UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF IOWA

Amended Independent Monitor's Report

Dates of Reviews:
September 30-October 1, 2024,
December 4-5, 2024
February 19-20, 2025
Date of Draft Report: March 10, 2025
Date of Original Report: April 4, 2025
Date of Draft Amended Report April 21, 2025
Date of Amended Report April 28, 2025

Submitted By: James M. Bailey, MCD-CCC-SLP
Court Appointed Lead Monitor
Melanie Reeves Miller, B.A.
Teri Towe, M.S.

Table of Contents

Methodology
"Provider visits were conducted over two-day periods in September 2024, December 2024, and February 2025. Twenty-four individuals were chosen for the two onsite (Sept 2024 and Dec 2024) and one remote (Feb 2025) community visits. The home/community visits included discussions with the individual and staff along with the review of documents provided prior and after the visits.

Generally, if the majority of components under an indicator or the number of indicators under a paragraph were in substantial compliance, the paragraph itself was also deemed to be in substantial compliance." An exception may occur if an indicator considered essential to the paragraph is not in substantial compliance. When this occurs, the entire paragraph may be held to partial compliance.

For Individuals and for components, a score of "1" reflected Substantial Compliance (SC), ".5" Partial Compliance(PC), and "0" Non-Compliance (NC).

Scores will be presented as follows:

Definition	Example
Compliance Determination *(this may be the only score posted if not based on individuals)*	SC / PC / NC
Score of Individuals below as a % *(if applicable)*	40%
Score of individuals / total possible score of individuals in the review group *(if applicable)*	8/20
Score of components below as a % *(if applicable)*	40%
Score of components / total possible score of components *(if applicable)*	40/100

Summary

The Monitoring Team wishes to acknowledge and thank the individuals, case managers, transition specialists and State staff for their ongoing collaboration and responsiveness to the requests made. Also, special thanks for their flexibility in handling the impact of weather to the February 2025 portion of the review.

Overall, individuals continued to look happy and content with their surroundings. Identified supports and equipment were mostly present in the individuals' homes and adaptive equipment and assistive technology were most often available, clean, and in good repair. Providers continued to show improved knowledge and comfort with the individuals. Individuals were being afforded new opportunities and exposure to new environments, but also old environments in a new way. Issues with risk mitigation, monitoring of plans and plan individualization continue to be needed areas of focus.

None of the ISPs included a full set of goals to address all major life areas. In particular. Many still had goals in place that were developed for the initial transition plan that were no longer relevant as they did not consider the Individual's new surroundings or that they had been in the home past the orientation phase.

Although most individuals had regular opportunities for community activities weekly to a few times week, the ISPs did not consistently provide expectations for frequent opportunities for community integration. While individuals had broadly stated goals for community participation, none of the goals facilitated integration or the development of relationships with others in the community. Additionally, there was no documentation available that showed how the individual participated in their weekly planning or how those choices were determined. This is especially needed for those with decreased communication and cognitive skills.

Case managers were noted to complete visits to the cadence required. Positive environmental factors reflected that case management was effective in many ways, and that the post-move monitoring and CIM process had shown some improvement. Issues remained, however, regarding the lack of a clear documentation system by case management that was precise in its ability to track an issue from beginning to end. Additionally, despite changes in status, case managers did not consistently convene the IDT to discuss and develop a mitigation plan. The continued lack of revisions of GRC-based plans were also observed.
While appointments appeared to be mostly scheduled, there were situations in which appointments, especially dental, remained delayed, but improvement had been noted over the past review. The State proposed and it is certainly possible that the initial backlog and issues with appointments may have been due to the influx of individuals into the community around the GRC closure date paired with an experienced provider network issue at the time, In previous reviews, dental appointments were often scheduled but ended up being cancelled, therefore the Monitor requested that the State follow up on these scheduled dental visits to ensure that the appointments were completed as scheduled.

As stated previously, for most individuals, the provider was following the support plans from GRC and had not yet updated them to reflect current environment and/or status. When they have needed some support, providers reported they had been able to

contact the Center of Excellence (COE) professionals. There was some concern that there may potentially be an overreliance on the COE, therefore, the State may want to continue to monitor and consider further encouraging the CMs to identify community providers for all relevant supports, such as Occupational Therapy, Speech Therapy, Dietitian, etc.

Risk mitigation continued to be a significant issue with individuals, as many had identified high risks with limited to no plans in place to mitigate such risk. As a result, many individuals passed the 365-day mark without having plans in place to effectively manage their risks. Plans were not in place and did not have clear health outcomes with measurable action steps that will support success with the desired goals/outcomes. For those remaining within the 365-day mark, the State has agreed to reassess their risk and to share the findings with the Monitor. For many of the remaining individuals past 365, the State reported that they would revisit those individuals and that their risks would also be reassessed. The implementation of risk re-assessment is appreciated and should be beneficial to the health and safety of the individuals touched by the process. The key to success will be to pull related information together into a cohesive plan, the implementation of that plan, and the subsequent monitoring of the plan.

Overall, Post-Move Monitoring (PMM) had occurred at the required cadence as required for all individuals reviewed. This is an area that has shown sustained success over the last two reviews. Generally, Post-Move Monitoring reports continued to reflect interview, with some observation as the primary form of evidence reviewed during the PMM visits. For numerous supports, observation of the individuals with their existing supports or of added supports along with interview and review of documentation should be utilized to verify adequacy of implementation. Any supports not fully in place or pending should be identified for follow-up action. This was not consistently done; therefore, the monitoring of transitions was not consistently revised and did not measure the timely and successful implementation of supports and services that were recommended for each individual's transition and in turn, did not guide the monitoring to identify potential events that could be disruptive to a successful transition or prompt the social worker and case managers to develop corrective measures. QA processes such as the PMM audit checklist was in place, but appeared to focus primarily on documentation standards and not if the PMM was noticing potential concerns etc. related to the individual.

The State is to be commended for the work that has been done in developing additional training and processes in an attempt to impact the comprehensiveness of supports as it relates to improving the quality of the ISP, the PMM process, as well as the identification of risks and their associated plans. Multiple meetings now exist at various levels where there is discussion of community issues. These included but were not limited to the Center of Excellence and PMM weekly meetings. Improvement projects existed as well and included but were not limited to the PMM audit process, and the CM audit process. An area that was lacking, however, was the presence of QA flexibility when gap issues were identified. Examples of this included the issues noted by the Monitor related to dentistry, ISP domains, and risk mitigation. While the State has provided training and directives for plans to be put in place, the State has not implemented increased monitoring or tracking to determine effectiveness of these gap interventions. That said, many of these processes have just recently been implemented, therefore the impact of these initiatives have not yet been seen, but the Monitor looks forward to seeing the execution and results of these interventions.

Summary of Compliance		
Paragraphs	**Status**	
191	Substantial Compliance as of 8/2024 status update	
200	Not Applicable for this Status Update	
201	Not Applicable for this Status Update	
203	Partial Compliance	
204	Not Applicable for this Status Update	
206	Substantial Compliance as of 8/2024 status update	
207	Partial Compliance	
208	Partial Compliance	
209	Partial Compliance	
210	Partial Compliance	
211	Partial Compliance	
217	Substantial Compliance as of 3/2025 status update	
226	Partial Compliance	
229	Partial Compliance	
230	Partial Compliance	
232	Partial Compliance	
233	Partial Compliance	

Section H.ii In-reach and Community Engagement: (189-192)		
Paragraph 191		**Compliance Score**
In collaboration with the MCOs and community providers, the State shall develop and provide competency-based training and information for MCO staff about the provisions of this Agreement, staff obligations under the Agreement, current community living options, the principles of person-centered planning, and effective community options counseling. These trainings will be provided to applicable disciplines during initial orientation and annually thereafter.		**Substantial Compliance**
#	Indicator	Indicator Score
1	A system is in place that offers initial and ongoing training to MCO staff regarding the agreement. (191)	Substantial Compliance
2	Trainings are provided for all applicable staff. (191)	Substantial Compliance
3	The State tracks the data from these trainings to ensure adequate MCO participation. (191)	Substantial Compliance
4	The trainings are comprehensive, and competency based. (191)	Substantial Compliance
5	The training subject matter reflects the needs of the population (community living options, person centered planning, and community options counseling. (191)	Substantial Compliance

Comments
Relevant stakeholders, including case managers, transition specialist, and community providers participated in a variety of offered trainings.

The Monitor facilitated training on Psychopharmacology & Development Disabilities, which was held on 3/20/24. This training provided education on the following:

- review of the assessment process necessary when considering treatment with psychotropic medications.
- identification of symptom clusters and appropriate psychotropic medications to address specific symptoms.
- review of the side effects of selected psychotropic medications
- review of the difference between medication side effects and adverse drug reactions
- the specific challenges of psychotropic medication in relation to people with developmental disabilities
- review of the role of data in prescribing psychotropic medication. The training was attended by GRC psychiatrists, social workers, the CIM, and other GRC leadership and staff. Responding to challenging behaviors

Case managers were provided training which included 19 chapters focused on improving services. These chapters included, but were not limited to person centered planning, critical incident reporting, and case management roles and responsibilities. A standard operative procedure was developed that outlined the training needed.

Iowa HHS launched a Learning Management System (LMS) on 5/2/24, the purpose of which is to provide a state-wide web-based learning management system for long-term services and supports (LTSS) providers, direct support professionals, family caregivers, and transition specialists to enhance and improve the delivery of long term services and supports.

On 6/14/24, HHS facilitated a training for case managers and transition specialists led by the Consent Decree Monitor's team focused on post-transition monitoring of former GRC residents. It provided education on the role of the CIM, the PMMs, case managers, and transition specialists. The training focused on improved delivery of case management services, including providing specific questions for following up on individuals, specific documentation guidance for identifying concerns or gaps in support, steps for following up on those concerns and gaps, and identification of Community Thresholds.

On 10/1/24, another training was held specifically for case managers and MFP transition specialists involved in the post-move care coordination for former GRC residents. The training covered post-transition monitoring under the Consent Decree, responsibilities of CIMs and post-move monitors, the role of case managers and MFP transition specialists, creating detailed documentation, and reviewing provider documentation.

At the time of this report, the State had also reached to the Monitor for assistance with the development of guidance that will be provided to case managers regarding life domains in an effort to improve their ISP goals.

Additionally, in response to the Monitor's concerns, the State required the CMs assigned to the target population (individuals within 365 days post-transition on 1/30/25) to receive training focused on risk management and the Fatal Five risk areas (aspiration, bowel obstruction, dehydration, infection, and seizures.)

Finally, Regional CIMs hired in July and August of 2024, received Learning Management System (LMS) training in the following:

- HCBS, Behavior Support Plan Development
- Mental Health Crisis Response
- Approaches to Challenging Behaviors
- Adopting a Trauma lens
- State Transition Plan update.
- Person Centered Planning
- HCBS Service Documentation
- Service Documentation and monitoring.
- QA Improvement
- Monitor and follow-up Case Management
- Behavior Intervention strategies
- Guardian- Conservator payee

Section H.iii Transition Planning		
Paragraph 200		**Compliance Score**
With respect to Woodward Temporary Residents transitioning to the community, the State, in consultation with the IDT, shall determine the essential supports needed for successful and optimal transition.		**Not Applicable**
#	Indicator	Indicator Score
1	The State shall ensure that essential supports are in place prior to the individual's discharge from Woodward, including behavioral supports, a crisis plan, and provision for both physical and mental health care. This determination will be documented.	Not Applicable
2	The absence of those services and supports identified as non-essential by the State, in consultation with the IDT, shall not be a barrier to transition. However, supports and services identified as non-essential shall be in place 60 days from the individual's discharge.	Not Applicable
Comments No individuals transitioned from Woodward Resource Center during this review period.		

Section H.iv: Community Integration Management (201-211)		
Paragraph 201		**Compliance Score**
The State will create a full time Community Integration Manager ("CIM") position. The CIM will be a Central Office staff member. The CIM will be responsible for oversight of transition activities, including ensuring effective communication and planning with residents at Glenwood, their Authorized Representatives, the IDT, and private providers about all aspects of an individual's transition and will address identified barriers to discharge. The CIM will have professional experience working in the field of IDD, and an understanding of best practices for providing community services to individuals with IDD. The CIM will also be responsible for identifying, evaluating, and addressing barriers to discharge. The CIM will provide oversight, guidance, and technical assistance to the IDTs by identifying strategies for addressing or overcoming barriers to discharge, ensuring that IDTs follow the processes described in this Agreement, and identifying and developing corrective actions, including the need for any additional training or involvement of supervisory staff. By the Effective Date, and until the position is filled, the State will designate a Central Office staff member with the appropriate experience to fulfill the CIM's duties. The CIM position will be filled within six months of the Effective Date.		**Not Applicable**
#	Indicator	Indicator Score
1	The Community Integration Manager (CIM) provides oversight of transition activities. Oversight includes review of all transitions for presence and quality. (201)	Not Applicable
Comments: No transitions occurred during this review period, however, the CIM continued to be active for those that received placement in the community. The CIM continued to work with the MCO case managers and MFP transition specialists to identify what was needed for each individual's transition and continued to work with providers and case managers as issues arise. Four regional Community Integration Managers were in place to support transition oversight and overall integration efforts. The CIM provided training to the new CIMs and remained available as a resource to community CMs if needed.		

Paragraph 203		**Compliance Score**
WRC Temporary Resident means a former Glenwood resident who is deemed to have moved to Woodward on a temporary basis because…		**Partial Compliance**
#	Indicator	Indicator Score
1	If an IDT recommended maintaining a placement at Woodward or placing an individual in another congregate setting with five or more individuals only because no other suitable community setting is available, it documented in the ISP or discharge plan the decision, the barriers to placement in a more integrated setting, and the steps the team would take to address the barriers.	Substantial Compliance
2	If an IDT recommends that a Woodward Temporary Resident remain at Woodward because it determines that placement in a community setting is no longer appropriate for the individual, the CIM will review the decision to ensure that the placement is consistent with the individual's needs and informed choice. The individual will no longer be a Woodward Temporary Resident. Within six months of determination, the IDT and CIM will perform an assessment to ensure that the individual is in the most integrated setting appropriate to his or her needs.	Not Applicable

Comments:
This paragraph will remain in partial compliance due to the lack of opportunity to score the paragraph in its entirety.

1. All Individuals were discussed with regards to the most suitable setting. The rationale for current WRC placement along with the goal to look for transition opportunities was documented in the ISPs and approved by the guardian. No transitions had occurred since becoming temporary WRC residents.

Referral lists for the six temporary WRC individuals were provided. The referral list contained all referral attempts along with the resulting decline/denial. Outreach to guardians and providers appeared to be ongoing.

2. No determination had been made regarding the temporary WRC residents and whether placement in the community was no longer considered appropriate. Barriers to placement in a more integrated setting were noted within the ISPs which contained some discussion. Improving transition focused discussion could be an area of focus to ensure comprehensiveness, but this was not considered to be a substantial issue. Temporary WRC residents will be evaluated during the upcoming April Review therefore this indicator may be scorable at that time.

Paragraph 204		**Compliance Score**
The State shall make every effort to ensure that no Woodward Temporary Resident remains at Woodward or is placed in another congregate setting with five or more individuals unless the individual has been offered a meaningful choice of community providers consistent with their identified needs and preferences, and the determination of placement has been reviewed by the CIM.		**Not Applicable**
#	Indicator	Indicator Score
1	There is evidence that the individuals have been given the ability to make an informed determination regarding where they should live.	Not Applicable
2	There is evidence the CIM had conducted an assessment and verified that the above in #1 as well as appropriateness of placement.	Not Applicable
Comments: No individuals residing at WRC were in line for community placement at the time of this review. Community placement efforts were reviewed for the six temporary WRC individuals and showed evidence of discussion with potential providers and guardians of the individuals. Documentation displayed the sharing of information and some degree of problem solving in response to identified barriers. Inclusion of the individual was noted throughout the process.		

Paragraph 206		**Compliance Score**
The State shall produce routine public reports or maintain current public data dashboards regarding the status of Glenwood's community integration efforts, including historical data reflecting by month: the proportion of residents in each stage of transition planning, the number of transitions accomplished, and the types of placements, and recommendations that individuals remain at Glenwood.		**Substantial Compliance**
#	Indicator	Indicator Score
1	Public reporting focused on integration efforts, including: • historical data reflecting by month: • the proportion of residents in each stage of transition planning, • the number of transitions accomplished, and the types of placements, and	Substantial Compliance

Comments:
The State has maintained their public dashboard prior to the closure of GRC as well as having offered the January 2025 Post-Move Monitoring Report as evidence of sharing their community integration efforts with the public. The report included, but was not limited to:

- transition placements
- Individuals monitored through the PMM process.
- PMM cadence compliance
- PMM QA reviews
- # of Outreach visits
- Community thresholds
- Abuse/Neglect Allegations
- Weight loss
- Relocation to a new home

Data/information related to the number of transitions as well as the placement of those transitions were contained within the PMM January 2025 report.

Paragraph 207		**Compliance Score**
The State shall ensure that information about barriers to discharge from involved providers, IDT members, and individuals' ISPs is collected from Glenwood and is aggregated and analyzed for ongoing quality improvement, discharge planning, and development of community-based services.		**Partial Compliance**
#	Indicator	Indicator Score
1	Information about barriers to discharge from involved providers, IDT members, and individuals' ISPs is collected from Glenwood and is aggregated and analyzed for ongoing quality improvement, discharge planning, and development of community-based services.	Partial Compliance

Comments:
The most recent Barriers to Community Placement report was dated 12/31/23. At the time of the 12/31/23 report, there were 28 individuals with identified barriers to community transition. This report tracked, among other things, IDT identified barriers, and previous actions that have occurred in an effort to address the identified barriers.

This spreadsheet of individuals and identified barriers included a brief analysis and completed actions, but lacked in a clear plan for ongoing quality improvement, discharge planning, and development of community-based services as contemplated in the Consent Decree. It is expected that this piece will be completed as part of the CM and CIM review/analysis that has recently begun.

The barriers impacting individuals were often problematic behaviors and health and safety issues. These same barriers to placement were also often the areas in which data and documentation was lacking within the community setting and the areas of risk most often experienced by individuals as noted in paragraph 209.6.i, therefore, a clear systemic plan to address was warranted. Per the State, the CM/ CIM review/analysis of the barrier report should begin to address this issue.

The State CIM reviewing the barrier report and stating that all issues were addressed by training is not sufficient to reflect a systemic analysis and approach resulting from the supplied data when the issues appear to be ongoing and not impacted form the existing training. A clear plan with outcomes to measure success were not developed and/or tracked.

Paragraph 208		**Compliance Score**
The State shall develop and implement quality assurance processes to ensure that ISPs for Woodward Temporary Residents are developed and documented in a manner that is consistent with the terms of this Agreement as they apply to Woodward Temporary Residents. The State shall develop and implement quality assurance processes to ensure that ISPs for former Glenwood residents who have transitioned to the community and Woodward Temporary Residents who transition to the community are implemented, in a documented manner, consistent with the terms of this Agreement as they apply to the two identified populations. These quality assurance processes shall be sufficient to show whether the applicable objectives of this Agreement are being advanced. Whenever problems are identified, the State shall develop and implement plans to remedy the problems.		**Partial Compliance**
#	Indicator	Indicator Score
1	Quality Management process and procedures are consistent with current, generally accepted professional standards of care. These processes timely and effectively detect problems and ensure appropriate corrective steps are implemented.	Partial Compliance
	a. The State will have quality assurance processes to ensure WTR individuals' ISPs are developed and documented consistent with the terms of this Agreement.	Substantial Compliance
	b. The State will develop quality assurance processes for the post-move monitoring process.	Partial Compliance
	c. The State will develop quality assurance processes for case management and transition specialist services to individuals who have moved to the community.	Partial Compliance
	d. When the State identifies problems, it develops and implements plans to remedy the problem.	Partial Compliance

Comments:
1. Overall, the QA process contained significant amounts of data, but lacked in its ability to clearly impact and address quality issues associated with community ISPs.

a. The ISPs reviewed by the Monitor for the Woodward temporary residents overall appeared to meet the needs of the individuals as they related to the identification of barriers and opportunities for community placement.

b. PMM Checklist Audits also existed, which were reviewed by the lead CIM and other State staff. They were designed to ensure the quality of post-move monitors' follow-up and documentation. The result of the review of the PMM was the identification of potential gaps paired with potential suggestions to the issue. A review of 10% of PMM checklists was completed and reviewed by the PMM QA Review Group monthly. During the meeting, the group reviewed the checklist and provided feedback. The review was much more focused on the documentation rather than the review of the overall quality and if the PMM was identifying all the issues needed.

c. Iowa Medicaid LTSS initiated a Community Case Management Audit Process that includes a review of ISPs (along with other case management documentation). The Community Integration Manager (CIM) will complete monthly reviews and provide oversight to case managers working with individuals who have transitioned out of state resource centers for a minimum of 365 days post transition. The CIM is responsible for ensuring that the requirements of the procedure are met. A Standard Operation Procedure (SOP) was developed in January 2025, finalized on February 3, 2025, and implemented on February 7, 2025. This SOP allowed MCO/MFP information to be

available to the Post Move Monitor and the HHS LTSS subject matter experts (SMEs) on a monthly basis. The Monitor looks forward to seeing the results from these audits.

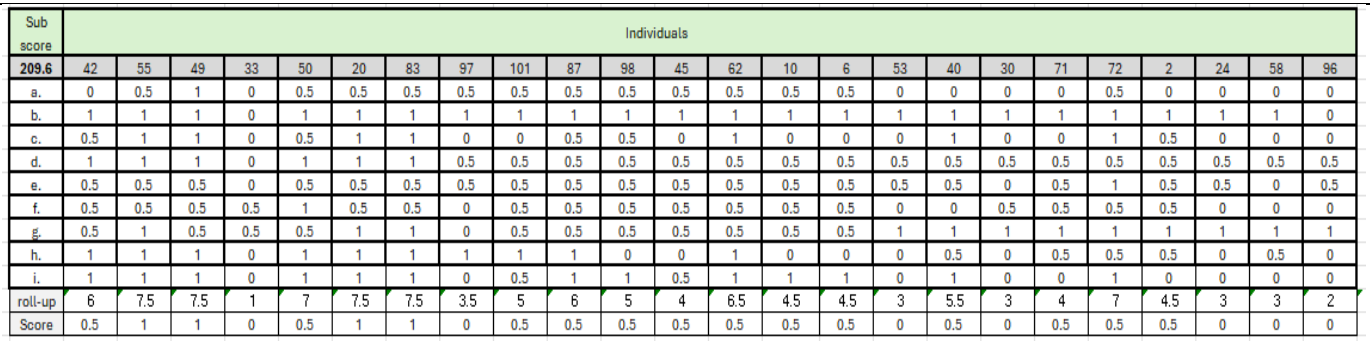
d. A clear process that showed the review of data and development of systemic measures to address the issues was noted with the Monthly Aggregate Review. During this review, individual thresholds as well as provider/systemic thresholds are reviewed and discussed. What was lacking was discussion of systemic needs and how those needs can be met. For example, the COE was being utilized on a frequent basis to support the providers, yet this was not looked at to determine if the frequent supports were due to lack of training, lack of implementation, etc.

The State implemented a SharePoint site to track incidents that meet the identified Community Thresholds for the target population within the 365-day post transition period. An incident must be entered into the SharePoint site as a Post-Move Monitoring Incident Report. Once a threshold is met, a record is created in the Community Threshold Log. Documentation related to any incident within the scope of Community Thresholds is documented in the SharePoint site and the Individuals IPR. Appropriate follow-up is completed and tracked on the site.

The State has done a nice job ensuring that issues were responded to by their Outreach Team. In addition, the State has an ongoing process to review data on a monthly basis to identify individual provider trends and address those issues through potential development of performance improvement plans.

It should be noted that while corrective actions have been noted, the Monitor has not seen consistent improvements at the community level as it relates to the ISPs and their overall quality as well as follow up by the PMM when issues are noted. So, while a process exists, one cannot determine if the process is yet effective as issues continue to be noted. Additionally, there was no evidence of clear problem solving based on improving ISP quality. It should be noted that the State has since reached out to the Montor for feedback on ISP Life Domains in an effort to improve the ISP goals and make them more meaningful to the individual.

<table>
<tr><th colspan="2">Paragraph 209</th><th>Compliance Score</th></tr>
<tr><td colspan="2">State shall conduct monitoring visits within each of four (4) intervals (approximately seven, 30, 60, and 90 days) following an individual's transition. Documentation of the monitoring visit will be made using a standard checklist that encompasses all areas of the transition plan and addresses whether all supports and services are in place according to the timeframes in Paragraph 200. This review shall include ensuring that the new provider has a current person-centered individual support plan in place, consistent with the requirements in Paragraph 183. The State shall ensure staff conducting this monitoring are adequately trained and shall assess a reasonable sample of monitoring visits to ensure the reliability of the process.</td><td>Partial Compliance</td></tr>
<tr><td>#</td><td>Indicator</td><td>Indicator Score</td></tr>
<tr><td>1</td><td>State staff member shall conduct PMM visits within each of four (4) intervals (approximately seven, 30, 60, and 90 days) following an individual's transition.
Individual Scores
42 55 49 33 50 20 83 97 101 87 98 45 62 10 6 53 40 30 71 72 2 24 58 96
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1</td><td>Substantial Compliance
100%
24/24</td></tr>
<tr><td>2</td><td>Documentation of the monitoring visit will be made using a standard checklist that encompasses all areas of the transition plan.
Individual Scores
42 55 49 33 50 20 83 97 101 87 98 45 62 10 6 53 40 30 71 72 2 24 58 96
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1</td><td>Substantial Compliance
100%
24/24</td></tr>
<tr><td>3</td><td>Documentation addresses whether all supports and services are in place according to the timeframes in Paragraph 200
Individual Scores
42 55 49 33 50 20 83 97 101 87 98 45 62 10 6 53 40 30 71 72 2 24 58 96
.5 .5 .5 .5 .5 .5 1 .5 .5 1 .5 .5 .5 .5 .5 .5 .5 .5 .5 .5 .5 .5 .5 .5</td><td>Partial Compliance
54%
13/24</td></tr>
<tr><td>4</td><td>Staff conducting this monitoring are adequately trained.
Individual Scores
42 55 49 33 50 20 83 97 101 87 98 45 62 10 6 53 40 30 71 72 2 24 58 96
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1</td><td>Substantial Compliance
100%
17/17</td></tr>
<tr><td>5</td><td>Staff conducting this monitoring have a reasonable sample of monitoring visits reviewed to ensure the reliability of the process.
Individual Scores
42 55 49 33 50 20 83 97 101 87 98 45 62 10 6 53 40 30 71 72 2 24 58 96
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1</td><td>Substantial Compliance
100%
24/24</td></tr>
<tr><td>6</td><td>The IDT developed a person-centered individual support plan in place, consistent with the requirements in Paragraph 183 (roll-up pf a-i) (209)</td><td>Partial Compliance
44%
10.5/24
55%
118/216</td></tr>
</table>

		
	a. The ISP defined individualized personal goals (such as community living, activities, employment, education, recreation, healthcare, and relationships).	Noncompliance 31% 7.5/24
	b. Individuals have ISPs that are current	Substantial Compliance 92% 22/24
	c. Personal goals are measurable.	Partial Compliance 40% 9.5/24
	d. The ISP identified the individual's strengths, needs, and preferences	Partial Compliance 60% 14.5/24
	e. ISP action plans indicated how they would support the individual's overall enhanced independence.	Partial Compliance 46% 11/24
	f. The ISP provides clear opportunities for community integration	Noncompliance 39% 9.5/24
	g. Provider staff supported the individual in an integrated setting: i. Staff demonstrated competence in use of equipment/devices. ii. Individual services are delivered by staff that understand the person's needs, preferences, and desired outcomes related to his/her ISP. iii. Staff are able to describe medical/behavioral/habilitation needs. iv. Staff was aware of the individual's SAPs, Outcomes, etc. v. Staffing was adequate to facilitate the individual community life outcomes. vi. Staff had been trained in the individual and their supports.	Partial Compliance 73% 17.5/24

Sub score	Individuals																							
209.6	42	55	49	33	50	20	83	97	101	87	98	45	62	10	6	53	40	30	71	72	2	24	58	96
a.	0	0.5	1	0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0	0	0	0	0.5	0	0	0	0
b.	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0
c.	0.5	1	1	0	0.5	1	1	0	0	0.5	0.5	0	1	0	0	0	1	0	0	1	0.5	0	0	0
d.	1	1	1	0	1	1	1	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
e.	0.5	0.5	0.5	0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0	0.5	1	0.5	0.5	0	0.5
f.	0.5	0.5	0.5	0.5	1	0.5	0.5	0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0	0	0.5	0.5	0.5	0.5	0	0	0
g.	0.5	1	0.5	0.5	0.5	1	1	0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	1	1	1	1	1	1	1	1	1
h.	1	1	1	0	1	1	1	1	1	1	0	0	1	0	0	0	0.5	0	0.5	0.5	0.5	0	0.5	0
i.	1	1	1	0	1	1	1	0	0.5	1	1	0.5	1	1	1	0	1	0	0	1	0	0	0	0
roll-up	6	7.5	7.5	1	7	7.5	7.5	3.5	5	6	5	4	6.5	4.5	4.5	3	5.5	3	4	7	4.5	3	3	2
Score	0.5	1	1	0	0.5	1	1	0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0	0.5	0	0.5	0.5	0.5	0	0	0

	h. Individual has documentation that showed what the person's day and week reflects and the Individual's role in its determination. This may take the shape of a weekly personal calendar where activities will be reflected or some other type of documentation that shows how the individual participated in scheduling his weekly activities and the completion of those activities.	Partial Compliance 52% 12.5/24
	i. The ISP identified individualized protections, services, supports, and treatments. Areas of increased risk were addressed through the ISP with clear interventions to mitigate.	Partial Compliance 58% 14/24

Comments:
1. Great improvement was noted in relation to the PMM cadence of meetings. For the September 2024 visit, PMM monitoring was reviewed for seven individuals. All received visits for all four intervals. For the December 2024 visit, eight of the eight individuals receiving PMM monitoring at the needed intervals followed by nine of nine individuals during the February 2025 review receiving PMM visits at the needed cadence.

2. The State used a standard format to document PMM visits with its launching noted during the September 2024 visit and full consistent implementation during the December 2024 and February 2025 visits.
3. For the individuals reviewed during the September 2024, December 2024, and February 2025 visit, while the amount of detail documented varied among post-move monitors, most were commenting, often without clear verification, on whether supports and services included in the transition plan were in place. Post move monitors were tracking appointments and summarizing recommendations, reviewing medication lists, and ensuring that adaptive equipment was in place and utilized. Although implementation data were not included, PMMs generally included a brief statement on implementation of action plans and engagement in the community.

Post-Move Monitoring reports continued to reflect more “interview” or “observation” as the primary forms of evidence during the PMM visits rather than the visual verification of the documents and/or tracking. For numerous supports, observation along with interview and review of documentation should be utilized to verify adequacy of implementation. Examples of this include, but are not limited to bowel tracking, blood pressure, and intake/output. Any supports not fully in place or pending should be identified for follow-up action. Therefore, monitoring of transitions did not measure the timely and successful implementation of supports and services that were recommended for each individual’s transition and in turn, did not guide the monitoring to identify potential events that could be disruptive to a successful transition or prompt the social worker and case managers to develop corrective measures. As stated previously in this report, this is an area that did show some improvement as part of the February 2025 review and with the increased access and focus on documentation and access to CM notes, it is the hope that continued improvement will be noted.

Some examples from the Monitoring Team visit where Post-Move Monitoring (PMM) was lacking sufficient detail and action included:

- Individual #33 had a PMM support to receive dental exams every six months. His last dental exam was 11/28/23. An appointment was scheduled for May 2024, but due to the significant amount of dental work needed, a referral was sent to a provider where he was placed on a lengthy waiting list. During interview, staff reported to the Monitoring Team that they have been instructed by the clinic to call weekly for appointment availability. All PMM reports since 12/18/23 reflected that the support was in place, verified by interview, yet the support was not in place and the support was not identified for follow-up action.

- Individual #50 had a PMM support requiring his blood pressure to be checked twice daily and if systolic was greater than 139 to recheck in two hours after giving his medication. If the recheck remained over 139 to contact the PCP. If the diastolic reading was less than 90, hold the medication and contact the PCP. The PMM reports completed indicated interview as the only evidence verification of implementation for the support. The narrative entries from the PMM did not indicate there was a review of the medication administration record.

- Individual #97 had a PMM support to become established with a new psychiatrist within 30 days of transition. The PMM noted on the 7-day visit that the DSP staff did not know if the appointment had been arranged. The 30-day monitoring visit indicated that the appointment would not occur until September 2024 (four months after his transition), and that the PCP would monitor his medications in the interim. At the 60-day monitoring visit, the PMM noted that staff reported that the appointment had not been scheduled as Individual #97's father needed to give approval. The 90-day PMM visit indicated that an appointment had been scheduled for 9/3/24. At the 120-day monitoring visit the PMM noted that Individual #97 was seen by the psychiatrist on 9/3/24, but that staff from the home (i.e., staff who were familiar with Individual #97) did not attend the appointment with him, so information about what was reported to the psychiatrist was relayed by staff who took him to the appointment and were less familiar with his needs. Although the support was scored as not being in place, none of these issues were carried into the PMM section for follow-up action.

  Additionally, Individual #97 had a PMM support to check his blood pressure and pulse once a week for six months and to notify the nurse if his heart rate was noted to be greater than 110, notify the PCP if heart rate was greater than 130, and transport to the ER or PCP office as soon as possible if heart rate was over 130 with any symptoms of shortness of breath, chest pain, or lethargy. The PMM noted at the 7-day visit that provider staff reported they did not have a blood pressure cuff or an O2 sensor, but were able to monitor his heart rate by taking his pulse and staff demonstrated. The PMM did not flag this support as not being in place. The PMM noted at the 30-day visit that the equipment for taking vitals was in place. The PMM reported at the 60-day, 90-day, and 120-day visits that the nurse provider came to the home weekly to obtain Individual #97's vitals. The PMM cited the evidence of the support being in place for each of these monitoring visits as Interview and did not indicate that documentation was in place or reviewed. At the 180-day visit, the PMM noted that per an email from the provider, "Heart rate is not checked weekly. We started checking monthly to obtain baseline data each month." The PMM scored the support as not being in place, but did not carry the issue into the PMM section for follow-up action. Individual #97 had a PMM support for his weight to be taken and recorded monthly. At the 7-day visit, the PMM noted that the provider did not have a scale in the home yet scored the support as being in place. At the 30-day visit the PMM noted that there was still no scale in the home, but scored the support as being in place.

  At the 60-day visit, the PMM observed Individual #97 to be weighed by staff on a typical bathroom scale and his weight was 182.2 pounds, an increase from 161.0 pounds in April 2024 before his transition. The PMM scored the support as being in place. At the 90-day visit, the PMM observed Individual #97 stand on the scale and his weight was 177 pounds. There was no indication that the PMM reviewed documentation to ensure weights were recorded.

At the 120-day visit, the PMM noted that staff reported Individual #97's weight to be 179 pounds as of 9/1/24. Again, the PMM did not indicate if documentation was reviewed.

The 150-day visit indicated Individual #97's weight was 192 pounds (nearly a 30-pound weight gain since the month prior to his transition). The PMM did not flag this as a concern for follow-up action. At the 180-day visit the PMM observed him being weighed and his weight was 190 pounds. Again, the PMM did not flag the weight gain as a concern for follow-up.

- Individual #101 had a medication change following her transition where she received Risperidone 1 mg twice per day. This medication was discontinued on 5/6/24 and Chlorpromazine 25 mg per day was ordered then increased to 75 mg per day on 5/20/24. The PMM scored the question related to medications remaining unchanged as a "Yes" and did not identify any follow-up actions.

- Individual #101 had a PMM support requiring oxygen saturations to be taken three times. For all PMM visits through 180-days, the PMM noted the support to be in place with the only evidence noted to be Interview. The 180-day visit did note both Interview and Documentation, but the note itself did not reflect the PMM reviewed documentation to verify the support.

- Overall, Individual #87's PMM reports were thorough and detailed. It would be beneficial for the PMM to describe documentation reviewed and expand the review of documentation during monitoring visits.

- Individual #98 had a PMM support to receive stretches to his right shoulder, elbow, and finger on a regular basis (currently 5x/week). For all visits from the 7-day through the 60-day, the PMM scored the support as being in place based on interview as the source of evidence. There was no indication the PMM observed the service being provided by staff to assess compliance. At the 90-day, 120-day, and 150-day visits, the PMM scored the support as not being in place based on a review of documentation as well as interview. However, the issue was not flagged for follow-up action.

- Individual #45 had a PMM support for him to be active by encouraging him to participate in community activities three times per week (e.g., swimming at the YMCA, bowling). MFP was to purchase a YMCA membership pass. At the 7-day visit, the PMM reported that Individual #45 had not had the chance to leave the house as staff were still getting to know him and his housemates, however, the support was scored as being in place. At the 30-day, 60-day, 90-day, and 120-day visits, the PMM noted that MFP was to purchase the YMCA pass on 8/1/24, but did not verify in subsequent monitoring visits that the pass was obtained. The PMM noted that Individual #45 had not been participating in activities as specified in the support, but was going shopping, going to get ice cream or to the agency office, van rides, etc. Although the PMM scored the support as not in place at the 30-day, 60-day, and 90-day visits, the support was not flagged for follow-up action. At the 120-day visit, the PMM scored the support as being in place, but the narrative findings did not support that Individual #45 was participating in activities as specified in the support or whether he was going to the YMCA. Individual #45 had a PMM support to be weighed weekly to track that he maintained a healthy weight. At the 7-day visit, the PMM noted that he had not yet been weighed, but scored the support as being in place. At the 30-day visit, the PMM noted that his weight on 7/17/24 was 215 pounds (a gain of 18 pounds since his last weight at GRC prior to transition). The PMM cited the source of evidence as interview and scored the support as being in place. At the 60-day visit, the PMM noted that direct support staff reported they were not aware he was to have a

weekly weight and there was no recent weight for August 2024. The PMM cited the source of evidence as interview and scored the support as being in place. At the 90-day visit the PMM noted that staff reported his weight on 9/11/24 as 228.2 pounds (gain of 31.2 pounds since June 2024, or 15.8% of his body weight). The PMM cited the source of evidence as interview and scored the support as being in place. At the 120-day visit the PMM noted that through interview with the agency QA Coordinator, his current weight was 150 pounds and noted how he was weighed. Staff reported that they weigh the wheelchair and Individual #45. Staff were asked to just weigh him, but the meeting ended before a weight was obtained. The PMM cited the source of evidence as interview and scored the support as being in place.

- Individual #6 had a PMM support to receive psychiatry services every three months as well as to continue to have CBC levels due to being prescribed Clozaril. For all PMM visits, the PMM scored the support as being in place based on interview. His most recent CBC was 6/4/24 and it was noted that he typically had the labs drawn the same day as his psychiatry appointment. The 8/15/24 psychiatry appointment was conducted virtually, and the labs were completed on 9/10/24 (out of the required range). The PMM noted at the 150-day visit that it was reported his labs were completed "last week" (no date given) and that the provider was trying to get his Clozapine refilled because the labs were not sent from the hospital to the pharmacy. The PMM scored the support as in place, but did not flag the issue for follow-up.

  It should be noted that over the months of January 2025 and February 2025, Individual #6 experienced 19 events (12 episodes of aggression, 3 serious injuries, 1 choking event, 2 falls, and 1 alleged abuse/neglect). The PMM primarily thanked the team for the information without any increased monitoring or follow-up. Thie individual was removed from the home and admitted to a psychiatric unit on 2/27/25.

- Individual #53 had a PMM support to encourage fluid intake of 8 oz every two hours. The PMM consistently documented verification of this support through interview and observation without indicating if the provider had a tracking system in place to document whether she consumed a minimum of 72 oz of fluids per day. In fact, the PMM noted at the 120-day visit that Individual #53's fluids were not tracked by the provider. While the PMM scored the support as not in place, a plan of action was not developed. The support specifically stated that Individual #53 would need to be encouraged to have fluid intake to decrease constipation. Encourage/offer 8 oz of fluids every 2 hours. Consume a minimum of 2160 ml (72 oz, 9 cups) of fluid. The PMM interviewed staff and observed her drinking a glass of Diet Pepsi at the 7-day visit. There was no indication that a documentation system was in place to record the recommended amount of daily fluids Individual #53 was to consume. At the 30-day, 60-day, and 90-day visit the PMM noted interview and observation, but did not verify that a tracking system was in place. On the 120-day visit, the PMM noted interview with the Executive Director who stated that fluids were not tracked, but a tracker would be put in place. The PMM noted interview with the Executive Director at the 150-day visit, but did not indicate if the tracker noted from the previous visit was in place. The PMM noted interview with the QA Coordinator that there were no current orders from the PCP to track Individual #53's fluids, but would request clarification at her upcoming appointment. At the 240-day visit, the PMM noted interview with the State Director who reported that fluids were not tracked and the PMM requested the fluid tracker. At no point during the PMM visits from the 7-day through the 240-day, did the PMM document the tracking of fluids was reviewed as in place or that the tracking indicated the recommended amount of fluid was being consumed. There was no plan of action from the PMM to elevate to the team for follow-up.

- Individual #40 had a PMM support to be weighed monthly with a suggested weight range to be maintained between 124 pounds and 15 5 pounds. The PMM noted at the 7-day visit that his weight was 161.4 pounds (last monthly weight at GRC was 160 pounds in May 2024). The PMM noted the 30-day visit, a weight had not been obtained for that month. The 60-day visit reflected that the PMM interviewed staff who stated that he continued to be weighed monthly with his current weight being 155.4 pounds (down from 159.8 pounds. in July 2024). The PMM documented that Individual #40's weight continued to decrease through the 150-day visit to 142.2 pounds. For all PMM visits, there was no indication the PMM had verified weight tracking through documentation.

- Individual #30 had a PMM support to monitor for constipation due to risk of bowel obstruction and fluid imbalance. Elimination was to be recorded on every shift, and he was to be encouraged to consume at least 80 oz of water per day. The PMM noted at the 30-day visit that bowel elimination was not being tracked nor was fluid intake. Staff reported that they encourage him to drink 80 oz of water, but he had been drinking 65 oz daily per his choice. The PMM scored the support as in place. On the 60-day visit, that staff reported elimination was being tracked, but not done correctly, yet the PMM scored the support as in place. The PMM failed to indicate if tracking was in place from the 90-day visit through the 150-day visit and noted that by report there had been no signs of constipation or need for PRN medications, yet scored the support as in place. At the 180-day and 240-day visits, the PMM indicated that elimination tracking was reviewed, but there were days when data were missing. Even so, the support was scored to be in place.

- Individual #71 had a support for career exploration. At the 7-day visit the PMM noted that the agency reported job development for community employment had been short staffed and further exploration may take a few months. The PMM scored the support as in place. All PMM visits through 180 days noted Individual #71 to be on a waitlist for career exploration, yet the PMM scored the support to be in place. At the 240-day visit, the PMM noted that after discussion with his MFP case manager, the career exploration goal was discontinued and would be reevaluated whether it was still appropriate for him when the waitlist decreased. The PMM scored the support to be in place. In none of the visits did the PMM identify a plan of action to address alternatives for career/work exploration.

- Individual #72's PMM reports contained substantive commentary on overall health and goal status, but was not based clearly upon the review of documentation and verification of supports during monitoring visits.

- Individual #2 had a support to monitor his bowel activity and record on the medication administration record. The PMM consistently noted that documentation for recording bowel activity was not in place for all PMM visits throughout the 240-day, but no plan to address was identified. At the 120-visit, the PMM noted that the plan to complete retraining had been completed and that the plan was to conduct another retraining the day following the PMM visit. Yet there was no f/u entry by the PMM to indicate this occurred, nor was there a notation at the next PMM visit that the training was reviewed and verified by the PMM. While the PMM at the 180-day visit indicated that tracking had been requested numerous times and had not been provided. Although an email was sent to the Provider State Director on 10/14/24 about the lack of tracking, the PMM did not document whether the identified action of the new nurse conducting training and reviewing the BM tracker weekly had occurred. At the 240-day visit the PMM did indicate that while tracking had improved compared to previous months, it was not being

completed consistently. Although the PMM sent an email to the IDT following this visit, the lack of bowel tracking as required by the support had not been fully implemented nor adequately provided since Individual #2's transition.

- Individual #24 had a support to obtain an annual dental exam in August 2024. At the 60-day visit (7/29/24), the PMM noted that the host home provider was attempting to locate a dentist who would accept her insurance. The PMM scored the support as being in place. PMM visits over 120 days indicated that the provider was still having difficulty finding a dentist, yet the PMM scored the support as in place. At the 150-day visit the PMM noted that an appointment was scheduled for 2/24/25 with a dentist, but was on a waiting list for an earlier appointment. At the 180-day visit it was noted that her appointment was moved to 1/24/25. The PMM notes reflected that the Host Home provider was having difficulty scheduling a dental appointment and the PMM provided the Host Home family some options for dental services in the area. However, there was no affirmative action noted by the PMM to elevate this to a higher level in order to support the Host Home provider and Individual #24 to obtain necessary care.

Lack of PMM follow-up was noted at times to have a potential impact on care due to a lack of thoroughness. This was an issue that was observed by both the Monitoring team and the Ltd Death Review Committee when they conducted their analysis post-mortem. Examples of this will be discussed in greater detail under par 209.6.i.

4. Staff who conducted PMM received the training provided by the State as well as the trainings that were developed in collaboration with the Independent Monitor.

5,For all individuals during the six-month review period, staff that conducted monitoring had a reasonable sample of monitoring visits reviewed to ensure the reliability of the process. Each individual in the review group had between five and seven visits documented between the 7-day and 180-day interval depending on their transition date.

6. Overall, the IDTs did not develop a person-centered individual support plan that was consistent to meet the needs of the individual. Goals were not consistently measurable and did not clearly address independence in a formal manner. Additionally, there was limited guidance regarding community outings and/or integration. Though outings occurred, there was a lack of meaning or expansion of skills tied to the outing. Increased risk was also not consistently identified and, therefore, plans to mitigate were mostly not developed.

a. None of the ISPs included a full set of goals to address all major life areas. In particular, ISPs did not develop goals to address day programming. Many still had goals in place that were developed for the initial transition plan that were no longer relevant. Case managers were not revising the ISPs as individuals became adjusted to their new home and community and providers were not suggesting a revision to goals to be more reflective of supporting individuals to gain independent and/or community living skills.

- The provider had updated Individual #49's ISP. It included commentary on the goals that were listed in her transition plan and noted that some of them were no longer relevant (e.g., she had a cooking goal, but consistently refused to participate). The ISP included one outcome to develop a routine for a meaningful day. This was a broadly stated goal that did not address developing relationships, increasing community integration opportunities, or recreation or day activities based on her known preferences.

- Individual #42 also had an ISP updated by the provider. His ISP noted that he had visited day program, but did not like it. His ISP did not develop outcomes related to exploring other day programs or describe how he might want to spend his day other than just getting out in the community more. The ISP noted that it was unclear what his hopes, dreams, and desires were for the future. His goals were to participate in community activities of choice and assist in preparing his own meals.

- Individual #55's ISP was updated in September 2024. It included the same goals that were in his previous ISP (2023) to spend more time with his family, have a job that he likes, and live in the community close to his family. These goals were broadly stated and not individualized based on information from assessments regarding his preferences, strengths, and needs.

- The ISP document submitted for Individual #33 was his Transition and Service Plan developed 9/21/23 prior to his transition to the community. Outcomes had not been updated to reflect his transition to the community. However, it was positive to note that staff interviewed were making sure they had opportunities to try out activities in the community and were working on skills to increase their independence at home.

- Individual #50 had a current ISP developed by the Provider in April 2024. The ISP was person-centered and identified his preferences and interests, things that are important to him, and specialized supports protocols. The ISP identified that Individual #50 indicated he would like to attend day program, and he used a sign that was interpreted to mean "work."

- Individual #20 had plan titled Transition and Service Plan dated 7/12/23 (in preparation for her transition on 11/1/23) and revised 12/13/23 at her 30-day post-transition meeting that included goals to maintain relationships with friends and family by calling a person of her choice weekly and a goal to engage in community outings she enjoys by choosing an outing weekly.

- Individual #50's ISP included goals to become familiar with his new environment through a variety of activities in his home and community through choosing an activity at least twice weekly and assisting in doing his laundry weekly.

- Individual #83's annual ISP from September 2024 included goals to place his dirty dishes in the sink after meals, increase his sensory skills, and cooperate with staff during nail care.

- The Plan provided for Individual #97 was the initial Transition and Service Plan from the MFP case manager with identified goals to participate in a personal hygiene task (e.g., washing hands, washing walker) at least 1x/day and making a video call to his guardian at least 1x/month on his iPad.

- The ISP provided for Individual #101 was the initial Transition and Service Plan from the MFP case manager. She had goals to do something in the community at least one time per week and do something in the home at least five days per week (meaningful day). A suggestion was for her to learn how to use the remote control for her TV. She also had a goal to walk at least 10 minutes every day with staff assistance.

- The plan provided for Individual #87 was the initial Transition and Service Plan from the MFP case manager (revised 4/29/24 at the 30-day meeting after transition and revised 9/23/24) with one identified goal to exercise for 30 minutes, 5 days a week by 3/26/25.

- The ISP provided for Individual #98 was the initial Transition and Service Plan from the MFP case manager with goals identified to cooperate to complete his oral care through 6/10/24, with assistance take out the trash on garage day with 1 prompt from 6/11/24 to 12/31/24 and independently from 1/1/25 to 6/10/25, and with assistance complete his laundry at least once per week through 6/10/25.

- The ISP provided for Individual #45 was the initial Transition and Service Plan from the MFP case manager with goals identified to participate in a household chore of his choice at least 1x per day, actively participate in an out of home activity at least 3x per week, and assist staff with being weighed 1x per month. Although the Plan indicated, the team did not develop a formal goal in the area of employment, the Plan indicated that it would be important to keep him busy and get him out of the house regularly to help with offsetting negative behaviors from lack of things to do.

- The ISP provided for Individual #10 was the initial Transition and Service Plan from the MFP case manager (revised 6/17/24) with goals identified to become comfortable in his new home by 5/19/25, practice safety skills in the community independently 85% of the time for 3 consecutive calendar months by 5/19/25 (added 6/17/24), choose and complete one task daily independently 80% of the time for 3 consecutive months (added 6/17/24)

- The ISP provided for Individual #62 was the initial Transition and Service Plan from the MFP case manager with goals identified to practice his safety community skills (including, but not limited to looking both ways when crossing the street, seat belt, remaining with group) at least once per week, to independently wait for an item or activity after receiving a first/then direction 75% of the time for 3 consecutive months, be redirected to his snacks with no more than 2 prompts through 5/11/25, and independently imitate a new sign used in the correct context 90% of the time for one calendar month until reaching a total of 6 new signs introduced one each month (added 6/11/24).

- The ISP provided for Individual #6 was the initial Transition and Service Plan from the MFP case manager (revised 7/8/24 and 10/7/24) with goals identified to explore his new community, engage in the community, clearly communicate his wants and needs, and keep his house and yard clean.

- Individual #53 had a person-centered plan developed by the community provider in November 2024. Goals included improving her social skills (at least once per day, participating in 1:1 activities with my staff for a minimum of 10 minutes), improving physical strength skills (at least twice per day, complete range of motion stretches and stand utilizing my EZ stand for a minimum of five minutes), and improving oral hygiene skills (at least two times per day, brush teeth with staff assistance).

- Individual #40 had an ISP developed with goals to decrease the number of times he displayed physical aggression, decrease the number of times he displayed self-injurious behaviors, decrease the number of times he displayed elopement behaviors, with

verbal prompts, void in the toilet 95% of trials, and communicate bathroom, please, thank you and medicine throughout his daily routine 45% of trials.

- Individual #30's goals were to get out of the house at least three times a week, learn about different events and activities that were available in the community, and participate in non-routine activity in the community. While these were good goals to offer further exposure to the community, they were broadly written, offering staff little guidance for implementation and did not specify specific training to occur around these activities.

- Individual #71's goals were updated in August 2024. Goals included assisting staff with being weighed, assisting with meal preparation, participating in, and completing career exploration activities. His goal to complete career exploration activities had been put on hold, however, the case manager reported that the IDT will begin focusing on employment opportunities going forward and will coordinate those activities with the employment program.

- Individual #72's ISP included goals to display fewer incidents of SIB, review his visual picture schedule, point to a coin, or bill that is named, and demonstrate how to unlock and lock his locker.

- Individual #2 had goals to participate in 15 minutes of activity at day habilitation and create a shopping list once per week.

- Individual #24 had goals to improve her communication skills through increased engagement with others, to not display compulsive episodes, and to increase her personal skills (handwashing).

- Individual #58 had goals to do a household chore of his preference weekly, assist staff with getting weighed, and participate in 1:1 staff time doing an activity of his choice at least three times weekly.

- Individual #96's goals were to participate in one recreation outings that was short in duration, live closer to her family, have more visits from family members, and stay connected with her friend.

b. Most individuals had an ISP that was developed within the past 365 days. For some individuals, support staff were still working from the initial transition plan. In some cases, plans had not been updated to reflect current supports and services.

- The Provider had developed updated ISPs for Individual #49, Individual #50, and Individual #42 that included current supports, preferences, and needs.
- The ISP provided to the monitoring team for Individual #55 was dated 10/4/24 (discharge date 10/3/23), which was after the review date. The case manager reported that his ISP meeting was held in September 2024.
- The ISP document submitted for Individual #33 was his Transition and Service Plan developed 9/21/23 prior to his transition to the community on 10/20/23.
- Individual #83's IDT had recently met in September 2024 for his annual ISP meeting.
- Individual #20 had plan titled Transition and Service Plan dated 7/12/23 (in preparation for her transition on 11/1/23) and revised 12/13/23 at her 30-day post-transition meeting.

- The ISP provided for Individual #97 was the initial Transition and Service Plan from the MFP case manager. He was discharged on 5/4/24.
- The ISP provided for Individual #101 was the initial Transition and Service Plan from the MFP case manager. She was discharged on 4/29/24.
- The Plan provided for Individual #87 was the initial Transition and Service Plan from the MFP case manager (revised 4/29/24 at the 30-day meeting after transition and revised 9/23/24).
- The Plan provided for Individual #98 was the initial Transition and Service Plan from the MFP case manager.
- The Plan provided for Individual #45 was the initial Transition and Service Plan from the MFP case manager. He was discharged on 6/18/24.
- The Plan provided for Individual #6 was the initial Transition and Service Plan from the MFP case manager (revised 7/8/24 and 10/7/24). He was discharged on 6/18/24.
- The Plan provided for Individual #10 was the initial Transition and Service Plan from the MFP case manager (revised 6/17/24). He was discharged on 5/20/24.
- The Plan provided for Individual #62 was the initial Transition and Service Plan from the MFP case manager. He was discharged on 5/13/24.
- Individual #53 had a person-centered plan developed by Community Provider in November 2024.
- Individual #40 had an ISP developed by Provider with updates on 7/15/24. He was discharged on 6/11/24.
- The ISP provided for Individual #30 was his transition plan, last updated on 5/24/24. He was discharged on 4/8/24.
- Individual #71 had a person-centered plan developed by Community Provider in May 2024. It was last revised in October 2024.
- Individual #72 had an ISP dated 2/28/24. He was discharged on 3/18/24.
- Individual #2's transition plan was updated on 4/22/24, the same day as his discharge.
- Individual #24's ISP was developed on 5/23/24. She was discharged on 5/30/24.
- Individual #58's transition plan was updated in November 2024. He was discharged on 4/18/24.
- Individual #96's ISP was dated 1/5/23. Her discharge date was 3/12/24. An updated plan was not submitted.

Even though timely, few of the ISPs had been revised based on what the provider had learned about the individual since transition, what the individual had identified that they wanted to do based on community experiences, etc.

c. Few of the individuals had measurable goals and measurable training objectives. Broad-based language was often used, such as "improving communication/assisting with meal preparation" or "safety awareness" without any specific direction for staff to follow. Because of this, there were no data to reflect measurable progress or lack of progress.

While the individuals had goals that were individualized and reflective of their preferences, the goals, as stated above, were broadly written with limited expectations for frequency of implementation (e.g., once a week, once a month) and were without any specific direction for staff to follow. Goals did not include expectations or criteria for achievement or the necessary individualized supports and opportunities for implementation.

Without the specificity and greater frequency of implementation, measurability was difficult to assess. There were no data to reflect progress or lack of progress. Several individuals had action plans or interventions that, if data were collected, would have provided the team with information as to whether the individual was making progress toward achieving the goal. It is important to have a way to determine if the individual is successful with their goal. Goals, as written, did not identify the evidence that would be collected to track, record, and evaluate progress.

Many goals were daily life activities that focused on participation or completion of tasks rather than supporting the individuals to increase their independent living skills, expand upon their interests, and/or achieve a positive change in their lives.

- Individual #97 had goals to participate in a personal hygiene task (e.g., washing hands, washing walker) at least 1x/day and making a video call to his guardian at least 1x/month on his iPad. These goals focused on participation and were more reflective of daily life activities and task completion rather than a larger life ambition or desire.

- Individual #101 had goals to do something in the community at least one time per week and do something at the home at least five days per week (meaningful day), and to walk at least 10 minutes every day with staff assistance. These goals were overly vague as to what the individual would accomplish. While the goal to walk at least 10 minutes every day was essentially measurable it did not describe how the goal would benefit the individual.

- Individual #87 had one goal to exercise 30 minutes 5 days per week by 3/26/25. While the goal was essentially measurable it did not describe the types of exercise or identify whether the individual was to increase intensity of exercise over time to achieve a broader goal, such as weight loss or cardiac health.

- Individual #98 had goals to cooperate to complete his oral care through 6/10/24, with assistance take out the trash on garage day with 1 prompt from 6/11/24 to 12/31/24 and independently from 1/1/25 to 6/10/25, and with assistance complete his laundry at least once per week through 6/10/25. These goals were daily life activities and were more reflective of task completion rather than a larger life ambition or desire and did not describe what was to be achieved.

- Individual #45 had goals to participate in a household chore of his choice at least 1x per day, actively participate in an out of home activity at least 3x per week, and assist staff with being weighed 1x per month. Although the Plan indicated the team did not develop a formal goal in the area of employment, the Plan indicated that it would be important to keep him busy and get him out of the house regularly to help with offsetting negative behaviors from lack of things to do. These goals focused on participation and were more reflective of daily life activities and task completion rather than a larger life ambition or desire and did not describe what was to be achieved.

- Individual #62 had goals to practice his safety community skills (including, but not limited to looking both ways when crossing the street, seat belt, remaining with group) at least once per week, to independently wait for an item or activity after receiving a first/then direction 75% of the time for 3 consecutive months, be redirected to his snacks with no more than 2 prompts through 5/11/25, wait for an item or activity after receiving a first/then direction,75% of the time for 3 consecutive months, and independently imitate a new sign used in the correct context 90% of the time for one calendar month until reaching a total of 6 new signs introduced one each month (added 6/11/24). While essentially measurable, these goals focused on

participation and were more reflective of daily life activities and task completion rather than a larger life ambition or desire. The goal to practice safety skills did not describe the type of skills the individual would be practicing or how the practice would provide him the skills necessary for more full community integration.

- Individual #10 had goals to become comfortable in his new home by 5/19/25, practice safety skills in the community independently 85% of the time for 3 consecutive calendar months by 5/19/25 (added 6/17/24), choose and complete one task daily independently 80% of the time for 3 consecutive months (added 6/17/24). These goals were daily life activities and more reflective of task completion rather than a larger life ambition or desire. The goal to practice safety skills did not describe the type of skills the individual would be practicing or how the practice would provide him the skills necessary for more full community integration.

- Individual #6 had goals to explore his new community, engage in the community, clearly communicate his wants and needs, and keep his house and yard clean. These goals were vaguely written and provided no expectation of implementation, and did not describe what was to be achieved by participating in the activity.

- Individual #53's goal to improve her social skills noted that she would participate in 1:1 activities with her staff for a minimum of 10 minutes. It was not clear what the expectation was for participation or achievement of her goal.

- Individual #30's goals were to get out of the house at least three times a week, learn about different events and activities that were available in the community, and participate in non-routine activity in the community. None of these clearly defined expectations for participation or included mastery criteria.

- Individual #71's goals included assisting staff with being weighed, assisting with meal preparation, and participating in and completing career exploration activities. None included specific staff instructions or mastery criteria.

- Individual #2 had a goal to participate in day habilitation for 15 minutes. The goal was not measurable as written. It was not clear what the expectations for participation were or how the IDT would determine when the goal had been achieved.

- Individual #24 had goals to improve her communication skills through increased engagement with others, to not display compulsive episodes, to increase her ability to appropriately respond to things, and to increase her personal skills (handwashing). Her goals were not measurable, and it was not possible to determine mastery criteria.

- Individual #58 had goals to do a household chore of his preference weekly, assist staff with getting weighed and participate in 1:1 staff time doing an activity of his choice at least three times weekly. None of his goals were measurable so that staff could determine when they were mastered.

- Individual #96's goals were to participate in one recreation outing that was short in duration, live closer to her family, have more visits from family members, and stay connected with her friend. The goals were not measurable and did not include mastery criteria.

- Individual #40 had goals to be active (supported by an action plan to activate a switch for him to indicate that he wanted to go outside), go on more outings to see different places (supported by a program to go on weekly van rides and community outings), to stay healthy (supported by a toileting plan), and to increase his happiness and mood by engaging with staff. Mastery criteria were not clearly stated.

On a positive note, staff were describing how individuals were learning to do new things in their home through informal training. It is this type of functional training that needs to be captured and used as a potential starting point for goal ideation.

d. For the most part, ISPs identified individual's strengths, needs and preferences and changes in conditions or medications. However, as noted above, few of the ISPs had been revised based on what the provider had learned about the individual since transition, what the individual had identified that they wanted to do based on community experiences, etc. Because these areas often change with one's environment and life situation, revision is needed to ensure what is documented reflects one's current status.

e. Although not measurable, most had broadly stated goals and action plans to address increasing independence in the home, but were not written to expand independence in the community. Additionally, most staff were able to describe ways that they offered opportunities for individuals to become more involved in daily life activities and gain further independence. Without goals, action plans, expectations for routines (formal or informal), there was a lot of "down" time in the individual's life which equated to watching TV or just sitting around. Staff typically conducted their work routines around the individuals and did not have the skills to necessarily involve individuals in daily life activities in their homes.
Some examples are noted below:

- Individual #42 had a goal to assist in meal preparation.
- Individual #55 had goals to maintain his communication and clean his room.
- Individual #49 had action steps to add activities to her calendar and choose and prepare a recipe.
- Individual #33 did not have an updated plan to support his overall independence in his new home or in the community.
- Individual #50 had a goal to become familiar with his new environment through a variety of activities in his home and community through choosing an activity at least twice weekly and a goal to assist in doing his laundry weekly.
- Individual #20 had goals to maintain relationships with friends and family by calling a person of her choice weekly and a goal to engage in community outings she enjoys by choosing an outing weekly.
- Individual #50 had goals to become familiar with his new environment through a variety of activities in his home and community through choosing an activity at least twice weekly and assisting in doing his laundry weekly.

- Individual #83 had goals to place his dirty dishes in the sink after meals, increase his sensory skills, and to cooperate with staff during nail care.

- Individual #53 had a goal to improve oral hygiene skills (at least two times per day, brush teeth with staff assistance).

- Individual #40 had communication and behavioral goals that might lead towards greater independence in his community interactions. He had a goal to use a communication switch to let staff know when he wanted to go outside, however, PMM notes indicated that he refused to use the switch, but instead would take staff's hand to guide them when he wanted to go outside. The IDT had not considered revising his plan to include other goals that might provide him with more independence.

- Individual #30's goals were to get out of the house at least three times a week, learn about different events and activities that were available in the community, and participate in non-routine activity in the community. While these activities might encourage independence, there were no goals that specifically addressed independence.

- Individual #71's goals to assist staff with being weighed and assisting with meal preparation minimally addressed greater independence.

- Individual #72's goals to review his visual picture schedule, point to a coin or bill that is named, and demonstrate how to unlock and lock his locker addressed greater independence.

- Individual #2 had one goal to address greater independence, to create a shopping list once per week.

- Individual #24 had goals to improve her communication skills through increased engagement with others and to increase her personal skills (handwashing).

- Individual #58 had goals to do a household chore of his preference weekly, assist staff with getting weighed and participate in 1:1 staff time doing an activity of his choice at least three times weekly.

- Individual #96's goals were to participate in one recreation outings that was short in duration, live closer to her family, have more visits from family members, and stay connected with her friend. None described how she would gain independence through participation in these activities.

f. Most individuals had regular opportunities for community integration activities weekly to a few times week, but the ISPs did not consistently provide expectations for frequent opportunities for community integration. While individuals had broadly stated goals for community participation, none of the goals facilitated integration or the development of relationships with others in the community. Community integration is not just taking a person to the store, for a ride, and/or to the park. It requires planning and development of formal activities based on the individual's preferences, exploring opportunities for non-paid relationships, and perhaps employment. It also involves skill building during those times to expand their engagement, and enjoyment. This was not consistently noted in the ISPs. There was limited direction towards how the person would be truly integrated.

- It was nice to see that Individual #50 was supported to start attending music therapy in July 2024 and had been going on Wednesdays where he participated in choir practice.

- Individual #20 was supported to purchase a zoo membership and had visited a few times this summer. Individual #49 was also participating weekly in in a community program focused on music.

- Individual #101 had a broadly stated goal to do something in the Malvern community at least one time per week. Staff reported that she enjoyed going to the boutiques in Glenwood, shopping at the Dollar Store, and going to Walmart.

- Although Individual #87 did not have a goal for community integration, he was living in a host home with a former GRC staff and was going on regular monthly overnight visits with his family and the host home provider was working on obtaining a YMCA membership. The host home provider reported that Individual #87 was rarely home daily and loved going to Bass Pro Shop several times a week.

- Individual #98 did not have a goal for community integration, but staff reported that his sisters visit with him on Sundays and take him out for a few hours. Staff reported that he enjoyed going to parks and watching birds.

- Individual #45 had a broadly stated goal to actively participate in an out-of-home activity at least 3x per week.

- Individual #10 had a goal to practice safety skills in the community independently 85% of the time for 3 consecutive calendar months by 5/19/25 (added 6/17/24). While this goal might result in greater independence in the community, it did not identify opportunities for community integration based on preferences identified through the person-centered planning process and did not offer staff guidance for expanding community exploration opportunities.

- Individual #62 had a goal identified to practice his community safety skills (including, but not limited to looking both ways when crossing the street, seat belt, remaining with group) at least once per week. As noted for Individual #10, this goal did not identify opportunities for community integration based on his specific interests and preferences.

- Individual #6 had broadly stated goals to explore his new community and to engage in the community. The IDT should individualize this goal based on an updated assessment of preferences and interests that included exposure to various activities and settings.

- Individuals #10, Individual #62, and Individual #6 lived together. Staff reported that the goal was for at least one community integration activity per week, but they typically went out in the community 2-3 times a week to parks or on errands. Staff reported that Individual #6 enjoyed going on errands with staff and was always ready for a trip. Individual #10 often would choose not to go out, but if it were a bigger type event, he wanted to participate.

- Individual #53 did not have any goals relevant to community participation. Her ISP had a broad statement that she would need support with community integration regularly on outings of her choosing. Staff reported that she had been out in the

community a few times for activities, such as shopping, however, there was no formal plan for community exposure or integration.

- Individual #40 had goals related to community participation, but none that supported integration. Staff noted that he went on occasional outings in the community, including attending a day habilitation program, however, there were no formal plans to ensure he had greater exposure to new things in the community and his ISP had not been updated to include what staff had learned regarding his preferences in the community or possible avenues for integration that he might like to explore.

- Individual #30 had broadly stated goals for outings and participation in the community. His staff reported that he went on outings in the community often and those outings were typically related to his preferences (record store, thrift store, restaurants). They commented that the IDT would like to see him more involved in the community and that the IDT was exploring day programming options. His ISP should be updated to reflect what they have learned, and goals should focus on what he would like to achieve related to becoming more integrated into the community.

- Individual #71 had a broadly stated goal to participate in career exploration. This activity could possibly lead to community integration opportunities; however, the goal was on hold and the IDT had not considered other activities to increase his community awareness and opportunities for integration. The case manager did express interest in the IDT, continuing to focus on employment options going forward, but the plan had not yet been formalized.

- Individual #72 did not have goals related to community participation or integration. His ISP included a list of outings that he enjoyed and had participated in when living at GRC. His ISP had not been updated to reflect what his host home provider had discovered since his transition regarding preferences and possible opportunities for integration. His provider did comment that he had been on multiple outings to new places and his list of preferences was expanding due to more exposure to the community. They were providing him with regular opportunities to explore the community, and some were likely to lead to meaningful integration.

- Individual #2's ISP did not address opportunities for meaningful community integration. During interviews, staff reported that he had frequent opportunities to explore his community, including going to Goodwill to shop for CDs, going to the YMCA, and going to church. These activities had resulted in him making new social connections and becoming more integrated into his community. Individual #2's IDT should update his ISP to include new preferences and support continued opportunities for community integration.

- Individual #24 did not have any goals that were focused on community participation or integration. She did not have an individualized daily/weekly schedule to ensure consistent exposure to opportunities in the community. Her ISP included some broad statements of things that GRC staff knew she liked doing in the community (shopping, going to the movies, picnics, etc.). Her new host home providers took her out in the community frequently and were able to describe numerous activities that she now enjoyed. They ensured that she was able to participate in those activities while offering her exposure to many new activities, people, and places.

- Individual #58 did not have any goals related to community integration. His ISP did not include plans for exposure to the community or assisting him to become integrated with his community other than to note that he would need supports, such as transportation to participate in the community. His staff did confirm that he had opportunities to take excursions into the community and noted that he loves going out to eat, attending social events and parades. His ISP had not been updated to include what they had discovered about what he enjoyed and how he participated in the community.

- Individual #96's goals were broadly stated and did not include plans to support community integration. Her staff indicated that she did have opportunities to go shopping, but so far had few opportunities for community inclusion.

g. All IDT members interviewed were able to articulate preferences and supports needed by individuals. Although observations were limited, staff could describe most techniques included in PNMPs and PBSPs. Staff described training that they received prior to transition for specific support needs and house managers/program directors described ongoing training available to staff. It appeared that staffing was adequate to provide all needed supports to individuals. Also, as stated previously, many of the PBSPs and/or PNMPs had not been revised and were written while the individual was at GRC. Staff knowledge, while adequate for techniques, were lacking when it came to their knowledge of reporting indicators. For psychiatric medications, staff could not clearly articulate psychiatric symptoms for which the medications were prescribed and what would be reported to the psychiatrist. This was also noted of target behaviors that were the focus of the PBSPs. That said, there has been improvement noted with this indicator since the Sept review and with continued success, this indictor may move to substantial compliance with the next review.

- Four individuals with a history of seizures (Individual #42, Individual #49, Individual #33, Individual #50) were discharged with a PRN prescription for Nayzilam with identical directions. Staff interviewed had difficulty articulating the protocol for administering Nayzilam spray in the event of seizures. They knew what the spray was prescribed to treat, but struggled stating the parameters of the order (e.g., spray in nostril for seizure lasting more than 5 minutes). As this was a PRN medication, there was no standalone seizure protocol; the PRN order on the medication administration record was in essence the protocol. Providers should consult with their new neurologist to develop an updated individualized crisis plan related to seizures. Since most had not had a seizure in years, it is likely that 911 should be called regardless of type or duration of seizure.

- Individual #97 moved from the home where he transitioned from GRC to a new provider home on 11/15/24. The case manager's notes reflected that he made a visit to the new home on 10/31/24 to visit and for his new staff to be trained. The case manager reported that "several staff showed up to be trained and the Center of Excellence assisted with the training." During the Monitoring Team's visit, it was discovered that Individual #97's records from his residency with the discharging provider were not provided to the accepting provider. Staff reported that the binder was provided, but no other documents related to his care, services, and supports since May 2024 were transferred to ensure continuity of care. This information was shared with the CIM and State during the onsite visit. The State and CIM have since noted that all provider information for this individual and for others in a similar situation were transferred to the new accepting provider and will become part of their standard process. The lack of sharing the individuals' personal record and information was of concern as there was no current information on which to base staff training. The training provided was from the Center of Excellence and based on the individual's initial transition plan and supports.

- Individual #40, by staff report, was experiencing issues with sleep. The psychiatrist had prescribed Trazodone, but staff reported that "it really wasn't helping," so the psychiatrist discontinued the Trazodone and prescribed an antipsychotic medication, Seroquel. When the Monitoring Team asked if there were data upon which the psychiatrist based this decision, staff reported there were none other than what they reported to the psychiatrist during clinic visits at the ICF program. Reports, since not based on data, were more general and subjective in nature.

Overall, individuals who were visited and were prescribed multiple psychiatric and anti-psychotic medications, did not have providers that had discussed, developed, or implemented a system to track psychiatric symptoms in order to provide measurable data to the psychiatrist for making informed treatment decisions with regard to psychotropic medication regimens. Because of this, staff reported that this information was often relayed to the psychiatrist at appointments verbally or in a general comment on the consultation form. This type of informality increases the likelihood of potential variances in what is reported and how it is reported. This may have also impacted the staff's ability to articulate psychiatric symptoms for which the medications were prescribed.

h. Person-centered plans should provide guidance for staff on what the individual's daily routine should include in terms of how and when identified supports are implemented and how the individual prefers to spend their day/evening/weekends. This guidance should be driven by the individual's preferences and input (either directly or through the assessment process). Some ISPs had a general outline of what their day looked like, but most were limited in content or direction. A daily or weekly summary or expected schedule would support staff to carry out their duties with regard to positioning, dining, medications, involving individuals in routine household activities, skill training, and appointments. This type of summary also demonstrates the person's active engagement and exercise of choice when scheduling what their week looks like. For those who are unable to easily express that choice, this becomes an ever-higher priority.

- ISPs for Individual #42, Individual #55, and Individual #49 included a daily summary of when supports would be provided and how they would spend their day.

- Individual #33 did not have an updated ISP with a daily schedule or summary.

- Individual #20 had a daily schedule/summary that included prompts for staff providing supports.

- Individual #50's ISP included a general overview of what a typical day looks like for him, but did not have guidance to staff for supporting him in completing daily activities.

- Individual #83's ISP provided an overview of what a typical day for him looks like or what staff should do to support him throughout this day.

- Individual #58's ISP noted that he did not work, had not shown any interest in searching for employment and he would like to be retired. There was no other discussion regarding how he might want to spend his days or his preferences in regard to a daily schedule. His staff were able to describe his daily schedule; however, a daily schedule/summary was not submitted in response to the document request.

- Individual #53's ISP did not include a description of what her day looks like. There was a comment that she was not attending day programming, but no description regarding what she was doing during the day. There were no documents submitted in response to the Monitor's request for a description of her work or day program or a summary of community outings.

- A daily schedule was submitted for Individual #40, however, it had little detail regarding activities listed. For example, the schedule noted "recreation, crafts, outings" from 4:00 to 4:30 daily and "leisure" from 7:00 -7:30 daily. It was not clear what activities would be offered, what supports staff may need to provide, or how Individual #40 would participate in planning his day.

- Individual #30's ISP included very little information about his daily schedule or preferred activities. There were no documents submitted in response to the Monitor's request for a description of his work or day program or a summary of community outings.

- Individual #71's ISP included a description of various supports he needed throughout his day, however, there was no discussion of his preferred schedule. No other documents were submitted that showed a daily schedule or other staff supports in place to guide staff throughout their day.

- Individual #72's documents included some notes regarding his daily activities; however, no daily/weekly schedule/summary was submitted.

- Individual #2 had a weekly calendar that included daily activities written in very general terms. It did not offer staff guidance in providing needed supports.

- Individual #24's ISP included some description of preferences for how she would like to spend her day, however, a daily/weekly calendar, or schedule of supports was not submitted.

- Individual #96's ISP included a description of some supports that she needed throughout her day relevant to her schedule at GRC, however, a daily/weekly calendar was not submitted in response to the document request. Her case manager reported that her recent move was, in part, due to her guardian's dissatisfaction with the lack of meaningful programming and engagement while at the previous provider. Since her transition to new provider, the IDT had discussed participation in day programming, but had yet to develop a calendar or schedule of activities.

i. About half of the ISPs did not include individualized protections and supports to minimize risks. The Monitoring Team continued to identify individuals who were identified at the time of transition as being at high risk for certain medical/behavioral issues. These risk areas included, but were not limited to constipation and aspiration, which are among the fatal five, and GERD, which is consistently ranked as the sixth leading cause of death in IDD individuals.

The lack of consistent tracking without justification/assessment was noted beyond psychiatric and also included behavioral data related to the BSP as well as risk mitigation. Valid reliable data is essential to the professional/team making informed decisions and

ensuring overall health and safety. If data is not needed, then a clear determination with supporting rationale should be provided with alternatives on how changes in status will be identified and shared.

The identification of risk should be a result of active evaluation/assessment/screening as well as thorough IDT discussion. The decision to provide certain supports ranging from an adaptive spoon to tracking particular indicators should be based on what achieves the best outcomes and quality of life. Part of the IDT process is to recognize that certain supports are considered standards of practice and deviations from those standards require thoughtful discussion with sufficient justification. The expectation is that this determination with the supporting evidence would be contained within the ISP. It is also the expectation of HCBS to have a clear plan that includes risk factors and the associated plans to mitigate the risk. The risk plans should have individualized goals. As of this review, this was not consistent, but initiatives have been put in motion that will hopefully begin to address this identified gap moving forward. Success of this program will lie in how well the risk plan is developed and ongoing implementation.

Federal regulations and the State ID Waiver Plan require risk assessment and management to be included in the ISP and places the responsibility for risk assessment and management on the IDT. Health risks, risks related to outcomes from taking certain types of drugs, and risks related to an individual's behaviors are risks being evaluated by the IDT. Data tracking is a risk mitigation technique that should, after evaluation of the risk and input from the individual's health care professionals, be considered by the IDT. For many individuals, this discussion and assessment did not consistently occur despite the support being in place prior to transitioning into the community.

Additionally, the IDT should identify alternatives that will give them the best information in lieu of those supports. For example, a mammogram is considered a standard of preventative care. If the person does not want one or cannot tolerate it, does not mean that the IDT is done with providing the support. It is now up to the IDT to determine what other options are available and how they can monitor for signs of potential issues without having a mammogram. If the barrier is behavioral, then the IDT should collaborate with the Behavior Specialist to address the issue. If it is a choice, then the IDT should explore other options. Again, it is the hope that the risk reassessment process will address this issue.

Other Issues noted include:

- Risks identified at the time of transition have not been consistently carried over to their new setting.
- Care plans/ISPs have not consistently been implemented/developed to address these risks.
- Methods of tracking and acquiring data that were once in place at GRC have not been consistently carried over to the community setting with no clear rationale or justification provided to support the withdrawal or suspension of these supports.
- Lack of monitoring to ensure implementation and/or effectiveness.

Some Findings from the compiled reviews were as follows:

- Individual #24 was identified as being at risk for aspiration, choking, and GERD. Three different food consistencies were noted. The transition plan stated that she was on a pureed diet while the Nursing Protocol stated Mech ground. Per interview, the CM stated she was on a regular diet. Additionally, the CM did not appear to be aware of why the individual required certain supports stating that they were due to her eating fast with no acknowledgment of the pharyngeal difficulties experienced by the individual.

Individual #24 was also noted to be at an increased risk of UTIs and was noted to have them frequently. The lone support for this issue was to encourage water and to have cranberry juice available. There was no tracking of intake to ensure appropriate proactive measures occurred and were effective.

- Individual #2 was noted in the transition plan to be at High risk for cardiovascular disease, deep vein thrombosis/pulmonary embolism, GERD, Infection, and Urinary tract infection. One of his care plans was focused on the tracking of bowel movement to help address the risk of constipation. While bowel movements were tracked, there were no clear proactive measures/actions assigned to the care plan. All actions were responsive and after an issue had already occurred, such as red blood in stools and firm abdomen. There was no discussion of proper diet that can help address constipation or body mobility movements that can also be preventive in nature. Additionally, there were no parameters set within the care regarding days without a BM. Per review of the data, bowel movements were absent for multiple days multiple times without intervention. An example was when the individual had, from 11/1/24 to 11/10/21, no bowel movements recorded, and no documentation of a provided bowel aid. SCL documentation for this time period also lacked any discussion regarding lack of BMs.

- Individual #53 was identified as being at risk for constipation/bowel obstruction. She was encouraged to have fluid intake to decrease constipation. This offering/encouraging 8 oz of fluids every 2 hours and to consume a minimum of 2160 milliliter (72 ounces / 9 cups) of fluid, but there was no evidence that this was being tracked and analyzed for effectiveness. While actions existed for issues, such as constipation, they were reactive in nature.

- Individual #58 was identified as being at high risk for aspiration and skin breakdown per the transition plan. The transition plan stated that fluid intake should be monitored as well as his weight. According to the provider risk plan for pneumonia, there was no connection to the PNMP and the supports as they were left off the risk plan. Rather the risk plan focused on the GERD aspect and avoiding meals prior to laying down. There was no mention of diet texture or strategies to help mitigate risk in the risk plan though they were identified as part of the PNMP.

- Individual #33 had had numerous UTIs and bouts of constipation. Case Management notes reflected his continued health issues, but did not offer enough detail on recommendations by various consultants to reduce his risks and ensure needed supports were in place and effective. He had also had some behavioral issues and medication changes without evidence that behaviors were being tracked, and data provided to the PCP or psychiatrist.

- Case manager notes did not reflect changes to health status or supports for all services for Individual #42. He was evaluated for swallowing issues though the outcome of that evaluation was not noted. There was no indication that risk plans were reviewed for efficacy.

- Individual #97 had significant weight gain following his move from GRC with no clear adequate actions to address. Individual #97 had a PMM support for his weight to be taken and recorded monthly. At the 7-day visit, the PMM noted that the provider did not have a scale in the home yet scored the support as being in place. At the 30-day visit the PMM noted that there was still no scale in the home, but scored the support as being in place. At the 60-day visit, the PMM observed Individual #97 to be

weighed by staff on a typical bathroom scale and his weight was 182.2 pounds, an increase from 161.0 pounds in April 2024 before his transition. The PMM scored the support as being in place. At the 90-day visit, the PMM observed Individual #97 stand on the scale and his weight was 177 pounds. There was no indication that the PMM reviewed documentation to ensure weights were recorded. At the 120-day visit, the PMM noted that staff reported Individual #97's weight to be 179 pounds as of 9/1/24. Again, the PMM did not indicate if documentation was reviewed. The 150-day visit indicated Individual #97's weight was 192 pounds (nearly a 30-pound weight gain since the month prior to his transition). The PMM did not flag this as a concern for follow-up action.

- Individual #97 moved from one home to another on 11/15/24. The only ISP was the initial plan developed by the MFP case manager. This plan did not include specific individualized protections and supports to minimize risk. As noted above, during the Monitoring Team's visit, it was discovered that Individual #97's records from his residency with the discharging provider were not provided to the accepting provider. Staff reported that the binder was provided, but no other documents related to his care, services, and supports since May 2024 were transferred to ensure continuity of care.

- Individual #101 was receiving Risperidone 1 mg twice per day at transition. This medication was discontinued on 5/6/24 and Chlorpromazine 25 mg per day was ordered then increased to 75 mg per day on 5/20/24. There was no system in place to document symptoms associated with her mental health diagnoses in order to inform the psychiatrist on the efficacy of the prescribed medication regimen for making treatment decisions. Staff reported that when she attends her psychiatric appointments, the physician could observe her in the waiting room via cameras. The PNMP from GRC was updated 4/11/24 prior to her transition and was still in place as a guide for staff.

  Individual #101 had an order on her medication administration record for Neupogen 480 mcg via tube to be administered PRN. Staff were unsure of the reason for the PRN medication and reported that it was an old medication that was no longer necessary, but the pharmacy continued to include on the monthly MAR.

- Individual #45 had gained more than 70 pounds since transition, however, the case manager had not elevated this to a critical level for action.

- Individual #30 had health care plans in place to address constipation, diet, diverticulitis, hemorrhoids, personal care, and his catheter care. All plans had been implemented in September 2024. For the most part the instructions were general in nature and did not provide enough information for staff to identify a change of status or provide consistent supports. For example, his goal related to diet was to encourage him to follow the recommended diet. The plan did not describe his diet. The approach section listed checking and documenting his weight, however, there was no ideal body weight noted and no instructions for when or what staff should do if his weight fluctuated. His plan to address his risk for constipation included a goal for staff to track his bowel movements. This did not describe a desired outcome and again there were no instructions for actions to be taken based on tracking information.

- Individual #71 had a number of high risks that were not addressed through a comprehensive health care plan that offered clear directions for staff to mitigate this risk. For example, he was at high risk for aspiration. The provider submitted a one-page

bulleted summary of supports to address all risk. The section that addressed aspiration did not include any supports related to dining. His PNMP did not include a detailed description of dining supports and his ISP just noted that he needs moderate assistance with eating, he used adaptive equipment, and his food is bite sized. Supports to address his risk for fluid imbalance were similarly broad with a statement to monitor his fluid intake daily with no parameters noted to determine what his fluid intake should be. His weight at discharge from GRC was 184.5. At the 7-day and 30-day PMM visit, the PMM noted no scale available, but marked the support as in place. On the 60-day (6/17/25) the weight was noted to be 217 (32-pound gain from discharge. The PMM noted that the IDT was not concerned. From 60-day through 180-day (10/15/24), weight was noted, but there was no comparison weight month to month. By 180-day weight was recorded by PMM as 232 pounds. The notes first mentioned that due to weight gain, his leg was rubbing on wheelchair (no comment on severity), but noted someone will look at wheelchair on 10/7/24 to adjust for weight gain. PMM commented that provider will begin weighing him daily due to continued weight gain. Though the IDT is now addressing his wheelchair and pressure points due to significant weight gain, it was not obvious that they recognized the role his weight gain played on his pressure wounds and therefore, did not address it as critical.)

- For Individual #58, in response to the document request for plans to address risks, the provider submitted a one-page bulleted list of strategies to reduce risks related to constipation, cardiovascular disease, GERD/respiratory compromise/pneumonia, fractures/osteopenia, and falls/skin breakdown. Supports needed were broadly stated and did not offer individualized parameters to assess risk status. For example, staff were instructed to check vitals daily and report triggers outside the parameters to the PCP, but there were no parameters given. Similarly, his plan for GERD stated to report signs and symptoms to the PCP, however, no specific signs or symptoms were included. His plan to reduce his risk for fractures stated follow safety plan as written. No safety plan was provided.

- Individual #96, had a number of healthcare plans, including plans for assistance with ADLs, bowel tracking, diet, and UTIs. These plans were discontinued when she transitioned from the provider. Her transition plan/ISP was updated when she moved into a new home, however, it did not include detailed healthcare supports and new healthcare plans were not developed. A PNMP was not submitted in response to the document request.

As stated previously, most individuals visited were prescribed multiple psychiatric and anti-psychotic medications, yet the providers had not developed or implemented a system for tracking of psychiatric symptoms or any other formal method to provide accurate measurable data or feedback to the psychiatrist to assist in making informed treatment decisions with regard to psychotropic regimens. This type of feedback is essential for those Individuals in which caregiver assistance is needed and who often serves as the individual's primary advocate and voice. Staff reported that this information was relayed to the psychiatrist at appointments verbally or in a general comment on the consult visit form, but staff could not clearly articulate psychiatric symptoms for which the medications were prescribed.

For individuals who also had behavioral support needs, the positive behavior support plan (PBSP) from GRC was mostly being utilized with limited to no objective behavioral data aside from daily staff notes or general records for assessment of behavioral stability. As with psychiatric symptoms, staff could not clearly articulate target behaviors.

For individuals with physical and nutritional support needs (choking, aspiration, skin breakdown, etc.), like the PBSPs, their physical and nutritional support plans (PNMPs) remained the same ones from GRC and were not consistently updated when there were changes in care. Additionally, upon review of 10 limited death reviews, many were related to the fatal five (aspiration, constipation, dehydration, seizure, and sepsis).

The Limited Death Review Committee consisted of members of the Superintendent, Director of Quality Management, Administrator of Nursing, Assistant Superintendent of Treatment Program Services, HHS State-Operated Specialty Care Division Executive Officer 2, Medical Director, and the HHS State-Operated Specialty Care Division Management Analyst 3. The purpose of this committee was to review potential issues contributing to the death of the individual. This committee also noted a lack of documentation (e.g., blood pressure, bowel tracking or intake) related to risk areas, often resulting in the inability of the review committee to clearly determine if supports were provided as needed.

The limited death reviews often provided good insight into the events but were significantly limited at times. For seven of the nine reviews, HHS had releases, but HHS truly verify only one that all of the relevant documents and information had been provided because individual passed while at WRC. For the others, there was a level of uncertainty regarding if the information submitted by the providers and CMs comprehensively reflected all of the services provided and events that occurred. Because of these limitations, the death reviews should not be looked at as a way to determine direct cause for an event but rather to help identify opportunities to improve overall services. That said, the pattern of issues identified in the completed limited death reviews were worth being noted as they are the same issues that have been observed by the Monitor when conducting the community reviews.

At the time of death, the lack of documentation and risk plans made it difficult to determine if issues were exacerbated by the lack of plan implementation. Many of the issues noted in August 2024 by the Ltd. Death Review Committee continued to be the same issues noted in the most recent review completed in February 2025.

Some examples are noted below.

- Individual #59 passed on 8/8/24 and had a diagnosis of slow transit constipation, and a history of mitral valve regurgitation. There were no specific supports listed in the PMM document regarding bowel management or bowel tracking. There was no documented training regarding the bowel management plan or daily bowel tracking by GRC with the community provider or host home provider, though the Individual Specific Needs document for the Individual stated "…report any signs and symptoms to nurse and health care professionals, record each bowel movement on the elimination tracker. Encourage physical exercise. Encourage him to drink at least 3500 cc of fluid daily." This was noted by the Ltd. Death Review committee to be an insufficient plan.

- Individual #17 passed on 10/14/24. There was a lack of documentation provided. The provider's plan stated that the individual's weight was to be obtained weekly with blood sugars taken and recorded at a minimum of weekly. Also, the recommendation from his 10/3/24 walk-in medical clinic visit stated his blood pressure should have been taken at least daily.

  Per the Ltd. Review Committee, these may have been completed, but there was no documentation to support their occurrence. Progress notes stated intermittently that blood sugars were being checked, but no documentation as to what the blood sugar

were at that time they were taken. Regular monitoring and documentation of his vital signs would have assisted in identifying a change in condition sooner with timelier medical intervention. It was also noted by the Ltd. Death Review Committee that based on the documentation, plans were not in place to mitigate risk areas.

- Individual #21 passed on 10/25/24 with multi-organ failure, malnutrition, and renal failure due to lack of intake (fluid and nutrition) as the probable cause of death. It was noted by the Ltd. Death review Committee that data received in July 2024 and August 2024 for fluid intake and bowel movements was sporadic. Better tracking was not completed until September 2024 due to new requirements. The new requirements included that the provider would have tracking mechanisms in place to track individual's bowel movements and fluid intake. There was also no discussion within the review that commented on weight tracking and if that was verified.

- Individual #103 passed on 5/18/24 due to aspiration pneumonia. On 3/25/24 and 3/26/24, it was noted that he had reduced food intake and was coughing. He was admitted to the hospital on 3/27/24. He was discharged on 4/10/24, with a diagnosis of aspiration pneumonia. The discharge document indicated that he was to have a normal diet. Per the PNMP while he was at GRC, he was to have a texture pureed diet texture. There was evidence that his diet had been changed, but it was not clear whether he had received an appropriate assessment for a change in diet.

- Individual #99 passed on 12/22/24 due to pneumonia, sepsis, and hypoxia. Per the review by the Ltd. Death Review Committee, there were issues with the PMM process, and the identification of issues associated with risk, as well as the appropriate review of documentation and follow-up. Oral intake was being tracked, however, during review it appeared that less than minimum standard amounts were being administered. According to the United States National Academies of Sciences, Engineering, and Medicine (NASEM), women should consume at minimum of 2.7 Liters of oral intake daily. At the time of documentation review for this meeting, she was averaging less than 1/3 of that consumption daily. Inadequate fluid intake would have caused severe dehydration, which could have potentially led to multi-organ failure, sepsis, and hypoxia. Also, there no documentation to support that the team came together to discuss changes in her health status leading to death. Last documentation in progress notes by MCO case manager was on 12/12/24. Additionally, it was found that provider staff did not notify the PMM, and the CM did not update supports as indicated by changes in status.

- Individual #51 passed on 12/2/24 due to cerebral hypoxia. The individual was noted to be eating in a vehicle, which was not conducive to mitigating his swallow difficulties. He had a modified textured diet and supervision during meals due to impulsivity while eating and oral dysphagia.

An issue noted across the Ltd. Death Reviews was that the review focused many times on what the PMM could do to improve the outcome, but did not address systemic issues noted as a result of the review. Per the State, this should begin to be picked up through the CM audit process.

In response to concerns by the Monitor and USDOJ, the State agreed to reassess the risk of the target population within 365 and many outside the 365-day mark. The timeline for this to be completed was based on reaching those at the highest needed first. Those most vulnerable were chosen by the State and Center of Excellence in collaboration with the Monitor.

There were 38 individuals that were included this reassessment process, known as Group One. The State created a plan for reassessment in two stages/waves to alleviate the burden on case managers and transition specialists. Joint determination by the Monitor and the State was that all case managers and transition specialists serving Group One received fatal five training before beginning their reassessment.

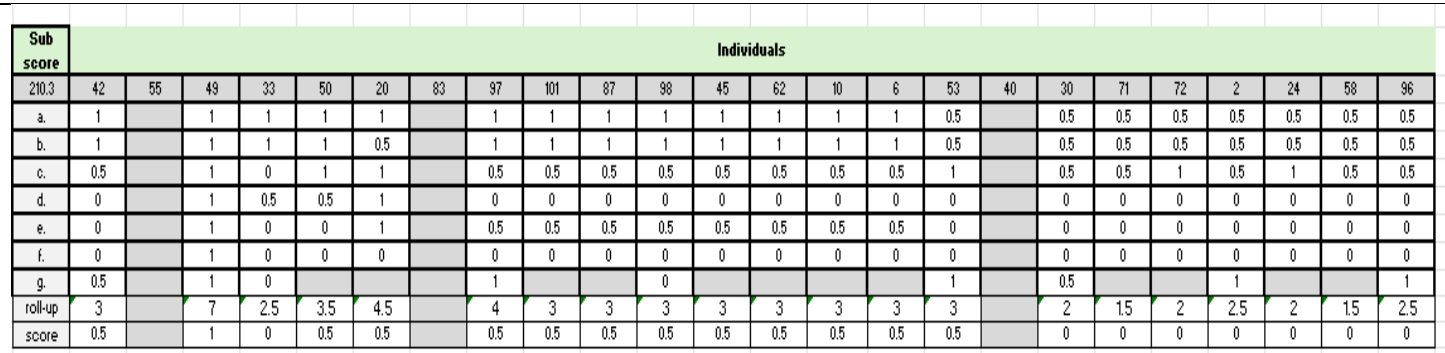
The final deadline date for stage/wave two was intended to accommodate case managers and transition specialists who had a heavy burden among stages/waves one and two. The expectation was that if the assigned CM or TS did not have any individuals in the first wave, they would commence their work immediately and achieve the result in a shortened timeframe.

Per the provided timelines, Group One stage/wave one would have their risk reassessed with an implemented risk plan no later than 4/18/25. The initial group, as stated previously, were those determined to be the most vulnerable. Group One stage/wave two would have their risk reassessed and risk plans implemented no later than 5/2/25.

The expectation by the State was that the fatal five training and the risk reassessment process would ensure that those who had not had their risk supports in place, many since the transition, would have those plans put in place by the due dates listed above. The individuals in Group One(stage/wave one and two) were transitioned from GRC between the months of March and June 2024 meaning that some of the individuals had gone over a year with no formal risk-reassessment or assurance that plans met the identified needs of the individuals.

<table>
<tr><th colspan="2">Paragraph 210</th><th>Compliance Score</th></tr>
<tr><td colspan="2">The State shall provide ongoing community case management to members of the Target Population who transition to the community.
a. For individuals receiving case management services pursuant to this Agreement, the individual's case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs and preferences. The individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence.

b. At these face-to-face meetings, the case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs. If any of these observations or assessments identifies an unidentified or inadequately addressed risk, injury, need, or change in status; a deficiency in the individual's support plan or its implementation; or a discrepancy between the implementation of supports and services and the individual's strengths and preferences, then the case manager shall report and document the issue, convene the individual's service planning team to address it, and document its resolution.</td><td>Partial Compliance</td></tr>
<tr><td>#</td><td>Indicator</td><td>Indicator Score</td></tr>
<tr><td>1</td><td>The individual's case manager met with the individual face-to-face at least once every 30 days with one visit every 2 months having occurred the individual's residence. (210a)
<table><tr><th colspan="22">Individual Scores</th></tr><tr><td>42</td><td>55</td><td>49</td><td>33</td><td>50</td><td>20</td><td>83</td><td>97</td><td>101</td><td>87</td><td>98</td><td>45</td><td>62</td><td>10</td><td>6</td><td>53</td><td>40</td><td>30</td><td>71</td><td>72</td><td>2</td><td>24</td><td>58</td><td>96</td></tr><tr><td>1</td><td></td><td>1</td><td>1</td><td>1</td><td>1</td><td></td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td></td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td></tr></table></td><td>Substantial Compliance
100%
21/21</td></tr>
<tr><td>2</td><td>The individual has received ongoing community case management services at the frequency required based on the individual's needs and preferences. (210a)
<table><tr><th colspan="22">Individual Scores</th></tr><tr><td>42</td><td>55</td><td>49</td><td>33</td><td>50</td><td>20</td><td>83</td><td>97</td><td>101</td><td>87</td><td>98</td><td>45</td><td>62</td><td>10</td><td>6</td><td>53</td><td>40</td><td>30</td><td>71</td><td>72</td><td>2</td><td>24</td><td>58</td><td>96</td></tr><tr><td>1</td><td></td><td>1</td><td>1</td><td>1</td><td>1</td><td></td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td></td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td></tr></table></td><td>Substantial Compliance
100%
21/21</td></tr>
<tr><td>3</td><td>Case Management contained the following minimal components as indicated: (roll-up of a-g) (210b)</td><td>Noncompliance
33%
7/21
46%
62.5/135</td></tr>
</table>

		
	a. Observed the Individual (clean, healthy, personal clothing/belongings)	Substantial Compliance 81% 17/21
	b. Assessed the environment (safety, cleanliness, personalization)	Substantial Compliance 79% 16.5/21
	c. Assessed the status of identified risks, injuries, needs, or other changes in status.	Partial Compliance 62% 13/21
	d. Assessed ISP appropriateness.	Noncompliance 14% 3/21
	e. Assessed the implementation of supports/services within the ISP. (Adaptive, sensory, AAC, etc.)	Noncompliance 29% 6/21
	f. Ascertained whether supports and services were implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs.	Noncompliance 5% 1/21
	g. Followed identified issues to resolution.	Partial Compliance 60% 6/10
4	In the event an unidentified or inadequately addressed risk, injury, need, or change in status; a deficiency in the individual's support plan or its implementation; or a discrepancy between the implementation of supports and services and the individual's strengths and preferences) were noted, the CM reported the issue and held an IDT to address the situation. (210b)	Noncompliance 0% 0/9

Sub score	Individuals																								
210.3	42	55	49	33	50	20	83	97	101	87	98	45	62	10	6	53	40	30	71	72	2	24	58	96
a.	1		1	1	1	1		1	1	1	1	1	1	1	1	0.5		0.5	0.5	0.5	0.5	0.5	0.5	0.5
b.	1		1	1	1	0.5		1	1	1	1	1	1	1	1	0.5		0.5	0.5	0.5	0.5	0.5	0.5	0.5
c.	0.5		1	0	1	1		0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	1		0.5	0.5	1	0.5	1	0.5	0.5
d.	0		1	0.5	0.5	1		0	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0
e.	0		1	0	0	1		0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0		0	0	0	0	0	0	0
f.	0		1	0	0	0		0	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0
g.	0.5		1	0				1			0					1		0.5			1			1
roll-up	3		7	2.5	3.5	4.5		4	3	3	3	3	3	3	3	3		2	1.5	2	2.5	2	1.5	2.5
score	0.5		1	0	0.5	0.5		0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5		0	0	0	0	0	0	0

Individual Scores																						
42	55	49	33	50	20	83	97	101	87	98	45	62	10	6	53	40	30	71	72	2	24	58	96
			0				0	0		0	0				0			0		0	0		

Comments:
This paragraph will remain in partial compliance due to the low scores associated with the identification of risks, injuries, needs, or other changes in status as well as the decreased presence of the CM assessing the appropriateness of the ISP, including the lack of an appropriate response when a risk occurred.

1. Documentation reflected that case managers for all individuals reviewed were making required monthly visits. Case managers interviewed were knowledgeable of the individuals and could mostly able articulate status of medical appointments, risk mitigation strategies, outcomes, and progress they have seen since transition.

2. Individuals received ongoing community case management services at the frequency required based on the individual's needs and preferences. Case managers were documenting monthly visits that included at least bi-monthly face-to-face visits in the home.

3. Case management notes were for the most part broadly written statements about what had happened over the past month. Rarely was there enough detail to determine whether a thorough review of supports and services was conducted or that they participated in planning and/or follow-up when concerns were noted, such as missed appointments or changes in support needs. During the Monitoring Team's interviews, case managers reported that there was little to no review of data and documentation during home visits. Monthly team meetings, including PMMs, were held in a discussion" format with little to no verification of implementation of services/supports.

As an example of a quality case management note format, the Iowa LTSS Assessment Summary utilized by Molina should be reviewed. The prompts address the requirements of this indicator in a manner that allows for recording substantive detail on the delivery of services and supports, gaps, or needs, identification of needed follow-up and revision, and a visit summary.

See comments below for 3a-3g for examples of specific findings.

a. Case management notes offered at least a brief comment on what they observed during monthly visits regarding individuals' appearance and personal care. For those individuals not scored as present, the CM would offer a description of the visit, but did not specify appearance and well-being. Some examples are noted below:

- Documentation for Individual #53 covering the period of July-December 2024 reflected that the case manager recorded observations of her appearance and interactions. However, the case manager did not comment on observations on whether she had adequate clothing and personal items or whether she appeared happy, healthy, and well overall.
- The case management notes for the period of July-December 2024 for Individual #24 did not specifically mention her appearance but did reflect whether Individual #CD participated in the visit and any interaction with the case manager.
- For the period of July-December 2024, the case manager commented on Individual #72s physical appearance, mood, and emotional well-being including interactions with the case manager and participation in the visits.

b. For the most part (79%), case managers commented on environmental issues in their monthly notes. This was a significant increase from the previous 6-month review when only 15% of the notes were adequate. Case management notes offered at minimum a brief description of what the individuals were doing at the time of the case manager's visit or interactions between the case manager and the individual. but were not always inclusive of an assessment of overall environment cleanliness, personalization, or notation of any safety concerns as noted in some examples below. .

- Documentation for Individual #53 covering the period of July-December 2024 did not always indicate whether the home was safe, accessible, or clean. The case manager noted concerns with adequate staffing and guardian concerns with overall supervision and oversight by the provider.
- The case management notes for the period of July-December 2024 for Individual #24 did not specifically mention the environment but did reflect a thorough conversation with the host home provider and a brief description of what Individual #24 was doing during the visit. During the visit of 11/20/24, the host home provider requested bathroom modifications to make things easier and more accessible for Individual #24.
- For the period of July-December 2024, the case manager for Individual #72 generally commented on the physical environment and personal items, noting he needed clothing at the August 2024 visit, but did not always indicate whether there were accessibility concerns or safety issues.
- Individual #20's home did not have a secondary egress point. This was not noted by the case manager; however, her staff were aware of this, and plans were already being made to add a ramp off the back deck.

c. As noted above, case management notes were not substantive in commentary and not focused on having the case manager review documentation and data. In several instances the case manager noted that medical records from appointments, data related to plan implementation, and health monitoring was not available for review, therefore, case manager notes did not always reflect changes to health status or supports for all services, and identification by the case manager of emerging issues continued to be an area of concern. While general tracking of indicators, such as bowel, weight, blood pressure, etc. was in place, case management notes did not reflect an assessment by case managers to identify potential emerging issues. This was the same for PMM visit notes.

However, the Monitoring Team has seen a general improvement in the case management documentation. Some case managers were utilizing prompts within the note format to capture summaries of community involvement, family visits, medical issues, appointments, review of MAR, behavioral issues, hospitalizations, hygiene/personal assistance concerns, physical environment, etc.

Additionally, the State just initiated a risk re-assessment process that includes additional training for the CMs and Transition Specialists as well as using that training to take a look at risk areas and intended plans of mitigation. This is also discussed in paragraph 209.i above. This process should have a direct positive impact on the identification of risk and the needed CM follow-up.

- Individual #33 had numerous UTIs and bouts of constipation. Case Management notes reflected his continued health issues, but did not offer enough detail on recommendations by various consultants to reduce his risks and ensure needed supports were in place and effective. He had also had some behavioral issues and medication changes without evidence that behaviors were being tracked, and data provided to the PCP or psychiatrist.

- Case manager notes did not reflect changes to health status or supports for all services for Individual #42. He was evaluated for swallowing issues though the outcome of that evaluation was not noted. There was no indication that risk plans were reviewed for efficacy.

- Case Management notes for Individual #97 described concerns, lack of services, and meetings with the provider for a transition. The case manager did a great job following up on the abuse allegations, making unannounced visits, and talking with the guardian. Once concerns were expressed by the guardian about continued services with the provider, the case manager acted promptly to contact another provider about an opening in one of their homes, met with the guardian, and arranged visits. However, Individual #97 had significant weight gain that was not adequately addressed by the case manager or team. Urgency did not occur until the guardian decided to switch providers.

- For Individual #101, there was no evidence that behaviors were being tracked, and data provided to the psychiatrist prior to medication changes.

- During the Monitoring Team's interview with Individual #45's case manager, it was reported that his guardian had visited a home operated by the provider with a vacancy and that it was anticipated that a 30-day notice would be given to the provider and plans for his transition would begin. This information was available to the Monitoring Team in case management notes provided. Additionally, Individual #45 had experienced significant weight gain yet the case management notes did not reflect an aggressive approach to identify potential causes or actions to address. Although the case manager made comments about the weight gain, for months, the question compared to whether the individual had experienced weight gain/loss was given a "no" response by the case manager.

- Individual #98 transitioned to a provider's home in June 2024. During the Monitoring Team's visit, he was the sole resident remaining in the home, as his three other housemates had transferred to different agencies. His bedroom was in the basement of the home and while he seemed to like his space, there was little documentation regarding how much interaction he was receiving from staff given this arrangement. Further, there was no indication the case manager assessed the arrangement for adequacy. Additionally, there was an overall lack of a process by the providers to assess and determine/update risk of the individuals.

- Case Management notes for Individual #30 did not reflect a review of documentation relative to goals or behavioral supports. The case manager was utilizing a standardized grid type note format with prompts (Post Move Action Plan) to review areas, such as health, recreation/leisure, physical environment, behavioral/mental health, and goals. The case manager noted, for example, Individual #30's current goals, but did not summarize progress or lack of progress. The December 2024 case manager note specifically indicated that the documentation the case manager was shown did not give a lot of information in particular about work on goals or behavior. The provider was to follow up with the case manager on whether any additional documentation is being done other than what was shared.

- The August 2024 case management note for Individual #71 indicated that for assessing implementation of his goal for career exploration, he had been waiting for work services to restart with the provider. The provider had been exploring ideas for him, including attending day hab as the agency was expanding this service. There was no assessment of progress related to this goal in the September 2024 note. The October 2024 note reflected that he was still on the wait list to begin services, but nothing had been identified that would be the right fit. The note also reflected that he could not be in his wheelchair for long periods of time, which meant that work would not be an option, but would continue to be looked at for him. The November 2024 case management note indicated that the goal for career/work exploration would be discontinued due to him remaining on the wait list for vocation services and not able to sit in his wheelchair for long periods of time. The goal would be re-explored when Individual #71 was able to maintain sitting position for longer in his wheelchair. The December 2024 case management note indicated that Individual #71 did not want to attend a day hab program at this time. There were no actions identified by the case manager to address the need for repositioning and how he could be supported in a work or vocational program based on his interest and preference other than to offer day hab as the option.

- Documentation for Individual #53 reflected numerous meetings to discuss ongoing issues with medication errors, documentation, protocols for prevention and identification of risks (e.g., UTIs, seizures, ambulation), coordination post-hospitalization and follow-up appointments. The August 2024 case management documentation reflected identification of 5 identified threshold that had been met and required review. Due to ongoing concerns from the guardians and lack of responsive action by the provider, the guardians requested exploration for a new provider and Individual #53 transitioned from one provider to another in November 2024. Case management notes for October, November and December 2024 reflected coordination for transition and more detailed assessment of services and supports.

- Case manager notes from July-December 2024 reflected that the case manager reviewed all services and supports, status of risks, and appointments with the host home provider and documented results or follow-up needed. The case manager noted that Individual #24 had lost weight and needed clothes. The host home provider reported difficulty locating a dental provider but reported to the case manager in November 2024 that an appointment with Boys town had been secured for 1/14/25.

- Case management documentation for the months of July-December 2025 for Individual #72 reflected that the case manager reviewed services and supports, change in status, appointments, identified risks, and documentation as well as gaps or needs in services. Individual #72 had lost weight due to healthy eating and walking daily (from 182lbs at transition to 156lbs in September 2024). Although the host home provider had reported difficulty obtaining a dental provider, an appointment was scheduled for June 2025.

d. Case managers generally commented on community outings, appointments, and overall delivery of services and supports, but did not assess overall Plan appropriateness. The overarching issue was that the case managers were not commenting on whether the Plan was currently reflective of the individual, his/her interests, and desires for increasing community life or independence. Also, there was, for the most part, no data on implementation for review and although case managers often commented on lack of data, there was no way to assess progress or lack thereof.

- Individual #50's case manager was not consistently commenting on day programing or community outings Additionally, for Individual #33 and Individual #50 whether supports were being implemented as written in his ISP were not consistent.

- Individual #42's case management notes did not reflect consideration of the appropriateness of ISP services and supports following transition.

- Individual #49's case management notes reflected a review of the effectiveness of supports and services, as well as frequent contact with the IDT.

- Individual #20's case management notes did include substantive commentary on the appropriateness of supports and services.

- Case management service goal and documentation review for Individual #53 for the period covering May-July 2024 indicated that she had 4 goals in her ISP to be implemented by the provider: a minimum of 10 minutes of 1:1 time with staff daily, to call her family weekly and visit her local family with assistance as desired, stand with the assist of staff and the EZ Stander up to 3 minutes twice daily to increase standing time to 5 minutes, and to brush her teeth twice a day with staff assistance. The case manager reported that the provider only had documentation related to the first two goals and did not have documentation to reflect implementation of using the EZ Stander or brushing teeth. The case manager further noted lack of documentation for the goals that were implemented and thus there was no assessment of overall ISP appropriateness. At the 9/4/24 meeting, the IDT discussed her goal to maintain relationships with her family and determined it was not a meaningful goal for her because she rarely asked to call someone, so the goal ended on 9/4/24. The IDT discussed the goal for her to build rapport with her staff and determined that as there were new staff working in her home, it should remain in place and be reviewed next quarter. The IDT reviewed the efficacy of her EZ Stander goal and that her ability to stand may be compromised due to the recent femur fracture but decided to keep the goal until recommendations from Ortho/PT/OT were received. The goal for Individual #53 to keep good, consistent oral hygiene had been in her MFP plan since her transition from GRC but never implemented by the initial accepting provider. After her transition to the new provider, the case manger's review of ISP appropriateness and goal implementation was more thorough for the months of November and December.

- For Individual #24, for the months of July-December 2024, the case manager did not specifically review ISP implementation or make an assessment on the appropriateness of her ISP and whether revisions were needed. However, the case manager did note that the host home provider felt Individual #24 had made lots of progress and was participating in more activities. She had started to quilt with the host home provider's daughter and was learning to use scissors safely. She was working on laundry chores, washing her hands, and was becoming more comfortable being in the kitchen and helping with meal preparation.

- Individual #72's case manager summarized community integration activities each month for the period of July-December 2024, noting that he had been to the zoo, to see fireworks, out to eat, to get a haircut, daily walks, on a trip to Branson, Missouri for Labor Day weekend with the host home family, to see Christmas lights, and to get a candy bar and pop daily. The case

manager reported that he was working on his goals to use a key to his home once a day and to follow his daily schedule. However, the case manager did not specifically make an assessment on the appropriateness of his ISP and whether revisions were needed.

- For the majority (18 of 21of individuals, notes did not specifically indicate that the case manager determined that the person-centered service plan was consistently implemented and adequately addressed the individual's needs, including review of data to determine whether the individual was making progress toward achieving goals and actions set forth in the plan. In the event of changes in status or needs, the case manager should identify follow-up actions, including making necessary adjustments in the ISP. In the event the individual has achieved a goal or is not making progress toward their identified goals, the case manager should also identify follow-up actions, including making necessary adjustments in the ISP. Section 210.g speaks to the CM completing that follow up to resolution.

e. Rarely were case managers reviewing data and assessment information to support consistent implementation of all services and supports. When supports and services were not implemented, there was little discussion regarding barriers to implementation. Several individuals had been scheduled for dental appointments, but not yet provided, therefore, these were scored as being partially present. Individual #49's and Individual #20's monthly case management notes reflected implementation of supports and services as described in the ISP with data and assessment of supports substantiated.

- Individual #42's transition plan identified the need for psychiatry, neurology, and dental appointment after moving to the community. He saw a neurologist in April 2024, four months after his move and saw a psychiatrist in May 2024, five months after his move. After almost a year, he had not seen a dentist in the community. The IDT was still trying to get an appointment at the Dental Clinic. Again, the case manager noted the delay, but had not assisted the IDT with options for obtaining a dental exam. The case manager noted when appointments were obtained, but did not address the delay in appointments.

- Individual #98, Individual #45, Individual #62, Individual #10, and Individual #6 all had appointments while Individual #97 and Individual #87 still did not have appointments scheduled.

- For the month of August 2024, the case manager for Individual #53, noted numerous issues with medication administration records not being accurately completed by staff, numerous questions for the provider agency that required multiple attempts to obtain accurate information and responses, lack of behavioral tracking, missed appointments, and failure of the provider to attend meetings. These types of concerns were repeatedly noted by the case manager for several months until a decision was made to refer Individual #53 to another provider for services. Lack of documentation and accurate records were a significant barrier to the case manager's assessment of implementation of services and supports.

- For Individual #96, the case manager noted lack of documentation and data to assess implementation of services and supports. For August 2024, the case manager reported that there was no documentation of whether required labs were completed. A 24-hour sleep tracker was not implemented as recommended, documentation for implementation of goals was not in place and in fact, staff could not find the goals in their Therap system. For September, the case manager reported that "documentation is so

sporadic the team does not feel they can give a good picture on how goals are running for Individual #96." The case manager also noted that the guardians had requested referrals for other providers due to ongoing concerns.

f. As reflected in the Monitoring Team's previous visit reports, case management notes for all but one individual did not reflect whether case managers reviewed data and documentation to assess ISP implementation, stability of the transition, and implementation of all supports and services. Case management notes reflected broadly stated observations or included pasted emails or summaries of correspondence with GRC and other provider representatives. There was also a lack of documentation related to medical or behavioral events, such as emesis, skin breakdown, aggression, etc. and if any follow-up occurred. Lack of documentation poses unneeded barriers to the provider's assessment. When the IDT determined that supports in the transition plan/ISP were no longer relevant or appropriate, there was no formal revision of plans. Some specific examples included:

- Individual #33's monthly case management noted did not reflect the implementation of services/supports within the ISP.

- There was no documentation for Individual #55 that described an ongoing discussion of how services could be provided in a more integrated setting.

- For Individual #42, case management documentation consisted of broadly stated comments that did not reflect whether supports were implemented at the recommended frequency or describe any specific progress. For example, the case manager had the following comments regarding outcomes - continues to like to cook, he helps with mixing, stirring, and pouring and also likes to gather the supplies from the cupboard. This was a restatement of the action plans without mentioning the frequency of implementation or skills acquired. There was a bullet list of where he had visited in the community, but no indication of his participation level. He had an action plan to take pictures in the community to add to his choice board. Implementation of this plan was not reviewed by the case manager.

- Individual #49's case manager notes reflected consideration of the appropriateness of supports. For example, the case manager consulted with the IDT when a new home became available that would better meet Individual #49's needs. Notes included Individual #49's response to supports and services and comments regarding the efficacy of supports.

- Case management notes for Individual #30 did not reflect that the case manager had assessed whether the services and support were implemented consistently with his preferences nor whether they were provided in the most integrated setting. For example, the case manager's notes had a prompt to review recreation and social supports, community involvement, and relationships. The September 2024 note reflected that the provider reported that Individual #30 and his housemates go out at least once a day for appointments or routine tasks, going to eat, and bowling. The notes did not reflect whether these activities were integrated with people without disabilities and how they related to Individual #30's interests and preferences. The December 2024 note reflected that Individual #30 and his housemates would be doing a gift exchange and decorating the house for the holidays. There was no indication the case manager probed to determine if Individual #30 had expressed a desire for any holiday celebrations or to participate in community activities and events related to the holiday season where he could participate with other members of his community.

g. As noted above, case management notes for all individuals were not substantive in commentary and not focused on having the case manager review documentation and data. Therefore, identification of emerging issues and following to resolution was an area of needed focus. Individual #33's case management notes did not reflect when new strategies were implemented and whether supports were effective. For example, Individual #33 was seen by multiple providers to address his constant UTIs and whether constipation was a factor contributing to these infections. Although supports were implemented, such as scheduling a colonoscopy and starting a lose dose of antibiotics, notes do not reflect when these occurred or the effectiveness of those interventions. There also was no documentation that the IDT met to review changes in supports and services.

- Case management notes for Individual #42 included a summary of supports and services for the month, but there was not always follow-through comments regarding the effectiveness of services and supports. For example, a case management note from 6/6/24 indicated that he had a swallow study scheduled for 6/26/24. There was no comment on the outcome of the swallow study the following month.

- The case manager for Individual #49 generally continued to note any issues through resolution.

- Since Individual #50's transition, there have been no significant issues for which the case manager would need to convene the team.

- Since Individual #20's transition, there have been no significant issues for which the case manager would need to convene the team.

- The case manager for Individual #97 did a nice job of following through on issues from month to month in the case management notes. IDT meetings were held to address concerns, allegations of abuse, and to seek a new provider. However, prior to the decision to transfer providers, the case manager did not fully identify issues for follow-up to resolution. For example, Individual #97 had significant weight gain following his move from GRC with no adequate actions to address.

- Individual #45 had gained more than 70 pounds since transition, yet the case manager had not elevated this to a critical level for action.

- The case manager for Individual #53 did a nice job of following through on issues-to-resolution by initiating a transition and working closely with the new provider to confirm staff were trained and supports were in place.

- The case manager for Individual #96 did a nice job of following through on issues to resolution by initiating a transition and working closely with the new provider to confirm staff were trained and supports were in place.

- The MFP and MCO case managers for Individual #2 did a nice job of following through on issues to resolution by initiating a transition and working closely with the new provider to confirm staff were trained and supports were in place.

- For all individuals receiving services from the provider in which individuals were transitioning out of, the case managers for the individuals increased their presence and oversight to ensure the individuals' safety and continuity of care.

- The case manager for Individual #53, Individual #2, and Individual #96 did a nice job of following through on issues from month to month in the case management notes. IDT meetings were held to address concerns, allegations of abuse, and to seek a new provider. However, oftentimes identification of issues from previous months were carried over without adequate resolution due to lack of documentation or participation by the provider to resolve.

4. For situations when an unidentified or inadequately addressed risk, injury, need, or change in status, a deficiency in the individual's support plan or its implementation, were noted, the CM consistently reported the issue and held an IDT to address the situation.

Due to non-risk-based type situations being addressed in other sections of the report (i.e., 210.3), this indicator will focus on the risk aspect of the paragraph.

As detailed throughout this report, most individuals in the review group experienced the need for the IDT to meet and revise supports and services. There was still not a process in place to formally revise ISPs to update strengths, preferences, goals, and objectives, or clinical and supports needs.

During interviews, the Monitoring Team learned more about how case managers were interacting with IDTs to ensure appropriate supports were in place, however, documentation rarely reflected these conversations. Without that documentation, it was not possible to determine when action was taken and what specific support/services were revised and how they were monitored for efficacy.

During interviews, staff reported, and documentation reflected, that appointments were scheduled and attended as needed. The GRC transition process has ensured that individuals have an initial consultation appointment with their community PCP prior to transition to establish care. For the most part, other specialty consultations, such as psychiatry, neurology, cardiology, etc. had been obtained, but sometimes there were delays in obtaining appointments.

Case management notes as well as interviews with the Monitoring Team indicated that the MFP and MCO case managers for Individual #53 and Individual #96 worked closely with the CIM to resolve issues and ensure supports were in place both prior to their subsequent transition from the provider to their new home. Due to lack of documentation and transfer of records from one provider to another at the time of their transitions, there were still concerns that plans to address risks were not comprehensive and conflicted across documents making it difficult to determine what protocols staff should be following.

The MFP and MCO case managers for Individual #2 also worked closely with the CIM to resolve issues and ensure supports were in place prior to and for his upcoming transition from one provider to another.

Some examples are noted below:

- Individual #33 had numerous UTIs and bouts of constipation. Case Management notes reflected his continued health issues, but did not offer enough detail on recommendations by various consultants to reduce his risks and ensure needed supports were in place

and effective. He had also had some behavioral issues and medication changes without evidence that behaviors were being tracked, and data provided to the PCP or psychiatrist.

- Individual #97 had significant weight gain following his move from GRC with no clear adequate actions to address.

- Individual #101 had an order on her medication administration record for Neupogen 480 mcg via tube to be administered PRN. Staff were unsure of the reason for the PRN medication and reported that it was an old medication that was no longer necessary, but the pharmacy continued to include on the monthly MAR.

- Individual #24 was identified as being at risk for aspiration, choking, and GERD. Three different food consistencies were noted. The transition plan stated that she was on a pureed diet while the Nursing Protocol stated Mech ground. Per interview, the CM stated she was on a regular diet. At the time of the review, no IDT meeting had been held to address the variances.

- Individual #2 had a significant increase in targeted behaviors following his transition. The CM reported that the IDT met to discuss behaviors and behavioral support strategies, and staff training was provided to the provider agency on behavioral interventions. His DSP was able to describe interventions that were effective to de-escalate behaviors, however, documentation did not show that the IDT updated his ISP or PBSP to reflect interventions. Individual #2 also had a support to monitor his bowel activity and record on the medication administration record. There was no plan in place and no IDT meeting was held to address the lack of support. Although the PMM sent an email to the IDT following this visit, the lack of bowel tracking as required by the support had not been fully implemented nor adequately provided since Individual #2's transition.

- Individual #71 gained a significant amount of weight following transition. By the 60-day PMM visit, he had gained 32 pounds. since discharge and by the 180-day visit, he had gained a total of 47.5 pounds. Documentation did not indicate that the IDT elevated this concern and developed a formal plan to address his weight gain until he began having wounds that resulted from his wheelchair no longer fitting.

- Individual #53 had a PNM support to encourage fluid intake of 8 oz every two hours, but there was no IDT held to discuss the plan for ensuring this occurred and the method for tracking. Also, for Individual #53, for the month of August 2024, the case manager for Individual #53, noted numerous issues with medication administration records not being accurately completed by staff. These concerns were repeatedly noted by the case manager for several months until a decision was made to refer Individual #53 to another provider for services. The CM attempted to schedule an IDT in June 2024, but it was not held until August 2024.

- Individual #45 had gained more than 70 pounds since transition, yet the case manager had not elevated this to a critical level for action.

<table>
<tr><th colspan="2">Paragraph 211</th><th>Compliance Score</th></tr>
<tr><td colspan="2">The State shall develop and implement a system to identify and monitor individuals in the Target Population who transition from Glenwood Resource Center (for at least 365 days following transition) to another placement and to identify and monitor former Woodward Temporary Residents who move to a community setting of less than five individuals (for 365 days following transition). For Woodward Temporary Residents who move to a community setting of less than five individuals, the monitoring will begin when the individual moves from Woodward to another setting. The purpose of the monitoring is to: ensure health and safety; ensure a current support plan is in place consistent with the requirements in Paragraph 183; ensure whether supports identified in the individual's transition plan and current support plan are in place and achieving outcomes that promote their social, professional, and educational growth and independence in the most integrated settings; identify any gaps in care; and address proactively any such gaps to reduce the risk of readmission, crises, or other negative outcomes. The monitoring system shall include both face-to-face meetings with individuals in the Target Population and tracking by service utilization and other data.</td><td>Partial Compliance</td></tr>
<tr><td>#</td><td>Indicator</td><td>Indicator Score</td></tr>
<tr><td>1</td><td>State staff member shall conduct PMM visits within each of four (4) intervals (approximately seven, 30, 60, and 90 days) following an individual's transition.
<table>
<tr><th colspan="24">Individual Scores</th></tr>
<tr><td>42</td><td>55</td><td>49</td><td>33</td><td>50</td><td>20</td><td>83</td><td>97</td><td>101</td><td>87</td><td>98</td><td>45</td><td>62</td><td>10</td><td>6</td><td>53</td><td>40</td><td>30</td><td>71</td><td>72</td><td>2</td><td>24</td><td>58</td><td>96</td></tr>
<tr><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td></tr>
</table></td><td>Substantial Compliance
100%
24/24</td></tr>
<tr><td>2</td><td>Documentation of the monitoring visit will be made using a standard checklist that encompasses all areas of the transition plan)
<table>
<tr><th colspan="24">Individual Scores</th></tr>
<tr><td>42</td><td>55</td><td>49</td><td>33</td><td>50</td><td>20</td><td>83</td><td>97</td><td>101</td><td>87</td><td>98</td><td>45</td><td>62</td><td>10</td><td>6</td><td>53</td><td>40</td><td>30</td><td>71</td><td>72</td><td>2</td><td>24</td><td>58</td><td>96</td></tr>
<tr><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td></tr>
</table></td><td>Substantial Compliance
100%
24/24</td></tr>
<tr><td>3</td><td>Documentation addresses whether all supports and services are in place according to the timeframes in Paragraph 200,
<table>
<tr><th colspan="24">Individual Scores</th></tr>
<tr><td>42</td><td>55</td><td>49</td><td>33</td><td>50</td><td>20</td><td>83</td><td>97</td><td>101</td><td>87</td><td>98</td><td>45</td><td>62</td><td>10</td><td>6</td><td>53</td><td>40</td><td>30</td><td>71</td><td>72</td><td>2</td><td>24</td><td>58</td><td>96</td></tr>
<tr><td>.5</td><td>.5</td><td>.5</td><td>.5</td><td>.5</td><td>.5</td><td>1</td><td>.5</td><td>.5</td><td>1</td><td>.5</td><td>.5</td><td>.5</td><td>.5</td><td>.5</td><td>.5</td><td>.5</td><td>.5</td><td>.5</td><td>.5</td><td>.5</td><td>.5</td><td>.5</td><td>.5</td></tr>
</table></td><td>Partial Compliance
54%
13/24</td></tr>
<tr><td>4</td><td>Staff conducting this monitoring are adequately trained.
<table>
<tr><th colspan="24">Individual Scores</th></tr>
<tr><td>42</td><td>55</td><td>49</td><td>33</td><td>50</td><td>20</td><td>83</td><td>97</td><td>101</td><td>87</td><td>98</td><td>45</td><td>62</td><td>10</td><td>6</td><td>53</td><td>40</td><td>30</td><td>71</td><td>72</td><td>2</td><td>24</td><td>58</td><td>96</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td></tr>
</table></td><td>Substantial Compliance
100%
17/17</td></tr>
<tr><td>5</td><td>Staff conducting this monitoring have a reasonable sample of monitoring visits reviewed to ensure the reliability of the process.
<table>
<tr><th colspan="24">Individual Scores</th></tr>
<tr><td>42</td><td>55</td><td>49</td><td>33</td><td>50</td><td>20</td><td>83</td><td>97</td><td>101</td><td>87</td><td>98</td><td>45</td><td>62</td><td>10</td><td>6</td><td>53</td><td>40</td><td>30</td><td>71</td><td>72</td><td>2</td><td>24</td><td>58</td><td>96</td></tr>
<tr><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td></tr>
</table></td><td>Substantial Compliance
100%
24/24</td></tr>
<tr><td>6</td><td>The State implemented a system to identify and monitor individuals in the Target Population who transition from Glenwood Resource Center (for at least 365 days following transition) to another placement.</td><td>Substantial Compliance</td></tr>
<tr><td></td><td>a. The State has a system for responding to issues identified in the post-move monitoring process, case management process, through providers, or otherwise.</td><td>Substantial Compliance</td></tr>
</table>

	b. The State has implemented a system of tracking by service utilization and other data.	Substantial Compliance
	c. The State responds to identified gaps in provider care by offering person-specific provider training.	Substantial Compliance
	d. The State responds to identified systemic gaps in provider care by offering topical provider training.	Substantial Compliance
	e. HHS Central Office shall receive and review routine, valid and reliable Quality Management reporting regarding the domains described above, and related trends; notification of complaints regarding resident well-being and staff relations, and related trends; and other relevant reporting regarding the Target Population. This shall include a review of the information described in Paragraph	Substantial Compliance

Comments
While many indicators were in substantial compliance, this paragraph will remain in partial compliance due to the scores associated the documentation of services and the importance of verifying that all supports and services are in place.

1.-5. Overall staff were trained and were seeing the individuals at the interval needed. The primary issue remained focused on the lack of detail within the PMM's ' records/notes or clear analysis of whether supports were in place or effective. This lack of analysis was often due to the lack of available data or confirmation via review of documentation. It should be noted that this was an area in which the Monitoring Team started to see improvement towards the end of the review cycle. For details, please refer to paragraph 209.1 to 209.5.

6. The HHS PMM Threshold Data Review Group (Data Review Group) was established in June 2024 and have been meeting monthly to review aggregate Community Threshold and incident data collected by the PMM SharePoint to identify trends in the data by individual, provider, or threshold type. The Data Review Group determines whether further remedial action should be taken, including whether a Performance Implementation Plan (PIP) may be warranted for a particular provider.

Members of this review group include the HHS State-Operated Specialty Care Executive Officer 2 (SRC Liaison), the HHS State-Operated Specialty Care Executive Officer 3, WRC Superintendent, HHS Social Worker 6 (Community Integration Manager) and the Division Director, State-Operated Specialty Care Division (Iowa HHS Central Office).

The group reviews data for the previous one-month, six-month, and 12-month periods for both threshold incidents and Community Thresholds. The data are dissected by provider, individual, and Community Threshold type. The group also reviews each individual's data for the past three-month period who are within the 365-day mark. The group reviews the progress toward remedy for each outstanding Community Thresholds for the current month and more deeply evaluates any outstanding Community Thresholds with remedies that have been outstanding past 60 days.

Currently, the Data Review Group uses the following definitions: "Individual Threshold" means that a single individual has experienced any type of Community Threshold. "Systemic Threshold" means that two or more individuals experience the same numerated type of Community Threshold.

Data Review Group remedial action is prompted when the group identifies a single provider has met one of the following Provider Thresholds:

- More than 4 Individual Thresholds in a six-month period.
- More than 8 Individual Thresholds in an eight-month period.
- A System Threshold has been met within one (1) year.
- The Data Review Group identifies concerns related to the data reviewed.
- In addition, if the Data Review Group determines that two or more providers are struggling with certain Community Threshold types or have met multiple thresholds in an identified time frame, the Data Review Group will assign Iowa Medicaid's Long-Term Services and Supports (LTSS) Bureau to reach out to the provider to discuss and debrief the issues.
- Beyond conferencing with the provider, where appropriate, the Data Review Group will require additional remedial action, which may include providing additional training and support to providers, following up on individual Community Thresholds, connecting the provider to additional supports and services, or putting in place a provider PIP.
- A PIP identifies clear expectations for improvement from a provider and is an opportunity to collaborate with the CIMs who facilitate the PIP process. The PIP process affords the provider the opportunity to evaluate their current processes, identify any gaps in services provided, and address how the provider will resolve the issues identified.

Additionally, in response to issues with PMM and CM documentation as well as follow-up, the State developed training to address these areas as well as concerns regarding the identification and development of risk plans. Additional information on training addressing gaps was noted under paragraph 191.

Section J: Organizational Accountability (216-228)		
Paragraph 217		**Compliance Score**
The State shall conduct the oversight necessary to ensure compliance with each provision of this Agreement and with HHS and GRC policies. The HHS Director shall receive reliable information, including through routine briefings, regarding these activities. (par. 217)		**Substantial Compliance**
#	Indicator	Indicator Score
1	The State shall conduct the oversight necessary to ensure compliance with each provision of this Agreement and with HHS and GRC policies. The HHS Director shall receive reliable information, including through routine briefings, regarding these activities. (par. 217)	Substantial Compliance

Comments:
This paragraph focused on high-level oversight. A more detailed review is contained within the other QA driven paragraphs.
1. HHS support staff remains in place to monitor implementation of the statewide action plan, and the paragraphs contained within the Consent Decree.

HHS's Iowa Medicaid Division collaborated with its Specialty Care Division to oversee compliance. Iowa Medicaid Division Leadership consists of:

- Iowa Medicaid Director is vacant.
- Iowa Medicaid Division, Deputy Director of Strategic Initiatives.
- Iowa Medicaid Deputy Director of Operations.
- Iowa Medicaid Division, Long-Term Services and Supports Bureau Chief. Specialty Care Division Leadership.
- Specialty Care Division, Director.
- WRC Superintendent.

The Director of HHS meets monthly with the Iowa Medicaid Division Leadership, the Specialty Care Division Leadership, and members of their teams to receive updates on Consent Decree compliance. Examples of these meetings were provided to the Montor for the months of October 2024 to January 2025. Other meetings designed to provide oversight included, but were not limited to the Performance Improvement Process, new CM audit oversight, PMM-COE meetings, and HHS/LTSS compliance meetings.

Paragraph 226		**Compliance Score**
Within one year of the Effective Date, the State shall establish reliable public reporting at least every six months, on the HHS website. The public reporting shall include the Quality Management reporting produced pursuant to Section IV.K below.		**Partial Compliance**
#	Indicator	Indicator Score
1	State shall establish a reliable method of public reporting that includes QM reporting (Section K) (par. 226)	Partial Compliance

Comments

1. Ongoing conversations have occurred with the Monitor and the State regarding the collection of data and reporting. The State has maintained their public dashboard prior to the closure of GRC as well as having offered the January 2025 Post-Move Monitoring Report as evidence of sharing their community integration efforts with the public. All data regarding threshold data were based on monthly counts of the issue. The report included, but was not limited to:

- Definition of various supporting professionals (MFP transition, COE, CIM)
- Transition placements
- Individuals monitored through the PMM process.
- PMM cadence compliance
- PMM QA reviews
- # of Outreach visits
- Community thresholds
- Providers reaching thresholds.
- Abuse/Neglect Allegations
- Weight loss
- Serious Injuries
- Community Training
- Relocation to a new home

The report provided a wealth of information with the majority of data focused on community thresholds, with some focused-on training and PMM cadence compliance. Overall, the information provided did not contain all relevant data, and did not offer analysis to clearly breakdown provided data. The analysis provided in the report was not consistently backed by supporting data and reflected more of a theory.

Several areas requiring attention were noted within the public report:

- Under Section B, Post Move Monitors in the 2025 PMM January report, it stated that "in every case where deficiencies were noted, the PMM QA Review Group provided feedback to the PMM, and the PMM timely corrected deficiencies. The PMM QA Review Group has noted on several occasions that PMMs have implemented the Review Group's feedback and recommendations to correct deficiencies beyond the particular documentation being reviewed." This statement offers a general description of what was done, but offered no detail regarding the type of deficiencies, or the recommendations given by the PMM QA review group.

- Certain portions of the report laid out the data in a way that required the reader to understand the correlation of the numbers as well as perform the math. For example, under figure 8, the graph showed both the number of thresholds and the number of

individuals, but to make it meaningful, one would have to do work to determine the rate. Figure 7 required the reader to conduct math to determine impact. According to the graph on Figure 7, Sept 2024 showed that 65 individuals were in the target population with 30 thresholds met. For October 2024, it showed that 63 individuals were in the target population with 23 thresholds met. Again, the data would be more meaningful if the it reflected a 46% threshold rate in Sept and a 37% threshold rate in October. Showing data in this format translates to better understanding of the reader and easier target setting when looking at quality. In contrast, Figure 3 conducted that math and showed the total number of visits due to the total number of visits completed along with the score percentage which made it more meaningful to the reader.

- Under "Where are Former GRC Residents Now?" it speaks to deaths that occurred while at GRC, but does not speak to deaths that have occurred in the community since transition outside of listing the number of "Limited Death Reviews" completed.

- Limited information obtained from the Limited Death Review was shared. Reoccurring themes and issues that had been noted is relevant when reporting quality. The section within the PMM January 2025 report provided more of a description rather than the acquired data. findings and analysis. Per the State, some of the issues identified in the ltd. death reviews will likely be identified in the case management audit and risk review processes and will be noted in the next 6-month report as those quality processes are implemented.

- The Report noted that the PIP process was being revised in 2025, and the Monitor will look forward to receiving more information on that revised process and the results in the next report. Figure 6 shows an increase in community thresholds in Dec 2024, but offered little analysis of the increase other than to say it was a cause for concern under Section IV.D. Analysis focused on statements backed by little supporting data. Statements, such as thresholds are coming down as people get more used to their new home is not necessarily an accurate reason nor is stating that ER visits are up due to inadequate usage unless data is provided to back such a statement.

- Figure 14 and IV.A identifies relocation and where the Individual relocated to, but offers no information regarding the reason for the relocation.

- Figure 18 speaks to the concept of the threshold being remedied. It was defined as when (1) all appropriate recommendations and/or supports are in place to prevent recurrence of the threshold, (2) the individual has returned to their baseline or is at their new baseline following the incident, and (3) the Outreach Team and medical professionals have no further concerns. The Monitor would be interested in seeing data on the recurrence of thresholds in the next six-month report as this will provide a more accurate means to determine outcomes/progress.

- Section IV.B noted that PMM performance has not been without deficiency, but offered no information on the deficiencies themselves. That stated, the report did provide information on training that was completed in 2024,

Section K: Effective Quality Management (229-235)		
Paragraph 229		**Compliance Score**
The State shall implement reliable Quality Management processes and procedures consistent with current, generally accepted professional standards of care. Such processes shall timely and effectively detect problems with the provision of protections, services, and supports; and ensure appropriate corrective steps are implemented.		**Partial Compliance**
#	Indicator	Indicator Score
1	Quality Management process and procedures are consistent with current, generally accepted professional standards of care. These processes timely and effectively detect problems and ensure appropriate corrective steps are implemented.	Partial Compliance
2	The State implemented a system to identify and monitor individuals in the Target Population who transition from Glenwood Resource Center (for at least 365 days following transition) to another placement.	Substantial Compliance
	a. The State has a system for responding to issues identified in the post-move monitoring process, case management process, through providers, or otherwise.	Substantial Compliance
	b. The State has implemented a system of tracking by service utilization and other data.	Substantial Compliance
	c. The State responds to identified gaps in provider care as needed to address the identified issues	Partial Compliance
	d. The State responds to identified systemic gaps in provider care as needed to address the identified issues.	Partial Compliance

Comments:

1. The State had a number of systems/processes in place to monitor the overall quality and to respond to any identified issues. Among these were:

- Case management certification process: This is a standard operating procedure used to articulate the requirement for Community-Based Case Managers (CBCMs) to complete a set of trainings outlined by Iowa Health and Human Services (HHS). The trainings are meant to improve the consistency of quality case management by ensuring access to a common set of training modules and resources.
- Post Move Monitoring Reports: See paragraph 206.
- Barrier Reports: See paragraph 208.1.
- Risk-re-assessment process: This process was not yet fully implemented at the time of this review, but the Monitor looks forward to seeing the impact at the individual/community level.
- CM audit process: Iowa Medicaid LTSS will also be initiating a Community Case Management Audit Process that includes a review of ISPs (along with other case management documentation. The Community Integration Manager (CIM) will complete monthly reviews and provide oversight to case managers working with individuals who have transitioned out of state resource centers for a minimum of 365 days post transition. The CIM is responsible for ensuring that the requirements of the procedure are met. When reviewing the CM audit process, it was noted that the process primarily consisted of ensuring what was noted was also noted in the documentation. The audit did not contain a clear review of the quality of the documentation and whether issues were being addressed in a timely manner.

- PMM checklist audits: This checklist was used to document all post-move monitoring follow-ups. While the audit checked to ensure all components were completed, it reflected more of a focus on documentation quality versus quality of service provided.
- Ongoing meetings of the COE and the PMMs
- Community Threshold Process: Procedure for identifying, tracking, and remedying Community Thresholds for individual providers to ensure services and supports are in place.
- Monthly Aggregate Review (PMM thresholds): Meeting minutes for November 2024, December 2024, and January 2025 were provided. Mintes showed review of thresholds at the provider and individual level.

Processes focused on PIPS and reviews: PIPS impacting Individual #13, and Individual #22 were reviewed. Thresholds were clearly identified; however, objectives were not measurable as they often made statements like "reduce the risk of serious injury" or "reduce the number of falls" without stating what the reduction should be or what would be acceptable.

2. While the State had a system that monitored the PMM process, the process had not yet shown itself to be effective as many of the issues noted when monitoring began still remaining. This included issues with identification, verification, and follow-up. Because of this, indicator d. will remain in partial compliance.

Paragraph 230		**Compliance Score**
The State shall maintain a Quality Management program that effectively collects and evaluates valid and reliable data, including data pertaining to the domains and topics identified in Paragraphs 211, sufficient to implement an effective continuous quality improvement cycle as set forth below. The Quality Management program shall use this data in a continuous quality improvement cycle to: a. Develop sufficient reliable measures relating to the domains and topics identified in Paragraph 211, with corresponding goals and timelines for expected positive outcomes, and triggers for negative outcomes. Produce routine, valid and reliable reporting on the defined measures and related trends; c. Identify significant trends, patterns, strengths, and problems at the individual and systemic levels; d. Implement preventative, corrective, and improvement actions to address identified trends, patterns, strengths, and problems; and e. Track the effectiveness of preventative, corrective, and improvement actions, and adjust such actions as needed if they do not result in expected prevention, correction, or improvement. This paragraph reflects the analysis of those two sections and identify significant trends, patterns, strengths, and problems at the individual and systemic levels; Implement preventative, corrective, and improvement actions to address identified trends, patterns, strengths, and problems; and track the effectiveness of preventative, corrective, and improvement actions, and adjust such actions as needed if they do not result in expected prevention, correction, or improvement		**Partial Compliance**
#	Indicator	Indicator Score
1	The State implemented a system to identify and monitor individuals in the Target Population who transition from Glenwood Resource Center (for at least 365 days following transition) to another placement.	Substantial Compliance
	a. The State has a system for responding to issues identified in the post-move monitoring process, case management process, through providers, or otherwise.	Substantial Compliance
	b. The State has implemented a system of tracking by service utilization and other data.	Substantial Compliance
	c. The State responds to identified gaps in provider care as needed to address the identified issues	Partial Compliance
	d. The State responds to identified systemic gaps in provider care as needed to address the identified issues.	Partial Compliance
Comments: Due to the potential negative impact of not consistently monitoring and addressing whether all supports were in place, this paragraph will remain in partial compliance. For details see the report sections identified below. 1. See 211.6 for information regarding the State's success in providing the training relevant to addressing the identified issues. While 211.6 focused on the training needed to address issues, this indicator focused on the implementation of preventative, corrective, and improvement actions to address identified trends, patterns, strengths, and problems; and track the effectiveness of preventative, corrective, and improvement actions, and adjust such actions as needed if they do not result in expected prevention, correction, or improvement. Due		

to the relative newness of many interventions designed to impact health, safety and ISP quality, the ability to determine if plans are effective. Issues that occurred such as with dental appointments were not followed up by the State as a systemic issue and not tracked to ensure appointments were being made accordingly and on time. Another example is the analysis of the impact of the trainings listed in 211. There is no pre-post analysis, and no measurable outcomes established to determine if interventions were successful and/or require revision. Additionally, the State just rolled out the risk re-assessment process, but there is no program in place that will measure the impact of that process and whether it meets the CD and/or HCBS guidance.

Paragraph 232		**Compliance Score**
The Quality Management program shall ensure that each IDT utilizes this continuous quality improvement information to track and trend the measures and triggers regarding resident outcomes, and to effectively identify, assess, and appropriately respond to positive and negative outcomes at the individual level.		**Partial Compliance**
#	Indicator	Indicator Score
1	Each IDT utilizes this continuous quality improvement information to track and trend the measures and triggers regarding resident outcomes	Substantial Compliance
2	The IDT uses data to effectively identify, assess, and appropriately respond to positive and negative outcomes at the individual level.	Partial Compliance

Comments:
1.-2. Information shared with the IDT on methods to improve were offered via the CIM as well as through the PMM process, and PMM community threshold process. The State utilized Post Move Monitor Community Thresholds to help identify potential concerns with the Individual as well as the Provider. Issues monitored included, but were not limited to:

- Two choking episodes in one year.
- Recurrent Aspiration pneumonia and/or recurrent non-aspiration pneumonia in one year.
- Unresolved falls related to balance and medical issues of more than six in 90 days.
- New or proposed enteral (g, j, or g/j tube) feeding.
- Unresolved Gastro-intestinal (GI) issues, including bowel obstruction and unresolved vomiting (>6 episodes in 30 days not related to viral infection or other known causes).
- Unresolved significant/unplanned/verified weight loss or gain that is not improving in 90 days with IDT management/Acute Care Plan or for individuals for whom the IDT requests special assistance.

When these issues were noted, the PMM would notify the Center of Excellence or the Center of Excellence with the CIM would reach out directly to the CM with concerns. This information would then be used to develop/modify a path forward.

Newly implemented or to be implemented were:

- The Bureau Chief of Long-Term Services and Supports has been added to the monthly data review process.
- A case management audit process that includes a review of ISPs and will culminate in a monthly compliance meeting that was scheduled to begin 3/28/25 and will provide an opportunity to discuss feedback, follow-up, questions, and/or compliance issues that may arise as part of the case manager audit.
- A new procedure has been set up for the LTSS team to meet monthly to discuss compliance issues, this will include the LTSS Bureau Chief, the CIMs, the LTSS Case Management SME, the LTSS Transition Specialist SME, a representative from Program Integrity, a representative from HCBS QI organization.

The Montor has not yet seen the results of these meetings, but looks forward to their implementation. Due to the impact not being seen at the community/individual level, this paragraph will remain in partial compliance.

Paragraph 233		**Compliance Score**
HHS Central Office shall receive and review routine, valid and reliable Quality Management reporting regarding the domains described above, and related trends; notification of complaints regarding resident well-being and staff relations, and related trends; and other relevant reporting regarding the Target Population. This shall include a review of the information described in Paragraph 211.		**Partial Compliance**
#	Indicator	Indicator Score
1	Quality Management process and procedures are consistent with current, generally accepted professional standards of care. These processes timely and effectively detect problems and ensure appropriate corrective steps are implemented.	Partial Compliance
2	The State implemented a system to identify and monitor individuals in the Target Population who transition from Glenwood Resource Center (for at least 365 days following transition) to another placement.	Substantial Compliance
	a. The State has a system for responding to issues identified in the post-move monitoring process, case management process, through providers, or otherwise.	Substantial Compliance
	b. The State has implemented a system of tracking by service utilization and other data.	Substantial Compliance
	c. The State responds to identified gaps in provider care as needed to address the identified issues	Partial Compliance
	d. The State responds to identified systemic gaps in provider care as needed to address the identified issue	Partial Compliance
	e. HHS Central Office shall receive and review routine, valid and reliable Quality Management reporting regarding the domains described above, and related trends; notification of complaints regarding resident well-being and staff relations, and related trends; and other relevant reporting regarding the Target Population. This shall include a review of the information described in Paragraph	Substantial Compliance

Comments:
1. Overall, the QA process contained significant amounts of data, but lacked in its ability to clearly impact and address quality issues associated with community ISPs.

a. The ISPs reviewed by the Monitor for the Woodward temporary residents overall appeared to meet the needs of the individuals as they related to the identification of barriers and opportunities for community placement.

b. PMM Checklist Audits also existed, which were reviewed by the lead CIM and other State staff. They were designed to ensure the quality of post-move monitors' follow-up and documentation. The result of the review of the PMM was the identification of potential gaps paired with potential suggestions to the issue. A review of 10% of PMM checklists was completed and reviewed by the PMM QA Review Group monthly. During the meeting, the group reviewed the checklist and provided feedback. The review was much more focused on the documentation rather than the review of the overall quality and if the PMM was identifying all the issues needed.

c. Iowa Medicaid LTSS initiated a Community Case Management Audit Process that includes a review of ISPs (along with other case management documentation). The Community Integration Manager (CIM) will complete monthly reviews and provide oversight to case

managers working with individuals who have transitioned out of state resource centers for a minimum of 365 days post transition. The CIM is responsible for ensuring that the requirements of the procedure are met. A Standard Operation Procedure (SOP) was developed in January 2025, finalized on February 3, 2025, and implemented on February 7, 2025. This SOP allowed MCO/MFP information to be available to the Post Move Monitor and the HHS LTSS subject matter experts (SMEs) on a monthly basis. The Monitor looks forward to seeing the results from these audits.

d. A clear process that showed the review of data and development of systemic measures to address the issues was noted with the Monthly Aggregate Review. During this review, individual thresholds as well as provider/systemic thresholds are reviewed and discussed. What was lacking was discussion of systemic needs and how those needs can be met. For example, the COE was being utilized on a frequent basis to support the providers, yet this was not looked at to determine if the frequent supports were due to lack of training, lack of implementation, etc.

The State implemented a SharePoint site to track incidents that meet the identified Community Thresholds for the target population within the 365-day post transition period. An incident must be entered into the SharePoint site as a Post-Move Monitoring Incident Report. Once a threshold is met, a record is created in the Community Threshold Log. Documentation related to any incident within the scope of Community Thresholds is documented in the SharePoint site and the Individuals IPR. Appropriate follow-up is completed and tracked on the site.

The State has done a nice job ensuring that issues were responded to by their Outreach Team. In addition, the State has an ongoing process to review data on a monthly basis to identify individual provider trends and address those issues through potential development of performance improvement plans.

It should be noted that while corrective actions have been noted, the Monitor has not seen consistent improvements at the community level as it relates to the ISPs and their overall quality as well as follow up by the PMM when issues are noted. So, while a process exists, one cannot determine if the process is yet effective as issues continue to be noted. It was unclear of the process used by the State in sharing results from the report with the specific CMs and Providers and the results of that information sharing. Additionally, there was no evidence of clear problem solving based on improving ISP quality. It should be noted that the State has since reached out to the Montor for feedback on ISP Life Domains in an effort to improve the ISP goals and make them more meaningful to the individual.

2. The HHS PMM Threshold Data Review Group (Data Review Group) was established in June 2024 and have been meeting monthly to review aggregate Community Threshold and incident data collected by the PMM SharePoint to identify trends in the data by individual, provider, or threshold type. The Data Review Group determines whether further remedial action should be taken, including whether a Performance Implementation Plan (PIP) may be warranted for a particular provider.

Members of this review group include the HHS State-Operated Specialty Care Executive Officer 2 (SRC Liaison), the HHS State-Operated Specialty Care Executive Officer 3, WRC Superintendent, HHS Social Worker 6 (Community Integration Manager) and the Division Director, State-Operated Specialty Care Division (Iowa HHS Central Office).

The group reviews data for the previous one-month, six-month, and 12-month periods for both threshold incidents and Community Thresholds. The data are dissected by provider, individual, and Community Threshold type. The group also reviews each individual's data for the past three-month period. The group reviews the progress toward remedy for each outstanding Community Thresholds for the current month and more deeply evaluates any outstanding Community Thresholds with remedies that have been outstanding past 60 days.

Currently, the Data Review Group uses the following definitions: "Individual Threshold" means that a single individual has experienced any type of Community Threshold. "Systemic Threshold" means that two or more individuals experience the same numerated type of Community Threshold.

Data Review Group remedial action is prompted when the group identifies a single provider has met one of the following Provider Thresholds:

- More than 4 Individual Thresholds in a six-month period.
- More than 8 Individual Thresholds in an eight-month period.
- A System Threshold has been met within one (1) year.
- The Data Review Group identifies concerns related to the data reviewed.
- In addition, if the Data Review Group determines that two or more providers are struggling with certain Community Threshold types or have met multiple thresholds in an identified time frame, the Data Review Group will assign Iowa Medicaid's Long-Term Services and Supports (LTSS) Bureau to reach out to the provider to discuss and debrief the issues.
- Beyond conferencing with the provider, where appropriate, the Data Review Group will require additional remedial action, which may include providing additional training and support to providers, following up on individual Community Thresholds, connecting the provider to additional supports and services, or putting in place a provider PIP.

A PIP identified expectations for improvement from a provider and offered an opportunity to collaborate with the CIMs who facilitate the PIP process. The PIP process afforded the provider the opportunity to evaluate their current processes, identify any gaps in services provided, and address how the provider will resolve the issues identified. While the PIP included expectations, those expectations were not always measurable as expected improvements were not always clearly defined.

While the State has responded to issues raised by the Monitor, the impact of that response has not yet been noted and, therefore, effectiveness or whether the issues have begun to be addressed are not yet able to be determined. This will be reviewed during the next status update and could transition to substantial compliance if impact is noted at the individual/community level.