UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF IOWA

Independent Monitor's Report

Dates of Reviews:
September 29-October 10, 2025
Draft Report: October 27, 2025
Final Report: December 23, 2025

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Methodology
Provider and Case Manager interviews were conducted remotely over the course of two weeks along with case reviews. The interviews included discussions with the case managers and Provider staff. Twenty individuals were included as part of this review. For this review, the Independent Monitor employed a dual-selection process to ensure a balanced and representative sample of individuals that had transitioned from Glenwood Resource Center (GRC) to community-based settings. Specifically, the Monitor randomly selected ten individuals, with an effort to avoid those who had participated in the previous review cycle whenever possible. In addition, the State identified another ten individuals for inclusion. All individuals selected for review were residing in the community and represented various stages of their transition from GRC. Notably, each individual had surpassed the 365-day post-transition period and, as such, was no longer receiving services of the Post Move Monitors.

For Individuals and for components, a score of "1" reflected Substantial Compliance (SC), ".5" Partial Compliance(PC), and "0" Non-Compliance (NC). In evaluating the State's progress under the Amended Agreement, compliance determinations are guided by the definitions set forth in Paragraphs 31 and 38:

- **Partially Compliant** indicated that the State has made tangible progress toward achieving substantial compliance with key components of a given provision; however, significant work remains to fully satisfy the requirements.
- **Substantially Compliant** signified that the State has met or achieved all, or nearly all, of the components of a particular provision.

These definitions provide the framework for assessing the State's performance across monitored provisions. Where the State is rated as "Partially Compliant," it reflects meaningful advancement but also highlights areas requiring further attention and improvement. A rating of "Substantially Compliant" demonstrates that the State has effectively fulfilled the majority of obligations under the relevant provision.

This approach ensures that compliance ratings are both transparent and consistent with the qualitative standards established in the Amended Agreement, supporting ongoing oversight and accountability.

Indicators and paragraphs marked as being in Substantial Compliance will move to Less Oversight. where they will begin their one-year maintenance period where they must remain in compliance noted as part of Paragraph 274 before exiting. The date in which the paragraph initially reached substantial compliance is noted within the summary of compliance.

Executive Summary

The Monitoring Team extends its appreciation to the individuals, case managers, transition specialists, and state staff for their ongoing collaboration and responsiveness throughout this review period.

This report identified persistent challenges in community case management and quality oversight for individuals that had transitioned from GRC to community-based settings. Key findings included:

- Case managers frequently did not meet required face-to-face visit frequencies. Documentation often lacked substantive assessment of risks, individualized goals, and progress tracking.
- Risk mitigation supports were a significant concern. These supports were often vague, missing measurable criteria, clear signs and symptoms for staff to monitor, and actionable guidance for intervention. Many relied on general statements without preventive strategies, baseline data, or protocols for reassessment.
- Critical risks such as choking, aspiration, falls, constipation, cardiovascular disease, and behavioral incidents were not addressed with sufficient detail. This increased the likelihood of missed early warning signs and delayed responses, potentially compromising safety, and quality of care.

Individual Support Plans (ISPs) generally did not reflect individuals' evolving needs, interests, or aspirations for independence and community integration. There was little evidence of systematic follow-up or resolution of identified issues, and the implementation and effectiveness of corrective actions were not reliably tracked. Public reporting and transparency remained limited outside of the Monitor's report.

A notable concern in this review was that the majority of compliance paragraphs related to the ISP and Case Management showed a decline since the previous six-month status summary. Prior to the 365-day mark, individuals were monitored by both the case manager, a Post-Move Monitor (PMM) and Money Follows the Person (MFP) case manager. The MFP case manager and PMM ensured adequate transition and handover to Managed Care Organization (MCO) staff. Now that individuals are post-365 days, this extra layer of review is absent, and the transition from MFP to MCO case management has contributed to a decline in both documentation quality and the effectiveness of risk management and oversight processes.

Overall, the report underscored the need for more robust, actionable, and measurable processes to ensure compliance, improve service quality, and effectively manage health risks for individuals in community settings. To address persistent issues in case management and oversight, the State is encouraged to invest in comprehensive, person-centered training with a focus on developing meaningful, measurable goals and plans. Additionally, more training was needed regarding how to better collaborate with the needed Subject Matter Experts/Professionals to develop the needed health and behavioral supports.

Despite these challenges, several positive findings were observed:

- All individuals reviewed had current ISPs.
- Many residential provider staff demonstrated a strong understanding of each individual's preferences and support needs, often providing more detailed descriptions of supports than were documented in the plans.
- Some providers developed supplemental plans to address gaps that offered comprehensive guidance for staff.
- Individuals living in host homes were frequently more integrated into their communities, with providers making efforts to offer new experiences and support independence.
- There were examples of effective collaboration among case managers, providers, and families, resulting in improved outcomes for some individuals.

While progress has been made in some areas, significant work remains to ensure that all individuals receive high-quality, person-centered supports that promote safety, independence, and community integration. As of this 6-month Summary, seven paragraphs were in partial compliance, and two paragraphs were in non-compliance. There were no paragraphs in substantial compliance at this time and Paragraph 183, and Paragraph 210 regressed from partial compliance since the previous six-month review period. Below is a high-level view of potential suggestions to help address the issues identified within this report.

Areas	**Suggestions**
ISPs-goals	Make goals measurable, update strengths/preferences, expand community integration
ISPs-health supports	Detail health supports to address areas of increased risk, reassess regularly, include baseline data, engage experts to assist with plan development
ISPs-training & collaboration	Person-centered training, Additional training focused on health/behavioral prevention and fatal five.
Case Management	Increase visit frequency, improve documentation, prompt for routine assessment
Quality Assurance	Implement robust QA, track corrective actions, continuous improvement
Public Reporting	Reliable, transparent reporting consisting of pertinent measurables.

Summary of Compliance

Paragraphs	Status
183	Non-Compliance *(previous report: Partial Compliance)*
208	Partial Compliance *(previous report Partial Compliance)*
210	Non- Compliance *(previous report: Partial Compliance)*
217	Partial Compliance *(previous report-Less Oversight-3/2025)*
226	Partial Compliance *(previous report-Partial Compliance)* **State requested to preserve issue with the inclusion of P226.*
229	Partial Compliance *(previous report Partial Compliance)*
230	Partial Compliance *(previous report Partial Compliance)*
232	Partial Compliance *(previous report Partial Compliance)*
233	Partial Compliance *(previous report Partial Compliance)*

Section H.i : Individual Support and Discharge Planning (179-188)	
Paragraph 183	
Each Resident shall have a Comprehensive Individual Support Plan (ISP).	Non Compliance

Summary:
Plans to address preventable and known health issues across providers and case managers showed notable inconsistencies in their level of detail, measurability, and relevance of supports. In many cases, ISPs lacked clear definitions of signs and symptoms, leaving staff uncertain about when additional intervention was warranted. Supports were often described in general terms and rarely included measurable criteria, making it difficult to assess their effectiveness or ensure accountability. This lack of specificity and consistency can hinder timely and appropriate responses to individual risks, potentially compromising safety, and quality of care. To truly protect individuals and support positive outcomes, risk plans must be comprehensive, actionable, and include clear, measurable indicators for both intervention and evaluation. For individuals with adaptive equipment designed to mitigate risk, the approach was to wait until there was an overt issue vs proactive assessments to ensure ongoing proper fit and effectiveness. Common health issues such as GERD. Examples included:

Individual #82's ISP included information about her preferences, strengths, and needs. In some cases, instructions for providing supports were vague or not individualized. For example, supports to address psychiatric symptom all stated therapy and medication management. To mitigate her risk for acid reflux, the ISP noted that her diet should be monitored, and she should avoid triggering foods. There were no trigger foods listed therefore increasing the risk of GERD.

Plans to manage the Individuals health care across providers and case managers showed notable inconsistencies in their level of detail, measurability, and relevance of supports. In many cases, plans lacked clear definitions of signs and symptoms, leaving staff uncertain about when additional intervention was warranted. Supports were often described in general terms and rarely included measurable criteria, making it difficult to assess their effectiveness or ensure accountability. This lack of specificity and consistency can hinder timely and appropriate responses to individual risks, potentially compromising safety, and quality of care. To truly protect individuals and support positive outcomes, ISPs must be comprehensive, actionable, and include clear, measurable indicators for both intervention and evaluation.

For individuals with adaptive equipment designed to mitigate risk and manage health, the approach was to wait until there was an overt issue vs proactive assessments to ensure ongoing proper fit and effectiveness. A persistent pattern of inadequacy was found in ISPs. Although all individuals with increased risks (e.g., constipation, obesity, choking, falls, aspiration) had supports within the ISP, the quality and effectiveness of these supports varied greatly. Most lacked measurable actions, clear timelines, and specific criteria for intervention. Plans often called for monitoring or encouraging activities but failed to define thresholds, success parameters, or escalation guidance. Signs and symptoms were inconsistently defined, leaving staff unsure when to act. Interventions were frequently limited to medication, with little focus on preventive strategies like diet or exercise. The absence of baseline data further hindered timely detection and response to health changes.

ISPs for individuals with complex needs frequently lacked specificity, measurable criteria, and actionable guidance, resulting in unclear or ineffective supports. For example, Individual #1's ISP broadly stated "24-hour supervision" for nearly all needs, but failed to provide detailed interventions or measurable actions for risks like obesity and diabetes, such as when to contact a provider or how to track progress. Individual #3's plan required physical assistance for daily activities but did not specify how or when staff should help, and risk plans for choking and falls omitted critical details like equipment reassessment or triggers for intervention. Individual #8's supports for asthma, constipation, and hypertension were not measurable and lacked preventive strategies, relying only on medication and basic monitoring. Individual #19's plan included adaptive equipment for dysphagia and aspiration, but inconsistencies in equipment use and missing actionable steps compromised safety. For Individual #32, supports for cardiovascular disease and constipation lacked baseline data and clear criteria, leading to delayed or inconsistent responses. Individual #34's supports for behavioral risks were generic, with no behavior support plan or strategies to reduce restrictions. Other examples included Individual #49, whose risk supports for falls and choking were vague and lacked guidance on monitoring symptoms or responding to emergencies, and Individual #61, whose plans for aspiration and hypertension omitted specific signs for staff to monitor or escalate concerns. Across these cases, the absence of detailed, measurable, and regularly updated plans compromised the effectiveness of health supports and the quality of care, leaving staff without the necessary tools to respond promptly and appropriately to individual risks.

The quality of support plans varied among case management providers and often between case managers within the same provider agency. Some residential providers had developed supplemental plans that provided more detail about the individual and supports needed. For example, the provider for Individual #27 developed a very detailed plan that would guide staff in supporting the individual throughout the day and in multiple activities. All individuals should receive this type of detail in all plans so that direct support staff can consistently provide supports in all situations.

<table>
<tr><th>#</th><th>Indicator</th><th>Overall Score</th></tr>
<tr><td>1</td><td>The IDT developed a person-centered individual support plan in place, consistent with the requirements in Paragraph 183 (roll-up of a-h)
<table>
<tr><th colspan="20">Individual Scores</th></tr>
<tr><th>183</th><th>#1</th><th>#3</th><th>#8</th><th>#19</th><th>#32</th><th>#34</th><th>#47</th><th>#48</th><th>#49</th><th>#61</th><th>#62</th><th>#63</th><th>#68</th><th>#77</th><th>#80</th><th>#82</th><th>#89</th><th>#91</th><th>#27</th><th>#118</th></tr>
<tr><td>a.</td><td>0.5</td><td>0</td><td>0.5</td><td>0.5</td><td>1</td><td>1</td><td>0</td><td>0.5</td><td>0.5</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0.5</td><td>0.5</td><td>0</td><td>1</td><td>0.5</td></tr>
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<tr><td>roll-up</td><td>4</td><td>2.5</td><td>3</td><td>6</td><td>7</td><td>5</td><td>4</td><td>3</td><td>4</td><td>3.5</td><td>4</td><td>2</td><td>3.5</td><td>6.5</td><td>4</td><td>3.5</td><td>4.5</td><td>3.5</td><td>7</td><td>4</td></tr>
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</table></td><td>Non Compliance
43%
8.5/20
53%
84.5/160</td></tr>
<tr><td></td><td>a. The ISP defined individualized personal goals (such as employment, housing, community engagement, relationships, healthy living, choice/control, safety, personal development &supported decision making)</td><td>Non Compliance
35%
7/20</td></tr>
<tr><td></td><td>b. Individuals have ISPs that are current and developed by an appropriate IDT.</td><td>Substantial Compliance</td></tr>
</table>

		100% 20/20
	c. Personal goals are meaningful and measurable and align with preferences and supporting skills.	Non Compliance 25% 5/20
	d. The ISP identified the individual's strengths, needs, and preferences.	Partial Compliance 73% 14.5/20
	e. ISP action plans indicated how they would support the individual's overall enhanced independence.	Non Compliance 35% 7/20
	f. The ISP provides clear opportunities for community integration aligned with the individual's preferences.	Non Compliance 18% 3.5/20
	g. Individual had 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.	Non Compliance 25% 5/20
	h. The ISP identified individualized protections, services, supports, and treatments. Areas of increased Health and Behavioral risk were addressed through the ISP with clear interventions to mitigate.	Non Compliance 35% 7/20

Comments

1. The IDT did not consistently develop a person-centered individual support plan.
   a. The ISP did not define individualized personal goals (such as community living, activities, employment, education, recreation, healthcare, and relationships). Most Individual Support Plans (ISPs) reviewed did not define truly individualized personal goals across essential areas such as community living, activities, employment, education, recreation, healthcare, and relationships. Instead, goals were often generic and not tailored to each individual's preferences, strengths, or aspirations. Many plans focused narrowly on basic daily living tasks like laundry or meal preparation, without addressing broader objectives such as community engagement, employment, or building new relationships. There was little evidence of goals that promoted integration into community groups such as churches, gyms, or volunteer programs or that provided training for independence in areas like banking, shopping, or healthcare management. Individuals living in host homes often experienced more organic community integration, but these efforts were not reflected or directed by their formal support plans, while those in larger settings had even fewer opportunities for meaningful

participation in the community.

Additionally, many goals lacked measurable criteria, making it difficult for staff to assess progress or determine when a goal had been achieved. For example, Individual #47, Individual #48, and Individual #49 had goals like "participate in one or two community activities weekly" were common but did not specify the individual's interests or desired outcomes, nor did they foster skill development or independence. Some goals, such as communication via sign language, were not functional or meaningful for the individual and were inconsistently implemented due to a lack of clear instructions or genuine interest.
Furthermore, staff and case managers could often describe opportunities and preferences verbally, but these were not translated into written, actionable, or measurable goals in the ISP, resulting in missed opportunities to support individuals in a truly person-centered way.

Not having meaningful, individualized, and measurable goals leads to limited personal growth, reduced independence, and missed opportunities for genuine community integration. Vague or generic goals make it difficult for staff to assess progress, provide consistent support, and respond effectively to risks, which can compromise safety and quality of care. This lack of specificity also undermines person-centered planning, resulting in plans that do not reflect individuals' evolving needs or aspirations. Ultimately, the absence of meaningful goals perpetuates isolation, stagnation, and systemic non-compliance, preventing individuals from achieving their full potential.

- Individual #1 had goals to complete his laundry with staff assistance, make two simple meals/snacks independently, and review his new address. He did not have goals related to community engagement, day programming or building new relationships. Per interviews with his host home provider and case manager, he was making progress on his goals. Although not integrated into his ISP, his host home provider reported that he had many opportunities to participate in activities in the community and had built some new relationships through frequent community interactions.

- Individual #3's goals focus on expanding their communication by making choices for participation in household task and increasing time in the community. Staff noted that he had gained independence through navigating his new environment, participating in household task and other activities. His community engagement and opportunities for social interaction were limited per interviews, and his goal to increase his time in the community was broadly stated with no specific guidance based on his preferences.

- Individual #8 had goals to develop his cooking skills, improve his social skills, and maintain good dental hygiene. His staff and case manager were able to describe various opportunities and his preferences related to community activities; however, this information was not used to develop goals and expand his opportunities in the community.

- Individual #19 had a goal to clean up after her meals and practice propelling her wheelchair. Staff reported that she was able to complete both tasks, however, without measurability, it was not clear how they would determine mastery of her goals. Her preferences and goals related to community integration and day habilitation were not defined in the support plan.

- Individual #32 had a more comprehensive set of goals that included completing household tasks, exploring career opportunities, gaining employment in the community, exercising, and choosing a healthy diet to address her healthcare risks.

- Individual #34 also had a more comprehensive set of goals to address a broader range of skills including learning to cook, participating in household task, working on an enclave, participating in his day habilitation program, and budgeting his money monthly.

- Individual #47 had two broadly stated goals to spend time in the community weekly and increase communication through learning sign language. Staff told the Monitoring Team that the IDT had recently added a goal to participate in a day habilitation activity, though he was not yet attending day habilitation, so the goal had not yet been implemented. Staff reported that his communication goal was not functional for him, and it had not been consistently implemented as instructions for implementation were not clear. There was no guidance or scheduled training to occur on his weekly visits to the community. During interviews, staff described informal opportunities to learn new skills related to household task. This training was not reflected in the ISP.

- Individual #48's ISP included goals in most major life areas, including independence, relationships, health, and day habilitation. He had goals to complete cleaning task in the home, attend day habilitation twice per week to increase his community integration and participate in group activities, participate in two activities per week in the community and eat healthy and be physically active. His day-habilitation and community outings goals were generic goals to participate without consideration of his personal preferences.

- Individual #49 had broadly stated goals to complete one daily household task, be involved in at least two community activities per week and two in-home activities per week and to participate in at least three group programs to increase socialization and build natural supports.

- Individual #27 had goals to be active in caring for her home and physical health, to expand her leisure interest at home and in the community, and to attend the day program for the entire scheduled time and explore different activities. When developing goals, the IDT did consider most major life areas.

- Individual #61 had two goals to participate in home skills task and work on healthy food choices. His goals did not include consideration for how he would spend his day, increased community integration, or building relationships in the community. Staff and his case manager described his goal on healthy food choices as giving him the option to choose between two healthy food choices. There was not an education component for learning about healthy choices. It was also reported that he participates in a home skills task daily and there was no plan for training in that area.

- Individual #62 had goals to wait for an item or activity after receiving a first/then statement from staff and a goal for increasing community safety skills by exiting the car safely, looking both ways before crossing the street and walking with staff. His ISP also included a goal to use sign language for requesting items. The case manager and staff reported that his sign language goal was not consistently implemented and that he had no interest in using sign language. His goals did not address his preferred activities for leisure, day habilitation, socialization, or increased community integration.

- Individual #63 had a goal to complete a household task with 70% accuracy with two prompts. His case manager reported that a new communication goal had recently been implemented for using cue cards to communicate his wants and needs. Staff described how he completed several household tasks, however, they did not have data related to his mastery of that goal and they were unable to describe mastery criteria. He did not have any goals related to community engagement, building relationships or goals related to his preferences for leisure or day activities.

- Individual #68 had goals to be involved in household activities and develop more peer relationships as well as find activities that he enjoyed participating in. Both were broadly stated and offered little staff guidance for consistent implementation and determining when goals were met. Staff described how he had become more independent around his house with household task, however, they were unable to describe what mastery of this goal might look like. His case manager reported that he goes on outings in the community and is involved in some routine activities, however, these were not addressed in his support plan.

- Individual #77 had a goal to complete a household task each week with staff assistance. His goal related to employment was discontinued. The case manager reported that his team would be updating his goals soon.

- Individual #80 had goals to complete a housekeeping task daily with staff assistance and complete at least one community activity with staff assistance. These participation goals did not describe her preferences, what training would occur or when the goal would be considered mastered. Staff reported that she participated in both activities routinely and was often engaged in the community. She was routinely given choices regarding her participation in activities in the home and in the community. Her support plan did not include guidance for expanding her community engagement, relationships, or independence in the community and did not encourage her to participate in her health management.

- Individual #82 has goals to socialize in the community with peers at least monthly and exercise at least three times per week. Per interviews, she routinely completed these activities, however, without mastery criteria, specific progress was not documented and goals continued to be implemented. Her host home provider described how she had gained independence in both her home and the community. They consistently exposed her to new activities, and new people in the community and fostered her independence. This was not reflected within her support plan. Her team should consider revising her ISP to include what they had learned about her and then establish measurable goals so her growth and independence would continue.

- Individual #89 had goals to complete a household chore, participate in a community activity at least three times per week and choose an item from her bag of preferred items. While the IDT considered her needs, goals were not individualized, nor did they include enough information for staff to implement them consistently and measure progress. Per interviews, she routinely participated and completed her goals.

- Individual #91 had a goal to live as independently as possible and engage in daily activities by introducing a simple enjoyable home-based activity that promotes emotional and cognitive stimulation. Action plans to implement his goal included offering him choices such as watching TV or listening to music for 10 minutes three days per week. According to staff this was routinely part of his day. His goals did not offer him an opportunity to try new things or learn new skills. His support plan did not consider how he might expand interactions in the community or with others.

- Individual #118 had goals to shower, brush his teeth and take his medication daily. He also had a goal to participate in activities at his day habilitation program. Staff were able to identify some of his preferences related to community engagement and social activities, however, his goals did not reflect his interest but instead were more related to compliance rather than skill building.

b. All individuals had an ISP that was updated within the past 365 days. For two individuals, assessments were not timely, so the team convened and updated the ISP within 365 days then further revised the support plan following assessment. Assessments are not being reviewed for comprehensiveness, only that they are present and completed timely.

c. Few of the individuals had measurable goals and measurable training objectives. Goals in the Individual Support Plans (ISPs) were frequently written without specific direction for staff, lacking clear expectations, criteria for achievement, or the necessary individualized supports and opportunities for implementation. As a result, the goals did not identify what skill would be mastered or the level of assistance required, and rarely included instructions on what evidence should be collected to track, record, and evaluate progress. This lack of specificity made it difficult to assess measurability, leaving no data to reflect measurable progress or lack thereof. Consequently, there was no reliable way to determine if individuals were successful in achieving their goals, and once goals were met, they were not revised to reflect new aspirations or skills. During interviews, program staff and case managers often provided anecdotal evidence of goal achievement, but there was no measurable data to support these claims, and none of the goals had been updated due to mastery. This highlights the need for ISPs to include clear, measurable objectives and a process for ongoing revision to ensure continued growth and meaningful outcomes for each individual.

Many goals were daily activities that focused on participation, compliance with request, or completion of tasks rather than supporting the individuals to learn a new skill, to increase their independent living skills or expand upon their interests or engage in new activities.

- Individual #1's goal to complete laundry did not specify how many times he would need to complete actions to consider the goal mastered. However, it was positive to note that there was action steps included to guide staff in determining what success would look like (take laundry to basement, put in washer, set dial, add correct amount of soap, move from washer to dryer, set dial). This amount of detail was rarely included in support plans. His goal to make two simple meals/snacks independently and review his address at least once weekly did not include mastery criteria and offered little guidance for implementation.

- Individual #3's goals focus on expanding communication by making choices for participation in household task and increasing time in the community. Neither goal was measurable. His goal to increase time spent in the community focused on communication, however as written, it was unlikely that steps to support the goal would increase his time spent in the community. There was also no measure of baseline time spent in the community or how much that would increase to successfully achieve the goal.

- Individual #8's goals to develop his cooking skills, improve his social skills and maintain good dental hygiene were not written in measurable terms. While two of the goals included the frequency of implementation, it was not clear when the goal should be considered mastered. Staff were able to anecdotally describe progress towards his goal but there was no measurable data recorded.

- Individual #19 had a goal to clean up after her meals, practice getting her own water and practice propelling her wheelchair. Staff reported that she was able to complete both tasks, however, without measurability, it was not clear how they would determine mastery of her goals. They did include some guidance for steps necessary to complete the goals.

- Individual #32 goals included completing household tasks, gaining employment in the community, exercising, and choosing a healthy diet to address her healthcare risks. Goals included more detail on the desired outcome, however as written, they were not measurable. For example, her goal to slowly make changes to her eating habits to reduce food that causes high blood sugar and add food that would help to reduce her blood sugar did not include criteria that would identify when the goal was met. Her goal to gain employment in the community had action steps to attend work as scheduled and complete her work task while at work. It was not clear how long she would have to do this before she was supported to seek a job in the community.

- For the most part, Individual #34's goals were measurable. For example, he had a goal to save at least $10 per month. His goal to complete at least one group activity was not measurable. It was not clear how staff would measure his participation in a group activity.

- Individual #118 had goals to shower, brush his teeth and take his medication daily. He also had a goal to participate in activities at his day habilitation program. As written, staff would be able to record data on progress, however, it was not clear how long he would have to successfully complete each task to consider the goal being mastered.

- Individual #47's goals to spend time in the community weekly and increase communication through learning sign language were not measurable. Staff reported that his communication goal was not functional for him, and it had not been consistently implemented as instructions for implementation were not clear. There was no guidance or scheduled training to occur on his weekly visits to the community, as written this was a goal for staff to complete by taking him on community outings.

- Individual #48's had goals to complete cleaning task in the home, attend day habilitation twice per week to increase their community integration and participate in group activities, participate in two activities per week in the community and eat healthy and be physically active. Although his support plan included some minimal guidance for staff implementing his goals, his level of participation for mastery of goals was not defined. His goal to eat healthy and be physically active was also not measurable as it was written.

- Individual #49 had broadly stated goals to complete one daily household task, be involved in at least two community activities per week and two in-home activities per week and to participate in at least three group programs to increase socialization and build natural supports. None of his goals included measurable criteria for completion.

- Individual #27 had goals to be active in caring for her home and physical health, to expand her leisure interest at home and in the community, and to attend the day program for the entire scheduled time and explore different activities. Her support plan did describe implementation of her goals in more detail however it still was not clear when the goal would be considered mastered. Staff reported that her goal to attend a day program had been discontinued. Staff also noted that she was able to

complete her goal related to caring for her home and physical health though mastery criteria was unclear, so she continued to work on those goals.

- Individual #61 had two goals to participate in home skills task and work on healthy food choices. Staff reported that he participates in a home skills task daily and there was no plan for training in that area. It was not clear how they would determine when that goal had been achieved. Staff described implementation of her healthy food choices as offering her a choice between two healthy food items. It was not clear how they would document progress if she always chose one of the items.

- Individual #62 had goals to wait for an item or activity after receiving a first/then statement from staff and a goal for increasing community safety skills by exiting the care safely, looking both ways before crossing the street and walking with staff. His ISPS also included a goal to use sign language for requesting items. The case manager and staff reported that his sign language goal was not consistently implemented and that he had no interest in using sign language. There was no staff guidance to ensure consistent implementation and data collection to determine progress for his first/then statement goal. His community safety goal did note that it would be implemented twice weekly and completed when he could complete the task 80% of the time for three consecutive months.

- Individual #63 had a goal to complete a household task with 70% accuracy with two prompts. Staff described how he completed several household tasks, however, they did not have data related to his mastery of that goal and they were unable to describe mastery criteria.

- Individual #68 had goals to be involved in household activities and develop more peer relationships as well as find activities that he enjoyed participating in. Both were broadly stated and offered little staff guidance for consistent implementation and determining when goals were met. Staff described how he had become more independent around his house with household task, however, they were unable to describe what mastery of this goal might look like.

- Individual #77 had a goal to complete a household task each week with staff assistance. His support plan defined his goal as removing sheets from his bed and putting new ones on twice per week with two prompts or less. With this information, staff could consistently document progress, however, it was not stated how many times he would have to complete this task to achieve his goal.

- Individual #80 had goals to complete a housekeeping task daily with staff assistance and complete at least one community activity with staff assistance. Although there were no specific criteria to determine when the goal had been achieved, staff reported that she participated in both activities routinely and was often engaged in the community. Per staff, she was routinely given choices regarding her participation in activities in the home and in the community. Her team should develop more individualized goals for skills/activities that she would like to learn/accomplish. Her goal for housekeeping task listed options for several possible tasks (wiping down the table, assisting with laundry, picking up items). Unless tasks are specific and instructions for training were included for consistent implementation, documentation on progress would not be meaningful for determining when a task was learned.

- Individual #82's goals to socialize in the community with peers at least monthly and exercise at least three times per week were not measurable as written. Her goal to socialize in the community had steps to choose an activity, invite a peer, budget money for the activity, then participate in the activity. It was good to see that her support plan described the steps for completion of the goal, however, it was not clear how many times she would need to complete the steps to have achieved her goal. Per interviews, she routinely completed these activities, however, without mastery criteria, specific progress was not documented and goals continued to be implemented.

- Individual #89 had goals to complete a household chore, participate in a community activity at least three times per week and choose an item from her bag of preferred items. Goals did not include enough information for staff to implement them consistently and measure progress. Per interviews, she routinely participated and completed her goals.

- Individual #91 had a goal to live as independently as possible and engage in daily activities by introducing a simple enjoyable home-based activity that promotes emotional and cognitive stimulation. Action plans to implement his goal included offering him choices such as watching TV or listening to music for 10 minutes three days per week. According to staff this was routinely part of his day. His goals did not offer him an opportunity to try new things or learn new skills and progress was not measurable as written.

d. ISPs included only general or minimal information about individuals' strengths, needs, and preferences, often lacking the detail necessary for staff to provide truly individualized supports. In several cases, needs were described in broad terms such as requiring assistance or monitoring without specifying what kind of help was needed, how much, or when. Preferences for activities, community participation, or daily routines were either absent or vaguely stated, and exposure to new experiences was rarely documented. While some plans, like those for Individual #19, Individual #32, Individual #68, and Individual #77, offered more detailed narratives or supplemental support plans, most did not consistently capture evolving interests or provide clear guidance for staff. As a result, staff may struggle to understand how best to support each person, and opportunities to update plans based on new experiences or changing preferences are often missed.

To improve, ISPs should include specific, regularly updated information about what individuals enjoy, how they want to spend their time, and the supports they need, ensuring that plans reflect each person's current aspirations and promote meaningful engagement. Specific examples were noted below:

- Individual #1's ISP included some information about his strengths, needs, and preferences. Statements regarding his needs were typically generalized to note that he needed assistance from staff but lacked detail in what specifically he needed assistance with and how much assistance was needed. For example, it was noted that he needed monitoring when using the toilet but there was no detail on what specifically needed to be monitored. It was noted that he needed verbal prompts for ambulating and moving about but there was no detail on what or when verbal prompts were needed.

- Individual #3's ISP included information on his strengths, needs, and preferences. Support needs were written in general terms with little information for staff to determine exactly what supports were needed. For example, it was noted that he needed assistance with all ADLs. Supports included a general statement that he has staff 24/7.

- Individual #8's ISP included minimal information about his strengths, needs, and preferences; most information was related to his health and safety. There was little information regarding his preferences related to activities, community participation, or daily schedule other than a statement that he enjoys getting out in the community to go out and eat or do activities. He had a limited list of preferences, with no documentation of exposure to new activities.

- Individual #19's ISP included a more detailed narrative about her strengths, needs, and preference. The narrative included her preference both at home and in the community. The ISP described specific supports needed throughout her day.

- Individual #27's ISP included minimal detail on her preferences. A paragraph describing her preferences noted that she does not attend any religious services but celebrates holidays with her staff and roommates, including Thanksgiving and Christmas. She preferred receiving magazines when people visited her house or when she had meetings in the community, she loved getting mail and handing money to the cashier when out in the community. Her strengths included that she was friendly, outgoing and had strong family supports. Her ISP provided minimal detail regarding her support needed. However, her provider agency had developed a Supplemental Plan of Support that was very detailed in describing her preferences and support needs for activities throughout her day.

- Individual #32's plan was also more descriptive of her strengths and needs. The IDT did a nice job describing how best to support her in all major areas of life. Information was somewhat limited to her preferences; however, she did have goals that presumably addressed her known preferences. The ISP did not document opportunities she had for new experiences and how that impacted her preferences.

- Individual #34's ISP included very little information about their strengths and preferences (friendly, easy-going, talkative, like to talk about food, money and going places) and for the most part, supports were very general in nature and offered staff little guidance in providing consistent support.

- Individual #47's ISP included narrative comments about his strengths, preferences, and needs.

- Individual #48's strengths, needs, and preferences were included in his ISP. As noted below, supports were not always specific on when and how support should be provided.

- Individual #49's strengths, needs and preferences were included in his ISP, however, there was little detail regarding how she wanted to spend her day, what she wanted to experience in the community, or what relationships were important to her.

- Individual #61 had a narrative description of his strengths, preferences, and needs included in his ISP.

- Individual #62's ISP included a description of his strengths, preference, and needs.

- Individual #63's ISP included minimal information regarding his preferences and support needs. For example, it was noted that

he likes to go into the community but offered little detail about his preferences for community outings. It was noted that he needed full physical support for a long list of activities but did not describe what those supports looked like in any detail.

- Individual #68 had a support plan developed by a Provider It was much more detailed than the ISP developed by the Iowa Total Care case manager, particularly related to his preferences. There was a lack of detail regarding his specific health care needs in both plans.

- Individual #77 had an ISP by the MCO with his input. It included information regarding his strengths, preferences, and needs. For the most part, information was individualized and addressed all key areas of life.

- For individual #80, the ISP developed by Wellpoint included little detail on her needs and preferences. The Provider had developed a supplemental support plan that included a much more descriptive narrative about her needs and preferences.

- Individual #82's ISP included information about her preferences, strengths, and needs. In some cases, instructions for providing supports were vague or not individualized. For example, supports to address psychiatric symptom all stated therapy and medication management. To mitigate her risk for acid reflux, the ISP noted that her diet should be monitored, and she should avoid triggering foods. There were no trigger foods listed.

- Individual #89's ISP included a summary of her preferences and general information regarding her needed supports throughout her day.

- Even though information was not in Individual #91's ISP, the criteria for this indicator was met since the provider developed a supplemental plan that included much more detail regarding the individual's preferences and support needs during various activities.

- For Individual #118's, the ISP provided some information regarding strengths, preferences, and need. For preferences, it was noted by staff that he liked calm, patient people who respect his space and give him time alone. He prefers staff who smile and offer fun things to do. He dislikes loud or chaotic environments and enjoys sensory activities, music, and being outside. His mom helps with all decisions. I like familiar routines and friendly staff. I do not follow any specific cultural health practices. He prefers services that are consistent and supportive. The description was not detailed enough to ensure that staff could provide person-centered supports throughout the day. More details about preferences for activities throughout the day would have been helpful to staff providing supports.

e. Although most plans included broadly stated goals and action plans aimed at increasing independence within the home, these goals were not measurable and rarely extended to expanding independence in the community. As a result, individuals were often supported to develop basic daily living skills at home, but there was little emphasis on fostering new skills or providing opportunities that would enable greater independence, participation, or integration in community settings. This limited approach meant that individuals missed experiences that could help them build relationships, access community resources, or develop new interests outside the home.

- The IDT had attempted to address greater independence for Individual #1 through goals to complete his laundry, practice making a simple snack or meal and learning his address. When interviewed, staff reported that he was able to successfully complete these tasks. There were no revisions to his goals to ensure he continued to develop greater independence. His host home provider informally provided many opportunities to learn new skills and increase his independence. These efforts and supports should be better documented within the ISP.
- Individual #3's ISP did not address how he would increase his independence. Goals did not describe how they might lead towards greater independence.
- Individual #8's ISP did not include information on how he might be supported to become more independent other than a goal to develop his cooking skills.
- Individual #19's ISP considered ways that she could become more independent at home with development of goals for greater independence. Her ISP did not include consideration of ways she could become more independent in the community other than by self-propelling her wheelchair which staff reported she could do. Staff could anecdotally describe ways in which she had gained more independence at home by taking her dishes to the sink and getting water from the refrigerator with minimal assistance.
- Individual #27's had goals that promoted greater independence by completing a household task, washing her hands, and brushing her teeth.
- Individual #32's ISP included opportunities for her to gain independence both at home and in the community. Staff interviewed could describe how they supported her in becoming more independent.
- Individual #34's ISP included goals to increase independence through household task, seeking employment, and budgeting his money.
- Individual #47's ISP included very little information on how his overall independence would be supported. It was noted that his communication was a barrier to his being more independent, however, staff reported that communication supports in his ISP were not functional.
- Individual #48's included a generic goal to contribute to his home environment, but little else that would support his independence.
- Individual #49's ISP included opportunities to become more independent at home by participating in cleaning task, learning to cook, and learning to manage her money.
- Individual #61 had goals to participate in home skills task and work on healthy food choices. Although these could lead to greater independence, as written, it was not clear what skills he might learn that would increase his independence.

- Individual #62 had a goal to increase his safety skills in the community. He also had a communication goal, however, staff reported that the goal was not functional for him. His IDT should continue to focus on communication skills that might increase his independence in the community.

- Individual #63 had one goal to complete household task. His provider described his mastery of this goal though there was no supporting data. Per his case manager, the IDT had recently met to develop a communication goal that would support him to be more independent, however, it had not yet been implemented. Overall, the ISP included little information on how staff could support their independence.

- Individual #68 had a broadly stated goal to be involved in household activities that was not measurable and did not describe how he would become more independent. His ISP did not include consideration of other ways that he might be able to gain greater independence. Staff described how he had become more independent around his house with household task, however, they were unable to describe what mastery of this goal might look like.

- Individual #77 had a goal to complete a household task each week with staff assistance. His support plan defined his goal as removing sheets from his bed and putting new ones on twice per week with two prompts or less. This goal supported greater independence in his home. He did not have any goals or plans to increase his independence in the community.

- Individual #80 had two goals to complete a household task and complete one community activity. Neither goal had enough detail related to implementation to determine if she would gain independence by participating in these activities. She had a long list of restrictions due to her lack of independence but no plans to provide training in those areas so that she could become more independent and remove restrictions.

- Individual #82's ISP did not specifically address training to increase her independence; however, her host home provider was very focused on nurturing her independence both at home and in the community. This information should be captured in her ISP.

- Individual #89 had goals for household tasks and increasing her success in the community. Although her ISP did not include measurable outcomes that included training where needed to become more independent. Their host home provider described how she was routinely supported to be more independent at home and in the community.

- Individual #91's ISP had one goal for engagement when offered choices. It was not clear what the expectations were for him to increase his independence. His plan did not consider training that might lead to greater independence.

- Individual #118 had goals to brush his teeth and take his medication. The provider reported that he had the necessary skills but would not always brush his teeth and take his medications. These goals were compliance goals that were not necessarily teaching new skills or developing greater independence. The IDT should consider training new skills based on their

preferences when developing goals.

f. Though most individuals had goals related to community participation, these objectives generally lacked the necessary structure to facilitate meaningful integration or the development of relationships within the broader community. Individuals residing in host homes were more frequently engaged in activities that could promote integration or valued social roles; however, for others, community outings tended to be limited to non-integrated experiences such as van rides, neighborhood walks, park visits, or attendance at isolated community events. Effective community integration requires intentional planning and the development of formal activities that are aligned with the individual's preferences, as well as the exploration of opportunities for non-paid relationships and, where appropriate, employment. Additionally, skill-building should be incorporated into these activities to enhance engagement and enjoyment. These elements were not consistently reflected in the Individual Support Plans (ISPs), resulting in limited guidance for staff on how to support individuals in achieving genuine community integration.

The absence of meaningful, measurable goals for community integration in Individual Support Plans (ISPs) is not just a missed opportunity, it undermines the purpose of person-centered planning. When goals are vague and do not actively promote integration or relationship-building, individuals are denied the chance to develop valued social roles, build lasting connections, and participate fully in their communities. This perpetuates isolation and limits personal growth, independence, and quality of life.

During the review of Individual Support Plans (ISPs), it was noted that none of the plans explicitly documented that increased community integration was not desired by the individual. In the absence of such documentation, the Monitor reasonably assumed that the default goal or preference was for increased community presence and integration. This assumption guided the evaluation of compliance with person-centered planning requirements, particularly those provisions that emphasize meaningful community participation and integration as a desired outcome for individuals transitioning from institutional to community-based settings. This approach aligns with the principles of person-centered planning, which require that individual preferences drive the development of goals and supports. Unless an individual or their team specifically indicates otherwise, it is appropriate to presume that greater community engagement is a positive and intended objective. More specific examples are noted below:

- Individual #1's ISP noted that he enjoyed being in the community, however, there were no plans to increase his community participation or to ensure that he had opportunities for meaningful engagement. Although not reflected in his ISP or goals, he seemed to be meaningfully engaged in his community, and the provider had done a great job of offering him many new experiences based on his preferences.

- Individual #3's ISP listed some possible outings but did not include opportunities for community integration.

- Individual #8's ISP did not include opportunities for community integration. Documentation indicated that he regularly went on outings in the community and regularly attended church, however there was no formal plan to increase integration.

- Individuals #19's ISP did not include plans to support more meaningful community integration.

- Individual #27's ISP did not include plans to support integration into the community other than a broadly stated goal to explore more leisure activities at home and in the community. There was not enough detail to provide her with clear

opportunities for community integration. After several incidents in the community, staff reported that they were slowly introducing outings into Individual #27's schedule and working with the Intellectual Disability Mental Illness (IDMI) Program at Iowa HC on ideas on how to incorporate more community engagement activities for her to be successful in. Her ISP had not been updated to include this information.

- Individual #34's ISP did not specifically address ways to provide opportunities for community integration. His staff discussed ways that he was able to visit a variety of places in the community and was beginning to form new relationships in the community; however, this information was not in his ISP. Team members expressed an interest in seeing him become more integrated into his community.

- Individual #47 had a brief description of opportunities for community integration that noted he would go out into the community and attend events with his family but was less likely to go with staff and his housemates. There was no plan to increase his opportunities when at home.

- Individual #48 had a goal to participate in activities weekly, with an action step to research places with staff. Although the goal lacked specific strategies to implement the goal consistently, it was a good start to exploring the community.

- Individual #49 had a goal to increase her community integration by attending three community outings each month. The goal was not individualized and did not consider her preferences. It was not clear that these outings would lead towards more meaningful participation in the community. Staff did report that she routinely attended church and a music group in the community.

- Individual #61's ISP did not provide clear opportunities for community integration.

- Individual #62's ISP did not include consideration of how he might increase his participation in the community in a meaningful way.

- Individual #63's ISP did not provide any clear opportunities for community integration. It was noted that he enjoyed spending time in the community, but his team did not develop goals or guidance based on his preferences for providing additional opportunities for community interactions. The trips in the community described by staff provided few opportunities for meaningful engagement with others with the exception of going to church on Sundays.

- Individual #68 had no goals specifically related to community engagement. His Provider's developed support plan noted that getting out of the house as often as possible was important to him. There was also a list of activities in the community that he enjoyed such as movies and sporting events, however, there was no plan for greater exposure to new activities or activities that might support meaningful integration.

- Individual #77's ISP noted that he liked going in the community and doing activities. There was little detail regarding how he could become more integrated into the community. It was noted that he attends church regularly and was routinely involved in

activities in the community. A list of community outings for the past six months included attending an Easter Egg Hunt, going bowling, attending a prom, going out to eat, shopping, to the zoo and various parks and lakes. Few of these outings offered opportunities for integration. He did not have any community related goals that might increase his meaningful participation in the community.

- Individual #80 had a goal to improve her community integration by completing an activity in the community weekly. Activities suggested included shopping, community center, library, out to eat, going to the movies and going to local lakes and parks. As written, the goal would not necessarily increase her opportunities for meaningful integration. For the most part, these were just one-time outings with no plans to interact with others or form relationships. The exception was regularly going to the community center; however, staff did not report that she had gone to the community center.

- Individual #82's ISP did not consider opportunities for expanding participation in the community. Per interviews, her host home provider supported her to frequently engage in new activities in the community and did provide opportunities for integration. Information from the provider should be used to develop goals for community exploration and integration based on her known preferences.

- Individual #89 had a community participation goal as well as a goal to address her anxiety in the community which was reportedly a barrier to greater integration.

- Individual #91's ISP did not include opportunities for greater community integration.

- Individual #118 had a goal to participate in activities. The activities were not defined and would not necessarily lead towards greater community integration. Provider staff reported that he was consistently engaged in regular activities through his day habilitation program in the community including volunteering with Meals on Wheels and the food pantry and cleaning parks. Goals should build on activities that he enjoys providing additional opportunities for integration.

g. There were instances where staff were less detailed in describing medical risks and supports, which was often attributable to the ISPs containing minimal information on certain medical diagnoses and strategies for risk mitigation. This gap underscores the importance of comprehensive and detailed documentation in ISPs to ensure that all aspects of an individual's needs, especially those related to health and safety, are clearly communicated and consistently addressed by all members of the support team. All residential provider staff interviewed demonstrated a strong understanding of each individual's preferences and support needs, and were able to clearly describe how supports were provided, including any training they had received. Staff could discuss the implementation of goals and whether individuals were making progress, and they consistently monitored individuals' health status and any changes. In many cases, staff provided more detailed descriptions of supports than were documented in the ISPs.

- Individual #1's host home provider was very knowledgeable about his strengths, preferences, and support needs. He described frequent exposure to new activities so that his preferences were based on informed choices. He was aware of his health care needs, supports to mitigate risk and the efficacy of behavioral interventions.

- Individual #3's provider staff were able to describe his preferences, strengths, and needs in detail. They described his routine

along with supports that they provide throughout his day.

- Individual #8's provider staff were able to describe their strengths, preferences, and support needs. They were aware of his healthcare risks and could discuss the efficacy of supports. They did note that at times, his activities were limited by the availability of staff.

- Individual #19's staff were able to describe supports in her ISP, along with her preferences, needs, and goals. They were eager to describe ways that she had gained independence and expressed that she was flourishing in her new environment. They described ways that they were able to encourage her to be more independent while offering supports needed to mitigate her risks.

- Individual #27's staff described her preferences, strengths, and needs. They talked about various supports that she needed throughout her day and described her goals and progress towards achievement. They knew the status of her medical appointments and strategies to minimize risks.

- Individual #32's staff knew her preferences and support needs. They discussed her physical health and behavioral health needs and what worked best for her in detail. They were also able to describe progress on goals and barriers to achieving her goals. When behavioral supports were not working, they sought assistance to revise her supports.

- Staff interviewed for Individual #34 were familiar with his preferences, outcomes, and support needs.

- Individual #47's staff were able to describe their preferences and support needs. During interviews, they described training for his specialized medical needs.

- Individual #48's staff were able to describe their preferences and support needs in detail.

- Staff were able to describe Individual #49's preferences, strengths, and needs.

- Individual #61's staff were able to describe their preferences and support needs. They were familiar with his risks and knew the status of supports.

- Staff were familiar with Individual #62's preferences and support needs. They were able to discuss his medical status and supports to address risks.

- Staff were able to describe Individual #63's routine, preferences, supports and strategies to minimize their risks.

- For Individual #68, staff were able to describe his routine and preferences. They were also aware of changes in medications and the reasoning behind those changes. They described supports needed throughout his day.

- Individual #77's residential provider was able to describe his preferences, risks, and support needs. He had few support needs related to risk but the provider could describe why he was at risk and what supports were provided to minimize risks.

- Staff were able to describe Individual #80's preferences and support needs. They were able to describe her risks and supports provided along with how and when she used her adaptive equipment.

- Individual #82's host home provider was very familiar with her preferences and supports including supports to address risks, medical diagnoses, and behavioral needs. They were able to describe training received prior to her transition.

- Individual #89's host home provider knew her well. She was able to describe her preferences, needs, supports and was aware of her medical status and supports to mitigate risks.

- Although Individual #91 had recently transitioned to a new provider, the provider staff were familiar with his preferences and his support needs. They were able to describe in detail how to provide medical supports and monitor risks.

- Individual #118's provider staff were able to describe his preferences and support needs, as well as his health status and interventions to mitigate risks.

h. Person-centered plans should offer clear, actionable guidance for staff regarding the individual's daily routine, specifying how and when identified supports are to be implemented and reflecting the individual's preferences for spending their day, evening, and weekends. This guidance must be driven by the individual's input either directly or through a thorough assessment process to ensure supports are truly tailored. While some ISPs included a general outline of daily activities, most lacked sufficient detail, or direction. Incorporating a daily or weekly summary or expected schedule within the plan would enable staff to consistently and effectively carry out responsibilities related to positioning, dining, medication administration, involvement in household activities, skill training, and appointments. Such documentation not only facilitates high-quality support but also demonstrates the individual's active engagement and exercise of choice in shaping their routine. For individuals who are unable to easily express their preferences, providing this level of detail becomes even more critical to ensure their needs and choices are respected and prioritized. The examples below highlight significant inconsistencies in how individuals' daily routines and scheduling preferences are documented within the ISPs.

- Information regarding how Individual #1 spent his day or how he was involved in determination of how he spent his day was not included in his ISP.

- Individual #3's ISP included a goal for him to communicate his choice regarding going out to eat twice a month and noted his preferences related to mealtimes, otherwise it was noted that he likes to keep busy during the day with his calculators, UNO cards, magazines, and flashcards. There was no indication that he was offered opportunities for meaningful engagement in other activities throughout the day.

- Individual #8's ISP did not include any information about his schedule or his preferences related to scheduling.

- Individual #19's documentation included a daily schedule that included consideration of her preferences.

- The Supplemental Plan of Support included detailed information about Individual #27's preferences related to scheduling and supports needed. It was noted that her routine was extremely important to her.

- Individual #32's ISP included information regarding preferences for her daily schedule. Although not a formal schedule and not comprehensive, information scattered throughout her ISP described her preferences and support needs throughout her day. It was nice to see the level of detail for supporting her in various activities.

- Individual #34's ISP did not provide information about his preferences related to his schedule or provide detail on when specific supports should be provided.

- Though not detailed, Individual #47's ISP described his preferred schedule and how those activities related to his preferences.

- There was no documentation submitted regarding Individual #48's or Individual #49's schedule or how their schedule reflected their preferences. ISPs did not include information regarding their schedule and related preferences.

- Individual #61's, Individual #62's and Individual #63's ISPs did not include information about their routine or schedule or their schedule related to preferences.

- Individual #68's Iowa Total Care ISP included little detail about his schedule and preferences. The supplemental plan included more detail about his daily routine and preferences. There was a paragraph describing what a typical day looks like for him that included some of his preferences. Additional grids described supports needed during various activities such as eating, grooming, bathing, and participation in household tasks.

- Individual #77's ISP included information about his preferred schedule. His typical day was described, and it was noted that it was very important for him to have routine in his daily schedule.

- Individual #80's documentation did not describe her schedule or her preferences related to her daily activities.

- Individual #82's ISP did not include information about her schedule other than a note that she was not a morning person. Per interviews, her host home provider indicated that the daily schedule was based on her preferences and preferred activities.

- Individual #89 did not have documentation of her routine or how her routine supported her preferences. Her provider indicated that her day was structured around her preferences.

- Individual #91's ISP did not describe his routine or daily schedule.

- Individual #118's ISP included his day program schedule but little information regarding how he spent time at home or when supports should be provided.

i. Supports to manage the Individuals health care across providers and case managers showed notable inconsistencies in their level of detail, measurability, and relevance of supports. In many cases, plans lacked clear definitions of signs and symptoms, leaving staff uncertain about when additional intervention was warranted. Supports were often described in general terms and rarely included measurable criteria, making it difficult to assess their effectiveness or ensure accountability. This lack of specificity and consistency can hinder timely and appropriate responses to individual risks, potentially compromising safety, and quality of care. To truly protect individuals and support positive outcomes, risk plans must be comprehensive, actionable, and include clear, measurable indicators for both intervention and evaluation. For individuals with adaptive equipment designed to mitigate risk, the approach was to wait until there was an overt issue vs proactive assessments to ensure ongoing proper fit and effectiveness.

The examples provided below revealed a persistent and concerning pattern of inadequacy in ISPs across individuals. While every person identified as having increased risks such as constipation, obesity, choking, falls, aspiration, etc. had a risk plan in place, the quality and effectiveness of these plans varied widely. Most notably, risk plans frequently lacked measurable actions, clear start and end dates, and specific criteria for intervention. For instance, plans often stated that weights should be monitored or that physical exercise should be encouraged, but failed to define thresholds for action, parameters for success, or guidance for staff on when to escalate concerns. Critical signs and symptoms were inconsistently defined, leaving staff without clear direction on what to monitor or when to notify medical professionals. In many cases, interventions were limited to medication administration, with little attention paid to preventive strategies such as dietary changes, physical activity, or behavioral supports. The absence of baseline data such as blood pressure readings or bowel movement frequency further compromised the ability to detect changes in health status and respond appropriately.

Additionally, ISPs often omitted essential details about adaptive equipment, environmental supports, and protocols for reassessment, which are vital for individuals with complex medical or behavioral needs. For example, mismatches in prescribed adaptive equipment for eating posed increased safety risks, and vague plans for behavioral holds or elopement failed to provide actionable steps for staff. This lack of specificity, measurability, and comprehensive guidance not only undermined the effectiveness of risk mitigation strategies but also placed individuals at increased risk for preventable harm. Without clear, actionable, and regularly evaluated support plans, staff may miss early warning signs, delay interventions, and fail to provide the level of support necessary to ensure safety and well-being. It is imperative that support plans be detailed, measurable, and regularly updated to reflect best practices and the evolving needs of each individual.

- Individual #1's ISP included broad statements about their support needs that offered little guidance for staff providing supports. For example, there were two grids in the ISP that identified his needs and had a column to describe supports to meet his needs. One grid included information on his needs related to home living, community living, learning, employment, health and safety, social interactions and protection and advocacy activities. The second grid related specifically to risks. The column that should have detailed specific supports/interventions for each need or risk stated "receiving 24-hour supervision and support in his host home with Iowa Focus" for almost all needs. Individual #1 was identified as being at increased risk for constipation, obesity, injuries related to behaviors, and diabetes, and while risk plans were in place for each area; their comprehensiveness and effectiveness were limited. The plans did not include clear start and end dates for actions, making it difficult to track implementation or progress over time. Actions within the plans were not measurable; for example, the obesity risk plan simply stated that he would weigh himself each month but did not specify thresholds for contacting the primary care

provider or what constituted a concerning change. Similarly, the diabetes risk plan encouraged physical exercise and limiting simple sugars, but did not define how success would be measured or provide parameters for staff to follow. Signs and symptoms requiring intervention were inconsistently defined, and the risk plans for injuries related to behaviors and constipation only mentioned monitoring for weight gain and no bowel movements for three consecutive days, without further detail on what other signs should prompt staff to notify the primary care provider.

- Individual #3's ISP included the broad statement that he needed partial physical assistance to full physical assistance for activities related to operating home appliances, bathing, personal hygiene, toileting, participating in recreational activities, preferred community activities, etc. without specifying details about how or when staff should assist. Individual #3 was identified as being at increased risk for choking and falls, and while risk plans were in place for both areas, their comprehensiveness and effectiveness were lacking. Across all risk areas, the plans were not measurable, making it difficult to determine whether interventions were effective or if adjustments were needed. The risk plans did not include clear start and end dates for actions, which is essential for tracking implementation and ensuring accountability. There was also a lack of information regarding warning signs or the cadence for reassessment of specialized equipment, which is critical for individuals with changing needs or complex health conditions. For choking risk, the plan specified the use of a youth spoon, but the actual equipment shared by staff did not match the plan, raising concerns whether the plan was updated or staff trained appropriately. The plan also failed to specify the type of chair to be used (such as a chair with arms), and did not include triggers for notifying physical therapy if there was a change in status or guidance on when to reassess equipment. For fall risk, the plan omitted important details such as the use of a gait belt when using a walker, and did not provide clear instructions on how to address the Individual's diagnosed blindness during ambulation only mentioning that supervision was needed, without specifying the level or type of support required. Additionally, there was no mention of adaptive strategies such as the use of "no tie" shoelaces, which could be important for safety and independence.

- Individual #8 was identified as being at increased risk for asthma, constipation, hypertension, and weight. However, the risk plans developed for these areas had several shortcomings. Across all risk areas, the plans were not measurable, making it difficult to determine whether interventions were effective. For example, the weight risk plan only required weekly weight monitoring, with no additional supports or strategies identified to assist with weight management, and no baseline or target parameters were provided. Similarly, the constipation risk plan focused solely on monitoring bowel movements and administering medication if there was no bowel movement for three days, but did not include preventive strategies such as dietary changes or increased physical activity. The hypertension risk plan indicated that medications should be administered and listed parameters for contacting healthcare providers, but did not specify which medications were being used or provide baseline statistics.

- Individual #19 was identified as being at an increased risk of dysphagia, aspiration, fluid imbalance, seizures, osteoporosis, and DVT.
  - For dysphagia, Individual #19 was placed on a pureed diet and monitored by staff at all times during meals to reduce the risk of choking and aspiration. Adaptive equipment which included a small sized spoon, dycem, and a divided plate was

used to further minimize aspiration risk. Staff encouraged the individual to eat slowly and take drinks between bites, which are important safety measures. However, a safety concern was noted: the picture of the spoon in the Mealtime Planning tab did not match the youth spoon with a built-up handle identified in the meal plan, indicating a potential inconsistency in the use of prescribed adaptive equipment. This discrepancy could compromise the effectiveness of the risk reduction strategies and should be addressed to ensure the individual's safety during meals.

Matching adaptive equipment is critical for safety because it ensures that the individual is using tools specifically designed to address their unique risks and needs. For someone with dysphagia or a high risk of aspiration, the correct spoon size, handle type, and other adaptive features help control food portions, support proper grip, and facilitate safe swallowing. If the equipment used does not match what was prescribed or planned such as a spoon with a different handle, there is an increased risk of choking, aspiration, or loss of control during eating. Consistency in equipment also helps staff follow care protocols accurately, reduces confusion, and maintains the effectiveness of risk reduction strategies. Any mismatch can compromise safety and lead to preventable incidents during mealtimes.

- For aspiration, Individual #19 had been placed on a pureed diet and was monitored by staff at all times during meals, using adaptive equipment such as a small sized spoon, dycem, and a divided plate to reduce the risk of aspiration. The individual was encouraged to eat slowly and take drinks between bites. However, the meal plan provided functioned more as a support plan for staff at the point of service, rather than a comprehensive risk plan. It lacked measurable components and clear directions for staff to follow if an issue arose, which were essential for ensuring safety and effective risk management.

  Risk supports should detail what signs or symptoms to watch for, thresholds for intervention, and step-by-step actions to take to prevent issues and the response to emergencies or changes in condition. Their purpose is to prevent harm and ensure prompt, effective responses to risks.

- For fluid imbalance, several important safety measures for Individual #19 had been noted in the ISP but were not included in the formal risk plans. Staff had been instructed to ensure the individual received 3000 ml of fluids daily and, when assisting with restroom use, to monitor output for any changes. If changes in urine output were observed, staff were directed to report this to the manager immediately, who would then notify the doctor for further instructions. The absence of these steps from the risk plan meant there was a lack of clear, actionable guidance and accountability for staff, which could compromise the individual's safety.

- For seizures, signs, and symptoms such as loss of consciousness, pale face, and fixed eyes had been included, along with directions for staff to call the nurse and document any incidents. However, although it was stated that the individual was on medications, no details were provided about which medications were used, and there was no mention of baseline status or criteria for measuring the success of interventions. This lack of specificity and measurable components may limit the effectiveness of the risk plan and make it difficult to evaluate outcomes.

- For fall risk, it was unclear as to when a mechanical lift vs a stand pivot would be used for transfers and a ramp which was

to be completed during transition was still not completed as of this date.

Heel protectors were needed to help reduce the risk of skin breakdown, but staff were not aware of this support, and the support was not being provided thus increasing the risk of breakdown due to increased heel pressure. No assessment had been provided that showed the discharge of this support.

- Individual #32's ISP included a lot of detail on how staff should support her with various activities, however, there was less detail related to health risks. Individual #32 was identified as being at an increased risk for cardiovascular disease. Constipation, skin breakdown, respiratory distress, obesity, aspiration/choking, & injury related to behaviors.

  - For cardiovascular, there was no baseline or threshold criteria. While the risk plan spoke to signs of cardiovascular concerns , there was no specificity to what those concerns were. Examples may include dizziness, and unusual fatigue. Not having a baseline blood pressure reading presents several safety concerns. A baseline provides a reference point for what is normal for the individual, allowing staff to recognize significant changes or trends that may indicate a health problem, such as hypertension, hypotension, or other cardiovascular issues. Without this reference, staff may not be able to identify when blood pressure readings are outside the safe range, potentially delaying necessary medical intervention. This increases the risk of undetected complications, such as stroke, heart attack, or organ damage, and undermines the effectiveness of monitoring and risk management protocols. In summary, the absence of baseline or threshold criteria can compromise timely and appropriate responses to cardiovascular concerns, putting the individual's safety at risk.
  - For constipation, there were no thresholds or criteria specified. The risk plan stated to give medications as prescribed and suppositories PRN but offered no clear trigger as to when these supports would occur within the risk.

    The absence of specified thresholds or criteria in the risk plan meant there was no clear guidance on when to initiate supports such as prescribed medications or PRN suppositories. This lack of defined triggers could have led to inconsistent or delayed intervention, increasing the risk of complications like prolonged constipation or bowel obstruction. Without measurable criteria, staff may not have known when to act, potentially compromising the individual's safety and the effectiveness of the risk management strategy. Upon review of the data, there were multiple days without BMs with the method of tracking varying. For example, No BMs were noted for 5 days in March 2025, 10 days in June/July 2025, 10 days in July 2025 and 6 days in July/August 2025.

    The risk supports for skin breakdown stated that staff should report anything unusual, but did not provide specific examples of what to look for, such as redness, open sores, or changes in skin texture. Additionally, although skin breakdown was partly caused by picking behaviors, the plan did not include any strategies to address or mitigate this behavior, such as behavioral interventions, use of protective clothing, or regular monitoring and redirection. This lack of detailed actions limited the effectiveness of the risk plan and may result in missed opportunities for early intervention and prevention.

    The risk supports for aspiration and choking only stated that overeating and gagging on food had not been a problem and it was unlikely to be a risk any longer. However, this conclusion was not supported by any data or by an assessment from

a swallowing specialist in the community. Without objective evidence or professional evaluation, the plan lacks a solid foundation for determining the actual level of risk, which could result in missed or delayed interventions if the risk persisted or re-emerged. Regular evaluation by qualified professionals and data-driven decision-making are essential to ensure effective risk management.

Aspiration and choking are serious safety risks, especially for individuals with swallowing difficulties or a history of gagging and overeating. If these risks are not properly assessed and monitored, there is a danger that staff may overlook early warning signs or fail to intervene promptly. Aspiration can lead to pneumonia, respiratory distress, or even death if food, liquid, or saliva enters the airway instead of the stomach. Choking can cause airway obstruction, which is life-threatening and requires immediate action. Without objective data or professional evaluation, the true level of risk may be underestimated, resulting in missed or delayed interventions if the problem re-emerges. Regular assessments by qualified professionals and clear, measurable monitoring protocols are essential to ensure the individual's safety and prevent potentially severe health complications.

The risk supports for behavioral holds was vague and did not provide baseline data or clear criteria for when holds should be used. There were no thresholds included for when to notify a behavioral health specialist, and the plan did not mention any data being tracked to evaluate the effectiveness of the interventions. These omissions increased the risk of inconsistency or inappropriate use of holds, delayed specialist involvement, and missed opportunities to improve care based on outcomes and trends.

- The risk supports for Individual #32 was vague and did not clearly define the specific goals or interventions being addressed, nor did it provide measurable criteria to determine effectiveness. The plan primarily mentioned that the individual was working with a diabetic educator to make small improvements in diet and exercise, but lacked additional detail on what changes were expected, how progress would be tracked, or what outcomes would indicate success. This lack of specificity made it difficult to evaluate whether the interventions were effective or if further adjustments were needed to support the individual's health and well-being.

- Individual #34's ISP outlined general supports needed such as staff assistance with improving my communication, needed help in the community with making purchases and making decisions and working with his team to reduce aggression, however, most supports listed were not individualized and did not provide enough detail for consistent implementation. Supports to address his behavioral risks were general in nature (i.e., medications, increased supervision). He was identified as having an increased risk for elopement, food seeking, unsafe behaviors, and constipation. Although there were several restrictions (locked cabinets, window film), no measures were planned to lessen them. It should be noted that despite all the restrictions and concerns over behaviorally based issues, there was no behavior support plan in place as the team said he had graduated.
    - The risk supports for elopement listed 24-hour supervision as the primary intervention but did not include strategies for preventing elopement, responding when an attempt is imminent, or identifying triggers that often lead to elopement. This lack of detail poses safety risks because staff may not be prepared to recognize early warning signs or respond effectively to prevent an elopement. Without proactive measures and clear response protocols, there is an increased risk that the individual could leave the supervised setting unnoticed, potentially resulting in harm or unsafe situations. Comprehensive risk plans should include specific prevention strategies, trigger identification, and step-by-step response actions to ensure

the individual's safety.

- The risk supports for food seeking recognized that the individual had a history of eating and drinking without limits and required monitoring, a set calorie diet, and locked cabinets to reduce overeating. Awake overnight staff and supervision were also provided due to previous incidents of stealing food and incarceration. However, the plan did not include specific behavioral strategies or measurable goals to address the underlying food-seeking behavior. This lack of detail increased the risk that the individual continued unsafe eating habits, potentially leading to health complications, further legal issues, or harm. Without clear interventions and monitoring protocols, staff may have missed opportunities to prevent risky behaviors and support the individual's long-term safety and well-being.
- The risk supports for constipation outlined which medications should be taken and set a threshold for medicinal intervention and provider involvement if there was no bowel movement in four days. However, it did not include strategies to mitigate constipation outside of medication, such as increasing physical activity, improving diet, or encouraging exercise. This omission increased the risk that staff relied solely on medication, potentially missing opportunities for prevention and early intervention through lifestyle changes, which are important for long-term health and safety.
- Additionally, it should be noted that there were no clear plans in place to remove the many restrictions (locked cabinets, and window film). There was no behavior support plan in place to address these behaviors or other unsafe behaviors.

- For Individual #48, supports in the ISP related to risk were at times general and did not offer staff guidance on how to provide those supports. Status and treatment for all psychiatric diagnosis were taking medication and needs supervision and support 24 hours a day. There were other needs listed where supports were not individualized or specific, for example, it was noted that partial physical assistance was needed with transportation, shopping, social interactions, recreation, community events and building access. He was identified as being at an increased risk of constipation, renal failure, hypertension, and falls.
  - The risk plan for constipation was vague and only stated that the individual took medications and that staff monitored bowel movements and notified the doctor if there was no bowel movement in 2–3 days. The specific medications were not listed in the plan, instead referring to a separate medication list, and there were no PRN parameters provided for when medicinal intervention should be implemented. This lack of detail increased the risk of inconsistent or delayed responses to constipation and limited the effectiveness of the plan in preventing complications.

  - The risk supports for hypertension stated that he took medications and referred to the Medication tab which contained the cadence for taking the medications. The risk plan also stated that signs to look for included dizziness and fatigue.

  - The risk supports for renal failure identified relevant signs and symptoms, but some lacked clear definition. For example, decreased urinary output was mentioned but not specifically defined, and restrictions on caffeine, beer, and sodium were noted without detailed guidance. This lack of specificity increased the risk that staff may have missed early warning signs or failed to implement necessary dietary restrictions, potentially compromising the individual's safety and the effectiveness of the risk management strategy.

  - The risk supports for falls stated that the provider would monitor symptoms and report adverse medication effects to

medical or mental health staff. It also indicated that the team would engage the individual if in distress, ensure safety while walking, and respond to falls or seizures, with caution advised during medication changes. However, the plan only mentioned that symptoms would be monitored and did not provide details on what specific symptoms to watch for or how monitoring should occur. This lack of specificity increased the risk of inconsistent monitoring and potentially delayed responses to safety concerns.

A vague or incomplete risk plan for falls poses significant safety risks to individuals. Without clear definitions of which symptoms to monitor and how monitoring should occur, staff may overlook early warning signs such as dizziness, unsteady gait, or changes in mobility. This can lead to delayed or inadequate responses to potential falls, increasing the likelihood of injury. Additionally, without specific guidance on reporting adverse medication effects or responding to distress, staff may not intervene appropriately during critical moments. The absence of detailed protocols can result in inconsistent monitoring, missed opportunities for prevention, and ultimately, a higher risk of falls, injuries, and related complications for the individual. Comprehensive, measurable, and clearly defined actions are essential to ensure timely and effective fall prevention and response.

- Individual #47's ISP included some individualized description of his supports and services. Information related to supports to minimize his risk did not include necessary details for providing those supports. He was identified as being at an increased risk DVT, respiratory compromise/pneumonia, aspiration, upper airway obstruction, and constipation. An overall issue with this risk plan was that it was presented as part of a larger summary making the tracking of the action steps etc. difficult to follow.
  - The risk supports for deep vein thrombosis (DVT) stated that staff were trained to identify signs of DVT but did not specify what those signs were. While the plan included opportunities and guidance for when staff could monitor for issues, the lack of clearly defined symptoms increased the risk that early warning signs such as swelling, redness, warmth, or pain in the legs could have been missed. Without specific guidance, staff may not have recognized or responded promptly to potential DVT, potentially leading to serious complications such as pulmonary embolism or other life-threatening conditions.
  - The risk supports for respiratory compromise and pneumonia addressed actions needed to protect the stoma during activities such as showers and referenced the individual's history with the stoma. However, it did not include criteria for determining the effectiveness of these interventions or specify when nursing staff or the primary care provider should be notified. This lack of measurable outcomes and notification guidelines increased the risk that staff might not recognize when interventions were insufficient or when medical attention was needed.
  - The risk supports for aspiration mentioned redirection during meals, the need for bite-sized pieces, and maintaining an upright position for 30 minutes after eating. It was also noted that he used a deep divided plate but when asked if it was still in use, staff stated "No." There was no evidence that the removal of this plate had been reviewed by an SLP. There was no language to specify which signs and symptoms staff should monitor for, nor did it outline the steps staff should take if aspiration occurs. This lack of detail increased the risk that early warning signs of aspiration such as coughing, choking, difficulty breathing, or changes in voice could have been missed or not responded to appropriately, potentially leading to serious complications like pneumonia or respiratory distress. Clear guidance on monitoring and response protocols is essential to ensure timely intervention and safeguard the individual's health.
  - The risk supports for constipation outlined supports such as the tracking of daily output, daily medication, and criteria for

when to use Milk of Magnesia (MOM) and to follow up with the PCP.

- Supports in Individual #49's ISP were often generic statements noting that MYEP provided supports without any specific detail. There were a few areas where more detail was provided such as bathing and toileting, dressing, and mealtime but many areas with no specific detail. Risk plans did not include measurable terms so that staff could evaluate the effectiveness of supports. Individual #49 was identified as being at an increased risk of falls, constipation, aspiration, seizures, UTIs, and DVT.
  - The risk supports for falls stated that the individual used a walker at all times and a wheelchair for long distances, but did not mention whether any assistance was needed during activities of daily living (ADLs) or transfers. This omission increased the risk that staff may have overlooked the need for support during critical times, potentially leading to falls or injuries.
  - The risk supports for choking stated that the individual had no teeth and pharyngoesophageal dysphagia, and included strategies such as modified food textures, foods to avoid, and frequency of sips or drinks. However, it did not specify which signs and symptoms staff should monitor for, nor did it outline what would require notification to the primary care provider or other professional staff who can accurately assess swallowing. This lack of detail increased the risk that early warning signs of choking—such as coughing, difficulty swallowing, or changes in breathing—could have been missed or not responded to appropriately, potentially leading to serious complications.
  - A risk supports for choking that lacks clear guidance on signs and symptoms for staff to monitor, as well as criteria for notifying healthcare professionals, poses significant safety risks. Without specific instructions, staff may miss early warning signs such as coughing, difficulty swallowing, changes in breathing, or sudden inability to speak, which can quickly escalate to a life-threatening situation. If choking occurs and staff are not trained on how to respond or when to seek medical help, there is an increased risk of airway obstruction, aspiration pneumonia, or even death. Comprehensive plans should include detailed monitoring protocols and clear response steps to ensure prompt and effective intervention, thereby safeguarding the individual's health and safety.
  - The risk supports for aspiration stated that they were on a modified diet and the need to eat slowly and take small bites and sips. Triggers to notify nursing and the PCP were noted within the plan.
  - The risk supports for deep vein thrombosis (DVT) did not provide a baseline blood pressure, even though the primary action was to check blood pressure. Without a baseline, staff lacked a reference point for what was normal for the individual, making it difficult to identify significant changes or trends that could indicate a health problem.
- Individual #61's ISP included minimal information regarding his support needs. Plans to mitigate risks did not include details that would be necessary to determine the efficacy of supports. Individual #61 was identified as being at an increased risk for aspiration, cardiovascular disease, hypertension, DVT, GERD, falls, and constipation.
  - The aspiration risk supports included interventions such as cutting food into small pieces and avoiding big gulps of water to reduce the risk of aspiration. However, it lacked specific guidance on which signs and symptoms should have prompted

staff to notify nursing or the primary care provider. This omission meant that staff may not have been adequately prepared to recognize and respond to early warning signs of aspiration, potentially compromising the individual's safety.

- The risk supports for hypertension had relied on blood pressure monitoring as the primary method of detection but did not include baseline measurements. Although it stated that concerns should be reported to nursing, it did not provide examples of what those concerns might be, resulting in a lack of clarity for staff regarding when to escalate issues.

- The risk supports for falls identified the need for an uncluttered house, an outside ramp, and reminders to slow down to be essential components but referenced no standing cadence for assessment and supports.

- The risk supports for constipation included criteria for offering laxatives and directed staff to monitor daily input and output, but it lacked specific details regarding what staff should have been looking for when monitoring input, such as a target amount/percentage to be achieved.
- The risk supports for GERD had noted that the individual needed to remain upright for 30 minutes after eating and required medication, but it lacked other important mitigating strategies. Specifically, the plan did not address dietary modifications, such as avoiding trigger foods like spicy foods, fatty foods, chocolate, caffeine, citrus, and tomatoes, or encouraging smaller, more frequent meals. Additionally, there was no guidance on monitoring symptoms, tracking dietary intake, or reviewing the effectiveness of interventions. As a result, staff may not have had clear instructions for preventing or managing GERD beyond the basic recommendations, which could have limited the effectiveness of the risk management approach.

- Individual #62's ISP included little detailed information regarding how or when supports were to be provided. There were overly broad statements noting that he needed full or partial support with no description of how to provide that support. Supports to minimize his risks also lacked sufficient detail for implementation and monitoring. He was identified as being at an increased risk for choking, GERD, seizures, weight, elopement, and constipation. An overall issue noted was that the risk plans were not measurable or written in a manner showing effectiveness.
  - The risk plan for choking included cues such as slowing intake, cutting food into small pieces, remaining upright after meals, elevating the head of the bed, and drinking water. However, the plan lacked measurable action steps and did not specify signs or criteria for when staff should notify nursing or other professionals. Signs that should prompt notification—such as coughing, difficulty swallowing, changes in breathing, or sudden distress—were not detailed, limiting the plan's effectiveness and potentially resulting in missed opportunities for timely intervention.

  - The seizure risk supports had mentioned the medications currently being taken as well as the cadence to return to the neurologist. However, it was missing signs and symptoms for staff to monitor, such as loss of consciousness, uncontrollable movements or jerking, confusion, dazed expressions, difficulty breathing, or bladder incontinence. Additionally, there was no information provided regarding whether the individual's current status reflected an increase or decrease from baseline, which is important for evaluating the effectiveness of interventions and identifying changes in

seizure activity. This lack of specificity may have limited the effectiveness of the plan and could have resulted in missed opportunities for timely intervention.

- The weight risk supports stated that they would be monitored daily by staff and that healthy snacks would be offered. The current weight of 169lbs was noted which was an increase of 20 lbs. since 5/2024. There was no other strategy identified that could impact weight loss as it appears the current method was not effective.

- The risk supports for elopement was not clearly tied to the risk at and. For example, it stated that safety skills were being worked on as part of the risk plan, but the safety skills focused on tornado and fire safety so unclear how this was related to elopement. The plan did contain equipment in place such as a door alarm but offered no clear plan to work towards removing these restrictions.

- There was no risk plan for falls, despite having several falls (6 since April 2025) and staff reporting unsteady gait with use of a gait belt and wheelchair.

- Individual #63 was identified as being at an increased risk for Deep Vein Thrombosis DVT, falls, osteopenia, seizures, choking and constipation.
  - For DVT, the plan stated that vitals were monitored and medications were taken but did not provide what medications, baseline vitals, or what would be monitored during bathing and dressing.

  - For the choking risk plan, interventions included small bites, supervision, and slowing down rate. Missing form the plan were signs and symptoms and what staff should do when issues occur including referral to doctor or swallow specialist.

  - For constipation, the risk plan contained good information on diet and constipation protocol. Missing was clarity regarding the purpose of intake monitoring and the target for that action.

- The ISP for Individual #68 provided minimal detail on supports needed throughout the day for various activities. It was noted that he needed full physical assistance with health and safety supports but supports needed were not described. Supports to prevent self-injury noted for staff to monitor him at all times, however, there was no description of what that meant or what staff should monitor. The Provider had developed a supplemental plan that provided more detail on individualized supports needed for various activities. Individual #68 was identified as being at an increased risk of aspiration, cardiovascular disease, constipation, falls, UTIs, and skin breakdown.
  - The aspiration risk supports had included interventions such as proper seating, frequent sips of water, limiting pills, and providing bite-sized pieces of food. However, the plan did not specify signs and symptoms for staff to monitor or outline what actions should be taken when these are noted. Signs and symptoms that should have prompted notification to nursing or the primary care provider include coughing or choking during meals, difficulty swallowing, changes in breathing, inability to speak or make sounds, bluish or pale skin around the lips or face, sudden distress or panic, and loss of consciousness. The absence of these details may have limited the effectiveness of the plan and could have resulted in

missed opportunities for timely intervention.

- The risk supports for constipation included water intake requirements, patience during bathroom breaks, documentation of BMs, and criteria for PRN meds and PCP notification.
- The risk supports for falls stated that he used a walker, had a pad alarm and bed railing on his bed. The risk plan did not mention how to determine the effectiveness of the supports in place, nor did it address the need for ongoing assessments given the use of multiple supports. This lack of measurable outcomes and regular evaluation could have made it difficult to ensure that interventions were working as intended and to identify when adjustments were needed to maintain the individual's safety. Staff reported that he shuffles his feet when tired and will "get up and go" from his wheelchair but this was not noted in the plan.
- The risk plan for skin focused primarily on repositioning and skin checks. The plan did not contain nutritional or hydrational impacts to rapid reskin.

- Individual #77 was identified as having an increased risk for falling. The risk management section stated that he had a history of falls and being unsteady due to orthostatic hypertension. The primary action step was to allow 30 seconds when initially standing. No other risks were identified in the ISP but when going to the care plans, constipation was also noted as a risk. It was unclear why this was also not addressed in the ISP.

- Individual #80's ISP did not include details on when supports should be provided throughout her day other than a description of some of her risk supports (mobility, dining). She did not have a clear risk plan integrated into the ISP. Based upon review of the entire document, it appeared risks were in the areas of falls, injuries related to behaviors, skin breakdown, and exploitation. It also appeared that she was at an increased risk of aspiration and/or choking as she is on a modified diet. Supports and interventions were noted during different sections of the report. It is essential for staff to have a location where all risk information is able to be reviewed. Per staff report, the behavior support plan currently in place remains the one from GRC. The individual experienced a broken femur in July 2024 but there remains lack of clarity regarding when to use the pivot disc vs stand pivot. Additionally, the individual has decreased communication skills and is unable to express how she is feelings such as if she is in pain. This has not been addressed by the team and would be helpful in identifying issues.

- Individual #82 was identified as being at an increased risk for obesity, GERD, and Hypothyroidism. Risk areas were noted under the medical and mental health section rather than the risk factor section.
  - For the obesity risk plan, it stated that he struggled with mobility and stamina but offered no interventions other than to state that they were working with the Host Home provider on portion control and healthy food choices. She also has a formal goal to exercise regularly and improve her overall health and wellness.

  - For GERD, the plan had stated that they used medication, monitored diet, avoided trigger foods, and elevated the head of the bed to reduce symptoms, but it did not provide details on the specific types of medications, which foods triggered GERD, or the degree of bed elevation recommended. Additionally, the plan did not describe dietary monitoring methods, such as maintaining a food diary, recording mealtimes and portion sizes, or tracking the frequency and severity of symptoms in relation to dietary intake.

For hypothyroidism, the plan had only stated that the person might experience daytime sleepiness and was taking medication, but it did not include any additional interventions, monitoring strategies, or information regarding the effectiveness of the current treatment. Best practices for monitoring and intervention should have included regular assessment of symptoms such as fatigue, weight gain, cold intolerance, dry skin, constipation, and changes in mood or cognition. The plan should also have specified routine monitoring of thyroid hormone levels through laboratory tests, documentation of medication adherence, and evaluation for potential side effects. Interventions could have included adjusting medication dosage based on lab results, providing education on the importance of lifelong medication adherence, encouraging a balanced diet and regular physical activity, and scheduling follow-up visits to track progress and prevent complications.

- Staff reported that there has been an increase in behaviors but have not sought out a new behavior assessment only stating that they did not feel it would offer any new information but this he is now in a new environment which can have a significant impact on the results.

- Individual #89's needed supports throughout her day were not well-defined. For example, it was noted that she needed full physical assistance when engaging in relationship, participating in leisure activity with others, making, and keeping friends. However, there was no specific information on what full physical assistance meant. She was identified as being at an increased risk of falls, and choking.
  - For the choking risk plan, it stated that she was on a pureed diet and needs to take small bites (one at a time) and frequent sips. It also stated that she should be upright for 60 minutes post meal. Missing from the plan were clear signs and symptoms in which should draw a response or action from staff. She was also identified as having ongoing pica events, but these were not included as their own risk or as part of the risk of choking. Staff reported that they were trained in December 2024 on how to prevent, but again these preventions were not included in the risk plan.

  - For the fall risk plan, it stated that she was at risk due to walking backwards, walking with her head down, and low vision. However, no strategies were listed to mitigate the risk, such as providing mobility aids, encouraging safe walking techniques, increasing supervision, or ensuring the environment was free of obstacles. The absence of these interventions may have limited the effectiveness of the plan and could have resulted in missed opportunities for fall prevention.

- Individual #91 did not have a clear comprehensive risk plan in the ISP. There was no section that identified the risks and the mitigating supports. Upon review of the ISP, it appeared that he had at least the risk of falls, but the various supports in place were not listed as part of a risk mitigation plan. This lack of a structured and detailed risk plan may have limited the effectiveness of staff in identifying, monitoring, and addressing their specific risks.

- Individual #27's ISP included very little specific information on how or when supports should be provided, however, the supplemental plan developed by her provider included detailed information on how staff should provide supports for most situations and activities. Individual #27 was identified as having an increased risk for Pica (compulsive eating of non-edible items) The risk plan had identified what types of items he might attempt to ingest and directed staff to keep non-food-like

items out of his reach. However, there were no interventions integrated into the risk plan that focused on reducing the behavior, which may have limited the effectiveness of the plan in addressing the risk associated with Pica.

- Individual #118's ISP described supports needed throughout his day in general terms with little detail. He was identified as having an increased risk of osteopenia, constipation, and seizures.
  - The risk plan for constipation stated triggers to look for, including but not limited to bloating, nausea, and fatigue. The only support strategy was over-the-counter medication. No discussion of other mitigating strategies, such as increasing dietary fiber, promoting adequate hydration, encouraging regular physical activity, or monitoring bowel movement frequency, was noted. This lack of comprehensive interventions may have limited the effectiveness of the plan in addressing the risk of constipation.
  - The risk plan for seizures identified common signs and symptoms for staff to monitor for. Intervention strategies included medications and the belief that it could be stress related but offered no strategies for mitigating the stress.

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

Comments:
ISPS were generally noted not to be consistently implemented. A general discussion is noted below with more specific examples noted throughout the report. While there was a plan to share information from audits with case Managers, the follow up to ensure impact was not noted.

1. Implementation in Individual Support Plans (ISPs)
   - General Findings:
     - The report repeatedly highlights that ISPs often lacked clear, actionable, and measurable implementation steps. Goals were frequently generic, not tailored to individual preferences, and lacked criteria for achievement or revision. Staff and case managers often verbally described supports and preferences, but these were not translated into written, actionable, or measurable goals, resulting in missed opportunities for person-centered planning and growth.
   - Examples of Implementation Gaps:
     - Many plans focused on daily living tasks (e.g., laundry, meal prep) but did not address broader objectives like community engagement or skill development.
     - Implementation guidance for staff was often missing, making it difficult to assess progress or mastery of goals.
     - Supplemental plans developed by some providers offered more detailed implementation guidance, but these were not consistently integrated into formal support plans.

- Impact:
  - The lack of meaningful, individualized, and measurable goals leads to limited personal growth, reduced independence, and missed opportunities for genuine community integration. Vague goals hinder staff's ability to assess progress and respond effectively to risks.

2. Implementation of Risk Supports
   - General Findings:
     - Support plans across providers and case managers show notable inconsistencies in detail, measurability, and relevance. Many plans lack clear definitions of signs and symptoms, measurable criteria, and actionable guidance for intervention. Implementation is often reactive rather than proactive, with preventive strategies and regular reassessment missing.
   - Examples of Implementation Gaps:
     - Plans for risks such as choking, aspiration, falls, constipation, and cardiovascular disease were often vague, lacking specific triggers for action or monitoring protocols.
     - Adaptive equipment was sometimes mismatched or not reassessed.
     - Interventions were frequently limited to medication administration, with little attention to lifestyle changes or behavioral supports.
   - Impact:
     Without clear, actionable, and regularly evaluated health support plans, staff may miss early warning signs, delay interventions, and fail to provide necessary support, increasing the likelihood of preventable harm.

3. Implementation in Case Management
   - General Findings:
     - Case managers did not consistently meet required face-to-face visit frequencies, and documentation often lacked substantive assessment of risks, individualized goals, and progress tracking. Implementation of supports and services was not reliably tracked, and corrective actions were not systematically followed up.
   - Examples of Implementation Gaps:
     - Case management notes were brief and lack substantive commentary on implementation.
     - Case managers relied on discussions with providers and individuals rather than reviewing documentation and data.
     - There was no consistent process for assessing the adequacy of risk plans or revising them when needed.
     - When issues were identified, convening of service planning teams and documentation of resolution is inconsistent.
   - Impact:
     - The lack of consistent expectations and competencies in case management undermines the ability to create comprehensive, individualized plans and respond to emergent situations. Implementation of corrective actions is not reliably tracked, limiting accountability and improvement.

4. Implementation in Quality Management and Oversight
   - General Findings:

- The State's Quality Management processes and procedures were in the process of being retooled. Current mechanisms (e.g., audits, service monitoring) have not yet demonstrated effectiveness in ensuring implementation of protections, services, and supports. Feedback was provided, but findings were not consistently written as action statements, and there were no system for tracking whether corrective actions were completed or effective.

- Examples of Implementation Gaps:
  - Audits and service monitoring vary in detail and thoroughness, impacting the consistency of implementation assessment.
  - There was no comprehensive tracking system for corrective actions, so problems identified may not be resolved in a timely or effective manner.
  - The Quality Management program was developing dashboards and process maps, but these were not yet operational for targeted quality assurance.
- Impact:
  - The absence of systematic tracking and evaluation of implementation undermines the ability to detect and address issues, falling short of professional standards of care. Continuous quality improvement cycles are not fully realized, and public reporting is limited.

5. Recommendations for Improved Implementation

Despite the establishment of a case management (CM) audit system and structured channels for sharing information between Managed Care Organizations (MCOs) and case managers, there has been limited progress in the effective implementation of corrective actions at the provider and individual levels. The persistence of these challenges indicates that, while oversight and communication mechanisms are in place, measurable improvements in service delivery and individual outcomes remain insufficient. Recommend investing in comprehensive, person-centered training for case managers, focusing on the development of meaningful, measurable goals and plans, and ensuring robust, actionable, and measurable processes for compliance and service quality. Follow up to ensure adoption of trained/audited skills.

Paragraph 210	**Compliance Score**
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	**Non Compliance**

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.	
Summary: The monitoring review found significant and recurring deficiencies in case management practices. Case managers lacked consistent expectations for reporting and essential competencies, resulting in incomplete individualized plans, poor assessment of needs, weak connections to community resources, and inadequate record-keeping. Documentation was superficial, with notes focused mainly on appointments and outings rather than evaluating whether Individual Support Plans (ISPs) reflected personal interests or promoted independence. There was little substantive review of documentation or data, and progress was difficult to measure due to missing implementation details. Although medical and psychiatric care was generally provided, delays in dental treatment were common. Healthcare supports were not routinely assessed or updated, and the note format did not prompt case managers to verify service delivery or address barriers, highlighting the need for more robust oversight and follow-up. Several cases illustrate gaps in care coordination and follow-up. Case managers did not consistently assess or document the status of risks, injuries, or changes in status. While risk mitigation supports were developed, identification of relevant signs and symptoms was often vague or omitted, making it difficult to determine the adequacy or effectiveness of supports. Data collected for monitoring (e.g., blood pressure, bowel, weight) was not routinely reviewed during monthly visits, nor were risk plans formally monitored at regular intervals. The Monitoring Team recommends adding prompts for routine assessment to case note formats. Individual #8's weight risk plan required weekly recording, but case management notes did not reflect review of this data. The monitoring review identified multiple gaps in case management and documentation for individuals transitioning from institutional to community-based settings. For Individual #32, constipation risk plans lacked physician-specific details, and case management notes did not reflect data review. Individual #62 experienced a significant 20-pound weight gain since May 2024, yet there was no evidence of ongoing weight monitoring or assessment of risk mitigation strategies. Individual #89 suffered severe dental neglect, resulting in the extraction of eight infected teeth after a two-year delay and a four-day hospital stay. Individual #8 required an ER visit due to prolonged absence of bowel movements, but subsequent planning failed to address key symptoms and behavioral factors. Despite repeated behavioral incidents for Individual #32, team meetings did not yield a clear or tracked mitigation plan. Following Individual #27's elopement, the response focused solely on increasing restrictions rather than investigating underlying causes or alternative interventions. Additionally, Individual #62 had ten ER visits, six related to falls, but IDT and planning meetings failed to acknowledge or address these incidents, offering no new supports and repeating existing measures. Individual #8 experienced a seven-day absence of bowel movements, leading to an ER visit; subsequent planning failed to address key symptoms and behavioral factors, with staff uncertain about whether the issue was medical or behavioral.	

These examples underscore missed opportunities for comprehensive assessment, targeted intervention, and effective documentation, revealing systemic weaknesses in case management, risk mitigation, and individualized care.

A core responsibility of case managers was to coordinate and advocate for individuals with intellectual and developmental disabilities (IDD), ensuring access to necessary medical and other services for a fulfilling life in the community. However, the documentation formats used by various providers often lacked critical details: while some prompted for listing medical appointments, they frequently omitted outcomes, recommendations, or follow-up actions. This resulted in systemic gaps in oversight, with case management notes failing to capture whether individuals' needs were being met, if risks were adequately addressed, or if care plans were effective. The absence of substantive commentary and outcome tracking undermined comprehensive, individualized support and limited accountability for service delivery.

#	Indicator	Indicator Score
1	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)	Partial Compliance 53% 10.5/20

#1	#3	#8	#19	#32	#34	#47	#48	#49	#61	#62	#63	#6	#77	#80	#82	#89	#91	#27	#118
0.5	1	0	0.5	1	1	0.5	1	1	1	0.5	0.5	0.5	0.5	0.5	0.5	0	0	0	0

2	The individual has received ongoing community case management services at the frequency required based on the individual's needs and preferences. (210a)	Partial Compliance 50% 10/20

#1	#3	#8	#19	#32	#34	#47	#48	#49	#61	#62	#63	#6	#77	#80	#82	#89	#91	#27	#118
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	0.5	0.5	0.5

3	Case Management contained the following minimal components as indicated: (210b) (roll up of a.-f.)	Non Compliance 0% 0/20 42% 50/120

Individual Scores																				
210.3	#1	#3	#8	#19	#32	#34	#47	#48	#49	#61	#62	#63	#6	#77	#80	#82	#89	#91	#27	#118
a.	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
b.	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
c.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
d.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
e.	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	0.5	0.5	0.5
f.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
roll-up	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5
score	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	a. Observed the Individual (clean, healthy, personal clothing/belongings)	Substantial Compliance 100% 20/20
	b. Assessed the environment (safety, cleanliness, personalization)	Substantial Compliance 100% 20/20
	c. Assessed the status of identified risks, injuries, needs, or other changes in status.	Non Compliance

		0% 0/20
	d. Assessed ISP appropriateness.	Non Compliance 0% 0/20
	e. Assessed the implementation of supports/services within the ISP. (Adaptive, sensory, AAC, etc..)	Partial Compliance 50% 10/20
	f. Ascertained whether supports and services were implemented consistently with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs.	Non Compliance 0% 0/20
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)	Non Compliance 30% 3/9
5.	In the event of an issue not related to immediate risk, the CM followed issues to resolution.	Non Compliance 0% 0/20

#1	#3	#8	#19	#32	#34	#47	#48	#49	#61	#62	#63	#6	#77	#80	#82	#89	#91	#27	#118
N/A	N/A	0	N/A	0	N/A	N/A	N/A	1	N/A	0	N/A	N/A	N/A	0	1	0	1	0	N/A

#1	#3	#8	#19	#32	#34	#47	#48	#49	#61	#62	#63	#6	#77	#80	#82	#89	#91	#27	#118
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Comments:

1. Case managers did not consistently meet with the individuals in the review group face-to-face every 30 days as required. The table below represents a summary of face-to-face visits based on documents provided to the Monitoring Team. A face-to-face visit may be accomplished either in-person or virtually as long as the Individual was part of that meeting. On average there were eleven potential face to face contacts for the case manager to complete. Thirty percent were consistently seen every month (80% of opportunities). Forty-five percent were sometimes seen each month(50-75% of opportunities), and twenty-five percent seldom had face-to-face visits each month (30% or less of opportunities).

It should be noted that the State's interpretation of this requirement of a face-to-face visit every 30 days ended at 365 days. The Consent Decree does not differentiate between pre and post 365 and therefore continued enforcement was applied. The State shared that this would require a change in their process as of now they only require a face-to-face every two months.

Face-to-face visits are crucial because they enable case managers to directly observe an individual's health, living conditions, and daily routines, which helps identify risks or needs that may not be evident in written documentation. These visits allow for a more thorough assessment of whether support plans are being implemented effectively and tailored to the person's preferences. In-person contact also builds trust, encourages open communication, and helps case managers advocate for necessary services. Regular visits promote accountability, ensure that interventions are adjusted as needs change, and support the individual's safety, independence, and integration

into the community. Without consistent face-to-face interaction, case managers may miss subtle changes or emerging issues, leading to gaps in care and reduced quality of life for those they support.

Individual	Face-to-Face Visits		Individual	Face-to-Face Visits		Individual	Face-to-Face Visits		Individual	Face-to-Face Visits		Individual	Face-to-Face Visits
#1	Between 9/2024 and 7/2025, Individual #1 received 8 face-to-face visits for a total of approximately 4.5 hours of case management services across 15 months. The case manager conducted an additional 3 visits via telephone for a total of 40 minutes.		#32	Between 9/2024 and 7/2025, Individual #32 received 9 face-to-face visits for a total of approximately 8 hours of case management services across 11 months.		#49	Between 9/2024 and 8/2025, Individual #49 received 10 face-to-face visits for a total of approximately 4.5 hours of case management services across 12 months.		#68	Between 9/2024 and 8/2025, Individual #68 received 15 face-to-face visits for a total of 7 hours of case management services across 12 months.		#89	Between 10/2024 and 4/2025, Individual #89 received 4 face-to-face visits. One additional visit was conducted virtually. The case manager did not indicate a length of time in visit notes.
#3	Between 8/2024 and 7/2025, Individual #3 received monthly face-to-face visits for a total of approximately 12 hours of case management services across 12 months.		#34	Between 9/2024 and July 2025, Individual #34 received 6 face-to-face visits at his home and an additional 3 visits at the provider's office. The case manager did not indicate a length of time in visit notes.		#61	Between 8/2024 and 8/2025, Individual #61 received 10 face-to-face visits. The case manager did not indicate a length of time in visit notes.		#77	Between 9/2024 and 7/2025, Individual #70 received 10 face-to-face visits. The case manager did not indicate a length of time in visit notes.		#91	Between 9/2024 and 7/2025, Individual #91 received 6 face-to-face visits, 2 of which were at his home while the others were at the provider's office or virtual. The case manager did not indicate a length of time in visit notes.
#8	Between 3/2025 and 8/2025, Individual #8 received 2 face-to-face visits at his home and one face-to-face visit at the provider's office for a total of 2.45 hours of case management services across 6 months. The case manager conducted an additional phone visit for 8 minutes.		#47	Between 8/2024 and 7/2025, Individual #47 received 9 face-to-face visits. The case manager did not indicate a length of time in visit notes.		#62	Between 9/2024 and 6/2025, Individual #62 received 6 face-to-face visits. The case manager did not indicate a length of time in visit notes.		#80	Between 9/2024 and 7/2025, Individual #80 received 8 face-to-face visits. The case manager did not indicate a length of time in visit notes.		#27	Between 8/2024 and 8/2025, Individual #27 received 9 face-to-face visits for a total of approximately 5.5 hours of case management services across 13 months.
#19	Between 9/2024 and 7/2025, Individual #19 received 6 face-to-face visits at her home. The case manager did not indicate a length of time in visit notes.		#48	Between 12/2024 and 8/2025, Individual #48 received 12 face-to-face visits (2 face-to-face visits were conducted at his home in 8/2024 and 4 face-to-face visits were conducted in 9/2024. The case manager did not indicate a length of time in visit notes.		#63	Between 8/2024 and 7/2025, Individual #63 received 10 face-to-face visits. The case manager did not indicate a length of time in visit notes.		#82	Between 8/2024 and 7/2025, Individual #82 received 11 face-to-face visits for a total of approximately 13.5 hours of case management services.		#118	Between 9/2024 and 8/2025, Individual #118 received 11 face-to-face visits for a total of approximately 7 hours of case management services.

2. The 20 individuals reviewed, all had transitioned from MFP as the primary case management agency to an MCO entity. There were four different agencies providing case management services:
    - Ten individuals were with one agency: Individual #1, Individual #3, Individual #32, Individual #34, Individual #48, Individual #49, Individual #68, Individual #82, Individual #27, and Individual #18
    - Eight from another agency: Individual #19, Individual #47, Individual #61, Individual #62, Individual #63, Individual #80, Individual #89, and Individual #91
    - One from one agency: Individual #77
    - One from one agency: Individual #8

From the Iowa HHS web site, changes were made starting in January 2025 to where each community-based case manager's caseload was to be limited to an average of 45 members per case manager. Expectations for face-to-face visits with members was increased from once every three months to at least every two months in person for members on the ID Wavier. Two training programs were created to improve consistence across agencies, an initial certification for new case managers and an annual refresher for all case managers. (https://hhs.iowa.gov/medicaid/about-medicaid/medicaid-projects/home/case-management)

A common theme of findings throughout this section related to Consent Decree #210 revolve around the lack of consistent expectations for reporting and essential competencies of case managers including creating comprehensive and individualized plans that align with an individual's needs and goals; the ability to conduct thorough assessments to understand needs and barriers; connecting individuals with community resources, services and programs; maintaining accurate, detailed records of progress and outcomes; and the ability to identify and respond to emergent situations.

The table above along with the indicators below all factor into the determination for scoring of the indicator below.

3. The Monitoring Team reviewed four agencies providing case management services to the 20 individuals in the review group. Each of these agencies had a standard note format that included the basic components for prompting the case manager to assess the minimal components required by the Consent Decree (see a-g below).

Three of the four agencies had a standardized contact note format that included questions to document observations from face-to-face visits, such as:

- Observations of the individual's physical condition
- Observations of the individual's physical environment
- Observations of the individual's mood and emotional well-being
- Upcoming and previous medical appointments

Only one agency had developed a question/prompt within the contact form for the case manager to review and document progress on all goals (including staff interventions, how the member responded, etc.).

The standardized note format for each agency was missing a critical component for review of identified risks and assessment of the adequacy of the risk mitigation plan. It should be noted that many of the questions were designed to elicit the information from the individual through direct report. One example of such question was "The member reports they are receiving all services as outlined on the person-centered service plan (ISP)/care plan?" The Monitoring Team finds it questionable that case managers could ascertain from individual report whether they were receiving all services and supports when many of the individuals reviewed did not have functional methods for communicating (e.g., devices).

The Monitoring Team had previously reported that case management notes were not substantive in commentary and not focused on having the case manager review documentation and data. In interviews, case managers continued to report that they did not routinely review data or documents other than medication administration records, staff daily notes, and incident reports, nor did case managers report that they requested documentation to review prior to visits. Most described their visits as "discussions with the provider and

individual" as the primary method for assessing the adequacy of supports and services.

Additionally, the State implemented a process for Community Integration Managers (CIMs) to conduct bi-monthly audits of case management documentation. The audit tool was designed to assess the minimal components required within this section, including whether the case manager has met with the member face-to-face at least every 30 days, reviewed documentation from all service providers, reviewed goal progress, convened the IDT as needed, etc. From review of the audits conducted in March 2025 and July 2025, all 20 of the individuals in the review group were audited. Many of the findings from those audits concur with the Monitoring Team's assessment such as:

- The case manager has evaluated that supports and services are being implemented consistently with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs.
- The case manager has reviewed and analyzed documentation all service providers, communicates with the team, and then documents review of the individual's progress.

As this process is still fairly new, the Monitoring Team is hopeful that these audits will result in positive changes. Case management notes reflected brief commentary about what individuals were doing and their general mood at the time of the face-to-face visit.

a. Case managers often commented on overall environmental conditions in their monthly notes but did not consistently address whether the home environment reflected the individual's personal preferences, as required by the ISP's person-centered planning approach. Documentation frequently lacked substantive assessment of personalization, making it difficult to determine if individuals' choices and preferences were being honored in daily routines and living arrangements. This highlights a need for more thorough and consistent documentation to demonstrate that individual preferences are actively considered and reflected in their homes.

b. The Individual Support Plan (ISP) is intended to ensure that each individual's home environment reflects their personal preferences, as part of a person-centered planning approach. However, the review found that case managers (CMs) did not consistently report on whether the home environment actually aligned with these preferences. Documentation from case management notes often lacked substantive commentary or assessment regarding the personalization of the individual's living space, and did not reliably capture whether the individual's choices and preferences were being honored in daily routines and home settings.

c. Case managers did not consistently assess or document the status of risks, injuries, or changes in status. While risk mitigation plans were developed, identification of relevant signs and symptoms was often vague or omitted, making it difficult to determine the adequacy or effectiveness of supports. Data collected for monitoring (e.g., blood pressure, bowel, weight) was not routinely reviewed during monthly visits, nor were risk plans formally monitored at regular intervals. The Monitoring Team recommends adding prompts for routine assessment to case note formats. Individual #8's weight risk plan required weekly recording, but case management notes did not reflect review of this data. Individual #32's constipation risk plan omitted specifics from the physician order, and case management notes did not reflect review of relevant data.

- Individual #62 had a risk related to weight. His current ISP indicated a 20-pound weight gain since his move in May 2024 from GRC. Case management notes did not reflect monitoring of weights to assess whether strategies to reduce the risk were effective.
- Individual #89 had numerous teeth (their last eight) extracted, when she finally received long-delayed treatment (approx. 2

years delayed). All teeth were infected resulting in a 4-day hospital stay and removal of all teeth.

d. Case Managers did not assess the appropriateness of the ISP. Case managers generally commented on community outings and appointments, but did not assess on whether the ISP 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.

e. As noted in Indicator 1c. above, goals were broadly written without any specific direction for staff to follow and providers had not developed implementation objectives or criteria for achievement nor were there expectations for data collection in order for the case manager to evaluate progress. Therefore, case managers provided anecdotal commentary related to implementation. For example:

- Individual #1 had goals to complete his laundry with staff assistance, make two simple meals/snacks independently, and review his new address. Per the prompt for the case manager to review progress, the 5/1/25 note indicated Individual #1 "is doing well on his goals. He enjoys making his own meals, hot dogs, or hot pockets. He completes his laundry with staff assistance. He continues to practice his address with assistance from staff."
- Individual #8 had goals to develop his cooking skills, improve his social skills, and maintain good dental hygiene. The case management note from 4/17/25 indicated Individual #8 stated that he is brushing his teeth twice a day. Staff noted that he says he does, and they check his breath and redirect him to brush again as needed. He has been cooking. He has been using the stove or oven with staff assistance. He made steak and macaroni and cheese. He has also made potatoes. He continues to need prompts to put the groceries away in the proper place."
- Individual #20 had a goal to clean up after her meals and practice propelling her wheelchair. Staff reported that she was able to complete both tasks, however, without measurability, it was not clear how they would determine mastery of her goals. Her preferences and goals related to community integration and day habilitation were not defined in the support plan. The case management note for 7/17/15 indicated Individual #20 "is doing very well. She continues to bring up her birthday every day since she loved it so much. She has been going out a lot for various activities. Over the past month, she has visited the zoo, the science center, Gray's Lake, and the Ankeny Festival, and she has enjoyed walks around the neighborhood in the morning when the weather is nice. She has no major health concerns and is eating and sleeping well. There have been no changes to her medications, and her psych medications have been helping; she has not exhibited any of the behaviors she had in the past before moving here. She recently went shopping and picked out some new clothes. Staff reports that she is receiving her services as scheduled. Her IDT feel her current restrictions remain appropriate at this time. No falls, ER visits, or hospitalizations. No questions or concerns."
- Individual #82 had goals to socialize in the community with peers at least monthly and to exercise at least three times per week. The case management note dated 5/20/25 indicated that Individual #82 had been attending day habilitation on Tuesdays and was happy with her day habilitation services. She stated that she wished she went into the community more, but she also understood that she had to share and take turns going into the community. The individual reported that at home she was helping to keep her home clean by doing chores every day. She reported that she wiped down the counters, helped by taking out the trash, and took care of the pets, and worked on keeping her bedroom clean. She also reported that she could not wait for the remodel to be completed so that she could move to the basement.

f. As noted above, a basic function of case management is connecting the individual with necessary medical (and other) treatment and monitoring recommendations from healthcare and other professionals. In essence, the case manager acts as a coordinator and advocate, ensuring comprehensive, individualized support that empowers the person with IDD to live a fulfilling life in their group home and community.

The case manager contact documentation format for individuals supported by Provider #1 (Individual #1, Individual #3, Individual #32, Individual #34, Individual #48, Individual #49, Individual #68, Individual #82, Individual #27, Individual #18) included questions for the case manager to document previous and upcoming medical appointments. The examples below are indicative of this issue and reflect a systemic omission in case management oversight:

- Individual #1: The case management note for 2/18/25 prompted the case manager to indicate if there have been any medical, dental, or mental health appointments in the last month. The case manager responded "Yes" but did not describe those appointments or the results of those appointments. For the prompt to indicate if there are any upcoming medical, dental, or other appointments as well as additional appointments, the case manager listed 2/18/25 PCP, 2/20/25 Psych, 2/21/25 Labs. The next contact note for 3/17/25 indicated "Yes" there were appointments in the past month (2/18/25 PCP, 2/21/25 labs) but did not elaborate on the outcome of those appointments or any recommendations from the provider, including follow-up needed.
- Individual #48: The case management note for 1/17/25 prompted for the case manager to indicate if there have been any medical, dental, or mental health appointments in the last month. The case manager responded "Yes" but did not provide comments as to what those appointments were or the outcome of those appointments.
- Individual #82: The case management note for 2/20/25 prompted the case manager to indicate if there have been any medical, dental, or mental health appointments in the last month. The case manager responded "Yes" with further details of 2/5/25 as the date for a chiropractor routine adjustment. The case manager also entered 2/20/25 as a gynecological appointment follow-up for incontinence issues, but provided no further details to recommendations from this appointment. For the prompt to indicate if there are any upcoming appointments, the case manager responded that a sleep study was scheduled for 2/20/25. The case management note for 3/20/25 indicated "No" there had not been any medical, dental, or mental health appointments in the last month and did not include details from the 2/20/25 sleep study or the 2/5/25 gynecological appointment. For the prompt about upcoming medical, dental, or mental health appointments the case manager responded "Yes" and listed a swallow study on 3/26/25 and pulmonology on 4/23/25. There was no explanation as to why the swallow study initially noted to be scheduled for 2/20/25 was now scheduled for 3/26/25. The case management note for 4/29/25 indicated "No" there had not been any medical, dental, or mental health appointments in the past month and noted there was a 4/30/25 follow-up appointment with the PCP from her recent ER visit on 4/23/25 that resulted in hospital admission due to aspiration pneumonia (discharged 4/25/25). There was no indication if the 3/26/25 swallow study occurred and any recommendations from this consultation.

The case manager contact documentation format for individuals supported by Provider #2 (Individual #19, Individual #47, Individual #61, Individual #62, Individual #63, Individual #80, Individual #89, Individual #91) included a question for the case manager to document upcoming medical appointments but no question for previous appointments which would prompt the case manager to document results and

recommendations from completed appointments and consultations. The examples below are indicative of this issue and reflect a systemic omission in case management oversight:

- Individual #19: The case management note for 12/11/24 indicated that there as a biopsy scheduled for 1/14/25 but did not indicate what type of biopsy. Under the prompt "Other Topics Discussed" the case manager provided the following detail:
  - *This Friday, she has a mammogram scheduled. On October 31st, she had a kidney care appointment where it was discovered that she had droplets of blood in her urine. Following lab tests on the 24th of the same month, a biopsy has been scheduled for January 14th to further investigate the issue.*

Under the prompt "Other Topics Discussed" in the 1/14/25 case management note, the case manager indicated:

- *Recently noticed some blood in her urine and underwent a biopsy of her bladder. Fortunately, the procedure results came back clear. Despite this positive outcome, she still has stage 3 kidney failure. It took her a few days to fully recover from the procedure. The nurse informed us that there is no follow-up need since the results were clear.*

- Individual #61: The case management note for 3/12/25 indicated "None that staff knew about" for question #16 about any upcoming medical appointments. There was no indication that the case manager reviewed documentation during the visit related to medical/health care supports, but rather based the response on interview with staff.
- Individual #62: The case management note for 1/6/25 indicated "Please see notes below" in response to question #16 any upcoming medical appointments? Under the prompt "Other Topics Discussed" the case manager indicated:
  - *He will see primary care doctor on 2/28/2025 for annual checkup. He will see dentist 4/9/2025, endocrinologist 4/29/2025 and urologist 6/6/2025.*

The LTSS monthly case management contact note for 4/23/25 indicated there was a Zoom meeting to finalize the risk plan. The case manager noted that the provider reported "he had a neurology appointment on 4/7/25 and there were no seizures. He will follow up in one year. He also saw cardiology on 4/7/25 and was cleared for his dental cleaning on 5/7/25.

The case manager contact documentation format for the Individual #77 (supported by Provider #3) included a question for the case manager to document upcoming medical appointments but no question for previous appointments which would prompt the case manager to document results and recommendations from completed appointments and consultations.

- The case management note for 3/31/25 indicated he was to have a psychiatry appointment on 4/2/25. The case management note for 4/15/25 also indicated he had an upcoming psychiatry appointment on 4/2/25 but did not elaborate on the outcome of this appointment as this note was after the scheduled psychiatry appointment.

The case manager contact documentation format for the Individual #8 (supported by Provider #4) included a question for the case manager to document medical and mental health appointments since the last contact as well as upcoming appointments. The structure of this case management contact note was narrative, but the case manager did not provide substantive commentary or detail including reason for appointment or results and recommendations from the appointment to ensure follow-up occurred.

- The case management note for 6/4/25 indicated that Individual #8 was seen by his PCP on 5/30/25, his therapist on 5/1/25, and the endocrinologist on 5/27/25. There was no commentary on the outcome of these appointments or resulting recommendations.
- The case management note for 8/14/25 indicated that Individual #8 had a psychiatry appointment on 5/1/25, endocrinology on 5/15/25 and 5/27/25, PCP on 5/30/25 for follow-up to an Urgent Care visit on 5/23/25. This note was almost three

months after the appointments occurred, yet here was no commentary on the outcome of the appointments or resulting recommendations.

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 case manager inconsistently convened an IDT meeting to discuss the situation and identify plans for a resolution. During interviews with the Monitoring Team, case managers reported that their main avenue for assessing supports was through discussion with provider staff, the individuals, and guardians. However, it was not always possible for the Monitor to determine what specific supports or services were revised and how they were monitored for efficacy.

   Case management notes as well as interviews with the Monitoring Team indicated that the case manager for Individual #27 had worked with the IDT to support her in moving to a more independent living space in the basement of her home which reduced environmental triggers that were leading to significant behavioral events. She was also supported by her team with a psychiatric admission to stabilize her medication regimen and return home. She has experienced significant improvements after both interventions.

   Case management notes as well as interviews with the Monitoring Team indicated that the case manager for Individual #82 had worked with the IDT to ensure she has a therapist for talk therapy which has helped her better regulate her anxiety and mood. The IDT is also working with the therapist to develop strategies for supporting Individual #82 to continue an important relationship with her family but to establish healthy boundaries.

   - Individual #49 was supported to move to a different home to better accommodate her mobility.
   - Individual #91 was supported by his case manager to transition to a new provider.
   - Individual #80 suffered from a broken femur on 7/25/24. Per interview, the individual started experiencing a change in behavior (decreased movement and increased difficulty transferring) on 7/18/25 but was not diagnosed until 7/25/24. Individual was unable to express pain. There were no parameters regarding when to use the pivot disc when transferring. A pivot disc, also known as a transfer disc or turntable, is a mobility aid designed to assist individuals with limited mobility during transfers between surfaces such as beds, wheelchairs, and toilets. Its primary purpose is to facilitate safe transfers and reduce the risk of falls and injuries. Additionally, the pivot disc helps minimize physical strain on caregivers by enabling smoother, controlled turning, and it promotes proper body mechanics by keeping the individual's feet aligned and stable, reducing the risk of slips or improper movements. Not using a pivot disc or other appropriate mobility aid during transfers increases the risk of bone fractures like the one experienced especially in individuals with limited mobility or underlying health conditions. Improper transfer techniques such as twisting, shuffling, or awkward movements can cause pain, damage to bones and joints, and increase the likelihood of serious injuries like fractures. Falls during unassisted or poorly assisted transfers are a leading cause of moderate and severe harm, including fractures, in healthcare and home care settings.
   - Individual #89 had numerous teeth (their last eight) extracted when she finally received long-delayed treatment (approx. 2 years delayed). All teeth were infected resulting in a 4-day hospital stay. This reflected lack of aggressive advocacy on part of the CM in assuring the services needed were provided in a timely manner. Effective case management requires not only the identification of service needs but also assertive action to overcome barriers and facilitate timely service delivery. The absence of such advocacy can result in unmet needs and adverse outcomes for individuals.

- Individual #8 had no bowel movements for seven days resulting in a recommendation by the PCP for the individual to visit the ER where they received treatment. An IDT was held on 6/4/25 where a plan was developed where the Individual agreed to let the staff know when he had voided and to allow them to see. The Individual mentioned that he has diarrhea not poop. This was not addressed in the meeting but should have as this is a common sign of constipation which should have been a flag for staff. It was also stated in the meeting that some staff think this could be behavioral but then offered no related insight/guidance or recommendation.
- Individual #32 experienced 15 behavioral incidents with holds from April 16, 2025, to August 9, 2025. The IDT met 5/8/25, 6/5/25, 7/3/25, 7/17/25, and 7/22/25. Though the IDT met frequently, a clear plan to mitigate or address the issue was not developed and tracked. Meetings primarily discussed the event and ended with either no recommendations, or a general statement such as "we are trying new things to redirect her."
- Individual #27 had an elopement event on 4/3/2025. The IDT met on 4/4/25 and spoke about the need for more restrictions (burners on stove) but did not speak about the triggers that led to the event or potential interventions outside of increased restrictions.
- Individual #62 had 10 ER visits between October 2024 and August 2025 with six being related to gait/falls. The IDT meeting held on 5/525 stated that he had not had any falls when in fact he had been to the Emergency Room on 4/21/25 with a forehead laceration. The IDT held on 7/17/25 also mentioned nothing of falls or the fact that he had been to the ER x2 for falls. The ER report mentioned that staff stated that they had been much weaker over the last few weeks but none of this was noted in the CM notes or as part of the IDT minutes. The ISP planning meeting on 8/5/25 mentioned the ER visits due to falls and unsteady gait but offered no new interventions or supports rather just repeating what was already in place.

5. As noted above and throughout this report, case management notes for all individuals were not substantive in commentary and not focused on having the case manager review documentation and data. Case managers were not routinely assessing the adequacy of risk plans or revising when needed. Therefore, identification of emerging issues and following to resolution was an area of needed focus. Additionally, the note format did not prompt case managers to assess whether the individual is receiving all services and supports at the intended frequency and if not, identify the barriers and develop plans of action to remedy. For example:

    - The 1/23/25 case management note for Individual #61 stated CBCM requested documentation to review back in November, but did not receive it from agency. CBCM requested the same documentation plus updated documentation on 1/23/25. CBCM observed Individual in his chair. He appeared to be doing well with no issues watching television. Staff stated he is doing well overall. He does not appear to have much of a cough at all anymore. He is eating and drinking well with no coughing or choking issues. Staff know they must cut up their food very fine. He is sleeping well. They do not have to help him much with hygiene, etc. They have noticed that he does not enjoy people in his room much, so staff only go in there to clean. CBCM had staff check the current MAR to make sure he has all of his medications, and he was not out of running out. He is not according to the MAR.
    - The 6/24/25 case management note for Individual #80 stated CM visited with member at his home for quarterly home visit. LTSS assessment summary was completed. No ER visits or hospitalizations have occurred. No falls reported. CM updated plan to correct an incorrect date on his plan. No new medications. No ER or hospitalizations. Individual is doing well and is enjoying his home. No over or under utilization of services noted. No inappropriate or unnecessary services are noted in place. CM let Individual know she will visit him again in a few months. Individual let CM know he is having a good summer and enjoying all

	his outings. Case manager will continue to monitor goals, services, and funding. CM ensured staff and member had contact information. CM will reach out again in the next month, or sooner, as needed.

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)		Partial 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. This paragraph focused on high-level oversight. A more detailed review is contained within the other QM driven paragraphs. There was no evidence of a high-level meeting where overall progress to the Consent Decree was reviewed and discussed with any action plans developed. The LTSS compliance meeting appeared to be the primary venue for reviewing the data acquired from the various intakes/reports which included but were not limited to the Service Monitoring Reports, the CM Audits, as well as the additional data noted as part of the data collection chart. Attendance at the LTSS Compliance Meetings had grown to include not only the LTSS Medicaid bureau but also staff from Aging and Disabilities, including the Intellectual & Developmental Disabilities Specialist/Olmstead Plan and the Disability Access Point Program Manager. Per the State, this has led to interdepartmental collaboration and strategic partnerships. There was evidence of LTSS Compliance meetings being held every two months (March 2025, May 2025, and July 2025), but these meetings focused mostly on the results of completed audits and not the overall status of the Consent Decree provisions and how the various pieces and action items aligned with substantial compliance. There was no review of action items intended to drive the CD forward.	

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)	

Comments:
For this paragraph, the State expressed reserve regarding this indicator being included within the review/report post 365 and that a primary reason for this reserve was the risk of individual identification.

P 226 speaks to the requirements of having public reporting on the HHS website. This paragraph also states that the public reporting should be based on elements contained within Section K of the Consent Decree. Within this section, it states that the State shall produce routine, valid and reliable reporting on the defined measures and related trends. 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. The last public report was provided in July 2025

Based on the continuation of P226:
To obtain compliance, the State should utilize QM indicators contained located within the CM audit tools, Service Monitoring, and other data collection points as the basis of such public reporting. The data analyst mentioned in the QM plan by the State could potentially assist in pulling and organizing these reports. Health risk data such as hospitalization, ER visits, Fatal Five Dx, employment, are all relevant indicators that should be shared and is appropriate for such reporting. It was unclear how reporting of indicators discussed above would risk identification of the parties to the general public if only data was utilized and shared.

Ongoing conversations have occurred with the Monitor and the State regarding the collection of data and reporting. Previously, the State had maintained their public dashboard prior to the closure of GRC as well as having offered the January 2025 Post-Move Monitoring Report (PMM) as evidence of sharing their community integration efforts with the public. Now with the State moving beyond 365 days, the PMM report was no longer active as there was no longer any post move monitoring. As a result of this transition, the State appeared to have focused more on the sharing of information with LTSS, MCO, Provider and other stakeholders. These meetings included the LTSS Compliance meetings, the monthly MCO Engagement meetings where CIMs were able to share audit results with MCO leadership, MFP Engagement meetings, and the CM Audit feedback process. Due to the target population being beyond 365 days, there were no MFP Engagement meetings beings held.

Public reporting was limited, with no established method for sharing information beyond the Monitor's Consent Decree Summary of Status which was shared with the MCOs. A highlighted summary of the Monitor Reports (and location of the posted report on the shared HHS website) were shared with the MCOs by the LTSS Bureau Chief at monthly MCO Combined Meetings, updates shared on June 11, August 13, and September 10, 2025.

Again, QM indicators contained within the CM audit tools, Service Monitoring and other data collection points were examples of where data could be pulled, analyzed, and shared for such public reporting.

The reports (CM audit and Service Monitoring Report) covered a variety of areas regarding the individual's ISP and CM services.

- The CM audit consisted of the CIM reviewing records and auditing community case management entity files to ensure thorough transition planning were identified from the assessment and adequately addressed by the IDT team and documented in the

case management notes.

- The Service Monitoring report occurred every other month and was aligned to occur between the CM audit cycle. The first review cycle occurred September 15 –October 15. The providers in the HCBS setting where the individuals reside were to be visited by the Community Integration Managers to validate that case management documentation accurately reflected real-time conditions in individuals' homes and ensured provider practices in HCBS settings aligned with person-centered planning and service delivery standards.

Information related to individual level remediation identified as a result of the case management audits were stated to occur directly with the case managers via emails from the CIMs. Feedback provided to the CMs was provided to the Monitor for the months of July 2025 and September 2025. CM Audits and Service Monitoring results were also shared as part of the LTSS Compliance meetings.

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

Comments:
The State did not have a reliable system to identify and monitor individuals in the Target Population who transitioned from Glenwood Resource Center (GRC) to another placement. Issues noted with the variability and ability to identify and resolve issues were the primary factors impacting compliance.

Although mechanisms such as Case Management (CM) audits and Service Monitoring reviews were in place, these processes had not yet demonstrated effectiveness. Persistent issues included gaps in identification, verification, and follow-up by case managers, as well as deficiencies in the quality of ISPs. While feedback was provided to case managers, findings were not consistently written in the form of action statements and were not measurable. Additionally, there was no evidence of systematic discussion or implementation of recommendations and review of their effectiveness. This is discussed earlier in this report under P208.

Recommendations should be presented as action statements because they provide clear, specific, and measurable guidance on what needs to be done, who is responsible, and how progress will be tracked. This format eliminates ambiguity, promotes accountability, and ensures that corrective steps are implemented effectively and in a timely manner. Action statements also support professional standards by making it easier to follow up, evaluate outcomes, and adjust interventions as needed, ultimately driving meaningful improvements and ensuring that identified issues are fully addressed.

As stated above, for the CIM Feedback July 2025 and September 2025, several issues with care and documentation were noted.
The lack of a comprehensive tracking system for corrective actions means that problems identified during audits and reviews may not be resolved in a timely or effective manner. This undermines the ability of the State's quality management processes to consistently detect and address issues with protections, services, and supports, and falls short of generally accepted professional standards of care. The review

determined that the current quality management system was ineffective, as numerous issues identified at the outset of the monitoring period persisted throughout the review. Despite the implementation of audits and service monitoring processes, recurring deficiencies such as inconsistent follow-up, lack of measurable action steps, and inadequate tracking of corrective actions remained unresolved. This ongoing recurrence of previously identified concerns underscores the need for more robust and reliable mechanisms to ensure timely identification, remediation, and prevention of systemic issues. To achieve compliance, the State would need to improve the consistency and reliability of the audits and implement a robust system for tracking corrective actions, ensure timely follow-up, and expand public reporting to promote transparency and accountability.
As stated in Paragraph 226, the reports (CM audit and Service Monitoring Report) covered a variety of areas regarding the individual's ISP and CM services.

For the CIM Feedback July 2025 and September 2025, several issues with care and documentation were noted. Additionally, public reporting was limited, with no established method for sharing information beyond the Monitor's Consent Decree Summary of Status. QM indicators contained within the CM audit tools and Service Monitoring as well as the other data collection points are examples of where data could be pulled for such reporting.

A data collection chart was shared with the Monitor, compiling data points from CM audits and Service Monitoring reports. To strengthen oversight and support targeted quality improvement, HHS planned to collect and analyze claims data, waiver performance measures, and critical incident reports alongside audit findings. Claims data would be used to track service utilization and validate delivery against care plans, while waiver performance measures would assess compliance and outcomes such as timeliness, member satisfaction, and access to care. Critical incident reporting would capture major events, including serious injuries, deaths, emergency mental health interventions, law enforcement involvement, medication errors with adverse outcomes, and instances where provider staff could not locate members under protective oversight. All of this information was relevant and as stated above, would be potential avenues for the State to pull data for their public reporting.

Despite these efforts, a system did not exist to ensure that identified gaps in individual care and systemic issues were fully addressed. The process lacked a method for ensuring that issues were identified in a consistent and measurable way that ensured improvement and/or corrections occurred in a timely manner. Ongoing issues are discussed above and again in P208.

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	Partial Compliance

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..	

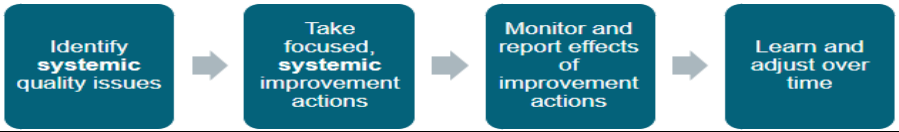
Comments:
To improve quality oversight and service delivery for individuals, HHS Medicaid stated they are enhancing its data collection and analysis capabilities. This included individuals transitioning from Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID) to Home and Community-Based Services (HCBS). This initiative focused on identifying actionable insights not only at the systemic level but also the individual level using more refined and validated data.

HHS was developing a Quality Management System to enable more timely, accurate, and actionable data insights.

- The first phase of this project focused on mapping beneficiary journeys over the past year through dedicated in-person meetings. This process involves documenting each step from an individual's request to transition from an ICF/ID to the community, through to the successful outcome of living independently and achieving personal goals. Key assumptions and enabling conditions necessary for success will be identified, with emphasis on the most important elements of the journey. Per the State, Subject matter experts will then select specific measures that would most impact outcomes, address known problem areas, and highlight what was most important to monitor and improve throughout the transition process. As for this review, this phase had not yet been completed.
- The next phase of the QMS project is the development of dashboards. The measures derived from the beneficiary journeys are in prototype development for dashboard visualization and analysis, therefore not yet available for this targeted QA project.
- Since much of the data from the prototype dashboard remained preliminary and unvalidated, the State has identified that Medicaid data analysts will be needed to assist with the project. Their responsibilities will include validating and cleaning the selected data set, ensuring data integrity for the subpopulation of HCBS transition members (former GRC individuals), tracking emerging trends, and populating meaningful visualizations to prompt targeted quality improvement activities.
- Per HHS, the process will begin as a pilot focused on those individuals from GRC that have moved to the HCBS setting. The purpose of this was that focusing on a smaller population allowed for deeper insight into the future use of the QMS dashboards. A QI Pilot team will be used to narrow the scope and focus on the former GRC individuals that currently reside in the HCBS setting, utilizing Plan-Do-Study-Act (PDSA) cycles.

Trends found in the data collected will be used to identify potential gaps and opportunities for improvement. Targeted data will be visualized for further review, and if issues or trends emerge, the Plan-Do-Study-Act (PDSA) cycle will begin. This process will involve defining the problem and collecting baseline data, identifying root causes using quality tools, piloting changes on a small scale, evaluating effects through data analysis, and then adapting, adopting, or abandoning the implementation based on the results.

- The overall visual process map was provided by HHS and is below.



The State's Quality Management program did not fully satisfy the requirements set forth in Paragraph 230. Although initiatives were undertaken to improve data collection and analysis, the processes in place primarily verified the existence of services rather than their quality or effectiveness. Efforts such as the development of dashboards and the mapping of beneficiary journeys demonstrated potential for future oversight; however, these tools remained in prototype form and were not yet operational for targeted quality assurance. Routine, validated reporting on service quality and outcomes was not yet established, nor was there a systematic approach for tracking, evaluating, or adjusting corrective actions. Consequently, the State did not demonstrate a continuous quality improvement cycle that encompassed reliable measures, identification of trends, implementation of corrective actions, and ongoing evaluation of effectiveness. While remediation steps and feedback were stated to be communicated directly to case managers via Community Integration Managers (CIMs), remediation steps were not consistently measurable and there was no system in place to track whether corrective actions were completed or effective. In order to achieve compliance, it was determined that the State must prioritize the measurement and reporting of service quality, implement systems for tracking and adjusting interventions, and provide clear evidence of continuous improvement in care. The process map provided by HHS is aligned with that concept but must be implemented to achieve success.

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

Comments:
The LTSS Case Management SME established a dedicated meeting space for Community Integration Managers (CIMs) to share audit findings directly with Managed Care Organizations (MCOs). The first round of meetings were held in late July and included CIMs, LTSS Policy SMEs, the LTSS Bureau Chief, and MCO leadership. These meetings provided feedback on both individual member level findings and systemic trends, highlighted gaps in service documentation as well as shared positive examples of case management practices.

To promote ongoing improvement, the State plans to continue these monthly meetings as a feedback loop, where they can share identified strengths and gaps in service delivery, ensuring compliance with CIM feedback, and fostering collaborative problem-solving among stakeholders. Additionally, the LTSS Bureau Chief will share highlighted summaries of Monitor Reports and their location on the HHS website during monthly MCO Combined Meetings, with recent updates provided in June, August, and September 2025.

Missing as noted in Paragraph 229 was the process for tracking action plans developed as a result of the findings and how effectiveness of the interventions provided.

While the State has established regular channels for sharing audit findings and quality management data with Managed Care Organizations (MCOs), a critical gap remains in ensuring that Interdisciplinary Teams (IDTs), the groups responsible for direct care planning were actually using this information to drive improvements in care. The current process focused on disseminating results to case managers, but lacked a formal system to guarantee that these findings were reviewed and acted upon by the IDTs. Without structured follow-up or accountability mechanisms, there was no assurance that identified issues were being addressed, nor was there a way to measure whether corrective

actions have led to meaningful changes in service delivery or individual outcomes. Ongoing issues noted as part of the ISP process questions the effectiveness of the current system to impact the IDT.

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
Comments: HHS Central Office is required to receive and review routine, valid, and reliable Quality Management (QM) reporting across key domains, including trends in service delivery, resident well-being, and staff relations. The current process involves the collection of data from Case Management audits, Service Monitoring reports, and feedback from Community Integration Managers (CIMs). These reports cover a variety of areas related to Individual Support Plans (ISPs), case management services, and provider practices in Home and Community-Based Services (HCBS) settings. However, the review found that while data is being collected and shared internally, there was no comprehensive system for tracking whether identified issues were resolved. The LTSS compliance meetings serve as the primary venue for reviewing data from audits and monitoring, with attendance from multiple departments including HHS to encourage interdepartmental collaboration. Summaries of Monitor Reports were to be shared with Managed Care Organizations (MCOs) during monthly meetings, and feedback loops were established to promote ongoing improvement and collaborative problem-solving. As stated previously, lacking was evidence of that sharing and the resulting actions. Despite these efforts, the process focused more on the presence of services and supports rather than the quality and effectiveness of those services. For the HHS Central Office to fully meet its obligations, future efforts should prioritize the measurement and reporting of service quality, and ensure systematic follow-up on identified issues,	