action Steps in ISP	Action Steps Implemented	Not Implemented Due to COVID-19	Action Steps Not Fully Implemented

Individual #429	12	7	5	0
Individual #225	11	2	0	9
Individual #127	16	3	7	6
Individual #457	15	5	5	5
Individual #355	11	4	6	1
Individual #50	8	3	5	0

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

Summary: In order to assign accurate risk ratings, IDTs need to continue to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings and update the IRRFs within no more than five days. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	225	429	355	394	357	378	148	16	50
a.	The individual's risk rating is accurate.	50% 6/12	0/2	2/2	2/2	2/2	0/2	N/R	0/2	N/R	N/R
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	33% 4/12	0/2	1/2	0/2	2/2	1/2		0/2		

Comments: For six individuals, the Monitoring Team reviewed a total of 12 IRRFs addressing specific risk areas [i.e., Individual #225 – polypharmacy/medication side effects, and constipation/bowel obstruction; Individual #429 – fractures, and gastrointestinal (GI) problems; Individual #355 – constipation/bowel obstruction, and weight; Individual #394 – aspiration, and infections; Individual #357 – cardiac disease, and infections; and Individual #148 – infections, and other: cancer].

a. The IDTs that effectively used supporting clinical data, used the risk guidelines when determining a risk level, and as appropriate, provided clinical justification for exceptions to the guidelines were those for Individual #429 – fractures, and GI problems; Individual #355 – constipation/bowel obstruction, and weight; Individual #394 – aspiration, and infections; .

b. For the individuals in the review group, it was positive that the IDTs completed IRRFs for individuals within 30 days of admission and updated the IRRFs at least annually.

However, often when changes of status occurred that necessitated at least review of the risk ratings, IDTs did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #429 – fractures; Individual #394 – aspiration, and infections; and Individual #357 – cardiac disease.

Psychiatry

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

Psychology/behavioral health

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

Summary: In summary, IOA and DCT were assessed regularly and the Center had a good protocol for both. IOA scores were acceptable for all individuals. DCT scores were acceptable for one of the seven individuals, however, as noted in the comments below, BHS staff were working with DSPs on improving DCT, the Center and State Office were working with the IRIS system, and other methods of assessing DCT were in place. Also, the Monitoring Team observed one exhibition of target behavior during the remote review; it was recorded timely on the data sheet by BHS staff.

#	Indicator	Overall Score	Individuals: 162	263	429	457	127	329	57	225	425
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	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.	14% 1/7	0/1	0/1	0/1			0/1	0/1	0/1	1/1

Comments:

1. Although this indicator is, and will remain, in the category of requiring less oversight, the following observation and recommendation is provided by the Monitoring Team:

- Individual #378 did not have a temporary or full PBSP, but verbal report and a review of Integrated Progress Notes suggested that he could, and did, display aggressive and self-injurious behaviors. In fact, his behavior health assessment completed in February 2021 referenced a recent communication screening during which he engaged in self-injurious behavior. Direct support professionals were interviewed and observations were completed as part of his assessment (which were good to see being done), his behavior health specialist should meet with other members of the team to determine whether a PBSP is warranted.

5. Based upon the information provided it was evident that IOA was assessed each month for the seven individuals who had PBSPs. It was particularly positive to learn that this included Individual #225, who had a temporary PBSP. This was a change from previous reviews in which temporary plans had been exempt from this level of oversight.

It was also positive to learn that monitoring was completed through direct observation in every case, but two, in which a video review was completed. IOA consistently averaged 80% or better. Completed monitoring forms reflected observed replacement and/or target behaviors and the data recorded by the behavioral health services staff member and the direct service professional who was working with the individual.

Data collection timeliness was assessed monthly for everyone, but Individual #225, and acceptable scores were reported for Individual #425 only. It was clear that behavioral health services staff continued to work with direct support professionals to improve timely documentation.

Of note was the system that Austin SSLC used to assess DCT. It was a computer-based procedure that automatically determined the date, time, and resultant frequency/timeliness of PBSP data entry into the electronic record (IRIS). But there remained some problems with this system. For example, a second entry within a two-hour block, although desirable from a clinical perspective, created an error in the computer system. In another example, an entry made even one minute past two hours was scored a 0, same as an entry that was made hours late or not made at all. The Center should solve this problem in order to have a computer-based system that can provide a more accurate (and valid?) measure of DCT. State Office and the Center were working on fixing this. All that being said, the Monitoring Team was impressed with the efforts of the BHS department and their desire to get data recorded timely.

To that end, during the weeks between the review week and the submission of this report, the Center initiated formal action to make corrections to way the electronic data system records data timeliness. State Office agreed to keep the Monitor informed of progress over the ensuring months. In addition, there was other evidence of the reliability and timeliness of PBSP data. First, the Center showed evidence that whenever a target behavior was discussed at IMRT, the BHS department did a check to see if the occurrence had been entered into the electronic data system and if so, if it was done within the two-hour required timeframe. The Monitoring Team requested documentation of this for one month (July 2021) and found that 35 of 40 incidents discussed at IMRT were recorded and of

those 25 of 35 were recorded timely. Some of the 10 included explanations from DSPs about the reason for the delay, such as the behavioral incident was lengthy and they entered it as soon as they could. Second, the BHS staff, when conducting IOA and TI observations, also looked for (and recorded) whether any behavior occurrences were entered into the data system and if so, was it done timely. Over the review period, this was documented as having occurred for 93% of the observations. Third, on Tuesday 7/27/21 at approximately 10:30 am, Individual #329 was observed slapping his head twice as he completed his request for a break SAP. A review of his data sheet from that day reflected documentation of this event.

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

Summary: One BHA did not have reference to cognitive assessment. Four individuals' FBAs incorrectly referenced the consequence procedures in the PBSP as the hypothesized functional consequences maintaining target behaviors. The Center conducted re-training for the BHS staff for whom this needed correction.

#	Indicator	Overall Score	Individuals: 162	263	429	457	127	329	57	225	425
10	The individual has a current, and complete annual behavioral health update.	89% 8/9	0/1	1/1	1/1			1/1	1/1	1/1	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.	100% 7/7	1/1	1/1	1/1			1/1	1/1	1/1	1/1

Comments:

10. All nine individuals had a current BHA that was available to the IDT 10 days prior to the individual's ISP, and eight of these assessments were considered complete. The assessment identified to determine Individual #162's cognitive abilities was the Childhood Autism Rating Scale. This is not an instrument for assessing cognitive abilities.

12. The functional behavior assessment was considered complete for three of the seven individuals (Individual #429, Individual #57, Individual #425). All of the assessments included the use of rating scales and at least one observation during which the individual engaged in at least one of his/her target behaviors. Likely antecedents to problem behavior were identified in each assessment.

Further, for four of the individuals, the FBA section about direct observation described how the DSP gave the individual access to a preferred activity immediately following problem target behavior. It was good to see that the BHS staff were able to observe occurrences of target behaviors and that they were able to identify possible staff actions that might be reinforcing the occurrence of target behaviors. Individual #263 transitioned to her room to watch television after displaying aggression towards a housemate. Individual #429 successfully escaped working on a SAP after becoming agitated. Individual #329 was taken for a walk after trying to pull a staff member's hair. Individual #162 was directed to play with Legos after ripping his shirt, however, the report noted that the BHS staff intervened and provided some coaching to the DSP.

For four individuals (Individual #162, Individual #263, Individual #329, Individual #225), the identified consequences were those outlined in their PBSPs rather than those hypothesized to be maintaining the problem behaviors. In other words, the section of the FBA for the specialist to discuss consequences should have discussed/hypothesized consequences that occur after exhibition of a target behavior that might be functioning to maintain the target behavior, rather than a description of the consequences that are implemented by staff as part of the PBSP. This was discussed at previous monitoring reviews and was not corrected/improved, resulting in the 0 scores. Three of these four FBAs were written by one BHS staff. Thus, this should be relatively easy to correct. Even so, elsewhere in the FBA, the Monitoring Team was able to find correct discussion about possible maintaining consequences.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.

Summary: Some PBSPs were implemented before consents obtained, and one was implemented about 10 days late. It was very positive to see that all PBSPs again met criteria for content and quality.

#	Indicator	Overall Score	Individuals: 162	263	429	457	127	329	57	225	425
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	57% 4/7	1/1	0/1	0/1			1/1	1/1	0/1	1/1
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.	100% 7/7	1/1	1/1	1/1			1/1	1/1	1/1	1/1

Comments:

14. Based on the data provided, four of the seven plans were finalized within 14 days of all consents. The exceptions were Individual #263 and Individual #225 whose plans were finalized before all consents, and Individual #429 whose plan was finalized 24 days after the last consent.

15. All of the PBSPs were considered complete. Individual specific feedback is provided below.
    - It was positive to find lists of preferences, sometimes quite extensive, as well as potential reinforcers identified through completion of the Reinforcement Assessment for Individuals with Severe Disabilities. For the seven individuals with PBSPs, this assessment was current.
    - It was also positive to find the following: a) guidelines for building rapport (e.g., Individual #57, Individual #225, Individual #425) or introducing oneself to the individual (e.g., Individual #429); b) guidelines for working with individuals with visual impairments (e.g., Individual #263, Individual #429, and Individual #329); c) information regarding observable signs that the individual may not feel well (e.g., Individual #329, Individual #57, Individual #425); d) provisions for respecting preferences during meals (e.g., Individual #263, Individual #57); e) cues for responding to personnel preferences regarding space (e.g., Individual #263) or interacting with others (e.g., Individual #425); f) guidelines for warning and preparing the person for changes in routine (e.g., Individual #162, Individual #263, Individual #225); g) guidelines for helping Individual #162 to wake up in the morning and ready for bed in the evening; and h) guidelines for helping Individual #329 ease back into his routine following home visits by first offering preferred activities.

- Many PBSPs included information regarding the individual's communication abilities. When augmentative systems are identified, it is essential that these devices (e.g., communication books/boards, iPads, etc.) be available to the individual. For example, Individual #329 had a communication board that was in his I-Book. This was not readily available to him. Individual #429 was reported to use an Object Symbol Communication System, but this was not used when she was observed. Individual #57 was learning to use an iPad to help him communicate his wants and needs, but this was only evident during a SAP observation.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
Summary: The Center was working on obtaining a qualified counselor.			Individuals:								
#	Indicator	Overall Score	162	263	429	457	127	329	57	225	425
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	N/A									

Comments:
24-25. Individual #225 was the only individual in the behavioral health monitoring team review group who had been referred for counseling. As reported by facility staff, the department counselor had made attempts to obtain guardian consent for Individual #225 to receive this service. These efforts were unsuccessful before the counselor resigned her position. The director of behavioral health services reported that she was seeking qualified candidates for a counseling position and had spoken with administrative staff about recruiting a community-based counselor who could provide this service. At the time of the remote review, Individual #225 was not participating in counseling services.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Since the previous review, improvement was noted with PCPs' completion of interval medical reviews on a quarterly basis (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable"). Indicator c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	225	429	355	394	357	378	148	16	50
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	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1

Comments: c. Per the instruction of State Office, and as memorialized in the State Office Medical Care policy #009.3, with an effective date of 2/29/20, PCPs are expected to complete IMRs quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable"). It appeared that PCPs at Austin SSLC were often following this guidance.

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

Summary: Since the previous review, Medical staff continued their efforts to improve the quality of the annual medical assessments, as well as the IMRs. For the nine individuals in the review group, the AMAs met the quality criteria, and most of the IMRs also met criteria. Indicators a and c will remain in active oversight.

#	Indicator	Overall Score	Individuals: 225	429	355	394	357	378	148	16	50
a.	Individual receives quality AMA.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
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.	89% 16/18	2/2	2/2	2/2	0/2	2/2	2/2	2/2	2/2	2/2

Comments: a. It was positive that for the nine individuals in the review group, PCPs developed AMAs that addressed the selected chronic diagnoses or at-risk conditions with thorough plans of care. As applicable to the individuals reviewed, these annual medical assessments also 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 (i.e., Individual #16's exam had been delayed due to repeated COVID-19 restrictions on his home), pertinent laboratory information, and updated active problem lists.

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 #225 – circulatory, and allergies; Individual #429 – gastrointestinal (GI) problems, and infections; Individual #355 – constipation/bowel obstruction, and weight; Individual #394 – seizures, and urinary tract infections (UTIs); Individual #357 – cardiac disease, and UTIs; Individual #378 – constipation/bowel obstruction, and skin integrity; Individual #148 – circulatory, and cancer; Individual #16 – skin integrity, and UTIs; and Individual #50 – spasticity, and seizures].

The IMRs generally followed the State Office template, and provided necessary updates related to the risks reviewed. The exceptions were for Individual #394 – movement disorder, and UTIs.

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	225	429	355	394	357	378	148	16	50
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	0% 0/17	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

Comments: a. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions (i.e., Individual #225 – circulatory, and allergies; Individual #429 – GI problems, and infections; Individual #355 – constipation/bowel obstruction, and weight; Individual #394 – movement disorder, and UTIs; Individual #357 – cardiac disease, and UTIs; Individual #378 – constipation/bowel obstruction, and skin integrity; Individual #148 – circulatory, and cancer; Individual #16 – skin integrity, and UTIs; and Individual #50– spasticity, and seizures).

In its comments on the draft report, the State disputed the findings for the following individuals' risk areas: Individual #225 – circulatory, and allergies; Individual #394 – movement disorder, and UTIs; Individual #378 – constipation/bowel obstruction, and skin integrity; and Individual #16 – skin integrity, and UTIs. In each case, the State cited the pages on which an IHCP addressing the chronic condition could be found. In conducting its original review, the Monitoring Team reviewed each of these cited IHCPs. The reason for the negative scores was related to the lack of inclusion in the IHCPs of complete medical care plans for these at-risk areas or chronic conditions. In other words, often the plans of care included in the individuals' AMAs were not included or only partially included in the IHCPs.

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

Dental

In a letter, dated 8/23/21, the Monitor notified the parties that the Center achieved substantial compliance with most of the requirements of Section Q of the Settlement Agreement. The exceptions are: 1) implementation of a policy/clinical guideline that is consistent with current generally accepted standards of care on perioperative assessment and management of individuals needing TIVA/general anesthesia for dental work, which the Monitoring Team will continue to assess and apply the findings to paragraph H.7 of the Settlement Agreement; and 2) personal goals/objectives for individuals who are at risk for dental problems, as well as the development and implementation of plans for individuals who require suction tooth brushing, which the Monitoring Team will assess as part of Section F. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Austin SSLC exited from the other requirements of Section Q of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the related outcomes and indicators.

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.											
Summary: For the one applicable individual, nurses completed a timely new-admission nursing record review and physical assessment. For three of the six individuals in the review group, problems were noted with regard to nurses' timely completion of quarterly nursing record reviews and/or physical assessments. Due to problems with the timeliness of physical assessments, as well as signature and entry dates on annual record reviews, Indicator a.ii is at risk of returning to active oversight.			Individuals:								
#	Indicator	Overall Score	225	429	355	394	357	378	148	16	50
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.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/R	N/A	N/R	N/R
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									

		Due to problems with the timeliness of physical assessments, as well as signature and entry dates on annual record reviews, this indicator is at risk of returning to active oversight.									
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	50% 3/6	1/1	0/1	0/1	1/1	1/1		0/1		

Comments: a.i. On 1/26/21, Individual #225 was admitted to the Center. On 2/18/21, her IDT held her first ISP meeting. Although the signature block was confusing, it appeared that on 2/5/21, the RNCM completed the initial nursing record review. More specifically, the confusion with the date of completion of the record review stemmed from a signature of one RN, who appeared to be the primary author of the document, dated 2/5/21, but then four signatures of one other RN, all dated 2/24/21. Based on the other entries in the document, the Monitoring Team used the 2/5/21 signature of the RNCM to assess timeliness.

In its comments on the draft report, the State offered the following clarification: "We are working with RNCM's [sic] to get an 'Addendum to Annual/Quarterly' IPN in place of re-entering the documents with updates post ISP. This was one of those cases where the IDT recommended a change and the RNCM entered it as requested."

Overall, the Center appeared to have a problem with the signatures and time-stamped entries on annual nursing assessments. This made it difficult to confirm when RNCMs actually finalized and submitted annual record reviews to IDTs in preparation for ISP meetings. Although Indicator a.ii is in less oversight, it is in jeopardy of returning to active oversight unless Center staff correct this issue. For example:

- Individual #355's annual nursing record review included signatures on 2/3/21, 3/22/21, 4/8/21 x2, and 4/12/21. His ISP meeting was held on 2/25/21.
- Individual #148's annual nursing record review included signatures and entries on 6/29/20, and 7/20/20. Her ISP meeting was held on 7/20/21. In its comments on the draft report, the State offered the same clarification quoted above.

In addition, the RNCM completed Individual #357's physical assessment 15 days prior to the annual record review, which was not recent enough. In its comments on the draft report, the State disputed this finding, and cited the section of the Center's Nursing Services policy that addresses timeliness of nursing assessments in relation to ISP meetings. The Monitoring Team's comment in the draft report relates rather to the time between the physical assessment and the record review. The lapse of 15 days was not recent enough to accurately inform the annual review.

a.iii. With regard to quarterly nursing record reviews and physical assessments, examples of problems included:

- On 2/10/21, Individual #429's RNCM completed her annual record review, and on 2/25/21, her IDT held her ISP meeting. A quarterly review and physical assessment was due in May 2021, but the RNCM did not complete them.
- On 2/25/21, Individual #355's IDT held his ISP meeting. As noted above, the date for the annual record review was unclear. However, a quarterly was due in May 2021. The RNCM completed it on 4/16/21, so it did not include three months of information.

- On 4/27/21, the RNCM completed Individual #148's annual nursing record review. Twenty-one days earlier on 4/5/21, the nurse completed the physical assessment. This was not recent enough to inform the quarterly review.

  The State disputed this finding, and again cited the Center's Nursing Services policy. The section of the policy the State cited did not address the lapse of time between the physical assessment and the record review, which was the issue with timeliness that the Monitoring Team identified. The physical assessment offers data that are essential to the assessment process, and so nurses needs to complete them in close proximity to the record review portion of the assessment.

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

Summary: Overall, considerable improvement is needed with the content of the new-admission and annual and quarterly nursing record reviews. In 60% of the examples reviewed of exacerbations of individuals' chronic conditions, nurses completed assessments in accordance with current standards of practice. All of these indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 225	429	355	394	357	378	148	16	50
a.	Individual receives a quality annual nursing record review.	0% 0/6	0/1	0/1	0/1	0/1	0/1	N/R	0/1	N/R	N/R
b.	Individual receives quality annual nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	17% 1/6	0/1	1/1	0/1	0/1	0/1		0/1		
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% 0/12	0/2	0/2	0/2	0/2	0/2		0/2		
d.	Individual receives a quality quarterly nursing record review.	0% 0/6	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;	17% 1/6	0/1	1/1	0/1	0/1	0/1		0/1		

	iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.										
f.	On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk.	0% 0/12	0/2	0/2	0/2	0/2	0/2		0/2		
g.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	60% 6/10	1/2	1/2	0/2	N/A	2/2		2/2		

Comments: a. Overall, considerable improvement is needed with the content of the annual and new-admission nursing record reviews. It was positive that most, but not all included, as applicable:

- List of medications with dosages at the time of the annual nursing assessment (ANA); and
- Allergies or severe side effects to medication.

The components on which Center staff should focus include:

- Active problem and diagnoses list updated at the time of ANA;
- Family history;
- Procedure history;
- Social/smoking/drug/alcohol history.
- Immunizations;
- Consultation summary;
- Lab and diagnostic testing requiring review and/or intervention; and
- Tertiary care.

b. and e. It was positive that for Individual #429, the RNCM completed an annual physical assessment as well as a quarterly physical assessment that addressed the necessary components. Problems with the remaining assessments included incomplete GI systems assessments (e.g., missing information about the individuals' most recent bowel movements, incomplete assessments of individuals' abdomens, etc.), missing information about the pain scales used, a lack of follow-up for abnormal findings, missing genital exams, missing abdominal circumferences, and incomplete information about capillary refill rates.

c. and f. For six individuals, the Monitoring Team reviewed a total of 12 IHCPs addressing specific risk areas (i.e., Individual #225 – polypharmacy/medication side effects, and constipation/bowel obstruction; Individual #429 – fractures, and GI problems; Individual #355 – constipation/bowel obstruction, and weight; Individual #394 – aspiration, and infections; Individual #357 – cardiac disease, and infections; and Individual #148 – infections, and other: cancer).

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. However, nurses included status updates, including relevant clinical

data, for about a quarter of the risk areas reviewed in the annual assessments (i.e., Individual #429 – fractures, and GI problems; and Individual #355 – weight), and for two of the 12 risk areas reviewed in the quarterly assessments (i.e., Individual #429 – fractures, and GI problems). Unfortunately, nurses had not analyzed this information, including comparisons with the previous quarter or year, and/or made necessary recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

d. It was positive that all of the quarterly nursing record reviews for individuals in the review group included the following, as applicable:

- List of medications with dosages at the time of the quarterly nursing assessment;
- Tertiary care; and
- Allergies or severe side effects to medication.

Most, but not all of the quarterly nursing record reviews for individuals in the review group included, as applicable:

- Family history.

The components on which Center staff should focus include:

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

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

- On 4/12/21, nursing staff administered a pro re nata (PRN, or "as needed") medication to Individual #225 for constipation due to no bowel movement in over 24 hours.
- Between 7:00 a.m., and 11:00 a.m., on 1/19/21, Individual #429 had six loose bowel movements.
- On 3/11/21, Individual #357 presented with pedal edema.
- On 1/19/21, Individual #357 was initially assessed for COVID-19 exposure, and then later, she received a COVID-19 positive diagnosis.
- On 1/7/21, at 12:20 a.m., Individual #148 developed a temperature of 39.4, and had a pulse of 119, respirations of 16, blood pressure of 98/52, and oxygen saturation of 97% on room air.
- On 4/22/21, Individual #148 presented with severe neutropenia.

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

- On 3/12/21, Individual #225 had a possible adverse drug reaction (ADR) to Olopatadine. Based on review of the IPNs and IView entries submitted, nursing staff did not complete and/or document an assessment.

- On 5/20/21, Individual #429 fell. A nurse completed a partial assessment, but did not complete and/or document an assessment related to any change in the individual's gait, which is part of the nursing assessment guidelines for falls.
- On 4/28/21, at 2:50 p.m., Individual #355 had an episode of emesis. At 5:00 p.m., a nurse completed a partial assessment, which was not consistent with the nursing guidelines on emesis. The nurse did not assess whether or not the individual had any abdominal distension or tenderness, and did not assess the individual's lung sounds. Subsequently, on 4/30/21, the individual was admitted to the hospital for a partial bowel obstruction.
- On 6/6/21, Individual #355 weighed 128.5 pounds, which was a decrease from the previous week's weight of 130.5 pounds, and a decrease from 5/21/21, when he weighed 134.6 pounds. Nursing staff did not assess him until 6/10/21, when they noted no changes and linked his weight loss with a hospitalization from which he had been discharged on 5/3/21.

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: Based on the review group, some IHCPs included clinical indicators, and/or defined the frequency of monitoring/review. A couple included measurable objectives to allow IDTs to track progress on the selected risk areas. However, 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: 225	429	355	394	357	378	148	16	50
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% 0/12	0/2	0/2	0/2	0/2	0/2	N/R	0/2	N/R	N/R
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/12	0/2	0/2	0/2	0/2	0/2		0/2		
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	17% 2/12	1/2	1/2	0/2	0/2	0/2		0/2		
d.	The IHCP action steps support the goal/objective.	0% 0/12	0/2	0/2	0/2	0/2	0/2		0/2		
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	33% 4/12	1/2	1/2	2/2	0/2	0/2		0/2		
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	42% 5/12	1/2	1/2	2/2	0/2	1/2		0/2		

Comments: a. through f. The IHCPs reviewed all included nursing interventions, but were missing key nursing supports. For example, RN Case Managers and IDTs generally had not individualized interventions in relevant nursing guidelines and included in the action steps of IHCPs specific assessment criteria for regular nursing assessments at the frequency necessary to address conditions that placed individuals at risk [e.g., if an individual was at risk for skin breakdown/issues, then an action step(s) in the IHCP that defines the frequency for nursing staff to assess the color, temperature, moisture, and odor of the skin, as well as the drainage, location, borders, depth, and size of any skin integrity issues]. In addition, often, the IDTs had not included in the action steps nursing assessments/interventions to address the underlying cause(s) or etiology(ies) of the at-risk or chronic condition (e.g., if an individual had poor oral hygiene, a nursing intervention to evaluate the quality of the individual's tooth brushing, and/or assess the individual's oral cavity after tooth brushing to check for visible food; if an individual's positioning contributed to her aspiration risk, a schedule for nursing staff to check staff's adherence to the positioning instructions/schedule; if an individual's weight loss was due to insufficient intake, mealtime monitoring to assess the effectiveness of adaptive equipment, staff's adherence to the Dining Plan, environmental factors, and/or the individual's food preferences, etc.). Significant work is needed to include nursing interventions that meet individuals' needs into IHCPs.

a. The IHCPs reviewed did not include interventions for ongoing nursing assessments that were in alignment with applicable nursing guidelines/standards of care.

b. IHCPs generally did not include preventative interventions. In other words, they did not include interventions for staff and individuals to proactively address the chronic/at-risk condition. Examples might include drinking a specific amount of fluid per day to prevent constipation, washing hands before and/or after completing certain tasks to prevent infection, etc.

c. The IHCPs with a measurable objective for tracking progress were for: Individual #225 – constipation/bowel obstruction, and Individual #429 – GI problems.

e. The IHCPs that included specific clinical indicators for measurement were for: Individual #225 – constipation/bowel obstruction; Individual #429 – GI problems; and Individual #355 – constipation/bowel obstruction, and weight.

f. The IHCPs that identified the frequency of monitoring/review of progress were for: Individual #225 – constipation/bowel obstruction; Individual #429 – GI problems; Individual #355 – constipation/bowel obstruction, and weight; and Individual #357 – cardiac disease.

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: Similar to the last review, the scores during this review showed timely referral of individuals to the PNMT, timely completion of PNMT reviews and assessments, and completion of the correct type of assessment (i.e., review or	Individuals:

comprehensive assessment). If the Center sustains its progress in these areas, after the next review, Indicators a through d might move to the category requiring less oversight. For the one individual in the review group who required a PNMT comprehensive assessment, the PNMT completed an assessment that met most of the criteria for quality. Center staff should continue its progress in all of these areas, and focus on the completion of post-hospital PNMT nurse reviews, as well as the quality of PNMT reviews. At this time, the remaining indicators will continue in active oversight.											
#	Indicator	Overall Score	225	429	355	394	357	378	148	16	50
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	100% 4/4	1/1	N/A	1/1	1/1	1/1	N/A	N/A	N/A	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	100% 3/3	1/1		1/1	N/A	1/1				
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	100% 1/1	N/A		N/A	1/1	N/A				
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	100% 4/4	1/1		1/1	1/1	1/1				
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	67% 2/3	N/A		1/1	0/1	1/1				
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	25% 1/4	1/1		0/1	0/1	0/1				
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/3	0/1		0/1	N/A	0/1				
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/1	N/A		N/A	0/1	N/A				

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

- On 5/11/21, Individual #225 met criteria for referral to the PNMT, because she fell more than 10 times in the previous 90 days. On 5/12/21, the PNMT completed its review.

  In terms of the quality of the PNMT review, it was positive the PNMT identified the presenting problem with recurrent falls, described the individual's available medical and social history (i.e., she had recently been admitted to the Center), and reviewed her risk ratings and current status. However, the PNMT provided incomplete information about the plans in place and/or in process to assist in mitigating the falls. For example, in the review, the PNMT mentioned a plan to taper Thorazine to address its potential impact on stability, but they provided no additional specifics on the tapering plan, nor did they address any additional review of medications and labs to ensure the individual's anemia was effectively addressed. Additionally, the PNMT referenced a behavior plan that Behavioral Health staff developed or were developing to address the individual's impulsivity, but the PNMT provided no information regarding the strategies. From a physical therapy perspective, the PNMT made no recommendations to enhance the individual's safety awareness when running.

  In its comments on the draft report, the State disputed the findings with regard to two of the issues related to the draft report, and asked that the Monitor change the score to a 1. While the Monitoring Team agrees with the State's comment that: "In body [sic] of review it states Psych has been tapering Thorazine since 2/21/21 with plan to discontinue by 7/2021," the PNMT set forth no plan to track the impact of this change on the individual's falls.

  Further, the State indicated: "In analysis of recent data section of assessment, it states …She also has anemia for which she receives ferrous sulfate daily. However, recent lab values are not significant enough to cause dizziness." The State did not quote the rest of this paragraph in its comments, which read: "Although side effects from her psych meds, especially Thorazine, and being anemic may substantially cause some dizziness. Hence, this could possibly be a contributing factor to her falls…" As indicated in the draft report, the PNMT did not recommend a plan to track these potential causes of her falls, and/or the impact of changes in medications or lab values on the falls. For this reason, as well as the other concerns noted in the draft report about the review, the Monitor did not modify the score.
- On 5/3/21, Individual #355 returned from the hospital with a diagnosis of a small bowel obstruction. On 5/4/21, the PNMT RN referred the individual to the PNMT. On 5/5/21, the PNMT completed a review. The only signature on the review was from the Occupational Therapist (OT). The review listed no other participants.

  The PNMT review noted by way of history that on 4/28/21, the individual had decreased intake with emesis; on 4/29/21, he had decreased intake with emesis; and on 4/30/21, he had decreased intake. Since the individual's admission, he had a total of 17 ED visits related to small bowel obstructions. As noted above, it appeared that the OT was the only PNMT member who conducted the review, which resulted in incomplete information and review. For example, the review included no evidence of nutritional review and the potential impact on the individual's overall level of functioning, including but not limited to digestion or lack thereof. The only nutritional area covered was intake. The PNMT offered no discussion of potential modifications to the individual's bowel regimen.
- During a hospitalization, on 8/17/20, Individual #394 had a gastrostomy tube (G-tube) placed. On 8/27/20, he returned to the Center. Based on submitted documentation, the PNMT RN did not complete a post-hospitalization review. On 8/31/20, he was

referred to the PNMT. On 10/13/20, the PNMT completed an assessment. Although this was not totally clear in the PNMT assessment itself, the State indicated in its comments on the draft report that "extenuating circumstances," that justified the delay was that the PNMT extended the monitoring of meals due to new BHS strategies. As a result, the PNMT completed the assessment within 45 instead of 30 days. The OT was the only signature on the assessment. Although other disciplines were listed, they had not signed the assessment. This issue is discussed in further detail below. The quality of the assessment is also discussed below.

- On 10/19/20, Individual #357 returned to the Center from a hospitalization for unresponsiveness with secondary aspiration. On 10/22/20, the PNMT received the referral, and on 10/23/20, the PNMT completed a review. The only signature on the review was from the RN. The review listed no other participants.

  In terms of the quality of the review, it addressed the individual's history and included a review of risk ratings. It also identified potential causes of the individual's aspiration (i.e., unresponsive due to cardiac issues). The PNMT did not offer recommendations outside of the criteria for re-referral. The PNMT did not set forth a plan to increase staff's monitoring of the individual for unresponsiveness as it related to aspiration risk.

f. In its Tier II document request, for each individual in the review group, the Monitoring Team requested: "PNMT Assessment/Review, if any within the last 12 months, including signature sheets." The Center provided signature sheets for only one assessment reviewed. As the Monitoring Team has discussed with State Office and stated in previous reports, without signature pages that include dates, it is not possible to determine which members of the PNMT participated in the PNMT assessments. Currently, for some of the individuals reviewed, the PNMT documents included a list of "participants" within the document. Given that PNMT members are licensed clinicians, the Center needs to have a mechanism to verify the participation of each clinician in the PNMT assessment process. The author or person entering information could potentially populate the list of "participants" without those clinicians having any role in the process or even knowing that they are listed as "participants." Other entries in IRIS provide a "signature" of sorts, because the system identifies the author of each entry as the user that entered the system using a password. Such entries are also time-stamped. Given the ongoing challenges with IRIS related to the inability to have more than one user "sign" a document, the State should propose a mechanism to allow this verification (i.e., allowing one user to simply include the names of "team members" at the bottom of the report does not suffice).

h. Individual #394's PNMT assessment met most of the criteria for quality, which was good to see. The one concern was the lack of measurable indicators and/or a goal/objective to allow the PNMT/IDT to measure the individual's progress, and determine whether or not the interventions were effective.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.	
Summary: Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. The plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause(s) or etiology(ies) of the PNM issues in the action steps.	Individuals:

Six out of eight PNMPs reviewed met the requirements for quality. One individual who should have had a PNMP did not. Given that during the previous review, the Center's score was 89%, and problems noted during that review as well as this review were minimal, if the Center makes needed improvements, and sustains its progress overall, after the next review, Indicator c might move to the category requiring less oversight.											
#	Indicator	Overall Score	225	429	355	394	357	378	148	16	50
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	0/1	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/17	0/1	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.	67% 6/9	0/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/17	0/1	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.	12% 2/17	0/1	0/2	1/2	0/2	0/2	0/2	0/2	1/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	6% 1/16	0/1	0/2	1/2	0/1	0/2	0/2	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	12% 2/17	0/1	0/2	0/2	0/2	0/2	0/2	0/2	2/2	0/2

Comments: The Monitoring Team reviewed 17 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 #225 – falls; Individual #429 - choking, and falls; Individual #355 – choking, and constipation/bowel obstruction; Individual #394 – skin integrity, and aspiration; Individual #357 – choking, and aspiration; Individual #378 – choking, and falls; Individual #148 – choking, and falls; Individual #16 – falls, and skin integrity; and Individual #50 – aspiration, and falls.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP.

b. Overall, ISPs/IHCPs reviewed did not 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(s) or etiology(ies) of the PNM issues in the action steps (e.g., if behavior was a frequent cause of falls, measurable interventions to address the behaviors should be included; or if an individual was at increased risk of choking due to a fast eating pace or improper positioning during meals, then measurable action steps are needed to address these factors).

c. Eight of the nine individuals reviewed had PNMPs and/or Dining Plans. Six of the PNMPs reviewed fully met the individuals' needs. The problems for the remaining three individuals included:

- Individual #225 did not have a PNMP. However, her falls placed her at increased risk, and she had mild oral-phase dysphagia. Strategies in these areas should have been included in a PNMP/Dining Plan.
- For Individual #355, the IHCP included the need to reduce his bite-size, but the PNMP did not reflect a related strategy. In addition, for this individual who had a history of 17 ED visits for small bowel obstructions, the PNMP did not specify his risk for small bowel obstructions or list the triggers.
- For Individual #357, the PNMP did not include aspiration risk as well as associated triggers in the PNMP. In October 2020, she had been hospitalized for unresponsiveness with secondary aspiration.

  In its comments on the draft report, the State disputed this finding and stated: "SLP/dysphagia assessment from 11/4/2020 indicates that, according to the PCP, individual [sic] #357 aspirated during an unresponsive episode and that her aspiration related illness was not related to oral intake. As such, there are no Hab related supports or known signs/symptoms aspiration, and this should not be reflected on the PNMP/Dining Plan." Although the risk might not be related directly to eating, the PNMP should identify her risk for aspiration. Moreover, the PNMP should identify unresponsiveness as a trigger, and reinforce that staff should staff alert a nurse immediately of any episodes of unresponsiveness due to the potential for aspiration.

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

e. The IHCPs reviewed that identified the necessary clinical indicators were those for: Individual #355 – constipation/bowel obstruction, and Individual #16 – falls.

f. The IHCP that identified triggers and actions to take should they occur was for: Individual #355 – constipation/bowel obstruction.

g. Often, the IHCPs reviewed did not include the frequency of PNMP monitoring/review of progress. Those that did were for: Individual #16 – falls, and skin integrity

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	225	429	355	394	357	378	148	16	50
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.	100% 2/2	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	1/1
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. It was positive that for the two applicable individuals, IDTs provided clinical justification for the continued use of enteral nutrition.

b. For Individual #394, from July 2020 to May 2021, speech therapy notes described observations/trials with by mouth (PO) intake. However, no clear plan outlined his return to oral intake. As indicated in the PNM audit tool, such a plan should include the following components, as appropriate:

- Staff training required prior to implementation;
- Staff roles and responsibilities (e.g., implementation and monitoring);
- Time and schedule of interventions;
- Specific triggers for when the plan should be stopped in the short-term;
- Milestones for proceeding with or indicators for discontinuing the plan in the longer-term;
- Documentation requirements (i.e., method for tracking progress); and
- Frequency of assessments and staff responsible.

In its comments on the draft report, the State disputed this finding, and stated: "Individual is currently in dysphagia therapy, and applicable changes to his plan are made as indicated by progress in therapy. For each change, the IDT met to discuss and any change to his Dining Plan was inserviced. At such a time as there is a definitive plan of return to full PO intake, the IDT would be informed, and the described action steps would be taken. At this time, the individual remains in therapy and return to oral intake is addressed through direct ST therapy… TX-AU-2107-II-75.DH… We would like for the individual score for #394 changed to 1/1 and the overall score changed from 0% to 100%." In its comments and in the documents referenced, and as indicated in the draft report, the State did not submit or offer evidence of an overall plan for the dysphagia therapy. Notes submitted provided action taken during the related therapy session, and the plan for the next session. However, this did not constitute a plan of care. As Indicator b references, a plan is

needed as the individual progresses along the continuum to oral intake, not only when there is a "definite plan of return to full PO intake." If the only staff responsible currently are therapy staff, then the plan should reflect this along with the other elements outlined.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: Given that over the last two review periods and during this review, for individuals in the review groups, OTs/PTs generally completed the correct type of assessment (Round 15 – 100%, Round 16 – 100%, and Round 17 - 100%), Indicator b will move to the category requiring less oversight. Center staff should continue to focus on improvements with regard to the quality of the content of OT/PT assessments. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	22	429	355	394	357	378	148	16	50
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.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	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.	88% 7/8	N/A	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	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, 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:	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	50% 4/8	N/A	0/1	0/1	1/1	0/1	1/1	1/1	0/1	1/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	N/A									

Comments: a.iii. and b. Most individuals reviewed received timely assessments that were also of the type in accordance with their needs. This was positive. The following describes the exception noted:

- For Individual #16, Center staff completed the annual assessment on a timely basis. However, the annual assessment indicated a re-assessment was needed after his release from droplet isolation, but Center staff did not provide evidence they completed it.

c. For Individual #22, the screening lacked clear recommendations to address impulsivity when getting up from her chair and decreased awareness when running, both of which appeared to have contributed to falls.

d. It was positive that Center staff completed OT/PT assessments for Individual #394, Individual #378, Individual #148, and Individual #50 that met all criteria for a quality assessment. The remaining assessments showed concerns with between one and three of the sub-indicators. With minimal efforts, Center staff could make continued improvements to the OT/PT assessments.

It was positive that all of the remaining assessments met criteria for the following sub-indicators:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths were used in the development of OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale); and,
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments.

Most of the remaining assessments, but not all met criteria, as applicable, with regard to:

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services; and,
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services.

Moving forward, Center staff should continue to focus attention on the following sub-indicators:

- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings; and,
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

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

Summary: Given that over the last two review periods and during this review, for individuals in the review groups, IDTs generally included functional descriptions of how they functioned from an OT/PT perspective in their ISPs (Round 15 – 89%, Round 16 – 100%, and Round 17 - 100%), Indicator a will move to the category requiring less oversight. ISPs reviewed contained needed descriptions of how the individuals functioned from an OT/PT perspective, which was positive. To move forward, QIDPs and OTs/PTs should work together to make sure IDTs discuss and consistently include information related to individuals' OT/PT strategies, interventions, and programs in ISPs and ISPAs. The remaining indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 22	429	355	394	357	378	148	16	50
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	100% 9/9	1/1	1/1	1/1	1/1	1/1	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 with this indicator, it 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% 11/11	1/1	1/1	1/1	2/2	1/1	N/A	2/2	2/2	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	0% 0/7	N/A	N/A	N/A	0/2	0/1	N/A	0/2	0/1	0/1

	or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.										

Comments: a. The ISPs reviewed included concise, but thorough descriptions of individuals' OT/PT functional statuses, which was positive.

c. As applicable, individual's ISPs/ISPAs often included the strategies, interventions and programs as recommended in the assessment

d. As applicable for the individuals reviewed, IDTs did not meet to discuss and approve implementation of OT/PT services or supports initiated or modified outside of an annual ISP meeting. For example, the IDTs for Individual #394 and Individual #148 did not meet to discuss and approve direct therapy for mobility, and the IDTs for Individual #357 and Individual #16 did not meet to discuss and approve direct therapy for wound care. In addition, the IDT for #50 did not meet to discuss and approve direct therapy related to a new positioning device.

Communication

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

Summary: Significant work continued to be needed to improve the quality of communication assessments and screenings in order to ensure that 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. The remaining indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	225	429	355	394	357	378	148	16	50
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.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's 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.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
b.	Individual receives assessment in accordance with their individualized needs related to communication.										
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.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	25% 2/8	N/A	1/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	N/A									

Comments: a. and c. For Individual #22, who was newly admitted, Center staff completed a screening on a timely basis. However, it did not meet criteria for quality screening. The screening contained basic information regarding language skills, but otherwise often lacked needed detail regarding the screening questions. For example, the screening stated the individual was able to understand two-step directions, but provided no context. Additionally, the screening did not explore her executive functions or other more complex, cognitively-focused communication needs. This was important because she had a personal goal to live independently, and was at an age where learning these skills was appropriate.

d. It was positive that two of eight comprehensive assessments reviewed met all applicable criteria for a quality assessment. It also was positive that all comprehensive assessments reviewed met criteria for the following sub-indicators:

- Discussion of 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.

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

- The individual's preferences and strengths are used in the development of communication supports and services;
- A comparative analysis of current communication function with previous assessments; and,
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated.

Moving forward, Center staff should continue to focus attention on the following sub-indicators:

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

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: The Center continued to make progress with regard to ensuring that individuals have needed formal supports included in their ISPs/ISPAs. These indicators will continue in active oversight. However, if the Center maintains its performance, at the time of the next review, indicator b might move to the category requiring less oversight.

#	Indicator	Overall Score	Individuals: 225	429	355	394	357	378	148	16	50
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, and it comprehensively addresses the individual's non-verbal communication.	100% 6/6	N/A	1/1	1/1	N/A	1/1	1/1	N/A	1/1	1/1

c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	100% 8/8	N/A	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.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	1/1

Comments: b. For the applicable ISPs reviewed, the respective IDTs documented a thorough review of individuals' Communication Dictionaries.

c. and d. Overall, it was positive that individuals' ISPs often included strategies, interventions and programs recommended in the assessments. In addition, when new communication services or supports were initiated outside of an annual ISP meeting, the respective IDTs met as needed to review and approve implementation. As noted with regard to Outcome #2 above, though, individuals' assessments often did not fully explore and/or recommend necessary communication interventions. As a result, the Monitoring Team could not confirm that individuals who should have had formal communication goals/objectives had them included in their ISPs. This indicator will remain in active oversight until assessments fully address individuals' needs, and ISPs reflect the corresponding interventions.

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.

Summary: Indicators 3 and 4 scored higher than at the last review, and indicator 5 scored lower than at the last review, due, in part, to COVID restrictions. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 162	263	429	457	127	329	57	225	425
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.	86% 19/22	2/2	1/2	1/2	3/3	3/3	2/3	3/3	2/2	2/2
4	SAPs are practical, functional, and meaningful.	77% 17/22	2/2	1/2	2/2	1/3	2/3	2/3	3/3	2/2	2/2
5	Reliable and valid data are available that report/summarize the individual's status and progress.	63% 10/16	1/1	1/1	1/2	0/2	0/2	2/3	3/3		2/2

Comments:

3. Nineteen of the 22 SAPs were based on assessment results. These were skills that the individuals could not perform based on either the Functional Skills Assessment (FSA) or the baseline probe. The four exceptions were the following:

- When the baseline probe was conducted for Individual #263 counting out a specified number of dollar bills, she was able to do so, further, her FSA noted she was able to count. In a comment on the draft version of this report, the State wrote that the individual's SAP was for combining money and that the FSA assessment indicated "none" for combining money, and that she did not have this skill and it was meaningful for her to learn. The Monitoring Team, however, found that the SAP is for teaching her to hand over the correct number of dollar bills once staff have told her the amount of her bill (rounded up by staff). In other words, she was not learning to combine different bills, and the SAP specifically states dollar bills. Although her FSA did note that she cannot combine bills, she was not learning to do this. She was learning to count out dollar bills. Her FSA noted that she can count objects.
- The objective for Individual #429's play music SAP indicated she would perform the skill with the same level of prompting that was needed during baseline
- Individual #329 was able to choose his clothing during baseline;.

4. Seventeen of the 22 SAPs were considered practical, functional, and/or meaningful. The five exceptions were the following:

- The goal identified in Individual #263's counting money SAP was to order food in a restaurant - this skill did not teach her to read a menu and interact with wait or counter staff to place her order. In a comment on the draft version of this report, the State wrote "This skill will be completed in a drive thru (COVID) with a menu that would not be handheld. Also, the individual has a visual impairment and would struggle to read a menu, so this suggestion is not appropriate. The SAP also mentions in the teaching instructions several functional restaurant skills and real-life applications of what the individual would do during skill training. This skill is meaningful for her, she cannot do this skill, and ordering food is a preference." In response, the SAP did not specify that this will be done at a drive- thru, and even if it was, the individual would not be seated near the drive-thru window and would hand her money to a staff member. Further, based on observation, it seemed the individual had sufficient vision to be able to order from a menu, perhaps with enlarged print.
- Individual #457's goal was to learn to play a game of Old Maid with a peer - her learning to match cards that were not those used in this card game did not allow her to become familiar with the game, nor did this SAP help her develop turn taking skills
- As written, the SAP for teaching Individual #457 to access a video on the computer was not practical - the enter key was not highlighted or otherwise marked for this visually impaired individual, and there are any number of adaptations that can be made to electronic devices (e.g., computer touch screens, touch activated iPads) to facilitate her learning. . In a comment on the draft version of this report, the State wrote "Individual 457 has an SAP to watch a video on the computer was indicated to not be practical. The comments indicate "Enter" is not highlighted or marked. These comments do not match the QSR definition of what is practical, and therefore should not affect scoring. In response, this visually impaired individual was not provided any support to learn to independently use the computer without adaptations made to the keys to accommodate her impairment. Further, the plan says that once she learns to do this with a PP prompt, she would move on to another skill, that is, her ability to operate a computer independently was not going to be developed.
- Individual #127's learning to choose a number form an array of three did not address her goal of attending a movie.
- As indicated during baseline, Individual #329 was able to make choices of which articles of clothing to wear

5. Sixteen of the 22 SAPs were reviewed for data reliability. The SAPs excluded from this analysis were those that had been implemented for less than three months. These were: Individual #162 - operate a DVD/television; Individual #263 - follow a picture schedule; Individual #127- put on shoes; Individual #225 - count money and make a smoothie; and Individual #457 -play video.

In determining this indicator, the state policy regarding monitoring of SAPs was reviewed. It indicates that SAPs should be monitored via direct observation once within the first three months of implementation and once every six months, thereafter.

Evidence was provided that 10 of the 16 SAPs were monitored for data reliability. The exceptions were SAPs that had been assessed more than six months prior to the remote review (Individual #429 - touch water symbol and Individual #127 - complete puzzle); SAPs that had been assessed via role play (Individual #127 - sort silverware and Individual #329 - request a break); and SAPs for which inter-observer agreement scores were less than 80% (Individual #457 - card game and play CD).

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 indicators will remain in active monitoring, however, there was some decrease in performance on indicators 10 and 12. Comments are provided below.

Individuals:

#	Indicator	Overall Score									
10	The individual has a current FSA, PSI, and vocational assessment.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.										
12	These assessments included recommendations for skill acquisition.										

Comments:

10. Three individuals did not have a vocational assessment (Individual #162, Individual #429, Individual #425). A day program assessment had been completed for each of these individuals. Individual #429 was of retirement age, but Individual #162 is only 25 years of age and Individual #425, at 63 years of age, still had a few years to engage in preferred and meaningful work.

12. Individual #127's FSA included five SAP recommendations. Only one SAP recommendation was in the FSAs for Individual #162, Individual #263, Individual #329, and Individual #425. Two SAP recommendations were found in the FSAs for Individual #429, Individual #457, Individual #57, and Individual #225.

SAP recommendations were found in the vocational or day program assessment for six of the nine individuals. No recommendations were found in the day program assessments for Individual #429 or Individual #425, or the vocational assessment for Individual #225.

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.

In a letter, dated 8/23/21, the Monitor notified the parties that the Center achieved substantial compliance with most of the requirements of Section Q of the Settlement Agreement. The exceptions are: 1) implementation of a policy/clinical guideline that is consistent with current generally accepted standards of care on perioperative assessment and management of individuals needing TIVA/general anesthesia for dental work, which the Monitoring Team will continue to assess and apply the findings to paragraph H.7 of the Settlement Agreement; and 2) personal goals/objectives for individuals who are at risk for dental problems, as well as the development and implementation of plans for individuals who require suction tooth brushing, which the Monitoring Team will assess as part of Section F. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Austin SSLC exited from the other requirements of Section Q of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the related outcomes and indicators. As a result, this Domain contains six less outcomes, and 21 fewer indicators.

Currently, this Domain contained 22 outcomes, and 101 underlying indicators. Nineteen of these indicators were moved to, or were already in, the category of less oversight after the last review. Presently, one additional indicator will move to the category of less oversight in the areas of physical and nutritional management.

Austin SSLC met and maintained substantial compliance with section K of the Settlement Agreement (Psychological Care and Services) and is now exited from the monitoring of this section and the outcomes and indicators under this domain: 4 outcomes, 17 indicators.

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

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

In behavioral health, six of the seven individuals were making progress, but the absence of acceptable DCT scores resulted in five of these six receiving zero scores. For the one individual who was not making progress, corrective actions were not identified.

Acute Illnesses/Occurrences

Since the last review, continued improvement was noted with regard to the quality of the acute care plans that nurses developed. For this review, four of the six acute care plans reviewed met the criteria for quality, and met the individuals' needs. Nursing staff thoroughly implemented three of the six acute care plans reviewed.

Nursing assessments at the onset of signs and symptoms of illness that are in alignment with relevant nursing guidelines, as well as on an ongoing basis for acute illnesses/occurrences remained areas on which Center staff need to focus. It is also important that nursing staff timely notify the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification.

Similar to the last review, for most of the acute events/illnesses that the Monitoring Team reviewed, it was positive that individuals received timely acute medical care, and follow-up care.

Implementation of Plans

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

It was very positive that for all 18 individuals' chronic or at-risk conditions reviewed, PCPs completed medical assessments, tests, and evaluations consistent with current standards of care, and identified the necessary treatment(s), interventions, and strategies, as appropriate.

Work was still needed on the timely review of non-facility consultations. In addition, the Center should focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

With regard to medication administration, areas that require focused efforts are medication nurses' adherence to the nine rights of medication administration, and infection control practices, as well as the inclusion in IHCPs of respiratory assessments for individuals with high risk for respiratory compromise that are consistent with the individuals' level of need, and the implementation of such nursing supports.

For most of the individuals observed, their adaptive equipment appeared to be the proper fit.

Based on observations, there were still numerous instances (33% of 30 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. Individuals were at increased risk due to staff's failure, for example, to intervene when they took large unsafe bites and/or did not swallow in between bites, ate at too fast a rate, ate most or all of their meal without taking sips of liquid, or drank a full glass of liquid, when staff were supposed to present the glass only a quarter full. In four instances, individuals were not positioned correctly during mealtime. It was good to see that texture/consistency was correct, and that adaptive equipment was correct.

In behavioral health, most staff were trained in the PBSPs.

In behavioral health, treatment integrity and IOA were assessed for all individuals and shown to meet criteria. Data collection timeliness is discussed in indicator 5.

Also in behavioral health, the graphic summaries continued to improve and Austin SSLC scored higher than ever before on indicator 20. Some corrections to graphs (correct labels of ordinates, compressed ordinates) were needed. There was very good discussion during internal peer review. Peer review follow-up occurred.

Restraints

Austin SSLC met the substantial compliance requirements of section C of the Settlement Agreement and was exited from monitoring. Thus, the Monitors did not conduct monitoring of this area.

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

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

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: Six of the seven individuals were making progress, but the absence of acceptable DCT scores resulted in five of these six receiving zero scores, otherwise they would have been scored 1 (i.e., 86%, 6/7). For the one individual who was not making progress, corrective actions were not identified.			Individuals:									
#	Indicator	Overall Score	162	263	429	457	127	329	57	225	425
6	The individual is making expected progress	14% 1/7	0/1	0/1	0/1			0/1	0/1	0/1	1/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	0% 0/1									
9	Activity and/or revisions to treatment were implemented.	N/A									

Comments:
6. The graphs provided by the facility suggested that six of the seven individuals (i.e., all but Individual #225) were making progress on most or all of their objectives. Inter-observer agreement scores were satisfactory for all seven individuals, but data collection timeliness scores were satisfactory for Individual #425 only, however, see the comments under indicator 5. For these reasons, he was the only individual who scored 1 on this indicator.

8-9. Individual #225 was not making progress, but there were no comments in the PBSP progress notes for Individual #225, therefore, corrective actions could not be identified.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.												
Summary: For about half of the individuals, most staff were trained in their PBSPs. For the other half, it ranged from about one third to three-quarters of their staff. The Center, however, had not submitted correct documentation of staff PBSP training. The Monitor agreed to accept a new submission of a correct set of documentation for a different set of eight individuals. For seven of these eight individuals (88%), 80% or more of their assigned DSPs were trained on the PBSP.			Individuals:									
#	Indicator	Overall Score	162	263	429	457	127	329	57	225	425

16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	57% 4/7	0/1	1/1	1/1			0/1	0/1	1/1	1/1
17	There was a PBSP summary for float staff.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.										

Comments:
16. A comparison was made between staff rosters and training rosters provided by the facility. This suggested that 80% or more of the assigned staff had been trained on the PBSP for Individual #263, Individual #429, Individual #225, and Individual #425. Data indicated that 69%, 36%, and 58% of assigned staff had been trained on the PBSPs for Individual #162, Individual #329, and Individual #57, respectively.

In the weeks between the review week and submission of this report, the Center learned that they were not correctly submitting documentation to the Monitoring Team. As a result, the Monitor agreed to a post-review week submission of a correct set of training documentation for another eight individuals. The results showed that staff for seven of the individuals (88%) had been trained in the PBSP.

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

Summary: The graphic summaries continued to improve and Austin SSLC scored higher than ever before on indicator 20. Some corrections to graphs (correct labels of ordinates, compressed ordinates) were needed. There was very good discussion during internal peer review. Peer review follow-up occurred.

#	Indicator	Overall Score	Individuals: 162	263	429	457	127	329	57	225	425
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.	57% 4/7	1/1	1/1	0/1			1/1	1/1	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.	100% 1/1								1/1	
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

20. Graphs were considered useful and complete for four of the seven individuals. These were Individual #162, Individual #263, Individual #329, and Individual #57. For the other three individuals:

- Through May 2021, one graph presented in Individual #429's progress notes depicted three different target behaviors. As these three behaviors occurred at very different rates, the range presented on the y or vertical axis was quite broad. This resulted in a poor visual presentation of two of the three measures, biting and rectal digging. Although this issue was resolved in May 2021 when agitation was graphed separately, the measure was identified as frequency, when in fact a duration measure was recorded. This same problem was then apparent in the May and June 2021 monthly progress notes when rectal digging was graphed with biting and inappropriate comfort seeking. The recording system for rectal digging had been changed to a duration measure in May 2021. The three behaviors occurred at very different rates, requiring a broad range on the y or vertical axis. Here, too, the graph was labeled frequency although this was accurate for two of the three behaviors.
- Over the four months of progress notes for Individual #225, one graph included four data paths making it difficult to read.
- The graph depicting the rates of Individual #425's three target behaviors was labeled frequency. However, physical aggression and property destruction were measured as episodes, while his protest behavior was measured in minutes.

22. In the six months prior to the remote review, Individual #225 had been presented to the Internal Peer Review Committee. There was evidence in the PBSP for Individual #225 noting that staff were advised not to allow her to hold onto their hands or arms, and for new/unfamiliar staff to first engage in rapport building activities. However, there was no indication of pairing newer staff with preferred staff or having preferred staff attention provided contingent upon Individual #225's interacting with others.

Note: During the remote review, an observation was conducted of a meeting of the Internal Peer Review Committee. This was very positive as several members of the behavioral health services staff posed questions and contributed suggestions as one staff member sought support in developing a group contingency plan for a newly developed home serving women with significant needs. Staff are commended for the presentation, the supportive discussion, and the thoughtful recommendations.

Outcome 8 – Data are collected correctly and reliably.

Summary: Treatment integrity and IOA were assessed for all individuals and shown to meet criteria. As noted in monitoring indicator 5, data collection timeliness did not meet criteria for most individuals.

Individuals:

#	Indicator	Overall Score	162	263	429	457	127	329	57	225	425
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.										
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.										

29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).										
30	If the individual has a PBSP, goal frequencies and levels are achieved.	14% 1/7	0/1	0/1	0/1			0/1	0/1	0/1	1/1

Comments:
30. Between January and June of 2021, there was evidence of monitoring of IOA, treatment integrity, and data collection timeliness for at least five months for six of the seven individuals. When monitoring was not completed, it was reportedly due to COVID-19 precautions. In every case, IOA and treatment integrity averaged 80% or better.

The only individual for whom data collection timeliness averaged 80% or better was Individual #425. However, see comments under indicator 5. The one individual for whom this monitoring did not occur each month was Individual #225. That being said, since March 2021, monthly monitoring of IOA had occurred for Individual #225 even though she had a temporary plan at that time. This likely helped ensure that data reliably and accurately reflected her baseline levels. Staff interviews were also documented each month, but there were no reported measures of data collection timeliness or observed treatment integrity for her.

Staff should not report zero scores in the individual's progress notes for treatment integrity and inter-observer agreement if these monitoring assessments were not completed (e.g., Individual #57's June 2021 progress report). Also, staff should ensure that scores reported in the narrative match those reported in the bar graph (e.g., in the June 2021 progress note for Individual #162 treatment integrity scores differed, and in the June 2021 progress note for Individual #429, both treatment integrity and inter-observer agreement scores differed).

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not develop goals/objectives that reflected clinically relevant actions that the individuals could take to reduce their at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	225	429	355	394	357	378	148	16	50
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/12	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	17% 3/12	0/2	1/2	0/2	0/2	1/2	0/2	0/2	1/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/12	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

		0/12									
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/12	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 #225 – circulatory, and allergies; Individual #429 – GI problems, and infections; Individual #355 – constipation/bowel obstruction, and weight; Individual #394 – movement disorder, and UTIs; Individual #357 – cardiac disease, and UTIs; Individual #378 – constipation/bowel obstruction, and skin integrity; Individual #148 – circulatory, and cancer; Individual #16 – skin integrity, and UTIs; and Individual #50 – spasticity, and seizures).

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

Although the following goals/objectives were measurable, because they did not specify what the individuals could do to improve their health, the related data could not be used to measure the individuals' progress or lack thereof: Individual #429 – GI problems, Individual #357 – UTIs, and Individual #16 – skin integrity.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. As a result, it was difficult to determine whether or not individuals were making progress with regard to taking steps to improve their chronic or at-risk conditions, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provision of medical supports and services to these nine individuals.

Outcome 4 – Individuals receive preventative care.

Summary: It was positive that the six individuals in the review group who needed screening for colorectal cancer received it. All nine individuals in the review group had up-to-date hearing and vision screenings. Four of five individuals had timely testing for osteoporosis. Three of the nine individuals reviewed received the preventative care they needed.

It appeared that two individuals were waiting for a breast ultrasound or a pap smear, respectively. However, limited services due to COVID-19 and now waiting lists were delaying their obtaining the needed testing. For one of these individuals, the delay extended back to 2019, though.

Individuals:

#	Indicator	Overall Score	225	429	355	394	357	378	148	16	50

a.	Individual receives timely preventative care:										
	i. Immunizations	67% 6/9	1/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 6/6	N/A	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A
	iii. Breast cancer screening	67% 2/3	N/A	N/A	N/A	N/A	1/1	N/A	1/1	N/A	0/1
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	80% 4/5	N/A	0/1	N/A	N/A	1/1	1/1	1/1	1/1	N/A
	vii. Cervical cancer screening	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									

Comments: a. The following provide examples of findings:

- The six individuals who needed colorectal cancer screening had it.
- All nine individuals in the review group had up-to-date vision and hearing screenings.
- On 1/15/18, Individual #429's last DEXA scan showed a T-score of -3.1. During the interview with the Monitoring Team member, the PCP indicated that an order for an updated DEXA scan was put in earlier that day.
- For Individual #355, the immunization record did not list the administration of the tetanus, diphtheria, and pertussis (Tdap) vaccination. The AMA listed a date of 4/16/15.
- For Individual #394, the immunization record did not list the pneumovax 23 vaccination. The AMA listed February 2011, as the month in which it was administered.
- The immunization record for Individual #357 did not include Prevnar 13.
- On 3/7/14, Individual #148 had her last pap smear with a recommendation to repeat it in five years. Reportedly, due to issues with a contract, it did not occur in 2019. The plan was to obtain it is 2020, but COVID-19 restrictions were in place for parts of 2020. No ISPA was submitted to show the IDT weighed the risks-benefits of delaying or moving forward with the preventive screening. Regardless, it was overdue as of March 2019.
- Due to her anatomy, Individual #50 could not undergo mammography, and required an ultrasound. On 1/22/20, her last ultrasound was completed. She, along with 40 other individuals, was on a waiting list for an appointment.

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	225	429	355	394	357	378	148	16	50
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.	Not rated (N/R)	N/A	N/A	N/A	N/A	N/R	N/A	N/A	N/A	N/A
Comments: a. During the week of the Monitoring Team's remote review, Individual #357 was in the hospital. Based on verbal reports, due to diagnoses of end stage severe pulmonary hypertension, and arrhythmia, the LAR made the decision to put an out-of-hospital DNR in place. Because of the recency of the hospitalization and decision-making, the documents submitted did not include information to confirm the clinical condition used to justify the DNR. As a result, the Monitoring Team did not rate this indicator.											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Similar to the last review, for most of the acute events/illnesses that the Monitoring Team reviewed, it was positive that individuals received timely acute medical care, and follow-up care. The remaining indicators will continue in active oversight until the Center's related quality improvement processes are assessed and deemed to meet the requirements of the Settlement Agreement.			Individuals:								
#	Indicator	Overall Score	225	429	355	394	357	378	148	16	50
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	88% 14/16	2/2	2/2	2/2	2/2	2/2	N/A	2/2	2/2	0/2
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	100% 7/7	N/A	2/2	2/2	N/A	1/1		1/1	1/1	1/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	100% 9/9	2/2	N/A	2/2	1/1	2/2	N/A	2/2	N/A	N/A

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	1/1		1/1	0/1	N/A		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, these indicators 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.										
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	100% 1/1	N/A		1/1	N/A	N/A		N/A		
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	100% 8/8	2/2		2/2	1/1	2/2		1/1		

Comments: a. and b. For eight of the nine individuals in the review group, the Monitoring Team reviewed 16 acute illnesses/occurrences addressed at the Center, including: Individual #225 (pain in right breast on 3/17/21, and fall on 4/8/21), Individual #429 (hand swelling on 5/3/21, and superficial laceration to forehead on 6/22/21), Individual #355 (cellulitis of left arm on 12/12/20, and COVID-19 positive on 1/12/21), Individual #394 (sleeping disorder on 12/1/20, and abdominal pain on 3/18/21), Individual #357 (rash to face on 3/15/21, and right cheek nodule on 6/2/21), Individual #148 (rash on buttocks on 4/23/21, and redness of nose and arm on 3/16/21), Individual #16 (sacral wound on 12/11/20, and COVID-19 exposure on 12/20/20), and Individual #50 (pustule on throat on 12/17/20, and right eye redness and drainage on 1/13/21).

It was positive the for these 16 acute illnesses/occurrences addressed at the Center, PCPs assessed most of them according to accepted clinical practice, and conducted necessary follow-up.

For Individual #50 (pustule on throat on 12/17/20, and right eye redness and drainage on 1/13/21), the provider did not provide differential diagnoses as part of the assessment process.

c. For five of the nine individuals reviewed, the Monitoring Team reviewed nine acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #225 (ED visit for fall with inability to move left lower extremity on 3/4/21, and ED visit for ankle pain on 5/1/21), Individual #355 (hospitalization for small bowel obstruction on 4/30/21, and ED visit for laceration to face on 5/25/21), Individual #394 (ED visit for multiple bruises on head with no history of fall or trauma on 6/24/21), Individual #357 (ED visit for unresponsiveness on 1/21/21, and ED visit for unresponsiveness on 5/15/21), and Individual #148 (ED visit for anemia, chills, and tachycardia on 5/18/21, and hospitalization for stroke on 5/27/21).

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

- It was positive to see that for most of the acute illnesses/occurrences reviewed that required hospitalization or an ED visit, the individuals received timely acute medical care, and follow-up care.
- According to a PCP IPN, dated 6/23/21, at 3:41 p.m., Individual #394 had multiple bruises on his head. He had no history of a fall or trauma. The PCP ordered a computed tomography (CT) scan. According to a PCP IPN, dated 6/24/21, at 12:49 p.m., a CT of the individual's head was scheduled for 7/7/21, but the PCP did not want to wait that long. The PCP sent to the individual to the ED. The PCP did not document a clear working diagnosis. The PCP noted a history of a subdural hematoma, and noted bruising of unknown origin. Upon the individual's return, the PCP noted no acute abnormalities, and ordered a complete blood count (CBC), and partial thromboplastin (PTT)/prothrombin time (PT)/international normalized ratio (INR).

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

Summary: Work was still needed on the timely review of non-facility consultations. In addition, the Center should focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

#	Indicator	Overall Score	Individuals: 225	429	355	394	357	378	148	16	50
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.	73% 11/15	2/2	0/2	1/1	2/2	2/2	N/A	1/2	2/2	1/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.										
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	33% 1/3	0/1	1/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: For eight of the nine individuals in the review group, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed included those for Individual #225 for allergy on 2/24/21, and optometry on 3/12/21; Individual #429 for gastroenterology (GI) on 2/9/21, and GI on 4/9/21; Individual #355 for optometry on 3/26/21; Individual #394 for neurology on 12/17/20, and neurology on 3/15/21; Individual #357 for urology on 4/19/21, and neurology on 6/21/21; Individual #148 for GI on 12/4/20, and cardiology on 4/7/21; Individual #16 for urology on 5/6/21, and urology on 6/10/21; and Individual #50 for optometry on 1/29/21, and neurology on 5/24/21.

b. PCPs did not conduct timely reviews for the following: Individual #429 for GI on 2/9/21 (i.e., report received on 2/10/21, with PCP review on 3/19/21), and GI on 4/9/21 (i.e., report received on 4/12/21, with PCP review on 4/29/21); Individual #148 for cardiology on 4/7/21 (i.e., a patient information note received on 4/15/21, with PCP review on 5/23/21); and Individual #50 for neurology on 5/24/21 (i.e., the PCP IPN was dated 6/4/21).

e. Concerns included:

- On 2/24/21, Individual #225 saw the allergist. This individual was newly-admitted, and although on 2/18/21, the PCP spoke with the IDT about available information related to her allergies at the initial ISP meeting, the IDT did not meet to discuss the more in-depth findings from the allergist following the consult on 2/24/21.
- For Individual #355, in the IPN, the PCP recommended referral to the IDT. However, based on documentation submitted, the IDT did not meet. The consultant recommended over-the-counter glasses for distance and reading. Moreover, no documentation was submitted to show that the IDT obtained the over-the-counter glasses for the individual.

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

Summary: It was very positive that for all 18 individuals' chronic or at-risk conditions reviewed, PCPs completed medical assessments, tests, and evaluations consistent with current standards of care, and identified the necessary treatment(s), interventions, and strategies, as appropriate.

Individuals:

#	Indicator	Overall Score	225	429	355	394	357	378	148	16	50
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #225 – circulatory, and allergies; Individual #429 – GI problems, and infections; Individual #355 – constipation/bowel obstruction, and weight; Individual #394 – movement disorder, and UTIs; Individual #357 – cardiac disease, and UTIs; Individual #378 – constipation/bowel obstruction, and skin integrity; Individual #148 – circulatory, and cancer; Individual #16 – skin integrity, and UTIs; and Individual #50– spasticity, and seizures).

a. For all of the individuals' chronic or at-risk conditions reviewed, PCPs conducted medical assessment, tests, and evaluations consistent with current standards of care, and the PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate. This was very positive.

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. For seven of the chronic conditions/risk areas reviewed, either no IHCP existed or the IDT assigned no interventions to the PCP.

Individuals:

However, for 11 of the IHCPs reviewed, documentation was found to show implementation of those few action steps that IDTs had assigned to PCPs and included in IHCPs/ISPs. Due to ongoing problems with the quality of the medical plans included in IHCPs, this indicator did not provide an accurate picture of whether or not PCPs implemented necessary interventions. 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	225	429	355	394	357	378	148	16	50
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	100% 11/11	N/A	N/A	N/A	1/1	2/2	2/2	2/2	2/2	2/2
Comments: a. As noted above, none of the IHCPs reviewed included a full set of action steps to address individuals' medical needs. For seven of the chronic conditions/risk areas reviewed, either no IHCP existed or the IDT assigned no interventions to the PCP. However, the action steps assigned to the PCPs were implemented for the following: Individual #394 – UTIs; Individual #357 – cardiac disease, and UTIs; Individual #378 – constipation/bowel obstruction, and skin integrity; Individual #148 – circulatory, and cancer; Individual #16 – skin integrity, and UTIs; and Individual #50– spasticity, and seizures. Due to ongoing problems with the quality of the medical plans included in IHCPs, this indicator did not provide an accurate picture of whether or not PCPs implemented necessary interventions.											

Pharmacy

After Round 14, based on the Center's scores over the past three monitoring cycles, DOJ and the State agreed that the Center achieved substantial compliance with most of the requirements of Section N of the Settlement Agreement. The exceptions are Section N.6 related to adverse drug reactions, and Section N.8 related to medication variances that the Monitoring Team will review as part of Section E, and Section N.5 related to quarterly monitoring for tardive dyskinesia that will be measured through Section J.12. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Austin SSLC exited from the other requirements of Section N of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the outcomes and indicators related to the exited provisions of the Settlement Agreement.

Dental

In a letter, dated 8/23/21, the Monitor notified the parties that the Center achieved substantial compliance with most of the requirements of Section Q of the Settlement Agreement. The exceptions are: 1) implementation of a policy/clinical guideline that is consistent with current generally accepted standards of care on perioperative assessment and management of individuals needing TIVA/general anesthesia for dental work, which the Monitoring Team will continue to assess and apply the findings to paragraph H.7 of the Settlement Agreement; and 2) personal goals/objectives for individuals who are at risk for dental problems, as well as the development and implementation of plans for individuals who require suction tooth brushing, which the Monitoring Team will assess as part of Section F. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Austin SSLC exited from the other requirements of Section Q of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the related outcomes and indicators.

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: Since the last review, continued improvement was noted with regard to the quality of the acute care plans that nurses developed. For this review, four of the six acute care plans reviewed met the criteria for quality, and met the individuals' needs. Nursing staff thoroughly implemented three of the six acute care plans reviewed. Nursing assessments at the onset of signs and symptoms of illness that are in alignment with relevant nursing guidelines, as well as on an ongoing basis for acute illnesses/occurrences remained areas on which the Center needs to focus. It is also important that nursing staff timely notify the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	225	429	355	394	357	378	148	16	50

a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	33% 2/6	1/1	0/1	0/1	0/1	1/1	N/R	0/1	N/R	N/R
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	17% 1/6	0/1	0/1	0/1	0/1	0/1		1/1		
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/2	N/A	0/1	N/A	N/A	0/1		N/A		
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0% 0/4	0/1	N/A	0/1	0/1	N/A		0/1		
e.	The individual has an acute care plan that meets his/her needs.	67% 4/6	0/1	1/1	1/1	0/1	1/1		1/1		
f.	The individual's acute care plan is implemented.	50% 3/6	0/1	1/1	1/1	1/1	0/1		0/1		

Comments: The Monitoring Team reviewed six acute illnesses and/or acute occurrences for six individuals, including Individual #225 – ED visit for allergic reaction and acute dermatitis on 2/6/21; Individual #429 – UTI on 5/8/21; Individual #355 – hospitalization for small bowel obstruction, and hyponatremia on 4/30/21; Individual #394 – ED visit for possible head injury on 6/23/21; Individual #357 – nodule to the right side of her face on 6/1/21; and Individual #148 - ED visit for non-displaced fracture of the left second toe on 4/16/21.

a. The acute illnesses/occurrences for which initial nursing assessments (physical assessments) were performed in accordance with applicable nursing guidelines were for Individual #225 – ED visit for allergic reaction and acute dermatitis on 2/6/21, and Individual #357 – nodule to the right side of her face on 6/1/21.

b. The acute illness/occurrence for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms in accordance with the SSLC nursing guidelines entitled: "When contacting the PCP" was for: Individual #148 - ED visit for non-displaced fracture of the left second toe on 4/16/21.

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

- On 2/6/21, at 3:30 p.m., Individual #225 presented with a rash on her hip. Nursing staff followed the assessment guidelines for skin integrity in conducting the initial assessment, including measurements of the affected area. At 4:35 p.m., nursing staff administered Benadryl. At 4:45 p.m., a nurse conducted an additional assessment, which again included measurements of the skin integrity issues. The nurse provided a description of the rash, including that the individual's face was now red on the left side, with mild swelling of her lips, but no swelling of her tongue and no wheezing. In notifying the PCP, nursing staff did not follow the nursing guidelines entitled: "When contacting the PCP," including use of the situation, background, assessment, and

recommendation (SBAR) format. At 8:12 p.m., the individual was sent to the ED. Although nursing staff completed the hospital transfer form, they did not complete an assessment according to the nursing guidelines for transfer to the ED, nor did they follow the guidelines for assessment upon the individual's return to the Center.

On 2/7/21, nursing staff initiated an acute care plan for impaired skin integrity. Although it included some of necessary interventions, it was missing interventions to monitor for drainage, and to notify the PCP of changes, as indicated in the skin impairment nursing guidelines.

On an ongoing basis, even though the acute care plan included an intervention for twice-a-day (BID) assessments, nursing staff did not conduct skin assessments at the required frequency, including measurements. This made it difficult to determine whether or not the issue was resolving.

- On 5/4/21, Individual #429 was agitated. Nursing staff contacted the PCP, who ordered a urinalysis (UA). In notifying the PCP, nursing staff did not follow the nursing guidelines entitled: "When contacting the PCP," including use of the SBAR format.

  Although, initially, the nurse conduced a partial review, it was not a full assessment for a possible UTI in accordance with the nursing guidelines. For example, the nurse did not assess the individual's voiding patterns, or the odor or color of her urine. The abdominal assessment included bowel sounds, but based on the notes, the nurse did not assess the individual for tenderness or distention (i.e., "normal for age/size" did not provide a thorough description). Staff made multiple attempts to obtain a sample for the UA, but it was not accomplished until 5/7/21.

  On 5/8/21, nursing staff initiated an acute care plan that included the necessary measurable interventions in alignment with the individual's needs, and the nursing guidelines on UTIs. Based on a review of a sample of documentation, nurses implemented the interventions as written.
- For Individual #355, on 4/28/21, nursing staff initiated an assessment when he experienced emesis, and then again, on 4/29/21. However, nursing staff did not initiate the initial assessment until three hours following the onset of symptoms. In addition, the nurse did not conduct a full assessment, including assessment of the individual's bowel movement patterns, or abdominal distension or tenderness (i.e., "normal for age/size" did not provide a thorough description).

  Nursing staff did not document if/when they notified the PCP, or what the notification included. On 4/30/21, the PCP did order the individual's transfer to the ED. On 4/30/21, at 6:27 p.m., the individual was sent to the ED. Nursing staff did not conduct an assessment prior to his transfer (i.e., the last assessment documented occurred at 7:16 a.m.). Upon the individual's return from the hospital, nursing staff followed the guidelines for assessment.

  On 5/3/21, nursing staff initiated an acute care plan that included the necessary measurable interventions in alignment with the individual's needs, and the nursing guidelines on abdominal distension/pain. Based on a review of a sample of documentation, nurses implemented the interventions as written.
- On 6/14/21, staff reported that Individual #394 had redness to his left eye. In conducting the initial assessment, the nurse did not include vision or neurological assessments. In addition, the nurse only completed a partial face, legs, activity, cry, and consolability (FLACC) pain assessment. On 6/14/21, at 6:11 p.m., and 8:55 p.m.; on 6/15/21, at 8:18 p.m., and 9:04 p.m.; and

on 6/16/21, at 9:00 a.m., nursing staff conducted assessments, but they did not assess the individual's vision or neurological status. On 6/23/21, staff found that the individual had old bruising (i.e., yellowing) to the right front temple area of his head. Nursing staff did not conduct a neurological assessment. The individual was not able to say how he received the bruising, and between 6/16/21, and 6/23/21, in their documentation regarding the redness to his left eye, nursing staff did not make any notations in their skin assessments about bruising to the right side of the individual's head.

On 6/23/21, a provider saw the individual, and on 6/24/21, he was sent to the ED for a computed tomography (CT) scan. In the IPNs and IView entries submitted, documentation was not found as to why the provider ordered a CT (e.g., worsening symptoms).

Upon the individual's return to the Center from the ED, the nurse assessed the individual's vital signs, and assessed him for pain, but did not complete a neurological assessment, as per the guidelines. The individual received Ketamine as pre-treatment sedation for the CT scan. It was positive that nursing staff completed post-anesthesia assessments according to the related guidelines.

On 6/23/21, at 10:45 a.m., nursing staff identified an injury to the individual's head. However, it was not until 6/24/21, at 11:35 p.m., that nursing staff initiated a post-anesthesia acute care plan, based on the use of Ketamine as pre-treatment sedation. The acute care plan included an intervention to assess the individual's gait every shift for two days. However, the individual was non-ambulatory, and dependent on a wheelchair for mobility. For the 24 hours prior to its discontinuation, nursing staff implemented the interventions included in the acute care plan (i.e., minus the one related to gait, which did not apply to this individual).

- On 6/1/21, nursing staff assessed Individual #357 for a hard raised nodule to the right side of her face. The assessment was in alignment with nursing guidelines for skin impairment. In notifying the PCP, nursing staff did not follow the nursing guidelines entitled: "When contacting the PCP," including use of the SBAR format. The nurse did not document specifics about the information provided.

  On 6/3/21, nursing staff initiated an acute care plan for risk for pain. Although it was not initiated within 12 hours of the discovery of the nodule, it contained the necessary measurable interventions. Nursing staff did not implement the intervention included in the acute care plan for measuring the size of the nodule BID, although they documented measurements at least daily. On 6/6/21, the individual went to hospital for unresponsiveness, and returned on 6/9/21. On 6/7/21, nursing staff discontinued the acute care plan, but upon the individual's return from the hospital, nursing staff entered no note indicating whether or not the issue had resolved.
- On 4/16/21, Individual #148 returned from an off-campus visit with difficulty walking and pain. As part of the initial nursing assessment, the nurse assessed the individual's ability to ambulate and weight-bear, and for edema and bruising. The nurse did not conduct an assessment of the individual's pain using a pain scale, did not assess the individual's vital signs or range of motion (ROM), and did not assess for deformity, all of which are included in the nursing guidelines for a suspected fracture. The nurse did follow the guidelines for notifying the PCP, and the PCP ordered the individual's transfer to the ED. Nursing staff did not conduct assessments prior to the individual's transfer or upon her return in accordance with the nursing guidelines for emergency/hospital transfers. For example, nursing staff did not complete skin assessments, including the Braden screening.

Nursing staff initiated an acute care plan that contained the necessary measurable interventions. Based on a review of a sample of documentation, nursing staff did not consistently use the FLACC scale to assess the individual's pain, or fully document whether or not the individual had her foot elevated on a pillow when in bed.

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

Summary: For individuals reviewed, IDTs did not develop goals/objectives that reflected clinically relevant actions that the individuals could take to reduce their at-risk conditions. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 225	429	355	394	357	378	148	16	50
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/12	0/2	0/2	0/2	0/2	0/2	N/R	0/2	N/R	N/R
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	17% 2/12	1/2	1/2	0/2	0/2	0/2		0/2		
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/12	0/2	0/2	0/2	0/2	0/2		0/2		
d.	Individual has made progress on his/her goal/objective.	0% 0/12	0/2	0/2	0/2	0/2	0/2		0/2		
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/12	0/2	0/2	0/2	0/2	0/2		0/2		

Comments: For six individuals, the Monitoring Team reviewed a total of 12 IHCPs addressing specific risk areas (i.e., Individual #225 – polypharmacy/medication side effects, and constipation/bowel obstruction; Individual #429 – fractures, and GI problems; Individual #355 – constipation/bowel obstruction, and weight; Individual #394 – aspiration, and infections; Individual #357 – cardiac disease, and infections; and Individual #148 – infections, and other: cancer).

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

Although the following goals/objectives were measurable, because they did not reflect a clinically relevant action the individuals could take to reduce the risk, the related data could not be used to measure the individuals' progress or lack thereof: Individual #225 – constipation/bowel obstruction, and Individual #429 – GI problems.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. As a result, it was difficult to determine whether or not individuals were making progress with regard to taking steps to improve their chronic or at-risk conditions, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provision of nursing supports and services to these six individuals.

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

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

Individuals:

#	Indicator	Overall Score	225	429	355	394	357	378	148	16	50
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need.	0% 0/12	0/2	0/2	0/2	0/2	0/2	N/R	0/2	N/R	N/R
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/9	0/2	0/1	0/2	N/A	0/2		0/2		
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% 0/12	0/2	0/2	0/2	0/2	0/2		0/2		

Comments: As noted above, the Monitoring Team reviewed a total of 12 specific risk areas for six individuals, and as available, the IHCPs to address them.

a. and c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, or that nursing interventions were implemented thoroughly.

A significant problem was the lack of measurability of the supports. For example, some of the individuals' IHCPs called for nursing physical assessments, but the IHCPs did not define the frequency (e.g., every shift, each Friday, on the first day of the month, etc.), or the interventions included terms that were not measurable (e.g., "encourage," "intervene for unsafe behaviors"). As a result, it was difficult to identify in IView entries and IPNs whether or not and where nurses had documented the findings from the interventions/ assessments included in the IHCPs reviewed.

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

- Individual #225 experienced a number of potential side effects from her medications, but her IHCP did not include a comprehensive set of interventions to monitor and address them. In addition, when she had medication changes that changed her potential side effect profile and/or she experienced a possible ADR, her IDT did not meet, and review and revise her IHCP as needed. More specifically:
    - On 2/18/21, the IDT developed an IHCP. The goal for polypharmacy/medication side effects addressed hyponatremia, even though it was not a primary side effect of any of her medications. Based on interview with the RNCM, the PCP requested that hyponatremia be the focus of the goal, and the pharmacist indicated that it was a possible side effect given the combination of medications she was prescribed. It was unclear, though, why the IDT did not include another goal(s)/objective(s) to address other potential side effects.
    - The individual's medication profile resulted in a high anticholinergic burden. Although the IDT included interventions in the IHCP to monitor for neurological side effects, they did not include monitoring for the potential side effect of constipation. Moreover, they did not include preventive interventions related to constipation or other possible side effects.
    - On 2/6/21, the individual had a possible ADR/allergic reaction, requiring a visit to the ED. Her symptoms included a rash, swelling, and redness to her right hip. According to an optometry consult, on 3/12/21, the individual also had a possible ADR to Olopatadine. After these incidents, the IDT did not meet to review and revise her IHCP, as needed.
    - On 4/15/21, the IDT held an ISPA meeting during which they noted that the plan was to decrease her trazadone dosage. However, the IDT never addressed the possible effects of doing so. On 5/19/21, during an ISPA meeting, the IDT noted that her Thorazine might contribute to her falls, and the psychiatrist would taper it. However, the IDT did not discuss further follow-up, and did not modify her IHCP, for example, to include nursing interventions to assess for specific effects that the medication changes might cause.
    - On 4/12/21, and 4/14/21, the individual experienced constipation episodes requiring the administration of PRN medications. As noted above, her IHCPs for medication side effects and constipation did not meet her needs. However, based on the ISPAs and IHCPs submitted, the IDT did not review and/or revise the IHCPs to include, for example, preventive interventions, or to assess whether the "bowel regimen for constipation" referenced in the constipation IHCP continued to meet her needs.
- Between 1/9/21 and 1/28/21, Individual #429 had multiple issues with diarrhea, placing her at high risk for dehydration. However, based on the ISPAs submitted, the IDT did not convene to review her IHCP, and make modifications as needed. The previous IHCP addressed constipation, as opposed to diarrhea. On 2/25/21, the IDT held her ISP meeting, and the IRRF included discussion of these incidents, and the resulting change in bowel regimen medications. On 3/17/21, the IDT met to discuss the risk-benefit of an off-campus appointment for her to have an EGD and abdominal ultrasound. On 2/9/21, the individual had been seen in the GI Clinic, which resulted in a recommendation to switch from Zoloft to a non-selective serotonin reuptake inhibitor (SSRI). There was no ISPA to discuss this recommendation, or any outcome/follow-up. As discussed during the RNCM interview during the review week, based on a review of documentation, the Monitoring Team member noted that in March 2021, 67% of the time, the individual had Type 7 stool between 7 and 9 p.m. In April 2021, after the change in

medication, she had Type 7 stool 43% of the time between 8 and 9 p.m. It appeared that once her Zoloft was removed, her Type 7 stools were cut in half. However, because the IDT did not meet to review the data and analyze the times of occurrence in comparison with other factors, such as medication administration, they did not identify the medication as a potential root cause of the diarrhea.

- On 5/11/21, Individual #355's IDT met following his discharge from the hospital on 5/3/21, for a partial small bowel obstruction, and hyponatremia. This meeting was not within five days of his discharge. The IDT reviewed changes to his medications. The ISPA noted that: "continuing fluid management intake of less than 2000 mg [sic] daily, bottle of water 3 times daily after med pass..." The IDT also noted that his "magnesium levels were increased to 600 mg twice daily." These interventions were not clear as to how many milliliters (ml)/cubic centimeters (cc) of fluid the individual should have daily, or if it was his magnesium citrate that was increased to 600 mg twice daily. On 6/8/21, the IDT held an ISPA meeting with the PNMT to assist it in completing a review, and to discuss changes due to his "recent hospitalizations from partial bowel obstructions." The IDT determined that his small bowel obstructions were related to his prolonged Clozapine use, and that there were no interventions that could be added/changed to address the risk other than placing him on a clear liquid diet or nothing-by-mouth (NPO) status following episodes of emesis. The PNMT recommended and the IDT agreed to "continue current supports in place," and to add the intervention for the procedure after emesis. However, as noted elsewhere in this report, the interventions included in his IHCP did not meet his needs, and the IDT did not take this opportunity to revise them. For example, the IHCP included no measurable preventive interventions (i.e., an intervention to offer him a bottle of water at each medication pass did not identify the size of the bottle, and the IHCP included no intervention to assist in ensuring he consumed a specific amount of fluid each day), and the IDT did not discuss adding them (e.g., exercise, fiber/diet changes, constipation medication changes).
- At Individual #355's ISP meeting, on 2/25/21, his IDT established a goal for weight that read: "[Individual] will achieve and maintain a weight of 145#s x next 12 months." From the goal, it was unclear whether he needed to lose or gain weight, and the goal did not provide interim measures or establish a safe amount of weight for him to gain, for example, monthly. The IDT included an intervention that read: "D-RD will modify [Individual's] diet to support a 10.25# gain to a weight of 145# X 12 months." This did not reflect specific interventions/strategies designed to assist the individual in gaining weight. The only other interventions in the IHCP were for the RNCM to enter weekly weights, monitoring of weights "by RNCM and dietician with notification to the IDT," and for the RNCM to complete quarterly comprehensive physical assessments, including abdominal circumference (which is a requirement for all individuals).

Based on review of information from the previous year, in April 2020, the individual was hospitalized, and had surgery for an ileus. During this hospitalization, he lost over 20 pounds. By time the IDT met on 4/28/20, the individual had gained back some weight, but he was still down 15.5 pounds. In January 2021, after having gained some weight back, he lost six pounds again, and no evidence was found to show that the IDT met to discuss the loss and/or review the plan, and revise it, as needed. As noted above, at his ISP meeting in February 2021, his IDT established a goal for his weight. From 4/30/21 to 5/3/21, he was hospitalized for a partial small bowel obstruction, during which he lost five pounds. Over the next month, he continued to lose an additional six pounds. No evidence was found that the IDT held a change of status (COS) meeting to review the plan and its implementation, and to make changes, as needed. As noted above, the IHCP as written did not set forth a specific plan with active interventions to assist the individual to gain weight and/or reduce his risk for further weight loss.

- Beginning in February 2021, Individual #357's IDT met a few times to acknowledge the individual's "unresponsiveness" episodes. Based on documentation submitted, these episodes occurred on 7/7/20, 10/13/20, 10/15/20, 1/21/21, 1/30/21, 5/15/21, and 6/6/21, and sometimes lasted for days. However, based on the ISPAs submitted, the IDT did not review any correlation with low blood pressure and/or pulse. The action they took was to increase her level of supervision (LOS). On 2/2/21, the IDT noted that the individual was hospitalized for a heart condition and atrial fibrillation, at which time they increased her LOS. In subsequent meetings, the IDT stated that they would not change her increased LOS until she had three months without unresponsiveness episodes. However, they did not review whether any changes to her IHCP might be needed to either make improvements or assess the reason(s) for the episodes. On 5/4/21, her IDT met to address left lower extremity (LLE) edema. The IDT did not review the IHCP interventions or their implementation. During this meeting, although the IDT agreed to elevate her legs at night, they did not update the IHCP to add a corresponding measurable intervention.

  As referenced elsewhere in this report, her IHCP did not include interventions sufficient to address her needs. For example, despite her high risk for cardiac disease, the IHCP included a number of clinical indicators in the goal/objective, but did not include interventions for nursing staff to regularly assess them, and/or the parameters for notification of the PCP. Some of the other concerns included that the IHCP did not include interventions for staff to apply the continuous positive airway pressure (CPAP) device at night, monitor labs such as sodium and Cholesterol, and/or monitor for edema. It also did not include action steps related prevention, such as exercise, and/or diet, including sodium intake, and dietary fiber.
- Following Individual #357's 11/9/20 hospitalization for aspiration pneumonia, the IDT conducted a COS ISPA meeting. However, at that time, they did not address infections. After another hospitalization in January 2021, for a COVID-19 positive diagnosis and UTI requiring antibiotics, the IDT did not conduct a COS meeting, and did not address a change in her infections risk until the February 2021 IRRF. On 3/23/21, the IDT met to discuss the individual's UTIs and the possible correlation between them and her unresponsiveness episodes, but they only noted they would continue to monitor. Her IHCP for infections included only three interventions. The only one assigned to nursing staff related to skin integrity, and required the RNCM to complete the Braden Scales screening quarterly. The remaining two were for medical and contradicted one another. One required the PCP to complete an interval medical review every three months, and the other required completion every six months. The IHCP included no preventive interventions, and no ongoing nursing assessments.
- Individual #148 was diagnosed with chronic lymphocytic leukemia (CLL), as well as cancer. Given that the individual was immunocompromised due to the CLL, as well as the radiation treatment and chemotherapy for cancer, her IHCPs for infections and cancer did not address her needs. For example, the individual had frequent UTIs for which the PCP prescribed prophylactic medications. Her IHCP for infections did not include interventions for regular nursing assessments consistent with the nursing guidelines for UTIs or infections, nor did it include preventive interventions to minimize her risk, such as drinking a specific amount of fluid per day, the prophylactic medications, etc. Other than tracking the number of hospitalizations, the IHCPs did not include clinical measures to track progress or regression. In September 2020, the individual was diagnosed with COVID-19-related pneumonia. When the IDT met, they noted she was immunocompromised, but they did not add/address the need for preventive interventions in her IHCP. In January and February 2021, she was hospitalized with diagnoses of sepsis, and urosepsis with a UTI. No evidence was found that the IDT held ISPA meetings following these hospitalizations, and/or that they made changes to her IHCP for infections.
- Similarly, Individual #148's IHCP for cancer did not include interventions to support the individual's treatment and management of her cancer. For example, the IHCP did not include any preventive measures such as reverse isolation when she

was neutropenic, or ways to address her immunocompromised status (e.g., good handwashing, etc.). Based on the ISPAs submitted, on 4/27/21, after she became neutropenic, the IDT met and discussed that she was placed in reverse isolation and moved to Infirmary. However, they did not discuss and make needed changes to the IHCP to add interventions to address her chemotherapy, any side effects, or the existing port.

Outcome 7 – Individuals receive medications prescribed in a safe manner.												
Summary: Areas that require focused efforts are medication nurses' adherence to the nine rights of medication administration, and infection control practices, as well as the inclusion in IHCPs of respiratory assessments for individuals with high risk for respiratory compromise that are consistent with the individuals' level of need, and the implementation of such nursing supports. At this time, all of these indicators will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	225	429	355	394	357	378	16	50	57	340
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R										
b.	Medications that are not administered or the individual does not accept are explained.	N/R										
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	50% 4/8	1/1	1/1	0/1	1/1	N/A	0/1	1/1	N/A	0/1	0/1
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	75% 3/4	N/A	N/A	0/1	N/A	N/A	1/1	N/A	N/A	1/1	1/1
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	75% 3/4	N/A	N/A	0/1	N/A	N/A	1/1	N/A	N/A	1/1	1/1
d.	In order to ensure nurses administer medications safely:											
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	33% 1/3	N/A	N/A	N/A	0/1	1/1	N/A	N/A	0/1	N/A	N/A
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and	33% 1/3	N/A	N/A	N/A	0/1	1/1	N/A	N/A	0/1	N/A	N/A

	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.											
	a. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	b. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R										
f.	Individual's PNMP plan is followed during medication administration.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.										
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).											
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.											
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	63% 5/8	1/1	1/1	0/1	0/1	N/A	1/1	0/1	N/A	1/1	1/1
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	33% 1/3	N/A	N/A	0/1	0/1	N/A	N/A	1/1	N/A	N/A	N/A
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	33% 1/3	N/A	N/A	0/1	0/1	N/A	N/A	1/1	N/A	N/A	N/A
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R										
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R										
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R										
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R										

l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R										
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R										

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of eight individuals, including Individual #225, Individual #429, Individual #355, Individual #394, Individual #378, Individual #16, Individual #57, and Individual #340. At the time of the remote review, Individual #357 was in the hospital, and Individual #50 was in isolation. Prior to the review, Individual #148 died.

c. With regard to nursing staff following the nine rights of medication administration, the following concerns were noted :

- For Individual #355, the medication nurse did not call out Clozaril as an allergy. As a result, the Monitoring Team member was not able to confirm that the medication nurse checked to ensure that the individual did not have an allergy to the medications administered (i.e., right medication). The Center's nurse auditor did not identify this as a problem.
- As the Center's nurse auditor identified, before pulling the medications, the medication nurse for Individual #378 stated that they were not expired, and did not check this during the first or second check.
- As the Center's nurse auditor identified, the medication nurse for Individual #57 needed to cut a medication in half and administer only half of it. However, the nurse did not set aside the extra half, and then, poured the second half into a cup to administer it. Appropriately, the Center's nurse auditor identified the issue and stopped the medication pass before a medication error occurred.
- The medication nurse for Individual #340 did not complete the first check for one medication, and did not complete the second check for another medication. The Center's nurse auditor stopped the nurse prior to administration to ensure she completed the additional checks. The medication nurse also threw one package away after the second check and realized what she had done, acknowledged it, and was able to complete the third check by looking into the trash, because the trash had just been emptied and the package was visible.

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

- On 8/17/20, Individual #394 had a feeding tube placed. His IDT did not include/add an intervention in his IHCP for regular respiratory assessments. The only related intervention was not measurable, and required nursing staff to assess his lungs each shift PRN for a "suspected aspiration episode."
- Individual #357 was at high risk for aspiration/respiratory compromise, and on 10/22/20, she was diagnosed with aspiration pneumonia, which the IDT related to an incident of unresponsiveness. Her IDT included an intervention for a nursing assessment if she had any choking incidents. Based on the documentation submitted, she had not experienced a choking event.
- Individual #50 was at high risk for aspiration/respiratory compromise, and received enteral nutrition. Her IDT included an intervention in her IHCP for nursing staff to complete a lung assessment each shift. Based on a review of a sample of documentation, nursing staff did not assess her breath sounds each shift.

g. The following concerns were noted with regard to medication nurses' adherence to infection control practices:

- During Individual #355's medication observation, the medication nurse handled the water pitcher, but did not clean it first. The nurse also removed juice boxes from the refrigerator as choices for the individual, but then, did not sanitize their hands prior to handling the medications and cup of water for the individual. The Center's nurse auditor did not identify these concerns.
- During Individual #394's medication observation, the medication nurse did not sanitize the water container/shaker prior to touching it. The medication nurse also touched the shaker container to the cup when transferring liquids after mixing them. The medication nurse did not apply sanitizer between all glove changes or after touching the individual to check his positioning. The Center's nurse auditor noted that the nurse had not cleaned the shaker, but did not note the other infractions.
- As the Center's nurse auditor identified, the medication nurse for Individual #16 did not fully rinse off soap residual following hand washing.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.

Summary: It was positive that for applicable individuals in the review group, IDTs referred individuals to the PNMT and/or the PNMT made a self-referral. IDTs and/or the PNMT did not develop goals/objectives that reflected clinically relevant actions that the individuals could take to reduce their PNM risks. As a result, it was difficult to determine whether or not individuals were making progress with regard to taking steps to improve their chronic or at-risk conditions, or when progress was not occurring, that the IDTs took necessary action. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	225	429	355	394	357	378	148	16	50
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	8% 1/13	N/A	0/2	1/1	0/1	0/1	0/2	0/2	0/2	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/13		0/2	0/1	0/1	0/1	0/2	0/2	0/2	0/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/13		0/2	0/1	0/1	0/1	0/2	0/2	0/2	0/2

	iv. Individual has made progress on his/her goal/objective; and	0% 0/13		0/2	0/1	0/1	0/1	0/2	0/2	0/2	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/13		0/2	0/1	0/1	0/1	0/2	0/2	0/2	0/2
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	100% 4/4	1/1	N/A	1/1	1/1	1/1	N/A	N/A	N/A	N/A
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/4	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 13 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: Individual #429 - choking, and falls; Individual #355 – choking; Individual #394 – skin integrity; Individual #357 – choking; Individual #378 – choking, and falls; Individual #148 – choking, and falls; Individual #16 – falls, and skin integrity; and Individual #50 – aspiration, and falls.

a.i. and a.ii. The IHCP that included a clinically relevant, and achievable goal/objective was for: Individual #355 – choking; (i.e., will eat safely by reducing bite size through use of a chopped diet at >90% compliance). Unfortunately, this goal/objective was not written in a measurable format).

Overall, though, IDTs did not identify activities in which individuals needed to engage or skills that they needed to learn to improve their health. For a number of individuals, IDTs included goals objectives for choking or aspiration that read something to the effect of: Individual will "eat safely" or "not have choking episodes" "with modified texture and Dining Plan techniques," and/or "with interventions in place per PNMP." Although this showed some improved thinking about the potential causes of the individuals' risks related to aspiration and choking and the strategies to address them, the IDTs had not individualized the goals/objectives or provided data to support the need for a SAP or strategies in a specific area(s). For example, based on monitoring results, was the individual or staff not cutting the food to the proper diet texture, was the individual not adhering to specific "Dining Plan techniques" designed to slow his/her rate of eating, and/or did the individual have poor chewing skills? Depending on the findings, the IDT could then

individualize the goal/objective to work on improvements in the specific prioritized area(s) in order to mitigate the risk to the extent possible. Analysis of data to support the goals/objectives that the IDT considered and agreed upon should be included in the IRRF.

Similarly, for falls, IDTs often included goals/objectives that read something like: "mobility will be performed with PNMP supports," or "with PNMP supports, will have less than one fall." Again, IDTs, with the assistance of Habilitation Therapy staff, need to identify more specifically, the underlying causes of the falls or factors that increased the individual's risk for falls in order to focus a goal/objective on actions that the individual could take or skills that the individual needed to learn to reduce his/her risk of falling. For example, does the individual need to communicate with staff before getting out of her/his chair or bed, so that staff can provide assistance; does the individual need to engage in lower extremity strengthening exercises; do Habilitation Therapy staff need to develop a goal to teach the individual to avoid trip hazards in his/her path, etc.? Once questions such as this are answered, the IDTs would have more information with which to fashion a goal/objective that addressed a specific prioritized cause(s) of the falls or risk for falls.

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 those for: Individual #225 – falls, Individual #355 – constipation/bowel obstruction, Individual #394 – aspiration, and Individual #357 - aspiration.

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

a.iii. through a.v, and b.iv. through b.vi. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. As a result, it was difficult to determine whether or not individuals were making progress with regard to taking steps to improve their chronic or at-risk conditions, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure clinically relevant outcomes for individuals, the Monitoring Team conducted full reviews of all nine individuals' PNM supports.

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.	
Summary: Given that over the last two review periods and during this review, for the individuals in the review group whom the PNMT discharged, IDTs held ISPA meetings during which the PNMT shared information from its reviews/assessments (Round 15 – 100%, Round 16 – 100%, and Round 17 - 100%), Indicator c will move to the category requiring less oversight. 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.	Individuals:

While continued work was needed, it was positive that for in four of six instances reviewed, when individuals' PNM risk increased or they experienced changes of status, IDTs took immediate action.											
#	Indicator	Overall Score	225	429	355	394	357	378	148	16	50
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/17	0/1	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	67% 4/6	0/1	N/A	1/2	1/1	2/2	N/A	N/A	N/A	N/A
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	100% 3/3	1/1	N/A	1/1	1/1	N/A	N/A	N/A	N/A	N/A

Comments: a. As noted above, none of the IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Monthly integrated reviews generally only included statements about the number of occurrences of bad outcomes (e.g., falls, fractures, diagnoses of pneumonia, etc.). They generally provided no specific information or data about the status of the implementation of the action steps. One of the problems that contributed to the inability to determine whether or not staff implemented supports was the lack of measurability of many of the action steps.

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

- On 3/18/21, Individual #225's IDT held an ISPA meeting, during which they discussed her medication changes and the impact on her falls and behaviors. However, as discussed in the PNMT section of this report, plans were not clearly set forth in the IHCPs to address her anemia, including review of medications and labs, and/or to address the individual's impulsivity, and to enhance the individual's safety awareness when running.
- In response to reports that Individual #355 was overstuffing his mouth, the SLP completed a meal observation. On 11/5/20, his diet was changed from regular to chopped, with follow-up on 2/5/21.
- On 5/11/21, Individual #355's IDT met following his discharge from the hospital on 5/3/21, for a partial small bowel obstruction, and hyponatremia. This meeting was not within five days of his discharge. Based on review of the ISPA, the IDT was not clear about the amount of water to be given, and IHCP did not reflect the changeover to clear liquids for 48 hours should emesis occur.
- In response to a decline in Individual #394's status, beginning on 7/20/20, and up until his return home on 8/28/20, habilitation therapy staff provided ongoing trials to reassess his swallow function and safety.
- Upon Individual #357's return from the hospital on 10/19/20, the SLP completed an observation to review her intake and swallow safety. The therapist concluded that no changes were needed.

c. For the individuals reviewed whom the PNMT had discharged, the IDTs held ISPA meetings during which the PNMT shared information from its reviews/assessments.

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 four observations, individuals were positioned correctly. However, efforts are needed to continue to improve Dining Plan implementation. Often, the errors that occurred (e.g., staff not intervening when individuals took large bites, and/or ate at an unsafe rate) placed individuals at significant risk of harm. Center staff, including Habilitation Therapies, as well as Residential and Day Program/Vocational staff, and Skill Acquisition/Behavioral Health staff should determine the issues preventing staff from implementing PNMPs correctly or effectively (e.g., competence, accountability, need for skill training for individuals, etc.), and address them. These indicators will continue in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	67% 20/30	
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	N/R	

Comments: a. The Monitoring Team conducted 30 observations of the implementation of PNMPs/Dining Plans. Based on these observations, individuals were positioned correctly during four out of four observations (100%). Staff followed individuals' dining plans during 16 out of 26 mealtime observations (62%).

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, presentation of food and drink, prompting, etc.). Individuals were at increased risk due to staff's failure, for example, to intervene when they took large unsafe bites and/or did not swallow in between bites, ate at too fast a rate, ate most or all of their meal without taking sips of liquid, or drank a full glass of liquid, when staff were supposed to present the glass only a quarter full. In four instances, individuals were not positioned correctly during mealtime. It was good to see that texture/consistency was correct, and that adaptive equipment was correct.
- It was positive that four individuals observed were positioned 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	225	429	355	394	357	378	148	16	50
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A				N/A					N/A
Comments: a. Although based on speech therapy notes, from July 2020 to May 2021, Individual #394 was participating in trials of oral eating, his IDT did not develop a measurable plan.											

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 applicable individuals reviewed did not have clinically relevant or measurable goals/objectives to address their needs for formal OT/PT services. In addition, QIDP interim reviews 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	22	429	355	394	357	378	148	16	50
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	50% 4/8	0/1	N/A	N/A	2/2	0/1	N/A	2/2	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/8	0/1			0/2	0/1		0/2	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/8	0/1			0/2	0/1		0/2	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/8	0/1			0/2	0/1		0/2	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/8	0/1			0/2	0/1		0/2	0/1	0/1

Comments: a. and b. Individual #429, Individual #355, and Individual #378 did not have needs requiring formal OT/PT interventions, but all did have OT/PT supports (e.g., a PNMP). The remaining six individuals did have needs for formal OT/PT services and supports, but most did not have clinically relevant and/or measurable goals/objectives to address those needs.

The goals/objectives that scored positively for clinical relevance were for Individual #148 (i.e., stair negotiation, and ambulation), and Individual #394 (i.e., stand-pivot transfers, and walking 350 feet). However, they were not measurable, because they did not specify the frequency of implementation or the criteria for achievement (e.g., three of four trials for three consecutive sessions). In addition, the IDT did not integrate the goals/objectives reviewed into the individual's ISP/ISPA. This was an important missing piece to ensure that an individual's IDT approved the OT/PT goals/objectives, was aware of the progress with regard to their implementation, and could build upon and integrate those goals/objectives into a cohesive overall plan. Integration of goals/objectives into the ISP/ISPA remains a key requirement overall.

c. through e. Although data were sometimes submitted to show therapists implemented goals/objectives, 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. This also made it difficult for the IDT to understand how the achievement of a therapy goal might impact the overall implementation of the individuals' ISPs, including their other action plans. The Monitoring Team conducted full reviews for all nine individuals. This included Individual #429, Individual #355 and Individual #378, all of whom did not require formal OT/PT interventions, but did have OT/PT-related supports.

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

Summary: For the individuals reviewed, evidence was not found in ISP integrated reviews to show that OT/PT supports were implemented, or that IDTs met to discuss and approve decisions to terminate the provision of services. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 22	429	355	394	357	378	148	16	50
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	N/A									
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/6	N/A	N/A	N/A	0/2	0/1	N/A	0/2	N/A	0/1

Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to OT/PT needs were implemented. As noted above with regard to Outcome 1, the individuals reviewed did not have measurable goals/objectives. In addition, regardless of whether existing goals/objectives met criteria for measurability, the QIDP monthly integrated progress notes did not document implementation. At times, therapists included data related to the

implementation of goals/objectives in IPNs, but this information was not summarized and included in the monthly reviews. OTs and PTs should work with IDTs to ensure that goals/objectives, including formal therapy plans, meet criteria for measurability and are integrated in individuals' ISPs through a specific action plan.

b. Overall, for the four applicable individuals, the IDTs did not meet as needed to discuss and approve termination of their goals/objectives.

On 4/12/21, the IDT for Individual #394 held an ISPA meeting in response to his discharge from PT 4/1/21, Based on the documentation submitted, the IDT did not discuss how Behavioral Health Services could potentially support and improve cooperation with the direct PT services he needed.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	116	206	94	457	5	63	84	143	91
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they moved to the category requiring less oversight.									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	86% 18/21	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		264	312	193	319	338	328	53	341	439
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	0/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		226	151	16						

c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	1/1	1/1						

Comments: c. The Monitoring Team conducted remote observations of 21 pieces of adaptive equipment and most appeared to be the proper fit. The exceptions were for Individual #94, Individual #338, and Individual #226, for whom the outcome was that they were not positioned correctly in their wheelchairs. 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.

As noted in the summary section above, 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. In an email to the parties, dated 6/27/18, the Monitors explained their decision-making process for maintaining some indicators in active oversight, including this one.

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.

In a letter, dated 8/23/21, the Monitor notified the parties that the Center achieved substantial compliance with most of the requirements of Section Q of the Settlement Agreement. The exceptions are: 1) implementation of a policy/clinical guideline that is consistent with current generally accepted standards of care on perioperative assessment and management of individuals needing TIVA/general anesthesia for dental work, which the Monitoring Team will continue to assess and apply the findings to paragraph H.7 of the Settlement Agreement; and 2) personal goals/objectives for individuals who are at risk for dental problems, as well as the development and implementation of plans for individuals who require suction tooth brushing, which the Monitoring Team will assess as part of Section F. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Austin SSLC exited from the other requirements of Section Q of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the related outcomes and indicators. As a result, this Domain contains one less outcome, and five fewer indicators.

Currently, this domain contains 10 outcomes and 26 underlying indicators in the areas of skill acquisition, dental, and communication. At the time of the last review, four of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, no additional indicators will move to the category of less oversight.

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

About the same percentage of SAPs were progressing as had been at previous reviews. The Center, however, was taking action for more (a higher percentage) of SAPs when progress was not occurring.

There was continued and marked improvement in the quality of the content of the written SAPs. Both indicators about SAP implementation scored lower than at the last review. With the improvement in the quality of SAPs, the Center is now ready to also focus on integrity and fidelity of implementation.

About half of the individuals were usually engaged in activities when observed by the Monitoring Team.

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

ISPs

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

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: About the same percentage of SAPs were progressing as had been at previous reviews. The Center, however, was taking action for more (a higher percentage) SAPs when progress was not occurring. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	162	263	429	457	127	329	57	225	425
6	The individual is progressing on his/her SAPs.	29% 5/17	0/1	1/1	1/2	0/3	1/2	0/3	1/3		1/2
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A									
8	If the individual was not making progress, actions were taken.	75% 9/12	1/1		1/1	2/3	0/1	3/3	2/2		0/1
9	(No longer scored)										

Comments:
6. To assess progress or the lack thereof, the Client SAP Training Progress Note is reviewed for each identified SAP. As noted previously, five SAPs had been implemented for two months or less, therefore, these were excluded from this analysis. Following a request, June 2021 progress notes were provided for the following SAPs: Individual #162 - turn on television; Individual #263 - identify correct number of bills; Individual #429 - play music; Individual #127 - sort silverware; Individual #329 - request a break and get dressed; Individual #57 - use tablet, play music, and get work; and Individual #425 - clean up his area and unlock a door. For the other six SAPs, the graphs that depicted progress through May 2021 were reviewed.

Of these 17 SAPs, it was determined that progress was being made on five. These were the following: Individual #263 - pay for her meal; Individual #429 - play music; Individual #127 - complete a puzzle; Individual #57 - use the tablet/iPod; and Individual #425 - clean his area.

Half of the 22 SAPs were first implemented back in 2018 or 2019. The same SAPs were continued year after year, often with little discussion regarding the individual's interest in the skill and/or the barriers to their acquiring the skill. A good example was Individual #457 whose three SAPs were first implemented in November 2018. At Individual #457's ISP meeting, these SAPs were continued. For her card game SAP, the behavior technician reported that she was making progress on this SAP. However, when the graphs were

checked, this was not the case. Staff should bring the graphs with them to meetings to ensure that objective data are reviewed as part of the discussion of progress or the lack thereof.

In some cases, the number of expected trials per month were quite low. Half of the SAPs reviewed were taught 12 or fewer times each month. This provided very little exposure to the task and may be competing with the individual's acquisition of the skill.

7. None of the individuals had mastered any of their identified SAPs.

8. There was evidence of action taken to address the lack of progress on nine of the 12 SAPs. This included the following: when progress was not evident for two or fewer months, it was noted that the behavior technician would observe for one more month to determine what action, if any, was necessary (Individual #457 - card game and play CD, Individual #329 - request break, and Individual #57 - obtain materials); the SAP was revised (Individual #329 - get dressed and Individual #57 - play music); the behavior technician would observe the SAP following staff report that the individual had the skill (Individual #329 - choose clothing); or the SAP was discontinued (Individual #162 - turn on television and Individual #429 - touch water symbol). An alternative SAP had been identified for Individual #162, but this action was not evident for Individual #429. There was no evidence of action taken for two SAPs that could have been addressed in their homes during COVID-19 restrictions (Individual #457- play video and Individual #127 - sort silverware). Lastly, it was noted that the behavior technician would continue to monitor Individual #425's unlock his door SAP, but no time frame was identified.

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

Summary: There was continued and marked improvement in the quality of the content of the written SAPs as evidenced by the highest score on this indicator yet seen at Austin SSLC. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 162	263	429	457	127	329	57	225	425
13	The individual's SAPs are complete.	68% 15/22	2/2 19/19	2/2 19/19	1/2 17/18	3/3 28/28	0/3 23/29	2/3 28/29	2/3 28/29	2/2 20/20	1/2 19/20

Comments:
13. Fifteen of the 22 SAPs were considered complete. It was positive to find photos depicting the placement of materials, information regarding the location of materials, and when appropriate, instructions for the staff member to first model the task. As discussed during the review, staff should clarify the length of the break for Individual #329 following his request, and to specify the placement of the wipe in Individual #425's clean up SAP.

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

Comments regarding those SAPs that were found to be incomplete are below.

- In Individual #429's touch the water symbol SAP, the verbal prompt was the same as the discriminative stimulus. If she did not perform the skill correctly, the location of the two symbols should be reviewed again for this visually impaired woman prior to repeating the instruction. Perhaps staff should have her touch this symbol before showering, washing hands, or engaging in any other water related activity.
- All three of Individual #127's SAPs were incomplete. In her shoe SAP, there should be a task analysis with her starting with one foot consistently. Further, the verbal prompt following an incorrect response should address the correct behavior rather than stating the error, i.e., "wrong foot." Although the instructions were very clear in her puzzle SAP, it was not clear how her pointing to a named number would generalize to her attending a movie or counting objects. In her sorting silverware SAP, the photo showed the utensils presented upside down rather than right side up. The instructions noted that staff would show her how to sort the forks, suggesting that only spoons were left for her to put with the other spoon. This reduced her need to discriminate between the utensils.
- Individual #329 was learning to request a break from working when a timer sounded. The instructions were somewhat confusing because it was noted that he had the option of grabbing the break card. This would suggest that his performance of the skill is not necessary during all instructional trials. One of the steps noted for staff to give the instruction, but the identified discriminative stimulus was the sound of the timer.
- Generalization was not addressed in Individual #57's SAP in which he was learning to obtain his materials. The SAP developer should consider how the materials are organized to decrease the amount of effort involved in his moving his wheelchair back and forth to obtain the materials.
- Individual #425 was learning to unlock his door. This was a two-step activity requiring a task analysis. If this has not been done already, staff might assess different locks to ensure the greatest level of independence possible when completing this activity.

Outcome 5- SAPs are implemented with integrity.

Summary: Both indicators scored lower than at the last review. With the improvement in the quality of SAPs (indicator 13), the Center is now ready to also focus on integrity and fidelity of implementation. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	162	263	429	457	127	329	57	225	425
14	SAPs are implemented as written.	17% 1/6	Refused	Refused	On hold	0/1	0/1	0/1	0/1	1/1	0/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	53% 9/17	1/1	0/1	0/2	2/3	0/2	2/3	2/3		2/2

Comments:

14. During the remote review, an observation of training on one SAP was scheduled for eight of the nine individuals. The exception was Individual #429 because her SAPs were on hold at the time of the review. Two of the individuals, Individual #162 and Individual #263, refused to participate in the scheduled SAP training. For the six others, comments are provided below.

- Individual #457 was learning to choose a matching card from an array of two. Individual #457 was not first prompted to use hand sanitizer as indicated the SAP. One very positive aspect of this SAP was that staff modeled the behavior before asking Individual #457 to match the cards. The staff member required coaching to implement this step. After the SAP was implemented, the staff member reported she would record a verbal prompt, when in fact, she had moved the card holder to obtain a correct response from Individual #457.
- Individual #127 was learning to put on her shoes. The staff member had Individual #127 obtain her shoes before running the SAP. Prior to delivering the discriminative stimulus, the staff member did not review the color codes for the right and left shoes. Following the initial instruction, the staff member repeated the verbal prompts several times before she was coached to use a more intrusive prompt. Eventually, Individual #127 refused to complete this SAP.
- Individual #329 was learning to respond to the sound of a timer to stop working and request a break. When the timer sounded, he continued to work. It was not clear that he actually attended to the sound. As such, additional observations were warranted to determine whether this was an effective discriminative stimulus. As he was also learning to use a communication board, it may be more practical to have him use this augmentative device rather than teaching him to hand over a break card. A gestural prompt as outlined in the SAP was not employed during the teaching session.
- Individual #57 was learning to use an iPod to communicate. The staff member first asked him if he'd like to use his device, and once he agreed, she told him to turn it on and press the red apple. She did not advance through the prompting hierarchy as noted in the SAP. It was positive to observe the behavior technician coach her and also correct her when she indicated she would score a gestural prompt. It was also positive to see the response from staff as Individual #57 used the device to communicate different information and interests.
- Individual #225 was able to make a smoothie with very little assistance from staff. As discussed, repeated probes should be conducted because it appeared that she had mastered this SAP. When discussing the expansion of her skills to other recipes, staff reported it was not always possible to obtain needed materials on short notice.
- Individual #425 was observed cleaning his tabletop following a snack. Although the staff member was positive and patient with Individual #425, he did not allow the prompting hierarchy indicated in the SAP. Rather, he repeated the verbal prompt several times to encourage Individual #425 to use a wipe to clean up.

15. Per state policy, SAP integrity should be assessed within the first three months and at a minimum of once every six months. Monitoring should be completed via direct observation. Goal levels were established at 80% or better.

Based upon the documentation provided, it was determined that nine of 17 SAPs had been monitored at least once over the six month period prior to the remote review with adequate treatment integrity scores.

These were the following SAPs: Individual #162- turn on the television; Individual #457 - choose cards and operate a CD player; Individual #329 - choose his clothing and get dressed; Individual #57 - use the tablet and get his materials; and Individual #425 - unlock the door and clean his area. The remaining eight SAPs did not meet this indicator for the following reasons: integrity was not assessed within the last six months (Individual #429 - touch water symbol and Individual #127 - complete the puzzle); the person refused to complete the SAP when monitored (Individual #263 - pay for her meal and Individual #429 - play music); the monitoring was completed via role play (Individual #127 - sort silverware and Individual #329 - request a break); the integrity score was less than 80% (Individual #57 - play music); or monitoring did not occur (Individual #457 - play a video).

Five SAPs were excluded from this analysis as they had been in place for less than three months (Individual #162 - operate a DVD//television; Individual #263 - complete a picture schedule; Individual #127 - put on her shoes; and Individual #225 - count money and make a smoothie).

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

Summary: The 71% score for this indicator is higher than in previous reviews and shows continued progress. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 162	263	429	457	127	329	57	225	425
16	There is evidence that SAPs are reviewed monthly.	71% 12/17	1/1	0/2	2/2	3/3	1/1	2/3	3/3		0/2
17	SAP outcomes are graphed.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
16. For 12 of 17 SAPs, there was evidence that a data based review had been completed each month in the individuals QIDP Monthly Report. The exceptions were the following: (a) the description of Individual #263's picture schedule SAP did not match the skill she was learning; (b) there were no data provided for Individual #263's pay for her meal SAP; (c) there was no review of Individual #329's dressing SAP; and (d) there was no review for March 2021 of either of Individual #425's SAPs.

Excluded from the analysis were SAPs that had just recently been introduced (Individual #162 - operate DVD/television; Individual #127 - put on shoes; and Individual #225 - count money and make a smoothie) and the sort silverware SAP for Individual #127 that had been on hold.

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

Summary: About half of the individuals were usually engaged in activities when observed by the Monitoring Team. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 162	263	429	457	127	329	57	225	425
18	The individual is meaningfully engaged in residential and treatment sites.	44% 4/9	1/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	The day and treatment sites of the individual have goal engagement level scores.										

21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	

Comments:
18. Observations were conducted throughout the week of the remote review. Based on multiple observations, it was determined that Individual #162, Individual #263, Individual #57, and Individual #225 were usually engaged in some meaningful activity. As noted previously, it will be important for staff to complete an assessment of Individual #162's vocational interests, strengths, and needs. He was frequently observed using an iPad in his room, but there were likely a range of skills he could learn to enhance his quality of like and greater independence.

For the other five individuals, observations revealed little meaningful activity.

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

Summary: Due to the restrictions necessitated by the COVID-19 pandemic, community recreational and training activities were suspended. These indicators will remain in active monitoring and be reviewed next time.

#	Indicator	Overall Score	Individuals: 162	263	429	457	127	329	57	225	425
22	For the individual, goal frequencies of community recreational activities are established and achieved.	Not scored due to COVID-19									
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	Not scored due to COVID-19									
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	Not scored due to COVID-19									

Comments:

Outcome 9 – Students receive educational services and these services are integrated into the ISP.

Summary: At the time of the remote review, there were no individuals in residence at the Center who were attending public school.

#	Indicator	Overall Score	Individuals: 162	263	429	457	127	329	57	225	425

25	The student receives educational services that are integrated with the ISP.	N/A										
Comments:												

Dental

In a letter, dated 8/23/21, the Monitor notified the parties that the Center achieved substantial compliance with most of the requirements of Section Q of the Settlement Agreement. The exceptions are: 1) implementation of a policy/clinical guideline that is consistent with current generally accepted standards of care on perioperative assessment and management of individuals needing TIVA/general anesthesia for dental work, which the Monitoring Team will continue to assess and apply the findings to paragraph H.7 of the Settlement Agreement; and 2) personal goals/objectives for individuals who are at risk for dental problems, as well as the development and implementation of plans for individuals who require suction tooth brushing, which the Monitoring Team will assess as part of Section F. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Austin SSLC exited from the other requirements of Section Q of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the related outcomes and indicators.

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: While some progress was noted since the previous review, work is still needed to improve the clinical relevance and measurability of communication 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	225	429	355	394	357	378	148	16	50
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	29% 2/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	29% 2/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	29% 2/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1

d.	Individual has made progress on his/her communication goal(s)/objective(s).	29% 2/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	13% 1/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	1/1

Comments: a. and b. Eight individuals reviewed had identified communication needs, but only two had clinically relevant and measurable communication services and supports. In addition, for Individual #225, the communication screening did not provide sufficient information about her communication needs to clearly identify whether she required a related goal/objective. As a result, the Monitoring Team could not confirm that these indicators would not apply to her.

The goals/objectives that were both clinically relevant and measurable were for Individual #429 (i.e., touch water activity) and for Individual #50 (i.e., touch tactile item). It was positive to see that the IDTs for both of these individuals also integrated these measurable goals/objectives into the individuals' ISPs.

In its comments on the draft report, the State disputed the findings for Individual #225, and Individual #148 stating that they did not have formal communication supports. The State also indicated: "Additionally, while the remaining individuals do have formal communication supports, they do not have goals/objectives for these supports as they are not in communication therapy, nor do they have ISP goals related to their communication supports. These should also be marked N/A." As described in the draft report, without sufficient information in the screening, the Monitoring Team could not confirm that Individual #225 did not need formal communication supports. For a number of the other individuals, the Center submitted documentation of communication-related goals/objectives (e.g., SAPs) that did not meet criteria. The communication audit tool does not limit "formal communication supports" to communication therapy. Rather, it indicates: "The measurable goal(s)/objective(s) could be related to formal communication services, including direct speech therapy/treatment or a SAP (e.g., related to AAC, EC, or language-based services and supports)."

c. through e. It was positive that some QIDP monthly integrated progress reports provided specific data, and analysis of the data, with regard to individuals' goals/objectives. The monthly integrated progress reports for both Individual #429 and Individual #50 included the needed data and analysis, and both documented progress toward achieving their goals/objectives. In addition, for Individual #50, the IDT took needed action when she met criteria for achievement. It was also positive that the QIDP monthly integrated progress note for Individual #378 included specific data reflective of his goal/objective (i.e., turn off music). However, the goal/objective did not include criteria for achievement sufficient to reliably show achievement of a skill (i.e., 75% achievement for a single month). Therefore, the data were not meaningful for measuring progress. Otherwise, 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. Both Individual #429 and Individual #50 made progress on clinically relevant and achievable goals, but were also selected for a full cross team or core group review, respectively. In addition, the Monitoring Team conducted a full review for Individual #22, who was selected for a full cross team review and also lacked an adequate screening assessment to support the identification of potential communication needs. For the remaining six individuals, full reviews were conducted 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 individuals have measurable action plans in their ISPs to address their communication needs, and QIDP monthly reviews include relevant data and analysis of data related to the implementation of communication strategies and SAPs, and that those strategies are implemented timely and completely. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	225	429	355	394	357	378	148	16	50
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	100% 2/2	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	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 needs were implemented. As described above with regard to Outcome 1, for Individual #429 and Individual #50, their ISP integrated reviews included data to show their measurable goals were implemented. This was good to see. However, because the remaining individuals did not have measurable goals/objectives to address their communication needs, this resulted in a false positive score overall for this indicator. Without a measurable strategy, QIDPs potentially would not be able to determine whether or not staff implemented it correctly, and/or whether the individual made progress. SLPs should work with IDTs to ensure that goals/objectives meet criteria for measurability.											

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: While improvement was noted, the Center should continue to focus on ensuring individuals have their AAC devices with them. Most importantly, SLPs should work with direct support professional staff and their supervisors to improve 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	282	244	94	116	60	202	344	47	10
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	88% 7/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	0/1

b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	88% 7/8	1/1	1/1	1/1	1/1	N/A	1/1	0/1	1/1	0/1
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	N/R									

Comments: a. and b. For most but not all, individuals observed, their AAC devices were readily available. The exceptions was for Individual #10 (i.e., picture choice system). The device was not present, and Center staff had to retrieve it.

It was positive that when devices/supports were present, seven of nine individuals observed could use them in a functional manner. The exceptions were for Individual #10, who could not use the device that staff retrieved despite staff assistance, and Individual #344, for whom the device, as presented, was not functional for his needs (i.e., multiple pictures were present when choices should have been limited to only two).

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

This Domain contains five outcomes and 20 underlying indicators. At the time of the last review, five moved to the category requiring less oversight. Based on information the Center provided, between the time of the Monitoring Team's last review and the onsite review, none of the individuals at Austin SSLC transitioned to the community. As a result, none of the outcomes or indicators in Domain #5 were scored.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.												
Summary: N/A			Individuals:									
#	Indicator	Overall Score										
1	The individual's CLDP contains supports that are measurable.	N/A										
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	N/A										
Comments: None.												

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.												
Summary: N/A			Individuals:									
#	Indicator	Overall Score										
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.										
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	N/A										
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	N/A										
6	The PMM's assessment is correct based on the evidence.	N/A										

7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	N/A										
8	Every problem was followed through to resolution.	N/A										
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A										
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A										
Comments: None.												

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.												
Summary: N/A			Individuals:									
#	Indicator	Overall Score										
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	N/A										
Comments: None.												

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.												
Summary: N/A			Individuals:									
#	Indicator	Overall Score										
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	N/A										
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.										

	and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.										
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	N/A									
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	N/A									
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	N/A									
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.										
19	Pre-move supports were in place in the community settings on the day of the move.	N/A									
Comments: None.											

Outcome 5 – Individuals have timely transition planning and implementation.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score									
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
Comments: None.											

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

- ISP document
- IRRF, including any revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment
- Active Problem List
- All ISPAs for past six months
- QIDP monthly reviews/reports (and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request)
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- These annual ISP assessments: nursing, habilitation, dental, rights
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment
- Functional Skills Assessment 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 within past two years, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.
- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.
- Data that summarize the individual's community outings for the last six months.
- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- The individual's daily schedule of activities.
- Documentation for the selected restraints.
- Documentation for the selected HHSC PI investigations for which the individual was an alleged victim,
- Documentation for the selected facility investigations where an incident involving the individual was the subject of the investigation.
- A list of all injuries for the individual in last six months.
- Any trend data regarding incidents and injuries for this individual over the past year.
- If the individual was the subject of an injury audit in the past year, audit documentation.

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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