PLAINTIFFS'
EXHIBIT

PPI 1400

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, by his next friend
and mother, Lillian Minor, *et al.*,
Plaintiffs,
v.

CHARLES SMITH, in his official capacity as the Executive Commissioner of Texas' Health and Human Services Commission, *et al.*,

Defendants.

Case No. SA-5:10-CV-1025-OG

THE UNITED STATES OF AMERICA,
Plaintiff-Intervenor,
v.

THE STATE OF TEXAS,
Defendant.

DECLARATION AND EXPERT DISCLOSURE OF NATALIE RUSSO

I declare under the pains and penalties of perjury under the laws of the United States and in compliance with Fed. R. Civ. P. 26(a)(2)(B), that the foregoing is true and correct and that I am submitting this disclosure regarding my work as an expert consultant in the above case.

1. My report, which is attached, contains a complete statement of all of my opinions as well as an explanation of the basis and reasons for those opinions.

2. My report describes the facts, data and other information I considered in forming my opinions.

3. There are no exhibits prepared at this time to be used as a summary of or support for my opinions.

4. My attached curriculum vitae states my qualifications and lists all publications I have authored within the past ten years.

5. Within the last four (4) years, I have testified as an expert or have been deposed in the following cases:

   a. Powell, et al., v. A New Vision Case Management Inc. et al., Case No. D-202-CV-2016-00160 (Second Judicial District Court, New Mexico);

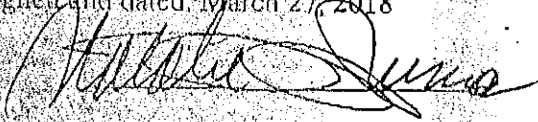
   b. J.L., through her next friend, Bruce Thompson, Esq., et al., v. New Mexico Department of Health, et al., Case No. 2:12-CV-1145 MV/GJF (D.N.M.);

   c. Kristen R., through her guardian and parent, Robin Pickering v. ENMRSH, Case No. D-202-CV-2014-07495 (Second Judicial District Court, New Mexico);

d. A.M., through her Guardian ad Litem, Joleen Youngers v. New Mexico Department of Health, Case No. D-101-CV-2013-01605 (First Judicial District Court, New Mexico).

6. I have been retained by the Plaintiffs and the United States as a joint expert in the *Steward v. Smith* litigation. My compensation in this litigation is $150.00 per hour for my review and preparation of reports and $300.00 per hour (NR) for deposition or testimony, plus expenses. My compensation is not dependent on the outcome of this litigation.

Signed and dated: March 27, 2018



Natalie Russo

CERTIFICATE OF SERVICE

I certify that on this 30th day of March, 2018, a true and correct copy of the foregoing Plaintiffs' and the United States' Declaration and Expert Disclosure of Natalie Russo was delivered via electronic mail and Federal Express to the attorneys for defendants at the addresses below:

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

Eric Steward, by his next friend and Mother, Lillian Minor, et al.,

Plaintiffs,

v.

Charles Smith, Executive Commissioner, Texas Health and Human Services Commission, et al.,

Defendants.

The United States of America,

Plaintiff-Intervenor,

v.

The State of Texas,

Defendant.

Civil No. 5:10-cv-1025-OLG

REPORT OF NATALIE RUSSO

I. PURPOSE/SCOPE

This report sets forth a general summary of the findings of my review of a sample of individuals with intellectual and/or developmental disabilities (IDD) who reside in nursing facilities in Texas. The purpose of this review was to examine the effectiveness of the Pre-admission Screening and Resident Review (PASRR) process and the provision of specialized services and active treatment in nursing facilities; to evaluate the adequacy of services delivered and transition planning; to assess the appropriateness and benefits of community placement for these individuals; and to determine whether adequate information was provided regarding available supports and opportunities were given to the individuals in order for them to make an informed choice related to their continued stay in a nursing facility.

II. EXPERIENCE

I am a registered nurse with advanced education and training and over 30 years of experience working in the field of behavioral health and intellectual and developmental disabilities.

During the course of my career, I have directly delivered health care, supervised the delivery of health care services, assessed and evaluated the outcomes of service delivery, conducted systemic and person-centered reviews of the care and treatment of individuals with disabilities, and developed and

implemented risk management and quality management programs designed to oversee health care and case management services to individuals with disabilities.

My experience also includes oversight of the delivery of the quality of health care, including, but not limited to PASRR services and supports, to individuals receiving services via Medicaid Home and Community Based Waiver Service programs. I have also provided numerous consultations to public- and private-sector organizations pertaining to the delivery of health care and IDD/behavioral health supports and services in accordance with regulatory requirements and standards of practice. I have conducted many individual client reviews for individuals in nursing facilities and other institutions, including reviews in Texas for individuals in the state-operated institutions for individuals with IDD – called the State Supported Living Centers – that are operated by the Texas Department of Aging and Disability Services (formerly DADS, now HHSC). My education, training and employment history are described in detail in my curriculum vitae, which is included as Attachment A.

III. MATERIALS REVIEWED

During the course of my review, I examined numerous documents, including, but not limited to, PASRR background documents and nursing facility and Local Intellectual and Developmental Disability Authority (LIDDA) documents and records for each individual in my review provided to me by Disability Rights Texas (DRT) and the United States Department of Justice (DOJ). I also reviewed applicable regulations and professional standards and guidelines.

I read the nursing facility and LIDDA case management records that were provided to me during my on-site visits for each individual. A complete list of all the documents I reviewed is attached.

A complete list of all materials that I considered is attached as Attachment B.

IV. METHODOLOGY

It is my understanding that an expert on statistics and research methodology drew a random sample of individuals with IDD residing in nursing facilities across the state of Texas, which was then limited to certain geographic areas. I further understand that DRT and DOJ contacted all individuals in the sample to obtain their consent to participate in the review and to release their records from the nursing facility and LIDDA.

I conducted this review in conjunction with three other experts, Barbara Pilarcik, R.N., Vickey Coleman, PhD., and Lauren Charlot, SW, PhD., who reviewed other individuals in the sample. I was asked to review 17 individual clients in (10) different nursing facilities in the areas of Brownsville, Houston, Austin, and El Paso. I was unable to review one individual in the Houston area because she expired prior to my review. Therefore, I conducted onsite reviews of 16 of the 17 individuals for review. The individual reviews primarily focused on evaluating six key areas: comprehensive functional assessments, specialized services, active treatment, service and transition planning, appropriateness and benefit of community living, and informed choice. To assess these areas in a consistent manner, Barbara Pilarcik provided training to all reviewers prior to our on-site reviews. In conjunction with the other three client review experts, I reviewed, discussed, and endorsed a series of probes as a guide for collecting and analyzing information, which I used in making my findings from the client review.

For purposes of this review, supports and services were reviewed for each individual for a 2-year period. My onsite reviews were conducted during the period of August 14-23, 2017. Using a person-centered approach to best inform my reviews, I examined multiple sources of information, including reviewing two (2) sets of records (nursing facility and LIDDA), directly observing the nursing facility program, and

interviewing the individual and family members or guardians, where available and appropriate, the LIDDA service coordinator, when available, and nursing facility staff as needed. I held interviews with 15 individuals during my onsite reviews and had a follow up phone call with one individual who was asleep during my onsite review.

After I conducted the onsite reviews, I completed a summary of my observations and findings concerning each individual's services and supports, which are set forth in Section VII of this report. When available, I also reviewed additional nursing facility and LIDDA records that were requested after the date of the visit in order to have the up-to-date record as of September 1, 2017.

V. STANDARDS

A. PASRR and Active Treatment

In determining the adequacy of the PASRR evaluations, assessments and service planning, specialized services, program of active treatment, transition planning, appropriateness and benefit of community placement , and informed choice for each of the sixteen individuals that I reviewed, I relied upon several standards. I used the federal and Texas PASRR rules, policies, and guidance issued by the federal Center for Medicare and Medicaid Services (CMS) and Texas Department of Aging and Disability Services (DADS) for PASRR Level I and Level II PASRR Evaluations. A PASRR Evaluation (PE) confirms whether the individual has ID or DD, and if so, should assess among other things whether the needs of the individual can be met in the community and identify the specialized services the person needs if s/he is admitted to a nursing facility.

Specialized services are those habilitative services for individuals with IDD which, in addition to standard nursing services, constitute a program of active treatment under federal regulations (42 CFR § 483.440(a)-(f). Active treatment is required by CMS in institutional settings that serve individuals with IDD, including nursing facilities. Active treatment requires that services are provided with the frequency, intensity, and duration to support the outcomes in the person's ISP.

A Comprehensive Functional Assessment (CFA) is necessary to determine the frequency, intensity, and duration of needed specialized services. The CFA, in combination with the PASRR Evaluation, should identify all habilitative services needed by the individual to deliver a program of active treatment. The assessments that make up the CFA should occur at approximately the same time.

The Individual Service Plan (ISP) contains individualized, measurable goals and objectives and the specific services and interventions to achieve those goals. A person-centered ISP is essential to delivering needed services. The ISP should include a transition plan that clearly describes the community living options and supports that would meet the specific, individualized needs of the person.

Transition Planning is process detailing the continuity of services and supports from one residential setting to another setting.

B. Appropriateness and Benefit from the Community

I have spent more than 30 years working with individuals with IDD. During that time period, I have observed numerous individuals with complex needs adequately served and supported in their communities to live the lives that they choose. In my professional opinion, most individuals with IDD can be appropriately and safely served in the community and benefit from living in more integrated settings.

C. Informed and Meaningful Choice

Informed choice about transition for individuals with IDD in nursing facilities requires the provision of detailed information in an manner that the person can understand and appreciate; the opportunity to visit community programs and participate in community activities; a concrete description in the ISP of what a life in the community would look like for the individual; a plan for the provision of meaningful and accessible community services that will meet the individual's needs; effective actions to address any barriers, concerns, and fears about community living, which are often based upon prior experiences in the community; and special efforts to address some of the consequences of institutionalization. Given the professional consensus that most individuals with IDD can live successfully in the community with appropriate supports, and the well-documented benefits of community living for individuals with IDD, there must be compelling evidence that the person has made an informed choice to remain in the nursing facility.

VI. SUMMARY OF FINDINGS

Quantitative data findings (N = 16)

Comprehensive Functional Assessments

None of the 16 individuals had a CFA consistent with federal requirements or that accurately identified all of the individual's strengths and needs. None of the individuals that I reviewed had their nursing facility Comprehensive Care Plan attached to their Individual Service Plans along with other providers' implementation strategies, as applicable to the individual reviewed.

Specialized Services

At the time of my reviews, none of the 16 individuals were receiving all necessary nursing facility and LIDDA PASRR specialized services. None of the 16 individuals were receiving all needed nursing facility specialized services. None of the 16 individuals were receiving all needed LIDDA specialized services. Although all residents reviewed were noted as receiving service coordination, in my opinion, service coordination was not delivered in accordance with the requirements of DADS and the Texas Annotated Code, which specify that the service coordinator must 1) monitor the delivery of all services and supports provided to the individual, and 2) must assist in accessing services and supports that help individuals achieve quality of life and community participation acceptable to the individuals or, when applicable, the individuals' guardians on behalf of the individuals. Also, there was no evidence that the nursing facilities reviewed the residents' PASRR evaluations forms when they experienced a significant change in their condition.

Fourteen (14) of the 16 individuals reviewed had one or more PEs completed during the two-year period. Eight (8) of the 16 individuals' PEs recommended alternate placement services through the Local Authority. Almost half (7) of the 16 individuals PEs recommended nursing facility specialized services such as therapies and durable medical equipment.

Of note, many of the 16 individuals had multiple PEs, and a significant majority of the recommendations for nursing facility and/or LIDDA services changed over the years and across the individuals' PEs and other records. For example, some individuals' initial PEs did not recommend nursing facility and/or LIDDA specialized services, but over the years, subsequent PEs included recommendations for nursing facility and/or LIDDA specialized services, and vice versa. The rationales for these changes were not documented in the records that were provided to me.

Across most of the individuals in my review, I found a significant number of them had unmet needs for habilitative physical, occupational, and speech therapies. Although most of the individuals were

receiving intermittent rehabilitative therapy services, none of the individuals were receiving all needed habilitative services through PASRR to prevent decline and to promote the individuals' achievement and maintenance of their highest practicable level of functioning. Despite the frequency and severity of needs of the individuals I reviewed, none of the individuals that I reviewed were receiving ongoing, consistent, habilitative physical therapy (PT), speech therapy (ST), or occupational therapy (OT) specialized services at the time of my visit. Failure to provide these services not only puts the individuals at risk for potential harm, but also impedes their ability to attain and maintain their desired goals.

One of the 16 individuals reviewed was participating in a day habilitative program outside the nursing facility, despite the fact that a number of individuals had expressed interest and/or their guardians or service coordinators indicated that the individual would benefit from a day habilitative program where they could attain or maintain daily living skills and socialization with other peers. Eleven (11) of the 16 individuals reviewed had mobility challenges and used wheelchairs to gain greater independence with their mobility. Many of the individuals exhibited behavioral challenges such as depression, loneliness, anxiety, frustration, anger, agitation, aggressiveness, yelling, screaming, etc. In some cases, these behavioral challenges stemmed in part from the inability to communicate their needs and desires. However, none of the individuals who suffered from difficult and/or challenging behaviors received behavioral support services that were adequate, consistent, and effective in meeting their needs. Of note, the individuals' staff members were not afforded adequate training on interventions and methods of interaction to meet the needs of the individuals with behavior challenges. Thus, these individuals needlessly suffered isolation, rejection, and, sometimes, segregation from others.

Many also participated in very few meaningful leisure time activities aside from playing Bingo, watching television, wandering through the nursing facilities, or sitting in the front lobby. Most of the individuals reviewed had not been outside the nursing home to attend or participate in community participation in many weeks, and more likely, years.

Active Treatment

None of the 16 individuals that I reviewed receives a program of active treatment. Absent qualified and trained staff with knowledge of habilitation and IDD issues, achievement of active treatment is not likely to occur.

Individual Service Plan

None of the individuals I reviewed had a person-centered ISP that was based upon a CFA, that included a transition plan so that the individual could make an informed choice about community living, and that was implemented consistent with their needs and preferences.

As reflected above, eight (8) of the 16 individuals have recommendations for alternate placement services in their PEs. Yet, at the time of my review, there was no evidence that these recommendations had been actively pursued on their behalf. None of the sixteen individuals reviewed were actively involved in the Transition Planning Process, despite the fact that a significant majority of them had expressed an interest in community living. Below are some examples of the failures to address the individuals' expressed interests in transitioning from the nursing facilities to the community.

One individual was admitted to the nursing home for convalescence after her hospitalization. The individual's 2016 PE indicated that she was to receive alternate placement services and service coordination from the LIDDA. In addition, it was noted, "Once the client is medically stable, she can benefit from group home and other community services out there in the community for individuals with specials needs. Client is on HCS." The individual had another PE in 2017, and it reiterated, "…she can

benefit from group home or other supports out in the community." The individual's Service Coordinator also noted in April 2017 that she would help meet the individual's need to relocate to Georgia (where the individual's sister resides)," and "…agreed to follow-up with IDD Supervisor and [individual's sister] to help meet the individual's need to relocate to Georgia." Notwithstanding the above, as of the August 2017 review, the individual was no further along with her transition to a group home with community supports and services than she was when she was admitted to the facility in November 2016. There was no documentation of discussion of what barriers, if any, existed, nor was there any documentation of how the CLO process was being implemented in a way to facilitate the individual's transition to a community-based home near her sister.

Another individual's 2015 annual ISP noted, "[Individual] desires Service Coordinator's assistance in seeking an HCS slot and has expressed a desire for HCS process to continue." Again in 2016, the individual's annual ISP noted that the individual was "…open to a host home, but pictures herself in an apartment…" At this time, the individual's Services Coordinator reported that he/she would send the individual a provider list, request an HCS slot, and search for a provider. Over the next year, the individual's strongest supporter of her transition to the community left her job at the nursing facility. In addition, there was significant turnover in Service Coordinators assigned to support the individual and her transition to community. Thus, over the year preceding the August 2017 review, the individual was not taken to visit any community living options nor had she met with any peers who had similarly transitioned from nursing facilities to community living options. No specific community placement was identified for the individual, and barriers to transition were not addressed. During my interview with the individual she clearly expressed her interest in leaving the nursing facility and "getting my life going again."

One individual's 2013 PE noted that she "expects to return to the community," and "would like to live somewhere other than the nursing facility." Notwithstanding the individual's expressed interest in community living, the Service Coordinator, wrote, "However, SC think the nursing facility is the appropriate placement…" In 2014, during the individual's service planning meeting, it was affirmed by the individual's interdisciplinary team that the individual "…would benefit from community living…" Contrary to the individual's and her team's expressed interest in achieving her transition to community living, the individual's subsequent PE's noted, "No," she did not expect to return to the community, and "[Individual] wants to remain at the nursing facility at this time due to her health." Accordingly, the individual has remained at the nursing facility for over six years. Of note, during my interview with the individual, she reported that she misses every aspect of her former life outside the nursing facility, e.g., she misses going out to the park, she misses going outside and looking at the trees, she misses her cat and her dog. The individual clearly stated more than once that she would like "this," that is the above, again. During my interview with the individual's Service Coordinator, she reported that, in her opinion, despite the individual's expressed interest and wishes, "As long as [individual] is comfortable, she is okay being at [nursing facility]. Clearly, this goes against the requirements that Service Coordinators are expected to follow.

Benefit from Community Living

In my professional opinion, all 16 of the individuals reviewed are appropriate for and could benefit from community living with appropriate supports and services. During my 30-plus years of experience in various capacities, I have observed numerous individuals with complex needs adequately served and supported in their communities to live the lives that they choose.

Informed Choice

Twelve individuals or their guardians have not made a choice to remain in a segregated nursing facility. Nonetheless, none of the individuals I reviewed were provided opportunities to visit community living or support providers. There were many and sundry reasons reported for why individuals were not provided these opportunities. For example, it was reported by several nursing facilities that they did not provide transportation or even encourage individuals to visit other community living or support providers. It was also reported by a number of nursing facilities that their transport vehicles were not in working order and/or were dedicated to providing transportation of individuals to medical appointments, not to transporting individuals to visits to community living or support providers. In addition, even when a nursing facility was aware that an individual was interested in visiting a community living or support provider, they relegated the opportunities for these individuals to get to where they wanted to go to the LIDDAs who forthrightly reported that, despite individuals' requests and/or recommendations for visits to community living or support providers, they did not provide transportation for nursing facility individuals to visit these entities. None of the individuals had all barriers to the community addressed. None of the individuals had an ISP that included a specific description of transition options in Phase II of Section 9. Just one of the 16 individuals received specialized services that provided him regular opportunities to spend time in the community or otherwise regularly spent time in the community.

Of the 16 individuals reviewed, 14 (88%) individuals and/or their legal guardian expressed an interest in learning more about the community. Twelve (75%) expressed an interest in transitioning to the community. Of the remaining four, one individual was not able to verbally express his wishes, and his mother, who is not his legal guardian, was adamant that he remain at the nursing facility. She was supportive, however, of the idea that he begin specialized services outside of the nursing facility. Another individual's son, who is her guardian, clearly expressed his desire for his mother to stay at the nursing facility, despite its many problems and failures to meet his expectations for proper care of his mother. The other two individuals, who were their own guardians, in my opinion, were provided some amount of information about community living options, and chose to remain at the nursing facility. Of note, the information that they were provided was not exhaustive by any means. It failed to include opportunities for the individuals to meet with peers who had successfully transitioned, attend meetings with and interview prospective community providers, attend individual and family community support groups, visit community living options, watch videos on community living, etc. Some of the barriers that appeared to be affecting their interest and/or willingness to participate in opportunities to learn more about their community living options were (1) physical barriers, such as suffering intolerable pain because one individual with spina bifida and a fractured hip was expected to ride in a van that did not accommodate her wheelchair, equipment malfunctions and lack of transportation; and (2) family members and/or nursing facility staff who openly and frequently voiced their biases against community living to the individuals, which caused them to fear what they did not know and had not afforded themselves the opportunity to experience.

Based on the aforementioned, it appears that the basic elements of informed choice were not provided to the individuals who expressed a desire to leave, to the individuals who claimed they wanted to stay and feared what they did not know, and/or to their families, who played a significant role in the process.

VII. INDIVIDUAL FINDINGS

S.J.

S.J. is a 56-year-old man who was admitted to a Friendswood, TX nursing facility in December 2016 on an exempted hospital discharge and with the expectation that he would not stay longer than 30 days. S.J. was diagnosed with Down Syndrome, legal blindness, Alzheimer's Disease, hypertension, and gastroesophageal reflux disorder. According to his sister, it was S.J.'s father who decided that S.J. would go to the nursing facility after his hospitalization because it was the place that was the residential program that was the closest to S.J.'s parents' home

Prior to S.J.'s admission, he enjoyed a very full life. He graduated from high school, and thereafter lived independently with occasional help from friends and family members. S.J. performed self care, including cooking his own meals, occasionally worked on a farm, socialized with friends and family at the Special Olympics, dances, community gatherings, and holidays, was involved in his church, and he helped others. His parents and sister were very supportive of his independent lifestyle.

S.J.'s father was until recently S.J.'s legal guardian. Approximately two months prior to the review, S.J.'s father suddenly died. This was devastating for S.J., who was very close to his father and visited with his parents regularly at their home and at the nursing facility. S.J.'s sister with whom S.J. is also very close, was in the process of obtaining legal guardianship of S.J. following their father's death, and she was present at the nursing facility on the day of the review.

When this reviewer met S.J., it was shortly after lunch, and he was sitting alone in his room. During most of the time this reviewer talked to S.J., he kept his eyes shut and only responded in short phrases, which were largely unintelligible. S.J. responded with "Yes" or "No" when this reviewer asked questions about S.J.'s family, his day at the nursing facility, and other simple questions about S.J.'s life at the nursing facility. During most of the interview, S.J. made verbalizations and gestured with his hands. S.J. spends most of his days inside the nursing facility sitting in his chair or lying in bed, although he was observed walking in the halls with his sister when she visited with him on the day of my review. S.J. generally does not leave the nursing facility to attend community events or activities.

S.J.'s sister was very eager to talk to this reviewer and tearfully spoke at length about her strong desire to have S.J. return to the life that he had prior to the nursing facility, that is, living a full life in a community home where he was almost always happy, engaging, and had not shied away from trying new things. At the time of the review, according to S.J.'s sister, however, S.J. was not happy and not participating in activities. Rather, according to reports from his Service Coordinator and sister, he was "very sad," and had recently stated, "I want to join my father and nephew [in heaven]." Earlier this year, S.J. also began fighting with other residents and suffered symptoms of anger, agitation, stress, anxiety, irritability, paranoia, nervousness, and rejection of care. These changes in S.J. prompted the nursing facility to obtain a psychiatric consultation. According to S.J.'s psychiatrist, S.J. suffers from an adjustment disorder with mixed emotional and conduct disturbances, anxiety disorder, and mild cognitive decline. Also, although S.J.'s behavioral health professional recommended specific interventions to address S.J.'s psychosocial needs, there was no evidence that the recommendations were consistently carried out. For example, S.J.'s behavioral health professional recommended that S.J. should be engaged in activities, especially those that would allow S.J. to relax. However, on the day of the review, S.J. was not assisted or encouraged to attend an ice cream social that was being offered to

the nursing facility residents. And although S.J. loves music, his sister reported that, especially more recently, SJ was not routinely assisted and/or encouraged to attend music activities at the nursing facility.

S.J. did not receive a comprehensive functional assessment of all habilitative areas that accurately identifies all of his strengths and needs or that takes into consideration all of S.J.'s recent life events and changes and his responses to them, and the nature and impact of his recent decline on his physical and cognitive functioning status.

S.J. does not receive necessary nursing facility and LIDDA specialized services with the intensity, frequency, and duration, to address all need areas. For example, S.J. is not receiving nursing facility specialized services with the appropriate intensity, frequency, and duration in order to meet his needs. He does not appear to have a behavior support plan to address some of the aggressive behaviors that began earlier this year. Also, S.J.'s P.E. dated 1/3/17 recommended OT specialized services to be provided by the nursing facility but there is no evidence that he received habilitative OT. In addition, the quarterly SPT notes indicate that he did not even receive a referral for an OT consultation until August, 2017. According to S.J.'s Service Coordinator, S.J. is ambulatory and occasionally uses a manual wheelchair for mobility and he sleeps on a pressure reducing mattress, but, despite his needs and deficits in activities of daily living, physical activity, and cognitive skills for communication, S.J. is not regularly participating in habilitative occupational, physical, or speech therapy. S.J. is also not receiving all need LIDDA specialized services. S.J. is supposed to be receiving Independent Living Skills Training (ILST), up to 2-3 hours a week to go to the park, but he has recently been refusing to get out of bed, get into the car, and go to the park. However, there was no evidence that this recent refusal was being consistently addressed by nursing facility or LIDDA staff or that any assessments related to these changes in behavior had been conducted.

S.J. is not receiving active treatment. He is not receiving a continuous active treatment program that included aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services to prevent or decelerate regression and loss of current optimal functional status. The services he does receive are not provided in a way that is continuous and consistent and that promotes independence and prevents regression.

S.J. does not have a professionally appropriate ISP that was developed on the basis of a comprehensive, person-centered assessment and included all needed services and supports to successfully transition to the community. Rather, S.J.'s current annual ISP dated May 9, 2017 and quarterly updates do not include meaningful outcomes but instead consist primarily of general and vague statements that fail to accurately portray S.J. and his specific strengths and needs, and his goals and objectives, which are not specific, measurable, or individualized, and lack sufficient, appropriate interventions. For example, despite the decline in S.J.'s health, his ISP repeatedly states that he "adjusted to the nursing facility," "walking and drinking his water," and "loves dancing." S.J.'s ISP's outcomes are vaguely stated goals for "participating in activities of choice," "assisting me with Bingo," "making sure I am hydrated," and "[going] to the park." It was unclear what, where, when, or how specific action steps are be taken by S.J.'s staff members to accomplish S.J.'s outcomes. And, although there were numerous notes, reports, and summaries in S.J.'s nursing facility records that indicated that he was not participating in activities, not going to the park, and refusing to get out of bed, neither the outcomes nor the action steps were revised to address S.J.'s lack of progress toward the attainment of his ISP outcomes. The transition plan for S.J. is similarly deficient. The ISP fails to include a transition plan, Phases II and III of Section 9 are not

completed, and the ISP also does not identify individualized barriers to transition. S.J.'s service coordinator was unfamiliar with his previous placement.

During the review of S.J.'s records, observations, and interviews with S.J. and his sister, it was clear that he would benefit from living in an integrated setting with appropriate community services and supports, which would provide him with a quality of life that would be similar to what he enjoyed prior to his admission to the nursing facility. In fact, on 1/3/17, S.J.'s P.E. indicated that S.J. was to receive alternate placement services, but there was no evidence that these services were delivered. The rationale documented by S.J.'s Service Coordinator for the failure to provide S.J. with alternate placement services was, "The nursing facility is appropriate at this time due to his decline in activities." Of note, in my opinion, S.J.'s decline in activities was significantly related to the nursing facilities pattern of failure to offer and assist S.J. to engage in a variety of activities that he would enjoy.

Neither S.J. nor his soon-to-be guardian made an informed choice for S.J. to stay in the segregated nursing facility. In fact, S.J.'s sister informed this reviewer that she would love for S.J. to live in a smaller, more individualized place. S.J. was not afforded opportunities to visit community living options, and he had not met any of his peers who had moved from the nursing home to community living. S.J.'s strongest advocate, his sister, repeatedly affirmed that S.J. would love to go on tours of group homes and receive assistance from his Service Coordinator to arrange a plan for transition, to address barriers to S.J.'s transition, and ensure timely implementation of these activities, especially because S.J.'s sister was very worried that the longer S.J. stayed at the nursing facility, the more likely S.J.'s health status and functioning would continue to deteriorate and the more isolated he would become.

R.M.

R.M. is a 53-year-old man diagnosed with an intellectual disability, autism, cerebral palsy, and a seizure disorder. For the past four years he has resided on a locked unit, called the Generations Unit, at a nursing facility in Austin, Texas. R.M. is designated as a legal adult.

R.M. spends most days behind the locked doors of the Generations Unit pacing up and down the hallway, taking and holding as many items as he can in order to try to satisfy the sensory input he craves. While nursing facility staff reported R.M. to be non-communicative, aggressive, and unaware of people, this reviewer witnessed him happily acknowledge his sister and say her name. R.M.'s sister tearfully recounted stories of R.M.'s life as a brother, friend, and community member– prior to entering the nursing facility. Since moving to the nursing facility, she reports, her brother does nothing. Her wish for R.M. is that he "live the best life that he can."

R.M. has almost no belongings whatsoever, no personal clothing, no underwear, and no footwear. His fingernails were very long and soiled with feces. His oral hygiene clearly had not been performed in many days, and more likely not for weeks, if not months. Records indicate that despite an acute need for dental care, R.M. has not seen a dentist in over two years. Of note, the nursing facility staff have a physician's order to administer a sedating medication to R.M. one hour prior to hygiene in order for the nursing facility staff to attempt to perform R.M.'s basic hygiene and grooming. His sister reported this intervention was not previously necessary.

R.M. was admitted to the nursing facility after being discharged from a local hospital where he was treated for low blood pressure and dehydration. Prior to his hospitalization, R.M. lived in a 24-hour supervised group home in Austin, TX with several other men, and before that, lived in a group home in the Dallas area. He enjoyed community life and functioned independently across most aspects of his activities of daily living. R.M. attended a day habilitation program, played kickball, went on picnics with his housemates, and was learning to use money. He participated in home-based chores and activities, going out into the community on shopping and leisure excursions, singing, laughing, and talking to others. In the nursing facility he no longer does most of these activities.

According to his hospital Discharge Summary, R.M.'s group home provider "refused to take [RM] back." He was initially transferred to another nursing facility where he became aggressive when staff initiated physical contact, resulting in the nursing facility refusing to admit him. R.M. was briefly brought back to the hospital until RM's current nursing facility accepted him as a resident of their facility. There was no evidence that efforts were taken to explore any community options or to address R.M.'s behavioral issues. Since his admission to the nursing facility, R.M.'s quality of life and capabilities have deteriorated. Further, R.M.'s sister reported that the nursing facility does not properly care for R.M. or assist and support him to participate in activities of daily living.

R.M. did not receive a comprehensive functional assessment that accurately identified all of his strengths and needs. R.M. did not receive assessments in the areas of sensorimotor development, affective development, speech and language development, cognitive development, social development, independent living skills, vocational skills, community participation, and integrated day activities. There were portions of assessments in various records, such as R.M.'s Minimum Data Set, physical examination report, and 2015 PASRR Evaluation, but they were not performed near or at the same time by an interdisciplinary team and not part of a single, complete, assessment with recommendations for planned interventions to meet R.M.'s desired outcomes.

Also, although R.M.'s nursing facility staff reported many areas where R.M. had suffered decline since his admission, R.M.'s LIDDA assessments failed to accurately portray this decline and frequently and simply concluded, "No issues," "Doing well," despite the presence of other contradictory LIDDA findings such as, R.M. "looked lethargic," "crying," "had falls," and "fingernails long and soiled." Nor was there a behavioral assessment in the records although R.M. was exhibiting self-injurious behaviors, such as "biting [him]self until he draws blood." Despite R.M.'s Service Coordinator's concerning findings during her visits, there was no evidence that sufficient actions were taken by R.M.'s Service Coordinator to ensure that R.M.'s needs were met.

R.M. is not receiving nursing facility specialized services LIDDA specialized services other than service coordination, even though he could benefit from and needs these services to maximize functioning and avoid deterioration. .His nursing facility and LIDDA records stated that his receipt of PT and OT stopped over one year ago. But, when R.M. suffered a fall, he was picked up again by OT on 5/26/17 for several weeks of rehabilitative therapy because R.M. demonstrated "marked debility," and "extensive decline of motor control and power that has contributed to a negative impact on his ability to safely perform activities of daily living." However, there is no indication in the record that R.M. received any habilitative OT or PT, or that he received any therapy for longer than a few weeks during the last two years. R.M. had received ST earlier in his stay at the nursing facility. However, according to the nursing facility and LIDDA records R.M. was discharged from rehabilitative ST in 2015. This occurred despite the fact that R.M.'s current nursing facility assessments indicated that his verbal communications were rarely, if ever, understood, and he was primarily non-verbal. In addition, R.M. is not receiving behavioral supports and does not have a behavior support plan in place to address his self-injurious and aggressive behaviors.

R.M. is not receiving a continuous program of active treatment that includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services. As noted above, R.M. did not receive a comprehensive functional assessment, and he is not receiving all of the specialized services that he needs to meet his habilitative needs. There is also no evidence that services were provided in a manner that promoted his independence and prevented his regression.

R.M. did not receive a professionally appropriate ISP that was developed on the basis of a comprehensive, person-centered assessment and included all needed services and supports to successfully transition to the community. Rather, R.M.'s ISP states that his strengths are "Unknown," and, curiously, his preferences are "hoarding," "walking around," and "in his own little world." R.M.'s ISP also states that he was "Sick" during the period in which he was supposed to receive speech therapy; the section entitled "History," is blank. Another ISP noted, "[R.M.] is admired for being a friendly person" yet noted that he "is rarely understood by NF staff." Nonetheless, speech therapy was not recommended. Section 9, phase II of RM's ISP, titled "Transition Plan," was left blank, and there was no indication that any barriers to the community were addressed. R.M. has not had the option to visit the community, there is no individualized description of what the community would look like for R.M., and the supports and services necessary for R.M. to transition to the community are not identified. R.M.'s service coordinator does not appear to be aware of R.M's prior experiences in the community and has made no apparent effort to contact R.M.'s sister, whose contact information is listed on his ISP and who is a primary support for R.M. R.M.'s sister reported that she has never heard that R.M. has a Service Coordinator; she has never heard of a "LIDDA," and she did not know what was meant by an "IDT" or an

"SPT." In addition, R.M.'s sister reported that she was never invited by the nursing facility to a Care Plan meeting held on behalf of R.M.

R.M. would be appropriate for and benefit from living in an integrated setting with appropriate community services and supports similar to what he enjoyed prior to his hospitalization and discharge to the nursing facility. R.M.'s physical and behavioral status has declined dramatically since his admission to the NF. He no longer speaks, engages with individuals, or participates in activities of daily living. In this reviewer's opinion, R.M. may be better served in a more integrated setting where he could interact with others and receive more individualized attention.

When R.M.'s sister was asked where she thought her brother would like to live, she became tearful and replied that her brother would be happier and would stand a chance to live the life that she knows he could live and enjoy in a community home similar to the home he had lived in several years ago in Dallas, TX.

R.M. has not made an informed choice to remain in a segregated nursing facility. At the time RM entered the nursing facility, it was noted that neither he nor his sister participated in the assessment of where to be placed and that they had not received information about alternatives to the nursing facility. According to R.M.'s records, R.M. did not receive information about community living options (CLOs) until two years after admission. According to R.M.'s Service Coordinator's notes, R.M. did not appear to understand her brief, approximately five-minute review of R.M.'s Community Living Options. R.M. was repeatedly left with standardized written materials that he is unable to read or comprehend about his options for community living. The presentation of information was not tailored to his unique communication style and cognitive abilities. Although his Service Coordinator notes that R.M. likely does not understand his community options, that is "[R.M. is] unable to communicate where he would like to reside," and needs a legal guardian to advocate for his needs, there is no follow up to help him understand what the community would look like for him. R.M. rarely leaves the locked hallway of the nursing facility, has no exposure to the community, and has not had the opportunity to visit any community options. There was no indication that R.M.'s Service Coordinator engaged in any meaningful assessment of R.M.'s strengths, preferences and needs and how they might be met in the community. His Service Coordinator's notes clearly implied that R.M. likely had not read, nor would he comprehend, the brochures the Service Coordinator left behind for him to read about his options for community living.

P.C.

P.C. is a 53-year-old, small-statured Hispanic woman with a diagnosis of Down Syndrome. During the visit, this reviewer interviewed P.C. with the assistance of an interpreter. On the day of the review, P.C. was not properly clothed in seasonally appropriate clothing. Rather, she wore what appeared to be a nightgown with a sweater over it and non-skid socks with no shoes. She was admitted to the nursing facility from an acute-care hospital in November 2016 as an expedited admission for convalescent care related to pneumonia and the insertion of a feeding tube. Prior to admission to the nursing facility, P.C. lived in a group home in the community. Although P.C. is now able to eat by mouth and generally feed herself independently, she has not returned to live in a community setting despite her desire to do so. P.C. is very connected to her siblings and extended family who live in Georgia. She lived with her mother in the community until her mother's death a few years ago, then she briefly lived at an ICF.

During my visit, P.C. was very soft-spoken and kept her head mostly held down and her eyes focused on her lap. She frequently used simple phrases and gestures to respond to questions about her life at the nursing facility, personal care, such as hygiene, hair, and nail care, opportunities to participate in activities both in and out of the facility, etc. For example, P.C .responded to the interview with comments such as, "I want a hat," and "I want to live."

P.C. has a positive PASRR Level 1 dated April 3, 2017 and a PE dated April 4, 2017. There is no comprehensive functional assessment of all habilitative areas in P.C.'s records that accurately identifies all of her strengths and needs.

P.C. is not receiving necessary nursing facility and LIDDA specialized services, with the intensity, frequency, and duration, to address all need areas. Absent comprehensive, person-centered assessments and professionally appropriate plans with specific interventions to achieve agreed-upon goals, it was not surprising to find that, as of the review, P.C. was still not receiving nursing facility specialized services. For example, P.C. still had no custom tilt-in-space manual wheelchair with a contour back, seat cushion, adjustable arm and head rests, and leg rests, although this had been requested in the past. Rather, at the time of the review, PC was confined to a geri-chair, which she was unable to independently operate, and which required staff assistance to take her to/from all activities. Additionally, while OT and PT specialized services were recommended at her IDT meeting on November 20, 2016, it does not appear that she is currently receiving PT or OT. P.C. does appear to have received time-limited OT and ST rehabilitative therapies for a few days each, those services are distinct from those P.C. needs to maintain and improve skills. These specialized services are needed to maintain or improve skills.

Also, as of May 2017, although P.C .was supposed to be receiving the LIDDA specialized service of ILST, there were conflicting reports across PC's records of the frequency/duration of these services. Her service coordinator reported a gap in these services for 3-4 weeks. In addition, although these services were supposed to be in place, in part to help ensure that P.C. attended and participated in daily activities and performed daily routines such as exercises and celebrating social and festive holidays, P.C.'s Service Coordinator documented that during her visits, she frequently found P.C. in bed, not participating, or even watching, activities that were underway at the nursing facility. In addition, when this reviewer asked PC's Service Coordinator what skills PC attained and/or maintained since she started receiving ILST, she replied, "Nothing."

P.C. is not receiving a program of active treatment. As noted above, P.C. did not have a comprehensive functional assessment, and she is not receiving all of the specialized services that she needs to meet her habilitative needs. There is also no evidence that services are provided in a manner that promotes independence and prevents regression.

P.C. does not have a professionally appropriate ISP that was developed based upon a comprehensive, person-centered assessment and that includes all needed services and supports to successfully transition to the community. For example, P.C.'s 7/1/17 nursing facility Care Plan failed to identify any nursing facility objectives with interventions to achieve PC's goal of moving from the nursing facility and into a community home closer to her family, and the "Transition Plan to the Community" section of P.C.'s 5/25/17 annual Individual Support Plan/Transition Plan, Section 9, Phases II and III was blank. The current ISP does not identify or address barriers to transition. Additionally, the ISP fails to include meaningful outcomes for P.C. and does not include habilitative goals to promote her independence and to prevent deterioration.

P.C. is appropriate for and would benefit from living in an integrated setting with appropriate community services and supports. Prior to P.C.'s admission to the nursing facility, she lived in a community group home. Prior to P.C.'s placement at the nursing facility, P.C. had numerous opportunities to make personal choices, such as what clothes she would wear; she actively participated along with her housemates and/or family members in community events and church; she independently ambulated; and she interacted and conversed with her family members in her primary language. P.C.'s PE notes that P.C. could benefit from a group home and other supports in the community. In my professional experience, individuals with P.C.'s level of need may successfully live in the community and nay be safely and adequately served in the community. P.C'.s service coordinator noted that she does not believe that P.C. is benefitting from remaining in the nursing facility.

On the day of the review, it was noted that P.C. had a television in her room, but was unable to operate it. She had no books, radio, or other personal items available to her to provide the sensory stimulation, sensory input, and individualized activities that were called for by her nursing facility Care Plan. During this reviewer's interview with P.C.'s Service Coordinator, she reported, "[P.C.] never goes out of the nursing facility." And, as indicated in P.C.'s nursing facility Care Plan, staff members made all of P.C.'s daily decisions, which were limited and constrained by the nursing facility's, and not P.C.'s, schedule of what, when, and whether activities of daily living would occur.

P.C. has not made an informed choice to remain in the segregated nursing facility. Multiple records note that P.C. and her family members, especially P.C.'s sister, want P.C. to move to either their home or to a community setting that was closer to her family, who live in Georgia. Thus, there is evidence that P.C., with her family's agreement and support, has made the choice not to remain in a segregated nursing facility. Although the record indicates that P.C. was offered an HCS waiver slot in the past and declined, there is no evidence that any meaningful efforts were made to address her desire to be closer to her family or other barriers to her transition to the community. Nonetheless, as of the date of my review, barriers to P.C. transitioning to the community had not been adequately identified or addressed, so P.C. remained in the nursing facility despite the fact that for many months prior to the review, 1) P.C.'s Service Coordinator reported that P.C.'s health status had improved and P.C. was stable; 2) P.C. replied, "Si," when her Service Coordinator asked her if she would like to move and be closer to her family; and 3) P.C.'s Service Coordinator's Individual Progress notes stated that P.C.'s Service Coordinator was reportedly helping P.C."…relocate to Georgia where her entire family now resides…" During my visit, when this reviewer asked P.C. if she wanted to move out of the nursing home to a home

closer to her family, P.C. sat up straight, leaned forward, and looked directly into the face of this this reviewer, and loudly stated, “Si!”

P.C. and her family had identified their desire for discharge from the nursing facility at least six months ago; however, P.C. has not transitioned from the nursing home to a group home closer to her family. It was also reported that the absence of a social worker at the nursing facility for at least the past two months had a negative impact on making progress toward P.C.’s transition.

N.F.

N.F. is a 68-year-old woman who was initially admitted to a nursing facility in Liberty, TX in December, 2002. The nursing facility record indicates that her initial admission to the nursing facility was on an exempted hospital discharge, which meant that N.F. had a less-than 30-day expected stay at the nursing facility. According to the nursing facility record, N.F. has a diagnosis of IDD and schizophrenia. N.F. is her own guardian.

Prior to N.F.'s admission to the nursing facility, she lived in the community with her husband. She had three children and a stepchild. N.F. worked doing cleaning. She had a supportive family and many friends. Sadly, N.F. experienced the death of her husband and three of her children, N.F.'s health declined to the point where her family physician was concerned that N.F. was not taking adequate care of her health, or the health of her child, who was disabled. Thus, N.F.'s family physician admitted both N.F. and her disabled child to the nursing facility. Within a year or so of their admission to the nursing facility, that child died.

In 2014, during one of N.F.'s psychological evaluations, it was noted that NF had many life skills and abilities. For example, prior to N.F.'s admission to the nursing facility, she prepared meals, read and prepared correspondence, cleaned, held a job, regularly met with friends, went on single and group dates, and was sociable and well-mannered. The evaluation concluded that N.F. would benefit from IDD services based on her needs and interests, including "wanting to live on her own…"

N.F. spends most of her days inside the nursing facility sitting in her wheelchair or lying in bed. As a rule, N.F. does not leave the nursing facility to attend community events or activities. She occasionally has gone to the Dollar Store. At one time, however, N.F. periodically accompanied the facility's former Director of Activities out of the facility to run errands in the community, but this no longer occurs. In addition, although NF reported to this reviewer that she would like to go to church in the community, this has not occurred. As of this review, an alarm was attached to N.F.'s wheelchair. Reportedly, this was done in an effort to prevent N.F. from eloping from the facility. But, in reality, it restricted her freedom of movement and access to the outdoors.

When this reviewer met N.F., it was shortly after lunch. N.F. was sprawled across her bed and sound asleep with food in her mouth. This choking risk was immediately reported to N.F.'s nurse. Over the next several hours, this reviewer made several attempts to visit N.F. in her bedroom, but she was extremely lethargic and unable to wake up from her heavy sleep. N.F.'s nurse suggested that this reviewer telephone NF in the morning to talk to her because N.F was likely to be awake by that time.

N.F.'s nurse reported to this reviewer, that, over the past several days, N.F. had two back-to-back inpatient psychiatric hospitalizations and had just returned to the nursing facility a few hours prior to our arrival. A review of N.F.'s nursing facility record corroborated N.F.'s nurse's report. The nursing facility records revealed that N.F had indeed been hospitalized twice in the past week because she was threatening to harm herself; she was extremely agitated; and she displayed an alteration in her mental status. In addition, the records indicated that N.F. received daily doses of five psychotropic medications during her hospitalization and was discharged on these medications for symptoms of major depressive disorder, recurrent and severe with psychosis.

There is a PE dated 10/21/2013 in N.F.'s LIDDA records. However, NF has not had a comprehensive functional assessment that accurately identifies all of her strengths and needs. Also, several of N.F.'s

nursing facility progress reports and summaries indicated that, since N.F.'s admission to the nursing facility, she had suffered decline – mentally and physically, up to and including inability to walk, loss of stamina, strength, coordination and balance, shortness of breath, cognitive communication deficits, falls with and without injury, dysphagia, incontinence, back-to-back inpatient psychiatric hospitalizations, and little to no involvement in activities. Nonetheless, these significant, negative changes failed to prompt a comprehensive functional assessment so that each of N.F.'s habilitative needs would be identified and addressed with planned interventions via a program of specialized services to meet N.F.'s needs, build upon her remaining strengths, prevent further regression and loss, and increase the likelihood that N.F. would regain at least some of the losses she suffered in skills, strengths, and abilities.

N.F. is not receiving all necessary nursing facility and LIDDA specialized services with the appropriate intensity, frequency, and duration in order to meet all of her needs. N.F.'s PE recommends specialized services to address the following needs: self-monitoring of nutritional support; self-monitoring and coordinating of medical treatments; self-help with activities of daily living; sensorimotor development; social development; functional learning skills; expressing interests and making independent decisions; independent living skills; vocational development; and speech and language. However, service coordination is the only specialized service recommended.

N.F.'s current ISP is unclear regarding her receipt of nursing facility specialized services because although the plan stated that NF "began [receiving] PT/OT/ST five days a week" to help NF improve her balance and strength, resume ambulation, improve her independence in activities of daily living, and improve her cognition and ability to swallow," it also states, that N.F. is receiving, "No specialized services at this time." A review of N.F.'s nursing facility records revealed that N.F. received some therapy services for intermittent periods of time, over the past several years. However, N.F. was not receiving PASRR habilitative therapy services at the time of my visit. According to the nursing facility record, in the past when N.F. received PT, OT, and/or ST it was billed through her own insurance plan not through PASRR. This has resulted in the provision of rehabilitative therapies that start and stop depending upon reimbursement versus habilitative therapies that are provided to build upon NF's strengths and mitigate, if not prevent, regression and loss of the abilities and independence in activities of daily living that NF had prior to her admission to the nursing facility.

N.F. is not receiving needed LIDDA specialized services. Reportedly, N.F. receives one hour per week of Independent Living Skills Training. There was no evidence that the delivery of one hour of specialized services per week has been effective in helping N.F. achieve her desired goal of more independence with daily living skills and the pursuit of community living. In fact, it was reported by N.F.'s Service Coordinator, that N.F. mistook the ILST staff for the nursing facility's housekeeping staff and did not even recognize the ILST as a person-centered support and services that was there to help her meet her needs. N.F. receives no additional LIDDA specialized services, except for service coordination.

N.F. is not receiving active treatment because she is not receiving a continuous program that includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services to prevent or decelerate N.F.'s regression and loss of current optimal functional status.

As referenced above, N.F. has well documented behavioral health challenges and needs. When this reviewer asked N.F.'s Service Coordinator if N.F. had behavior support services and specifically trained staff members who were knowledgeable of and following an individualized Behavior Support Plan to help meet N.F.'s behavior support needs and reduce her need for multiple psychotropic medications,

the answer was "No." According to N.F.'s Service Coordinator, the nursing facility has its own psychiatrist, but N.F. does not have a behavior plan, nor does she receive behavior support services in accordance with a plan that meets her needs.

N.F. does not have a professionally appropriate ISP that was developed on the basis of a comprehensive, person-centered assessment and included all needed services and supports, including those needed to successfully transition to the community. Rather, N.F.'s current annual ISP and quarterly updates consist of primarily general and vague statements that fail to accurately portray N.F. and her specific strengths and needs, and her goals and objectives were not specific, measurable, or individualized, and lacked sufficient interventions in order to attain. For example, N.F.'s ISP references two outcomes: 1) N.F. will determine her daily schedule, which includes activities, and 2) N.F. will maintain regular contact with her family. The role of N.F.'s Service Coordinator was to "encourage" N.F. to participate in activities, and "encourage" N.F.'s contact with her family.

Reportedly, according to N.F's sister, for months, N.F. has been crying and begging nursing facility staff to take her to see her family home, which was where she lived for many years with her mother, father, and siblings, and to go to visit the cemetery where her family, including her husband and children, are buried. There was no evidence of any steps planned, taken, or otherwise underway to address either of NF's desired and personally-valued goals.

During an interview with N.F. and from my review of her records and talking to nursing facility and LIDDA staff it is clear that N.F. is appropriate for and would benefit from living in an integrated setting with appropriate community services and supports. In my professional experience, individuals with N.F.'s level of need can live successfully in the community.

N.F. has not made an informed choice to stay in the segregated nursing facility. Rather, it appears as though her sister, who is not her legal guardian, made the choice for N.F .to stay in the nursing facility. N.F. reported to this reviewer that she wanted to live in the community again so that she could, "Get my life going again," "Visit my friends," "Go to church," and "See my momma's people." The service coordinator's notes reflect N.F.'s frequent expression of her desire to move to the community. In fact, in 2016, during N.F.'s ISP process, it was specifically referenced in Section 2 of N.F.'s Transition Plan that N.F.'s Service Coordinator, "Will send N.F. a provider list and request an HCS slot," and the nursing facility social worker "Will assist in search for a provider." However, within a few months of these plans, it was noted that during a CLO, "N.F. knows she could live elsewhere if she wants to, but after talking to her sister, she wants to stay at the nursing facility." Although N.F. was offered an HCS waiver slot twice in the past and has declined those slots, there was no evidence that there were sufficient follow-up steps to ensure that N.F. could take advantage of those slots by addressing all the barriers to her placement. For example, there is no evidence that N.F. was offered meaningful individualized alternatives to the nursing facility or even opportunities to visit community programs or to hear from individuals who successfully transitioned from nursing facilities to community living homes. She also does not appear to have any opportunities to participate in community activities, and she is not receiving any LIDDA specialized services in the community. Such activities would likely help reduce barriers to N.F.'s transition and alleviate some of N.F.'s sister's worry and concern that N.F.'s behavioral needs could not be met in the community.

A. P.

A.P. is a 40-year-old woman with a developmental disability who was admitted to a nursing facility in August 2015 on an expedited admission for convalescent care after hospitalization for treatment of urosepsis. A.P. has diagnoses of sacral spina bifida without hydrocephalus, stage IV pressure ulcer of her ischium, pressure ulcer of her left hip, dermatophytosis, iron deficiency anemia, urine retention, muscle wasting and atrophy, major depressive disorder, and chronic pain. A.P. is her own legal guardian. A.P. is very well spoken and forthcoming about her life. A.P. attended high school and some college, where she was enrolled in information technology courses. A.P. has a son, who is almost 13, and he is the most important thing in her life. A.P. calls her son once a day, which is the highlight of her day. Prior to A.P.'s hospitalization and admission to the nursing facility, A.P. lived in another nursing facility, and prior to that placement, she lived in an apartment with her son and her sister. According to A.P., it was hard on her sister to help with A.P.'s care and to also help her with her son while caring for her own children.

There is no evidence in either A.P.'s nursing facility or LIDDA records that indicates that she received a comprehensive functional assessment that accurately identified all of her strengths and needs. Nonetheless, a review of NF's nursing facility records and an interview with the nursing facility's Director of Rehabilitation revealed a number of concerning findings. Over the past year, A.P. fell numerous times. During one of these falls, which occurred while a nursing facility staff member was transferring A.P. from her bed to her wheelchair, she fractured her right hip. A.P.'s orthopedist recommended that she receive surgical repair of her hip, but A.P. refused to provide consent for the surgery. A.P. also developed blisters on her lower back, buttock, hip and thighs, and she suffered with chronic pain and periods of depression. Notwithstanding these significant, negative events and outcomes, there was no evidence in AP's records that she received an updated comprehensive functional assessment so that each of A.P.'s habilitative needs would be identified and addressed with planned interventions to meet A.P.'s needs, build upon her remaining strengths, and prevent further regression and negative events.

A.P. is not receiving all necessary specialized services with the appropriate intensity, frequency, and duration in order to meet her needs. A.P.'s wheelchair was broken for almost a year, and during that time, A.P. was placed in a geri-chair, which prevented her from being able to independently ambulate. According to A.P., she was extremely frustrated and cried every day that she had to use the geri-chair. Although A.P. received her repaired wheelchair a couple of weeks prior to the review, the manual wheelchair's wheels were still broken, and it still did not properly accommodate A.P.'s size. Thus, A.P. wore a waist restraint to keep her from falling out of her wheelchair. As of my review, her wheelchair continued to be in disrepair and failed to properly and safely meet her needs.

A review of A.P.'s nursing facility records revealed that A.P. received some rehabilitative therapy services for brief and intermittent periods of time, but no PASRR nursing facility habilitative services. As of the time of my review, A.P.'s current nursing facility Care Plan indicated that she would receive physical and occupational therapy services for 90 days with a rehabilitation goal of being able to safely transfer into her sister's car. But, the nursing facility Director of Rehabilitation stated that neither she (the physical therapist) nor the occupational therapist were going to touch A.P. because of her untreated fractured hip. Thus, it is unclear whether or not A.P will ever be able to safely transfer into her sister's car, which would severely limit, if not eliminate, her ability to visit with her son and family at her sister's home and participate in community outings and events.

A.P. does not receive any LIDDA specialized PASRR services, except for Service Coordination. Although A.P. would be a good candidate to participate in a day habilitation program or supported employment,

given her level of functioning, she was not receiving either of those services and they had not been recommended for her. A.P.'s quarterly SPTs repeatedly indicated that A.P. needed cancer prevention and detection screening tests, but, as of the review, there was no evidence that these important tests/examinations had occurred.

A.P. is not receiving a continuous active treatment program that includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services to prevent or decelerate A.P.'s regression and loss of current optimal functional status. A.P. spends most of her days playing games on her Kindle inside the nursing facility sitting in her wheelchair or lying in bed. A.P. goes outside usually only for her cigarette breaks. A.P. reported that in the past her sister frequently picked her up by car and they would go back to her sister's apartment, shopping, or to restaurants, but since A.P. fractured her hip it has become too painful to transfer to her sister's car, and the nursing facility does not have reliable transportation that can accommodate A.P.'s wheelchair. Although the nursing facility has a van to transport the residents, it was broken at the time of our visit.

A.P. does not have a professionally appropriate ISP that was developed on the basis of a comprehensive, person-centered assessment and included all needed services and supports to successfully transition to the community. Rather, A.P.'s current annual ISP and quarterly updates consist of primarily general and vague statements that fail to accurately portray A.P. and her specific strengths and needs, and her goals and objectives, which were not specific, measurable, or individualized, and lacked sufficient interventions in order to attain. For example, A.P.'s ISP referenced the outcome: A.P. will continue to work on upper body strength for transferring. Yet, it is unclear how A.P. can "work on" strengthening her upper body because she is not receiving nursing facility specialized habilitative services, and because A.P.'s hip fracture has significant affected her ability to transfer. But, there is no reference in A.P.'s ISP as to how this significant change in functioning is, or will be, evaluated and addressed. This was unfortunate for A.P. who stated to this reviewer that she would enjoy going out of the nursing facility, especially to a casino, with her best friend, but she could not go because she would not be able to tolerate the pain of riding in a vehicle that did not accommodate her wheelchair. A.P.'s ISP also does not address A.P.'s potential barriers to community living, such as her concerns about and the availability of transportation.

During an interview with A.P. it was clear that she was appropriate for and would benefit from living in an integrated setting with appropriate community services and supports.

A.P. was offered and declined an HCS waiver slot in 2016, and it appears that A.P. made a choice to remain in the nursing facility. But, the CLO process is insufficient. There was no evidence that A.P. has been afforded opportunities to talk to peers with similar conditions who have successfully and safely transitioned community living. And, there is no evidence that A.P. had an opportunity to visit any appropriate community programs, especially options that might bring her closer to her sister and her son. That being said, A.P. repeatedly stated that she did not want to leave the nursing facility. In A.P.'s words, she said, "I'm over wanting to live a different life. I don't like to go places because it's too hard on my body to travel in a vehicle that does not accommodate my wheelchair." It was unclear to this reviewer if A.P. truly did not want to leave the nursing facility or if, over the past year, her falls, fracture, and chronic pain, had worn her down and left her without hope for a different, if not better, quality of life.

L.D.

L.D. is a 70-year-old man who has resided at a nursing facility in Cedar Park, Texas since May 2012. L.D. is his own legally authorized representative and has a sister who lives in a nearby town. He is an avid Dallas Cowboys fan, attends church weekly on-site at the nursing facility, and is quite proud to have quit smoking. His Service Coordinator said that he is very social, participates in all nursing facility activities, and is a member of the nursing facility's Resident Council. L.D. is not offered the opportunity to leave the nursing facility for activities.

L.D. was admitted to the nursing facility for convalescent care after suffering a stroke that required hospitalization. Prior to L.D.'s hospitalization, he lived in a group home with several other men where he functioned independently across most aspects of his activities of daily living and participated in home-based chores, such as laundry, assisting with meal preparations, and shopping. In addition, L.D. attended a day program where he participated in workshop activities and community activities, such as bowling, writing, and arts and crafts.

According to L.D.'s sister, because of his increased care needs L.D. was unable to return to his group home and no residential community settings were presented as options. Absent other options, L.D. ended up at the nursing facility, and, according to LD and his sister, it was unclear to either of them at the time of L.D.'s admission that L.D. would live at the nursing facility for "such a long time," as L.D. stated numerous times to this reviewer during the visit.

L.D. has not received a comprehensive functional assessment that accurately identified all of his strengths and needs. Although L.D. received various nursing facility assessments throughout his stay they were conducted over a period of several years and do not present a comprehensive picture of L.D.'s strengths and needs. Also, although several of L.D.'s nursing facility assessments indicated a significant decline had occurred in L.D.'s mobility, speech, continence, and independence in activities of daily living, he did not receive a comprehensive re-assessment.

L.D. is not receiving all of the LIDDA and nursing facility specialized services that he needs, even though he could benefit from and needs additional services to maximize functioning and avoid deterioration. L.D.'s LIDDA records stated that his intermittent receipt of OT, PT, and ST services were stopped almost a year ago because he was not tolerating therapy well; however therapy notes indicate that he was tolerating therapy well and was discharged for reaching maximum potential. There were no explanations for this apparent discrepancy in L.D.'s LIDDA record, nor were there explanations for why L.D. was not tolerating his therapy. There was no evidence that a plan was developed to address and resolve the barrier(s) to L.D.'s tolerance of the therapy services, which L.D. clearly needs in order to prevent additional regression and loss of functioning.

In addition, L.D. and his Service Coordinator reported that L.D.'s customized manual wheelchair (CMWC) had been broken for many months. L.D. was relegated to a manual facility wheelchair that was not customized and failed to properly support his size and his left-sided hemiplegia causing buttocks pain that L.D. mentioned multiple times during our conversation. Of note, the day before this reviewer's visit to L.D.'s nursing facility, it was reported that L.D. had a fall while trying to reposition himself in his wheelchair. L.D'.s service coordinator had no knowledge of when his CMWC would be repaired and returned to L.D. The Director of Rehabilitation reported that L.D.'s CMWC was never sent out for repair. Rather, it simply went missing, and there was no plan to replace it.

In addition, L.D. received no behavior assessment or behavior support plan to address his reported behavior challenges and needs. Rather, L.D.'s nursing facility record indicated that LD's anxiety, agitation, and problems with impulse control were managed with potent psychotropic medication.

L.D. is receiving ILST; however the provider was coming into the nursing facility rather than bringing L.D. into the community due to transportation issues. L.D.'s service coordinator reported that this service generally involved an individual visiting L.D. in the nursing facility and bringing him food. LD's Service Coordinator's 2/17/16 report noted that L.D. was provided with regular opportunities to participate in community outings and events. However, other record notes and reports from 2016, as well as L.D.'s own reporting, clearly contradict that report and indicate that L.D. has not left, and apparently never leaves, the nursing facility to attend or participate in community events.

Of note, L.D.'s 2017 LIDDA records affirmed that L.D. is not receiving community based services and supports, which was a curious statement given that the same LIDDA records put forward a goal and outcome for L.D. to go on outings to community stores and restaurants.

L.D. is not receiving a continuous active treatment program that included aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services to prevent or decelerate L.D.'s regression and loss of current optimal functional status. As noted above he is not receiving the recommended specialized occupational, physical, and speech therapy services, which would help limit his physical pain and the worsening of his contractures. Although he previously lived in the community, he has minimal interaction with the community and is not provided opportunities to gain skills to overcome barriers to community activities. Nor does LD have opportunities to develop new skills or to maximize his independence.

L.D. does not have a professionally appropriate ISP that was developed based on a comprehensive, person-centered assessment and included all needed services and supports to successfully transition to the community. Rather, LD's current annual ISP and quarterly updates consist primarily of general and vague statements that fail to accurately portray L.D. and his specific strengths and needs. The goals and objectives listed in LD's ISP were not specific, measurable, or individualized, and the interventions provided to attain them were insufficient. For example, L.D.'s ISP stated that his "strengths" were that he was "quite mobile" in his wheelchair, although his wheelchair was broken and he "plays Bingo well," however it was unclear how this "strength" was measured. L.D.'s ISP also fails to specifically identify what others needed to know and do to support him.

Moreover, L.D.'s ISP does not include the interventions necessary to help him transition to the community. Section 9, Phase II of L.D.'s ISP is not completed; therefore there is no individualized description of what the community might look like for L.D. Quarter after quarter, L.D.'s ISP reiterates the same goals and objectives with the same interventions despite L.D.'s failure to make progress toward the achievement of his goals/objectives.

L.D. is appropriate for and would benefit from living in an integrated setting with appropriate community services and supports, which would provide him with an improved quality of life. In my professional experience, L.D. does not need to remain in the nursing facility. Individuals with L.D.'s level of need can successfully live in the community, and L.D. would likely have more opportunities for integration in a community setting. L.D.'s service coordinator agrees, "[LD] would benefit from the community and would be easy to place."

L.D. has not made an informed choice to remain in a segregated nursing facility. During L.D.'s Service Coordinator's Community Living Options reviews with L.D., he reportedly responds, "I'm alright," when asked if he would like to leave the nursing facility. There is no indication that the presentation of materials during the CLO was individualized to accommodate L.D.'s communication style and cognitive disability. Although L.D.'s service coordinator reported that there is a video about community options, she had not shown it to L.D. or his sister.

Moreover, barriers to L.D.'s transition have not been addressed. He has not had the opportunity to meet with a peer who successfully transitioned from a nursing facility or to visit group home because the LIDDA does not provide transportation. L.D. does not know why he is in the nursing facility and expressed a desire to get out of the nursing facility to visit his sister, eat steak, attend sporting events, and visit community living options.

When L.D.'s sister was asked where she thought her brother would like to live, she replied that although her brother might be happier in a community home-like setting, she was concerned that he might not be safe in a community setting. There is no evidence that her concerns about safety in the community had been addressed in any meaningful way.

L.D. reported to this reviewer that he did not know why he was at the nursing home, except for, "[My sister] brought me here." When L.D. was asked if he would enjoy going outside of the nursing home to a sporting event, L.D. said, "Yes." When L.D .was asked if would like to live in a home, if he would like to live with other people, even if that meant that he was not closer to his sister, he replied "Yes" and "Yes." When L.D. was asked if he would tell his Service Coordinator what he told this reviewer, he said, "Yes." When L.D. was asked why he wanted to move, he replied, "Because been here a long time (sic)."

R. W.

R.W. is a 67-year-old man who was admitted to a Liberty, TX nursing facility in 2012. Prior to R.W.'s admission, he lived with, and was cared for by, his mother who passed away in 2008. From 2008 to 2012, R.W. lived with family members, but primarily with his sister. According to R.W.'s most recent PE dated 10/21/13, he has diagnoses that include severe intellectual disability, schizophrenia, psychosis, hypertension, and vision impairment. R.W. is his own legal guardian.

When this reviewer met R.W., it was shortly after lunch, and he was lying in bed. R.W. was very sleepy, and his statements to this reviewer, as well as his responses to questions, were difficult to hear and understand. R.W.'s lethargy was likely associated with the sedating side effects of the multiple psychotropic medications he was administered on a daily basis. R.W. spends most of his days inside the nursing facility sitting in his wheelchair or lying in bed. R.W. does not leave the nursing facility to attend community events or activities except for one day a week when he attends day habilitation. Although R.W. reported to this reviewer that he would like to go to church in the community, this has not occurred due to problems with transportation. R.W. attends some of the nursing facility's celebrations of residents' birthdays, occasional activities such as bowling, and church service on site at the nursing facility.

R.W. does not have a comprehensive functional assessment of all habilitative areas that accurately identified all of his strengths and needs. Also, several of R.W.'s nursing facility progress reports and summaries indicate that, since R.W.'s admission to the nursing facility, he has suffered gradual decline, developed incontinence, needed verbal and physical assistance with all care, and was intensely angry, sad, depressed, nervous, worried, stressed, and anxious. Although during December, R.W. started seeing a counselor, who made specific recommendations to address R.W.'s psychosocial needs, there was no evidence that the recommendations were consistently carried out. For example, R.W.'s counselor recommended that R.W. should make choices and decisions as much as possible with regard to his daily activities. There was no evidence that this recommendation was implemented. Rather, R.W.'s choices and decisions were constrained by the nursing facility and their staff members' daily schedules and at their convenience. Even R.W.'s choice to drink coffee without a thickening agent was not addressed. Rather, R.W.'s choice to drink coffee without thickener was construed by the nursing facility to be a maladaptive behavior that needed to stop.

R.W. is not receiving all necessary nursing facility and LIDDA specialized services with the appropriate intensity, frequency, and duration in order to meet his needs. At the time of RW's PE, he was recommended to receive "All" specialized PASRR services, however, the only specialized service specifically checked by the local authority on R.W.'s PE was "Service Coordination." The section of R.W.'s PE that referenced nursing facility specialized service recommendations was blank.

At R.W.'s December 7, 2016 IDT meeting, it was recommended that R.W. receive OT, PT and ST specialized services but as of my visit, R.W. was not receiving those needed nursing facility specialized services and there was no evidence that he had received them. According to R.W.'s Service Coordinator, R.W. had a manual wheelchair for mobility, and he was not regularly participating in OT, PT, or ST. According to R.W.'s nursing facility records, R.W. fell out of his wheelchair more than once, but there was no evidence that his IDT or SPT considered whether or not R.W. would benefit from the PASRR service of a custom manual wheelchair to help reduce his risk of falls and falls with injuries. R.W.'s nursing facility records indicated that R.W. was not receiving PASRR habilitative therapy services. Rather, R.W. periodically received several weeks of skilled OT, PT, and ST services usually in response to

an incident, such as a fall, coughing/choking during a meal, hospitalization, etc. but no ongoing habilitative specialized services to address the documented ongoing risks such as falls and potential for aspiration. Although R.W. is now receiving some LIDDA specialized services, he lived in the nursing facility for years without these services even though his service coordinator acknowledged that he would have benefited from them before. In addition, R.W.'s Service Coordinator's June 2015 assessment noted that R.W. has expressed a desire for more community involvement. Also, R.W.'s June 2015 assessment notes that he would benefit from pre-vocational services, but he doesn't seem to get them or any other supported employment services.

R.W. is not receiving a continuous active treatment program that includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services to prevent or decelerate R.W.'s regression and loss of current optimal functional status. R.W. is not receiving all needed specialized services as described above and did not receive a comprehensive assessment. In addition, the services he does receive such as OT, PT and ST are not provided continuously and consistently and they are not provided to promote independence and to prevent regression.

R.W. has well documented behavioral problems with some of the other male residents, and one male resident in particular, who reportedly calls R.W. names. However, there are no planned interventions to address this problem except for psychotropic medications and counseling, as referenced above. Unfortunately, R.W. has not had any behavioral assessments and behavior support plan to address and resolve these problems via planned interventions. When this reviewer asked R.W.'s Service Coordinator if R.W. had behavior support services and specifically trained staff members who were knowledgeable of and following an individualized Behavior Support Plan to help meet R.W.'s behavior support needs, the answer was "No." According to R.W.'s Service Coordinator, the nursing facility was "…Not on board with PASRR specialized services," and they "…Did not understand the difference between rehabilitation and habilitation".

R.W. does not have a professionally appropriate ISP that was developed on the basis of a comprehensive, person-centered assessment and includes all needed services and supports, including services and supports needed to successfully transition to the community. Rather, R.W.'s current annual ISP and quarterly updates consist of primarily general and vague statements that fail to accurately portray R.W. and his specific strengths and needs, and fail to include meaningful outcomes. Instead, his goals and objectives, which are not specific, measurable, or individualized, lack sufficient interventions in order to attain. For example, R.W.'s annual ISP repeatedly states that his strengths were his laugh, sense of humor, positive outlook, and friendliness. According to all of R.W.'s other records and notes, his actual psychosocial status was quite different from what was repeatedly referenced verbatim in his ISP from one year to the next. In fact, R.W.'s other nursing facility records, notes, assessments, and summaries describe him as hostile, angry, depressed, sad, worried, anxious, and negative. And, his strengths are described as his steadfast willingness to work on developing trust, expressing his feelings, using coping mechanisms, etc. Clearly, R.W.'s ISP was not developed on the basis of a person-centered assessment, and it lacked meaningful outcomes. For example, the ISP's only outcomes for R.W. are vaguely stated goals for daily interactions with others, determining his daily schedule, and participating in an activity 2 to 3 times a week. R.W.'s ISP further stated the action steps for R.W.'s staff to provide "gentle reminders during daily schedule as well as encouraging positive relationship with male residents." It was entirely unclear what, where, when, or how R.W.'s staff members would implement these action steps. R.W.'s ISP also fails to identify and address individualized barriers to transition and Section 9, phases II and III are not completed. The ISP does not

identify plans or actions to help R.W. address any concerns or barriers around transition and does not include strategies to help him make a choice about transition.

Review of R.W.'s records, observations, and interviews with R.W. all indicate that he would be appropriate for community living and may benefit from living in an integrated setting with appropriate community services and supports.

R.W. has not made an informed choice to stay in the segregated nursing facility. During this reviewer's interview with R.W., he was unsure who his Service Coordinator was, but he offered that he would like to leave the nursing facility and go to Clover, where his relatives live. However, his ISP does not reflect his desire to leave the nursing facility or address barriers to his transition to the community. In fact, on 3/15/17, R.W.'s LIDDA record indicated that R.W. "expressed interest in living in a group home. [R.W.]'s SC stated that she would follow up with DC." From that point forward, there were no further references to actions taken to follow-up on R.W.'s interest in moving into a more integrated community setting appropriate to meet his needs. Rather, just the opposite was documented in the CLO conversation from 3/15/17 "[R.W.] does not appear to want a change [in living arrangement] at this time." It was without any explanation whatsoever that R.W. reportedly decided not to move and to remain in the nursing facility. Further, R.W. was not afforded any opportunities to visit any community programs, and he had not met any of his peers who had moved from the nursing home to community living even though reportedly, there are four nursing facility residents who have successfully transitioned from R.W.'s nursing facility to community placements.

R.F.

R.F. is a 64-year-old Hispanic woman who has resided at a nursing facility since January 2016. She speaks Spanish and some English. R.F. is legally blind and is diagnosed with an intellectual disability, dysphagia, diabetes, seizure disorder, and chronic kidney disease that requires dialysis three times a week. R.F. is designated as a legal adult, and she has no guardian. When this reviewer met R.F., she was sitting in the dining room waiting for breakfast to be served. R.F. was alert and engaging. She held this reviewer's hand, showed off her collection of nail polish, and informed this reviewer of her dialysis schedule.

The seating arrangement at the nursing facility was task-oriented and R.F. was seated at a table with other residents who needed assistance. There were no naturally occurring social interactions between staff and residents during breakfast.

Prior to R.F.'s admission to the nursing facility, she lived with her sister and received care from a home health agency. She independently ambulated around her home and, according to her sister, R.F. was "able to do a lot to assist with ADLs [activities of daily living]." Following a hospitalization, R.F. was admitted to the nursing facility with a discharge plan to return to her sister's home within six weeks. Over a year and a half later, R.F. continues to reside at the nursing facility, and no one from the LIDDA who was present during the review was knowledgeable of why R.F. was still living at the nursing facility.

This reviewer spoke to R.F in her room with the help of a Spanish-speaking interpreter. Although R.F. initially indicated that she liked living in the nursing facility and would miss her roommate, she consistently indicated a strong desire to transition to the community. During conversation with R.F., this reviewer asked R.F. if she knew where she was living. R.F. replied, "A nursing home." This reviewer followed up by asking R.F. why she was living at a nursing home. R.F. replied, "My sister brought me here." When this reviewer asked R.F. if she wanted to live someplace else such as a home possibly with other people, she replied, "Yes." When this reviewer asked R.F. if she would move out of the nursing facility to a home in the community, R.F. replied, "Yes." When this reviewer asked R.F. if she wanted to move to a home that was closer to her family, RF replied, "Sí, Gonzales," which is the name of the town where R.F. grew up.

R.F. did not receive a comprehensive functional assessment of all habilitative areas that accurately identified all of her strengths and needs. RF has not received assessments in the areas of sensorimotor development, affective development, speech and language development, cognitive development, social development, adaptive behavior, independent living skills, vocational skills, community participation, and integrated day activities. She had PASRR Level 1 the day before she was admitted to the nursing facility that was positive for IDD and a PE a few days later. She has received OT, PT, and other nursing facility assessments but not as part of a coordinated collaborative effort to present a comprehensive picture of R.F.'s strengths and needs.

Although several of R.F.'s nursing facility progress reports and summaries indicate that since R.F.'s admission to the nursing facility, she was showing signs of depression, including refusing care, such as checks of her blood glucose levels, gaining weight, withdrawing socially, and not participating fully in activities of daily living. Notwithstanding these significant changes, there was no evidence of an assessment of her behavioral health status, needs, strengths, and adaptive behaviors that R.F. could build upon to mitigate the likely sadness and depression over the recent death of her mother. The

single psychiatric diagnostic evaluation filed in R.F.'s records included an assessment with recommended strategies for R.F.'s nursing facility staff, but none for R.F.

R.F. is not receiving nursing facility or LIDDA specialized services with the appropriate intensity, frequency, and duration in order to meet her needs. Despite her need for OT, PT, and ST to improve her functioning and avoid regression, it appears that R.F. is receiving no nursing facility specialized services, and has previously only received these therapies on a time-limited, intermittent basis. During R.F.'s January 2017 annual SPT meeting, R.F.'s Service Coordinator encouraged the nursing facility to place R.F. on PASRR services to help with her habilitation, especially via PT. Instead she was released her from the PT program. When R.F. began to decline, she was re-enrolled in therapy to bring her back to her baseline, but not to gain any habilitative skills. Reports from R.F.'s Service Coordinator, the Director of Rehabilitation, nursing facility records, and LIDDA records conflict. It appeared as though R.F. received some time limited rehabilitative PT, OT, and ST intermittently over the past year. Despite, R.F.'s Service Coordinator's effort, R.F. was discharged from PT, OT, and ST in March 2017. R.F. was picked up again by PT in May 2017, due to her risk of functional decline and generalized muscles weakness, but was discharged again in June 2017.

Predictably, absent ongoing PASRR habilitative nursing facility specialized services, R.F. regressed from being able to walk up to 200 feet on level surfaces with a walker, safely transfer, independently complete some activities of daily living using no assistive devices, and intelligibility of speech, to unclear speech, need for assistance with most activities of daily living, weight gain likely related to fluid retention and immobility, increased difficulty standing and transferring, increased risk of falls, and increased risk of skin breakdown. Also, during an observation at mealtime, R.F. was not provided with her adaptive utensils or plate guard. As of the review, RF's physician ordered PT, OT, and ST to evaluate R.F. and treat her per PASRR specialized services but the evaluations were still pending at the time of review.

R.F. is not receiving LIDDA specialized services, except for service coordination even though she has been recommended for and would benefit from would benefit from ILST. R.F.'s Service Coordinator acknowledged that R.F. would likely benefit from day habilitation and ILST given R.F.'s desire to be involved in activities, her social nature, and the potential for skill development. R.F. did not receive ILST for six months after the initial recommendation and strikingly, RF's ILST recommendation was canceled when RF's mother died. When this reviewer asked the LIDDA staff to explain what the death of R.F.'s mother had to do with R.F.'s receipt of independent living skills training, it was reported to this reviewer that R.F. was enrolled ILST for the sole purpose of transportation to see her mother. And, since her mother died before R.F. was able to visit, R.F. reportedly had no need for independent living skills training.

R.F. is not receiving a continuous active treatment program that includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services to prevent or decelerate R.F.'s regression and loss of current optimal functional status. R.F. spends three days a week at dialysis. On the other days of the week, R.F. spends much of her day sitting in her wheelchair in her room, hallway, dining room, or in the therapy room, that is, wherever nursing facility staff wheel her. When this reviewer asked for a status report on R.F.'s progress toward attaining her nursing facility Care Plan goal to "be able to navigate in familiar surroundings," the nursing facility staff responded with an assertive statement, "We cannot have a visually impaired person navigating around the facility in a wheelchair." R.F. is not receiving any services for the blind. R.F.'s service coordinator was not familiar with any training that was provided to the staff who work with R.F. about

how to care for someone with a vision impairment. Other than for dialysis, R.F. does not leave the nursing facility or interact with people outside the nursing facility.

R.F. does not have a professionally appropriate ISP that was developed on the basis of a comprehensive, person-centered assessment and includes all needed services and supports to successfully transition to the community. Rather, R.F.'s current annual ISP and quarterly updates consist of vague statements that fail to accurately portray R.F., her specific strengths, needs, goals, and objectives. Those listed are not specific, measurable, or individualized, and lacked interventions for attainment. For example, R.F.'s ISP outcomes are to stay healthy and not in pain and to participate in favorite activities such as Bingo, music, and singing. The single outcome that is individualized "I want to visit my mother," was not achieved before her mother's death and had been discontinued. The section for R.F.'s needs, requests, considerations, which are necessary for staff to know when supporting her to achieve her outcomes, are blank.

It is clear that R.F. would benefit from living in an integrated setting with appropriate community services and supports, which would provide her with a quality of life that would be similar to what she enjoyed prior to her hospitalization and transfer to the nursing facility. In fact, upon admission to the nursing facility and for several months after admission, it was the plan for R.F. to return to her sister's home with supports and services to meet her needs.

Nonetheless, after several months stay at the nursing facility, it was noted by R.F.'s Service Coordinator that she reportedly "decided" and "requested" to remain in the nursing facility and not move back in with her sister. There was no indication that the Service Coordinator conducted an individualized assessment of what R.F. would need to live in the community or identify and address barriers to community living including her recorded concerns about the ability community providers to ensure her health and safety.

R.F. has not made an informed choice to live in the segregated nursing facility and has repeatedly expressed a desire to return to the community. R.F. is isolated in the nursing facility and without opportunities to participate in community activities or gain functional skills. Although R.F. has indicated a desire to transition to the community and was offered a waiver slot, her CLO consistently indicates that she wishes to remain in the nursing facility, Section 9 of her ISP is blank, and there is no description of community alternatives or an adequate discussion of barriers. A CLO from 2017 states that R.F. "is hesitant to leave NF and is apprehensive about the ability of a provider to ensure her health and safety" yet no specific actions were taken to address this concern. While CLO's occurred at mandated intervals, the information provided was not tailored to her cognitive abilities, she was provided no individualized explanation of her options, and not afforded any opportunities to visit community living options. R.F. was handed brochures that she could not see or read. Her sister was provided with a list of HCS providers to begin contacting on her own. While there were some concerns about her sister's ability to provide adequate care, there was no indication of any effort to address those concerns or explore other community options. As noted above, during this review R.F. indicated a preference to live with, or closer to, her sister.

The record indicates that R.F. declined the waiver slot because she "changed her mind and said she would rather stay at the NF than go live with her sister." Neither R.F. nor her sister were offered an individualized plan of the supports and services that could support her in her sister's home, no other community options were explored, Section 9 phase II of her ISP was left blank, her goal was not changed to "transition to the community", and individualized options were not identified and presented.

O.L.

O.L. is a 69-year-old woman diagnosed with an affective disorder, major depression, dementia, and obesity who resides at a nursing facility in Austin, TX. She was admitted to the facility in June 2015. O.L. was sitting in the dining room when this reviewer arrived. She was conversant, polite, and responded to this reviewer's questions with stories from her life. O.L. permitted and escorted me to see her semi private room: the furniture was rusty, paint was peeling off the walls, the sink did not drain, and she had virtually no personal possessions. O.L.'s only clothes were items left behind by residents who had passed away. O.L. spends her days sitting in the dining room or pacing up and down the hallways occasionally speaking to a resident or two. O.L. clearly expressed her preferences, and she stated, "I don't like it [here] because you can't go nowhere."

All nursing facility records and O.L. indicate that she was admitted to the nursing facility from her son's home in June 2015. At that time, it was noted in O.L.'s records that her son was unable to care for her at his home. Nonetheless, O.L. wanted to leave the nursing facility, and she was expecting to return to the community. There was no indication that an alternative placement in the community was offered at the time of O.L.'s admission to the nursing facility and she did not receive information regarding the services and support alternatives to the nursing facility admission. The PASRR evaluation also noted that placement in a nursing facility was not appropriate at that time. Because of her desire to leave, O.L. was considered an elopement risk. In addition, O.L. frequently wandered in and out of other residents' rooms. As a result of her behaviors, she was transferred to the Generations Unit, which is a locked unit. At the time of the review, O.L. was no longer residing on the Generations Unit. However, visitors and residents must pass through multiple locked doors to enter and leave the nursing facility.

O.L. is designated as a legal adult, but her son provided consent for O.L.'s placement on the locked Generations Unit, psychotropic medications, and other treatments. Two years later, O.L. remains at the nursing facility with no planned interventions for transition to a more integrated setting appropriate to meet her needs.

O.L. no longer had the eyeglasses or dentures that she was admitted with. The location of these items was unknown. O.L. was prescribed new eyeglasses on 5/9/17 and they were reportedly "dispensed" by the nursing facility social worker on 6/9/17, but, as of the review, O.L. did not have any eyeglasses to help correct her multiple vision problems.

O.L. has not received a comprehensive functional assessment. There was also no indication that O.L. received evaluations by OT, PT, ST, psychology, or psychiatry within the first month of her admission. She has not received assessments of her social development, cognitive development, adaptive behaviors, and independent living skills. She has received various nursing assessments throughout her stay but they were not part of a coordinated effort and do present a comprehensive picture of O.L.'s strengths, needs, and preferences.

O.L.'s records are incomplete and contain many omissions and contradictions. O.L.'s initial June 2015 PASRR Level 1 Screen and June 2015 PASRR Evaluation indicated that she had an intellectual disability and mental health problems. O.L. reportedly refused mental health services saying, "I don't want anything, and I don't need anything." A note from August 2015, indicates O.L. was "found not to have an IDD diagnosis, but has an MI diagnosis and can benefit from other MH services." There was no evidence in the record that a PASRR Evaluation was conducted in which O.L. was determined not to have an intellectual or developmental disability. O.L. signed a PASRR refusal form for mental health

services but her record does not include any documentation that she has refused IDD services. In 2016, an Interdisciplinary Team meeting (IDT) was held and O.L. again refused mental health services . In April 2017, another IDT was held, and O.L. was no longer refusing MH PASRR services. In April 2017, at a PASRR IDT, the LIDDA planned to provide O.L. with ILST and case management. But, in May 2017, there was a note in O.L.'s records that stated, "Individual is inappropriate for PASRR due to impaired cognitive abilities." This statement was concerning given that PASRR specialized services are indeed for persons who have impaired cognitive functioning and are specifically designed to help them attain improved functioning and/or decelerate regression and loss of functioning.

O.L. is not receiving nursing facility specialized services and LIDDA specialized services in accordance with her needs, even though she could benefit from these services to maximize functioning and avoid deterioration. O.L.'s PASRR Evaluation dated June 2015 recommended LIDDA specialized services of alternative placement services, service coordination, and determination of intellectual disability. No nursing facility specialized services were recommended. Although O.L. was placed on a locked unit due to concerns related to her behaviors, she did not receive behavior supports. O.L. suffers from pain in her knees, but she was not receiving PT. She enjoys self-selected social interactions and may benefit from ILST, as recommended in her IDT meeting, and Day Habilitation. She has not been offered either.

O.L.'s diet was downgraded from regular textured food to pureed because she eats too fast and was at increased risk of choking and aspiration. There are no behavior support services provided to help address O.L.'s mealtime behavior problems prior to or in conjunction with the severe downgrade the texture of her diet. After two years without any necessary specialized services O.L. began receiving time limited OT and ST at the end of August.

O.L. is not receiving a program of continuous active treatment of services, consistently implemented across settings. As noted above, O.L. is not receiving habilitative therapies, not afforded the opportunity to acquire skills to increase self-determination, and offered no services to increase community exposure.

Although requested, there is no evidence of an ISP in O.L.'s record. Because there is no ISP in the record, there is no indication that there is an individualized plan that was developed to identify the services and supports that O.L. would need to transition to the community, or that there is any plan for O.L. to move out of the nursing facility. There is no indication that O.L.'s strengths, needs, and preferences have been assessed in order to determine the services that she would need in the community.

O.L. would benefit from living in an integrated setting with appropriate community services and supports. In the past when O.L. lived in the community, she cooked meals, such as fried chicken and steak, for herself and her friends. O.L. was able to go where she wanted to go via bus because the bus stop was right in front of the door to her home. When asked about her life in the nursing facility, OL stated that she "Don't like it here." O.L. also stated that she "Can't go nowhere," "Can't go outside," but she "Just don't say nothing," "I just do what I got to do to get along with them," "There's nothing else to do." When this reviewer asked O.L. if she knew where she was, she replied, "I'm in a terrible place. My son and wife had no room for me." The segregation and lack of services in the nursing facility have likely contributed to her loss of skills and independence.

O.L. has not made an informed choice to stay at the segregated nursing facility. During my conversation with O.L., she indicated her strong desire to leave the nursing facility saying, "I would do it right away: quick, fast, in a hurry." Despite her 2015 PASRR Evaluation indicating that O.L. would like to leave the

nursing facility and that her needs can be met in the community, she has not received any information about alternate placement. No community options have been considered or presented to O.L., and she has had no opportunity to visit community living locations. Rather, O.L. lives in a segregated nursing facility and kept behind multiple locked doors and without the quality of life she once enjoyed.

L. G.

L.G. is a 64-year-old man who has been living in a nursing facility near Houston since at least 2015. While some of his records state that he has been in the nursing facility for more than 8 years, others state that he was admitted in 2015. L.G .has diagnoses that include cerebral palsy, hemiplegia due to a cerebral infarct, hypertension, hepatitis C, chronic obstructive pulmonary disease, Parkinson's disease, schizophrenia, major depressive disorder, and anxiety disorder. L.G. is his own legal guardian. According to L.G., his doctor at the psychiatric facility sent him to the nursing facility, and although he reported that he "liked it at first," currently, he reported that the situation "Is not good." This reviewer asked L.G. if, when he was admitted to the nursing facility, an estimated length of stay was discussed with him. L.G. said that it was not ever discussed and he had no idea how long he was going to stay.

Prior to L.G.'s admission, he lived with his sister. L.G. also talked about many different life experiences that he had prior to living with his sister. For example, LG obtained his GED; he was a laborer; he spent some time in the army; he attempted to rob a pawnshop, was arrested, and imprisoned; and he was also homeless.

When this reviewer met L.G., he was sitting in his wheelchair in the hallway of the nursing facility. L.G. was eager to talk to me about his life before admission to the nursing facility, life at the nursing facility, and his hopes for his future, which included moving out of the nursing facility. Several months prior to the review, L.G. went on occasional community outings with his ILST staff member, however, since this staff member's resignation, L.G. spends his days inside the nursing facility sitting in his wheelchair and reading. L.G. does not leave the nursing facility to attend community events or activities.

L.G. did not receive a comprehensive functional assessment that accurately identified all of his strengths and needs. There were no assessments in the records for independent living or vocational skills. Also, several of L.G.'s nursing facility progress reports and summaries indicated that, over the past two years, L.G. had suffered gradual decline in his abilities to carry out his activities of daily living and he was no longer able to ambulate and transfer without extensive assistance. However, there were no updated assessments for L.G. in light of his changed abilities. In addition, although L.G. attempted suicide in April 2017 and was briefly admitted to an inpatient psychiatric hospital and his psychiatrist noted L.G.'s refusals of care, decreased appetite, and social withdrawal, L.G.'s April 2017 ISP incorrectly indicate that he had no mental health behavior problems that impacted upon his physical and psychosocial functioning. Curiously, L.G.'s social services assessment status after his suicide attempt noted that L.G. "[h]as been in good mood," and the only intervention recommended by the social worker to help address L.G.'s psychosocial needs, status, and functioning was, "L.G. will come to the social worker if he has any problems."

At the time of L.G.'s most current PE, which was done on 6/22/16, he was recommended to receive specialized services to develop self-monitoring of his nutrition, coordination of his medical treatment, and self help with his activities of daily living. The section of L.G.'s PE that referenced nursing facility specialized service recommendations indicated that he was to receive specialized OT. However, at the time of my visit, L.G. was not receiving nursing facility specialized PASRR services with the appropriate intensity, frequency, and duration in order to meet his needs. L.G. had a manual wheelchair for mobility that caused him pain when sitting and was a factor related to L.G.'s recent fall out of his wheelchair. L.G. was supposed to have a wedge cushion on the seat of his wheelchair to help promote an anatomically correct position and improve sitting balance and comfort when L.G. sat in his wheelchair. However, L.G. did not have the wedge cushion. Upon follow-up with the nursing facility Director of

Rehabilitation, it was revealed that the Director does not have access to the PASRR website that is needed in order to obtain authorization to provide PASRR habilitative services and durable medical equipment for residents eligible, and recommended, for PASRR services. L.G. would benefit from habilitative occupational therapy to address the contractures in his right hand and leg. According to L.G., and his record confirmed, at one point he was enrolled in eight weeks of OT. L.G. stated that he "likes it when he can get it." L.G. also reported that he was receiving ST, but it "doesn't help me at all." It appeared that the OT, ST, and PT were time-limited rehabilative therapies. For example, despite numerous requests for therapies, the records reflect that LG only received ST sporadically for four weeks in June and July 2017, and received PT once in May 2016, once in October 2016, and twice in April 2017.

In addition, L.G.'s PE specifically indicated that the LIDDA was to provide him with alternative placement services, ILST, and service coordination. However, L.G. was not receiving alternate placement services via the LIDDA. The LIDDA was, however, providing LG with ILST one day a week. The former ILST staff member took L.G. into the community on outings that included going to the store for vanilla milkshakes, which L.G. reportedly loved to do. According to the current ILST staff member, who was at the facility on the day of the review, she frequently uses flash cards as a method of training but does not take L.G. into the community or to the store for vanilla milkshakes. Instead, the ILST staff member reported that L.G.'s socialization goal is to get him out of his room. During an interview with L.G.'s Service Coordinator, it was reported that the ILST program had been "great" for L.G. and that he loved going and working on his socialization skills. When this reviewer asked the Service Coordinator if she thought that L.G. would benefit from doing more in the ILST program, the Service Coordinator replied, "He might. There's no way to state for sure. We can check next quarter."

L.G. is not receiving a continuous active treatment program that included aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services to prevent or decelerate L.G.'s regression and loss of current optimal functional status. There is no evidence that L.G. received a comprehensive functional assessment and he is not receiving all needed specialized services. Further, L.G. was not receiving services to promote independence and self-determination.

L.G. was attending a few self-selected nursing facility based activities, but since his suicide attempt in April, it was noted during his 4/24/17 SPT that he was not participating in therapies or activities as much as he used to do. When this reviewer asked L.G.'s Service Coordinator if he had behavior support services and specifically trained staff members who were knowledgeable of and following an individualized Behavior Support Plan to help meet L.G.'s behavior support needs, the answer was that L.G. was "seeing a psychologist," but L.G.'s Service Coordinator did not know how often L.G. received psychology services and whether or not the services were meeting L.G.'s needs, except for that L.G. had reportedly had "no behaviors [of attempted suicide] since the prior incident of attempted suicide."

L.G. does not have a professionally appropriate ISP that was developed on the basis of a comprehensive, person-centered assessment and that includes all needed services and supports including those needed for L.G. to successfully transition to the community. Rather, L.G.'s current annual ISP and quarterly updates consist of the same primarily general and vague statements that were referenced in the prior quarterly update and fail to accurately portray L.G.'s current status and his specific strengths and needs. L.G.'s ISP's goals and objectives are also general and vague, lack sufficient interventions needed for L.G. to attain those goals and objectives, and were not revised when progress was made or not. For example, L.G.'s ISP states that he was "doing very well," and "does not currently participate in any therapies" because "he does not wish to do so," which was consistent with his goal of only participating

in activities that he chooses. In my opinion, L.G.'s lack of activities does not demonstrate progress, and is based on the fact that L.G.'s choices of activities were severely constrained by his confinement in the nursing facility. L.G.'s 5/3/17 ISP update states that he has "been getting out more and interacting with other residents; however he has not participated in activities as much." L.G.'s ISP also incorrectly indicates that he loved participating in ILST with Ms. C., even though it was clear that Ms. C. was no longer working with L.G. LG's ISP had no transition goals. Section 9, phases II and III of his ISP are not filled out, and there is no description of what the community would look like for L.G .or strategies to address any barriers to transition.

From the review of L.G.'s records, observations, and interview with L.G., it is clear that he would be appropriate for and benefit from living in an integrated setting with appropriate community services and supports, which would provide him with a quality of life that he desired.

L.G. has not made an informed choice to stay in the segregated nursing facility. He was not provided with alternate placement services by the LIDDA; he was not afforded any opportunity to visit any community living options; and he had not had any opportunity to meet peers who had moved from a nursing home to community living. L.G. reported that he would like to visit a community placement. During this reviewer's interview with L.G., he was unable to remember the name of his Service Coordinator, but he reported that he was sure that he told her that he wanted to move from the nursing facility, but his Service Coordinator had left him hanging. L.G. also stated that he would enjoy attending a day habilitation program. However, according to L.G., day habilitation services had not been offered to him. L.G.'s ISP does not acknowledge his interest in the community and fails to address any barriers to L.G. transitioning to the community. As this reviewer was leaving, L.G. asked, "Will you leave me hanging too?"

R. B.

R.B. is a 68-year-old woman with a developmental disability who was admitted to a nursing facility in the Houston area in July 2012 after she was hospitalized for treatment of a significant change in her health. R.B. has diagnoses that include with cerebral palsy, diabetes, dysphagia, hypertension, seizure disorder, hypothyroidism, glaucoma, dementia, bipolar disorder, schizophrenia, anxiety disorder, cerebral infarction with right side hemiplegia, and a history of breast cancer.

Prior to R.B.'s hospitalization and admission to the nursing facility, R.B. lived in a community group home. R.B.'s son, who is her legal guardian, refused for R.B. to move back to the group home after her hospitalization because he had concerns that the group home could no longer provide the care for her that she needed. Thus, R.B.'s son chose to have R.B. admitted to a nursing home that was close to where he lived, which made it convenient for him to frequently stop by and visit her.

When this reviewer met R.B., it was shortly after breakfast. R.B. was sitting alone at a table. She was holding tightly to her purse and paging through her Bible. This reviewer asked R.B. if it were all right to visit with her for a while. R.B. smiled and nodded. R.B.'s personal hygiene was unkempt. R.B.'s fingernails were long, jagged, and dirty. She was wearing a wig that was not combed or properly positioned on her head. Her clothes were askew and it looked like some of her breakfast had spilled onto her clothes and stained them.

R.B. was pleasant and soft spoken. Although it took her time to process what was being said and formulate her response, this reviewer learned that R.B. liked the group home where she lived prior to her hospitalization. R.B. affirmed that she often sat outside, went out shopping and to church, was well groomed and dressed, and independently accessed public transportation. R.B.'s report stood in stark contrast to her current life in the nursing facility. For example, when R.B. was out of bed, she was confined to a wheelchair; she had no opportunities to leave the nursing facility, except for medical appointments; and she had no belongings in her room except for a doll.

The nursing facility and LIDDA records indicate that R.B. did not receive a comprehensive functional assessment of all habilitative areas that accurately identified all of her strengths and needs. In addition, a professional with qualifications and training on people with intellectual and/or developmental disabilities did not conduct R.B.'s PE until four and one half years after R.B.'s admission to the nursing facility because R.B.'s initial PL1 incorrectly failed to identify that she might have IDD.

During R.B.'s 5 years at the nursing facility, her functional status declined. For example, she was no longer walking, her ability to verbally communicate declined, her blood pressure was not controlled, she developed signs and symptoms of psychotic behavior that resulted in increased number and dosage of psychotropic medications, and she suffered falls, choking, and an episode of rectal bleeding. These significant negative changes failed to prompt a comprehensive functional assessment. Thus, each of R.B.'s habilitative needs was not identified and addressed with planned interventions via a program of specialized services to meet R.B.'s needs, prevent further regression and loss, and increase the likelihood that R.B. would regain at least some of the losses she suffered in her skills, strengths, and abilities.

R.B. is not receiving all nursing facility and specialized services with the intensity, frequency and duration to address all need areas. At the time of my visit, R.B. was not receiving nursing facility specialized services. As noted above, R.B.'s ability to walk and swallow has declined, and her right arm contracture

has worsened. The nursing facility's physical therapist affirmed R.B.'s decline in her ability to ambulate. Further, the speech therapist stated that R.B. should be receiving PASRR specialized services and the ISP indicates that R.B. is to receive specialized services for range of motion, but she does not because the therapist does not know how to bill for it. Although R.B. had a wheelchair, it was purchased by the nursing facility and was missing its headrest and foot pedals. Thus, R.B. frequently slid off the seat of her wheelchair and needed assistance with repositioning. According to R.B.'s son, this sometimes resulted in R.B. having an outburst, which the nursing facility staff members attributed to maladaptive behaviors and not the more likely triggers of her outbursts, which were her fear of falling and the pattern of failure of nursing facility staff members to understand or respond to her calls for help. The Service Coordination Progress notes from May 2, 2017, indicate that the LIDDA Diversion Coordinator offered specialized therapy services and the guardian expressed he would like for R.B. to receive all three nursing facility services. Nevertheless, there is no indication that R.B. ever received OT, PT or ST specialized services. Also the diversion coordinator spoke to the team about durable medical equipment that might be appropriate for R.B. including a customized manual wheelchair and a pressure relief mattress. However, it does not appear that R.B. currently possessed all components of her customized manual wheelchair or pressure relief mattress. R.B. also appears to have received rehabilitative OT services for a short period of time to address activities of daily living, self-care tasks, and feeding, but those OT services also appear to have been time-limited and rehabilitative in nature. The physical therapist reported that R.B. was not receiving PT and that she would likely lose some functioning and after that occurred because the nursing facility did not offer a restorative program for its residents.

Additionally, although a review of R.B.'s nursing facility records revealed that the nursing facility purchased a Touch Talk assistive augmentative communication device to help R.B. improve her ability to communicate, she was not receiving any habilitative ST to assist with the acquisition of skills needed to meaningfully utilize the augmentative communication device. She does appear to have received an intermittent period of ST but those services also appear to have been time-limited and rehabilitative rather than habilitative. A demonstration of the device by the nursing facility's speech therapist revealed that although R.B.'s eyes lit up when she saw the device, but she was unable to use it because it was not properly programmed and she did not know how to turn it on or how to navigate through the various screens and displays on the device.

R.B.'s Service Coordinator also stated that there was usually high tension between the nursing facility and R.B.'s son, which was most often related to who was responsible for what health care services. For example, R.B. was supposed to see an eye specialist because of a lesion on her retina. But, this appointment has been significantly delayed because the nursing facility will transport R.B. to the eye specialist, but will not supervise her offsite or stay with her during the appointment, something that is unacceptable to R.B.'s son. So, according to the Service Coordinator, the nursing facility has taken the position that R.B.'s son must arrange for and take R.B. to the appointment.

R.B. does not receive LIDDA specialized services, except for Service Coordination. R.B.'s Service Coordinator reported that he follows up on R.B.'s son's concerns regarding care at the nursing facility. For example, when R.B.'s Service Coordinator visits R.B., he checks to see if R.B.'s fingernails are dirty, whether or not any of her clothes are missing, etc. When this reviewer discussed other LIDDA specialized services with R.B.'s son, he expressed an interest in an opportunity for his mother to receive ILST by an outside ILST program staff member at the nursing facility. Notwithstanding R.B.'s son's expressed interest in this program for his mother, she was not receiving those services nor was the need for ILST addressed in her ISP. R.B. also does not have a behavior support plan or receive any behavior

services from the LIDDA to help reduce her target behaviors and enable her to engage in a gradual dose reduction of her psychotropic medications.

R.B. is not receiving a continuous active treatment program that included aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services to prevent or decelerate R.B.'s regression and loss of current optimal functional status because there is no CFA that accurately assesses all of her habilitative need areas. In addition, she is not receiving needed nursing facility specialized services including PT, OT and ST.

R.B. does not have a professionally appropriate ISP that was developed on the basis of a comprehensive, person-centered assessment and that includes all needed services and supports including those necessary for R.B. to successfully transition to the community. Rather, R.B.'s current annual ISP and quarterly updates read more like a plan for R.B.'s nursing facility staff members than a person-centered road map for the delivery of R.B.'s supports and services to meet her desired physical and psychosocial health goals and objectives. For example, although one of R.B.'s ISP's preferences was to receive the best care possible, there were no interventions specified to address the fact that she was not receiving dental care, and had not seen an eye specialist since she was diagnosed with a lesion on her retina. There is also no transition plan for R.B. and Section 9, Phases II and III of the ISP are not completed. There is no description of what the community would look like for R.B., and barriers to transition were not identified in the ISP.

From separate interviews with R.B. and R.B.'s Service Coordinator, it is clear that R.B. is appropriate for and may benefit from living in an integrated setting with appropriate community services and supports. In my professional experience, individuals with R.B.'s level of need may live successfully and safely in the community. When R.B.'s Service Coordinator visits R.B., he reported that he usually finds her sitting in a wheelchair by herself with her purse and her Bible. She only attends few select activities in the nursing facility, such as several church services a week. RB does not leave the nursing facility to attend community events or activities. According to the nursing facility Social Services Manager, R.B. would be better off in a group home because she needs the active treatment and specialized services that the nursing facility does not provide.

R.B.'s son has made a choice that R.B. remain in the segregated nursing facility. And, R.B.'s son has declined a waiver slot for R.B. However, R.B.'s son's choice seems to be based on a lack of appropriate available options, a failure by the LIDDA to provide opportunities to view community placements that might meet R.B.'s needs, or talk with peers whose relatives have successfully and safely moved to the community, and he has not been presented with any community living options that offer him reasonable alternatives to the nursing facility that also demonstrate the capacity to provide a safe living environment for his mother.

R.B.'s son reported that R.B. had previously been in a community group home that was "horrible," and he noted his concerns about his mother's safety at length. During this reviewer's interview with R.B.'s son, he stated that he would consider transitioning R.B. to a community living home if he were shown an option that was "great," and would actually be "accountable for doing everything that they say that they will do and providing the services they committed to provide." However, there is no evidence that the CLO process adequately considers or addresses R.B.'s guardian's concerns even though the CLO form notes that R.B.'s son was not pleased with the nursing facility care provided to his mother.

J. A.

J.A. is an 80-year-old woman who was admitted to a nursing facility in Friendswood, TX in December 2013 on an expedited admission for convalescent care after an acute hospitalization. J.A. has diagnoses of intellectual disability, dementia with behavioral disturbance, altered mental status, frontal lobe syndrome, atrial fibrillation, hypertension, schizo-affective disorder, contracture, and muscle wasting and atrophy. J.A. is her own legal guardian.

When this reviewer met J.A., she was lying in bed. J.A. has not been out of bed for three years, except for when she takes a shower on a shower trolley, which she loves. During our conversation, J.A. shared with me that she would like to live in a home, but wondered who would want to live with her; how her home would be paid for and what her sister, Jeanie, would think of the idea adding "I'd love to live in a house if people would cook for me. If Jeanie thinks [moving to the community] is okay, then yes!"

According the nursing facility records, J.A. has not had a comprehensive functional assessment that accurately identifies all of her strengths and needs.

At the time of my review, J.A. was not receiving all necessary nursing facility and LIDDA specialized services with the appropriate intensity, frequency and duration to address all need areas. In fact, J.A. was not receiving any nursing facility or LIDDA specialized services other than service coordination. Although several of J.A.'s nursing facility progress reports and summaries indicated that J.A. suffered from paranoia, delusions, and especially paranoid delusions about the nursing facility kitchen/dietary staff, as well as other mental health problems, J.A. saw a behavior specialist (BCBA) only very briefly during the period of May and September 2016. Yet, despite J.A.'s continued behavior problems and needs, which affected her quality of life on a daily basis, she was not receiving behavior support services nor was there an individualized behavior support plan in place to guide and direct J.A.'s nursing facility staff members' interactions and interventions. In addition, there were no behavior assessments and strategies in place to help reduce J.A.'s time spent in bed, improve her adherence to clinical professionals' recommendations, or to reduce her risk of pressure injury and continued muscle wasting and atrophy.

There is no continuous active treatment program in place for J.A. Rather, records, observations, reports from nursing facility staff and J.A.'s Service Coordinator all affirmed that J.A. does not get out of bed and has not been out of her bed in three years.

Despite J.A.'s lack of progress toward her achievement of most of her ISP goals, her ISPs were verbatim from one year to the next. There is no indication that there are plans or goals for J.A. that are based on her individual needs and desires or relevant professional assessments and that include all services and supports to address her needs. Nor is there any indication that there are any plans to help J.A. transition to the community or to identify and address any barriers to community living. Of note, in May 2016, J.A.'s nursing facility social worker recommended that J.A. receive an alternate placement in a smaller setting because, "The nursing facility is not good for J.A."

In my opinion, J.A. would benefit from living in an integrated setting with appropriate community services and supports. J.A. could be safely and adequately served in the community, and it appears as though continued institutionalization is not necessary for her. Individuals with her level of need may live successfully in the community and her life may be more integrated if she lived in the community.

There is no evidence that J.A. has made an informed choice to stay in the segregated nursing facility. As noted above, during this reviewer's interview with J.A., she simply, yet clearly affirmed that she would like to live in a home with the appropriate community services and supports that would keep her safe. Yet, this has not been identified as part of J.A.'s Community Living Options process. J.A.'s Service Coordinator told me that when she presents the CLO process to J.A., she asks J.A. and her sister whether they want things to "stay the same". J.A. does not appear to have been presented with any opportunities to visit community programs or to meet with other individuals with similar needs who have successfully transitioned from a nursing facility to the community. Further, it appears that there have not been efforts made to address J.A.'s long time both in the institution and in bed or the other potential barriers to her transition to the community.

M.H.

M.H. is a 61-year-old man who resides at a nursing facility in El Paso, TX. M.H. is designated as a legal adult. When this reviewer met MH, he was sitting in his wheelchair in the doorway of his bedroom. M.H. was dressed in a Dallas Cowboys hat, sports pants, and jacket. He frequently mentioned his friend, a nursing facility employee who works in the dish room. M.H. enjoys interacting with visitors from the community and participating in nursing facility activities. M.H. communicated with verbalizations and gestures but this reviewer was unable to understand him. M.H. does not leave the nursing facility for activities and is not encouraged to independently navigate the nursing facility because the nursing facility staff reported that "[M.H.] will try to go into the dining room and there is no supervision there." His fingernails were long and dirty, and he was unshaved. M.H. is diagnosed with Down Syndrome, diabetes, gastroesophageal reflux disorder (GERD), and other medical conditions.

M.H. was admitted to the nursing facility almost two years ago for rehabilitation after hospitalization for a surgical procedure. At that time, his PASRR level I screening noted that he would like to live in a community group home. According to M.H.'s mother, prior to M.H.'s hospitalization, he lived with several other men in a community group home where he was independent across many of his activities of daily living. M.H.'s mother summed up M.H.'s abilities when she stated, "He could take care of his self." M.H.'s mother reported that M.H. could not remain in the group home because it did not have a wheelchair accessible shower or bathroom.

M.H. did not receive a comprehensive functional assessment that accurately identified all of his strengths and needs. In addition, several of MH's current nursing facility assessments filed in M.H.'s nursing facility record indicated a significant decline had occurred in M.H.'s mobility, speech, and independence in activities of daily living since his prior assessments. However, M.H. did not receive appropriate assessments to evaluate these declines or to identify additional services M.H. might need to attain and maintain prior level of functioning or, at least, decelerate loss of functioning.

M.H. is receiving one, but not all necessary, LIDDA specialized services and few if any nursing facility specialized services, even though he could benefit from and needs additional services to maximize functioning and avoid deterioration. M.H. does not receive LIDDA specialized services other than service coordination even though his service coordinator acknowledged that he would benefit from and be appropriate for ILST and a day habilitation program. M.H.'s Service Coordinator reported that the LIDDA's day habilitation program had a waiting list, could not provide transportation to individuals in wheelchairs, and she was not even certain whether or not day habilitation services could be offered to nursing facility residents.

Although M.H. has received intermittent rehabilitative OT and PT, he has not received any habilitative therapies on a long term basis. M.H. would benefit from continuous habilitative PT and OT to maintain his current level of mobility and self care, which has been declining. His recent ISP noted: "Without therapy, patient at risk for falls, increase[d] need for caregiver assistance and decreased need to propel WC [wheelchair] in NF." Although one record suggested that M.H. was receiving PT as a specialized service, his service coordinator was not familiar with this, and the therapist noted that he was only receiving restorative PT and that it has stopped because of his foot surgery. M.H. would likely benefit from ST to increase his ability to communicate with others and convey his preferences. However, as of the date of my review, M.H. had not received a ST assessment. Of note, M.H.'s Service Coordinator was under the false impression that M.H. was not permitted to access PASRR specialized services until he exhausted all other benefits.

M.H. was not receiving a continuous active treatment program that included aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services to prevent or decelerate M.H.'s regression and loss of current optimal functional status. M.H. spends most of his days sitting in his wheelchair in the hallway outside his room. According to the nursing facility staff, and confirmed by M.H.'s LIDDA staff, M.H. will attend activities, such as balloon volleyball and Bingo, which are held inside the nursing facility, when he is invited to attend by the activities staff. But, M.H. does not leave the nursing facility to attend community events or activities.

M.H. does not have a professionally appropriate ISP that was developed on the basis of a comprehensive, person-centered assessment and includes all needed services and supports to successfully transition to the community. Rather, M.H.'s current annual ISP and quarterly updates consist of primarily general and vague statements that fail to accurately portray M.H. and his specific strengths and needs, and his goals and objectives. The few goals listed were not specific, measurable, or individualized, and lacked sufficient interventions. For example, in M.H.'s ISP his stated strengths are that he is a Dallas Cowboys fan, a participant in activities, and he is able to "move around" in his wheelchair.

M.H.'s ISP also fails to specifically identify what others needed to know and to do in order to support him. For example, M.H.'s ISP indicated that to support him others needed to know that he needed supervision for all of his activities of daily living, which was a significant understatement of his need for moderate to maximum assistance across all activities of daily living. M.H.'s ISP was not revised to reflect the significant health challenges he suffered and his resulting increased needs for specialized supports and services since the development of his annual ISP. For example, since the development of M.H.'s annual ISP, he was hospitalized for treatment of a serious bone infection and the partial surgical resection of his right foot. M.H.'s ISP, however, reiterates the same goals and objectives with the same interventions despite M.H.'s failure to make progress toward the achievement of his goals and objectives.

In addition, M.H.'s ISP fails to describe the services and supports needed to successfully transition to the community. Section 9, Phase II, of M.H.'s ISP is not filled out, therefore there is no individualized description of what a community transition plan might look like for M.H., what his life in the community might look like, or how to address barriers to his transition.

From my review of M.H.'s records, observations, and interviews with M.H. and his mother, it is clear that he may benefit from living in an integrated setting with appropriate community services and supports, which would provide him with a quality of life that would be similar to what he enjoyed prior to entering the nursing facility. Nonetheless, M.H.'s mother reported that she does not want him to leave the nursing facility because M.H. is settled and happy at the nursing facility where the staff "spoil him" with Dallas Cowboys paraphernalia. However, when M.H.'s mother was asked whether or not she thought that M.H. would prefer to leave the nursing facility to attend and participate in community activities during the day, she replied without hesitation, "He would love it!" In addition, M.H.'s mother reported that she recalled being told on one occasion that there were places that were day programs where M.H. could go, but no one followed up with her about it.

According to M.H.'s Service Coordinator, who conducted his Community Living Options review, M.H. does not have an understanding of the information presented to him and there have been no attempts to individualize the presentation of the information to reflect M.H.'s unique communication and

cognitive abilities. Although some of M.H.'s LIDDA records note, "He does not have an understanding of what was explained to him," others contradict that report, stating that MH understood what was explained to him, and he nodded "Yes" when he was asked if he liked residing at the nursing facility. On the basis of M.H.'s head nods, M.H.'s Service Coordinator concluded, "He wishes to remain at the nursing facility." There was no evidence in the record that the service coordinator made any attempt to engage in a meaningful conversation with M.H. that focused on his preferences, strengths and interests. During the on-site interview with M.H., his verbalizations were unintelligible. It is my opinion that M.H. has not made an informed choice to remain in a segregated nursing facility. But, M.H.'s mother, who is not his legal guardian, has made a choice for M.H. to stay in the nursing facility.

M.H.'s Service Coordinator acknowledged that it would be helpful to offer M.H. and his mother the opportunity to visit a group home. Additionally, she stated that although she thought M.H. would enjoy visiting community homes, the LIDDA staff do not take clients on visits to community homes or day programs. The LIDDA also noted that their experiences with nursing facilities have revealed that they do not, as a rule, provide transportation for their residents to participate in day programs, visit providers, or community events. There is no indication in M.H.'s ISP that those or other barriers to community living – including his mother's resistance to his move - had been identified and addressed.

S.P.

S.P. is a 72-year-old woman who was admitted to a Houston, TX nursing facility in 2011 from a rehabilitation center where she had been recuperating after a decline in her health status. According to S.P., prior to her stay at the rehabilitation center, she lived in a duplex in the community with her cat and dog, and she received in home services and supports from a home health provider.

S.P. has diagnoses that include cerebral palsy, hypertension, atrial fibrillation, seizure disorder, chronic obstructive pulmonary disease, and anxiety disorder. According to S.P., she was not able to do anything when she was at the former rehabilitation center, but now she is trying to become more mobile and getting stronger. This reviewer asked S.P. if, when she was admitted to the nursing facility, an estimated length of stay was discussed with her. S.P. said that it was not ever discussed and she had no idea how long she was going to stay.

S.P. spends her days inside the nursing facility sitting in her wheelchair. S.P. does not leave the nursing facility to attend community events or activities. In fact, the last time S.P. recalled leaving the nursing facility was when she went to Wal-Mart six months prior to the review. S.P. attends a few self-selected nursing facility-based activities, such as Bingo and storytelling, but typically her day is spent reading or watching football, especially the Houston Texans.

When this reviewer met S.P., she was lying in bed with her oxygen running, but her oxygen tubing and nasal cannula was coiled up underneath her body and of no benefit. S.P. wanted to eat her breakfast of cereal and milk, but she needed help removing the tight cellophane wrap from her cereal bowl. S.P. was eager to talk to us about her life before admission to the nursing facility, her interests in sports, cats, dogs, and nature, life at the nursing facility, and her hopes for her future, which included moving out of the nursing facility.

At the time of S.P.'s 10/22/13 PE, it was clearly documented, "Ms. P. expects to return to the community," but "service coordinator thinks the NF [nursing facility] is the appropriate placement . . . " Over three years later, on 1/26/17, another PE was completed, and it indicated that SP no longer expected to return to the community because "Client's medical needs are currently met at NF [nursing facility]." Of note, S.P. is designated as a legal adult. S.P. is her own legal guardian and decision-maker, and she had not deferred her decision making to her Service Coordinator. S.P.'s current Service Coordinator admitted that she had "little information" on S.P.'s file; and she had not talked to S.P.'s daughter, nor had she spoken to S.P.'s friend, who was also referred to as S.P.'s daughter-in-law, but this was not confirmed. Thus, S.P.'s Service Coordinator did not know why S.P. transferred to the nursing facility, but she did know, and reported to me, that S.P. was "told that she had options and she did not need to stay [at the nursing facility] permanently." Yet S.P. remained in the nursing facility years later despite her original choice and expectation to return to the community.

According to nursing facility and LIDDA records, S.P. did not receive a comprehensive functional assessment that accurately identified all of her strengths and needs. Rather, according to her Service Coordinator, the only assessments she was aware of that S.P. receives are her PEs. Of note, there were some nursing facility assessments filed in S.P.'s record.

S.P. is not receiving all needed specialized services with the appropriate intensity, frequency, and duration in order to meet her needs. S.P. is not receiving any nursing facility specialized services. Despite S.P.'s documented chronic pain and contractures, she does not have a CMWC. Rather, she has a

nursing facility generic manual wheelchair for mobility. According to S.P.'s nursing facility records, she was enrolled in several sessions of OT and PT but these appear to have been rehabilitative or restorative therapy, not habilitative OT or PT. S.P.'s Service Coordinator admitted that she only spends approximately five to ten minutes a month with S.P. and relies upon S.P.'s nursing facility staff to tell her what S.P. needs. However, S.P.'s Service Coordinator also reported that although the nursing facility staff affirms that they are knowledgeable of PASRR and the meaning and importance of habilitative services for residents with ID/DD, they have nonetheless continued enrolling S.P. in their restorative nursing program and "pick her up on therapy services as needed," rather than ensuring that S.P. receives an uninterrupted, continuous program of habilitative services that meets her needs.

S.P. was also not receiving specialized services from her LIDDA, other than Service Coordination. S.P.'s Service Coordinator reported that the LIDDA only recently started working with a day habilitation program in the area that was willing to accept residents from nursing facilities. When this reviewer asked the Service Coordinator if she thought that S.P. would benefit from attending the day habilitation program, the Service Coordinator replied that it is up to S.P. to express if she wants to leave the nursing facility to participate in any community activities.

S.P. is not receiving a continuous active treatment program that includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services to prevent or decelerate SP's regression and loss of current optimal functional status, and meet her habilitative needs to promote her independence and self-determination.

S.P. does not have a professionally appropriate ISP that was developed on the basis of a comprehensive, person-centered assessment and that includes all needed services and supports including those necessary for S.P. to successfully transition to the community. Rather, SP's current annual ISP and quarterly updates consist of the same primarily general and vague statements that were referenced in the prior quarterly updates and fail to accurately portray S.P.'s current status or her specific strengths and needs. S.P.'s ISP's goals and objectives are also general and vague, lacking sufficient interventions needed to order to attain those goals, and were not revised regardless of whether progress was made or not. For example, S.P.'s ISP stated that she was "losing weight, but being monitored," and that she "continued to receive restorative [physical therapy]." There are no goals set for S.P.'s weight or nutrition status in order to help S.P. work on self-monitoring her nutrition and health; and there are no references to what, if any, goals and objectives are to be achieved via the nursing facility's restorative PT program. Also, S.P.'s most current quarterly ISP, dated 5/18/17, notes that she reported that another resident hit her. Although it was noted that the other resident was separated from S.P., there are no references to whether or not the physical abuse was reported and what, if any, strategies were put in place to protect SP from harm/abuse.

In addition, S.P.'s ISP does not include a transition plan that describes the services and supports needed for her to successfully transition to the community. Section 9, Phase II, of her ISP is not completed, and in fact, in multiple ISPs, the entirety of Section 9 "Transition Plan" is blank. There is no description of what S.P.'s life in the community might look like.

From the review of S.P.'s records, observations, and interview with S.P., it is clear that she was appropriate for and would benefit from living in an integrated setting with appropriate community services and supports, which would provide her with a quality of life that she desires. In my opinion, S.P. may safely live in the community with the supports and services that she needs.

Although S.P. has declined a waiver slot, there was no evidence that S.P. has made an informed choice to stay in the segregated nursing facility. In fact, several months prior to the review, during the CLO process, it was noted that S.P. "would like to live on her own and have her own place…" But, this was not pursued because reportedly she needs health care to become more "stable" before she can leave the nursing facility. When this reviewer asked S.P.'s Service Coordinator to explain what becoming "more stable" meant and to answer whether or not S.P. understood what becoming "more stable" meant, she was unable to do so. And, there is no clarifying information documented in Section 9 of S.P.'s ISP regarding what, if any, true barriers prevent S.P.'s transition to community living and what steps need to be taken to address the barriers, if in fact they exist.

S.P.'s service coordinator reported that when S.P. was offered a waiver slot, she had a 10-minute conversation with S.P., which involved going over the provider list. However, no specific community options were identified for S.P., and the CLO process was not individualized for her. S.P. has not visited any community providers and S.P.'s service coordinator does not believe that S.P. has had any opportunities to speak with individuals who have transitioned from a nursing facility. During this reviewer's interview with S.P., she clearly stated her desire to move out of the nursing facility and into a community home. She fondly recalled her memories of living in her home and the simple pleasures that were what she lived for – sitting with her beloved cat and dog, going outside, going to parks, looking at the trees and nature – all things, she loves and has lived without for over six years.

C.S.

C.S. is a 39-year-old man who was living at home with his mother prior to his February 2010 admission to a nursing facility in Houston, TX. C.S. has diagnoses that include moderate intellectual disability, hypoxic ischemic encephalopathy, seizure disorder, glaucoma, and hypertension. He also had a history of falls. According to C.S.'s mother, who was present at the facility on the day of the review, C.S. entered the nursing facility because of his numerous seizures and his doctor's recommendation for him to come to the nursing home. A review of C.S.'s nursing facility records revealed that he receives multiple seizure medications, which control his seizures. C.S. is his own legal guardian.

C.S. spends his days inside the nursing facility playing table games, talking to other residents, or laying on his bed in his room. According to C.S.'s nursing facility records, during the year prior to my review, C.S. left the facility six times to attend church, six times to go to the barber shop, and six times on field trips with destination not documented. When this reviewer met C.S., it was shortly after lunch. This reviewer met with C.S. in his bedroom, which was a small room that he shared with another resident. C.S. wore a helmet as protective headgear due to his risk of falling. C.S.'s room was malodorous and not clean. I observed that there were feces on the curtain separating C.S's bed from his roommate and on his bureau. He had clothes, but only a few belongings. C.S. was very talkative. He spoke about his interests, health, people in his life, church, and what he has learned to do better since he came to live at the nursing facility in 2010. C.S.'s interests were very limited, in part because, over the past seven years, he has rarely left the nursing facility. In fact, he expressed a belief that if he left the nursing facility, even for a brief time and/or only to go outside in the nursing facility courtyard, he would likely suffer a fall and possibly a fatal injury. When this reviewer asked C.S. for the names of his friends, he stated the names of the nursing facility residents that live on his unit. C.S. reported that he attends church several times a week at the nursing facility. His mother also takes him out to a community church approximately once a month. The one and only thing that C.S. stated that he has learned to do better since his admission to the nursing facility in 2010 was playing table games.

There was no evidence that C.S. has received a comprehensive functional assessment of all habilitative need areas that accurately identified all of his strengths and needs. In addition, his initial PL1 inaccurately indicated that he was negative for ID/DD. Other nursing facility assessments also failed to accurately identify all of C.S.'s strengths and needs. For example, his annual MDS assessment failed to document the areas of C.S.'s intellectual disability and epilepsy, which were two important areas that significantly impacted C.S.'s functional status and needs.

C.S. is not receiving necessary nursing facility specialized services with the appropriate intensity, frequency and duration in order to meet all of his needs. C.S.'s Service Coordinator reported that C.S. does not receive any nursing facility specialized services. She also reported that she does not tell the nursing facility team what specialized services C.S. would, or could, benefit from; rather she relies upon the nursing facility to identify C.S.'s needs and then she offers suggestions for specialized services. However, C.S.'s Service Coordinator reported that the nursing facility staff members do not appear to understand the difference between rehabilitation services and habilitative specialized services. And, in fact, none of the nursing facility residents at C.S.'s nursing facility who are on her caseload, including C.S., receive specialized services from the nursing facility. The nursing facility records indicated that C.S. had a PT evaluation and plan in April 2017 to address falls and muscle weakness but it appears from the record that he only received time-limited rehabilitative PT for approximately one month, not PASRR habilitative physical therapy. C.S.'s nursing facility Care Plan also indicates that C.S. receives restorative care exercises to address balance and muscle strength, but not specialized services.

C.S. also does not receive all needed LIDDA specialized services. In fact, he does not receive any PASRR specialized services from the LIDDA except for Service Coordination even though C.S.'s ISP indicates that he "wants to participate in meaningful day activities". During this reviewer's interview with C.S.'s Service Coordinator she reported that she was not aware of any other type of specialized services recommended for C.S., including, but not limited to, employment services. C.S.'s Service Coordinator was also not aware of any individuals with disabilities residing in nursing facilities who were receiving employment services. According to C.S.'s Service Coordinator, until recently, the LIDDA was only able to provide Service Coordination, but, currently, there are day habilitation programs in two locations in the Houston area which are able to provide services to residents of nursing facilities. However, his service coordinator reported that participation in this program had not been discussed with or offered to C.S. The record indicates that after my visit on August 17, 2017 the SPT agreed to look into day habilitation to determine if it is appropriate for C.S.

As referenced above, C.S. is receiving some health care services, but he is not receiving a continuous active treatment program that includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services to improve C.S.'s functional capacity and/or prevent or decelerate possible regression and loss of current optimal functional status.

C.S. does not have a professionally appropriate ISP that was developed on the basis of a comprehensive, person-centered assessment and included all needed services and supports including those necessary to allow C.S. to successfully transition to the community. Rather, C.S.'s current annual ISP and quarterly updates consist of the same primarily general and vague statements that were referenced in the prior quarterly update and fail to accurately portray C.S.'s current status and his specific strengths and needs. The sole outcome in C.S.'s ISP's is also general and vague, lacking sufficient interventions in order to ensure its attainment. For example, C.S.'s ISP outcome states, "C.S. would like to participate in meaningful day activities." Yet C.S. is not receiving any specialized services in the community, such as day habilitation or supported employment, even though these services have been recommended for him. When this reviewer asked C.S.'s Service Coordinator to explain the outcome and how progress/lack of progress toward attainment would be measured, she was unable to do so. Further, when this reviewer asked C.S.'s Service Coordinator if the interventions to achieve a "meaningful day" were expected to occur on a daily basis, C.S.'s Service Coordinator answered that she did not know and had never thought about it that way before. Section 9, phases II and III of the ISP were not completed and there is no description of what the community might look like for C.S.

From my review of C.S.'s records, observations, and interview with C.S., it is clear that C.S. has tremendous potential to benefit from living in an integrated community setting with appropriate community services and supports. C.S. is educated, reasonably healthy, without behavior problems, independent for most activities of daily living, friendly, easy to get along with, and communicative. He is also very social and enjoys spending time with other people. In my opinion, C.S. could be served in a community setting and would likely thrive there.

C.S. was offered and declined an HCS waiver slot in 2016, and he appears to have made a choice to remain in the nursing facility. According to C.S.'s Service Coordinator, she has asked C.S. if he would like to pursue community options and she has shown him a booklet that describes options for community living. But, in response to these efforts by C.S.'s Service Coordinator to offer and explain community living options to C.S., his repeated responses have been that he likes living at the nursing facility. During

my interview with C.S., he denied a desire to move from the nursing facility, apparently because the most influential people in his life – his mother and doctor - have convinced him that if he were to leave the nursing facility, he would very likely fatally injure himself. His mother stated to me that the nursing facility was C.S.'s "permanent home." Nevertheless, C.S.'s ISP fails to address C.S.'s fears, concerns and any other barriers to C.S.'s transition to the community.

C.S.'s Service Coordinator reported that if C.S. were interested in learning more about community living options, she would refer him to a website where he could look up his options by zip code. C.S.'s Service Coordinator further stated that she has a video that shows what it means to transition to community living, but she will not show the video to C.S. unless he asks to see it. Again, this appeared to be an unrealistic expectation for C.S. to ask to see a video that he likely does not know exists. In addition, C.S. has not had the opportunity to visit any programs in the community or to speak with any individuals with similar disabilities, such as a seizure disorder, who have successfully transitioned from a nursing facility to the community.

R.O.

R.O. is a 60-year-old woman who has resided at a nursing facility in El Paso, Texas for over 13 years. She is diagnosed with mild intellectual disability, non-Alzheimer's dementia, anxiety disorder, seizure disorder, and other health problems. R.O.'s sister in law is her legal guardian and was visiting her when I arrived.

Prior to R.O.'s admission to the nursing facility, she lived with her mother. R.O. and her mother spent their days together working in and around their home, listening to the radio, watching television, and engaging in their individual interests, such as puzzles and gardening. R.O. was ambulatory, continent, very friendly and outgoing, and functioned independently across many aspects of her activities of daily living. R.O.'s health declined when her mother was admitted to a nursing facility and R.O. was soon admitted to the same facility. Her sister in law reported that R.O. was on hospice when she arrived at the facility, but 13 years later, R.O. continues to reside in the same facility.

R.O. spends much of her day in bed waiting for her sister-in-law to visit. Once R.O.'s sister-in-law arrives, her sister-in-law coaxes her to get out of bed, provides R.O. with hygiene, verbally interacts with R.O. and engages R.O. in activities such as watching the news on television, attending a facility-based activity, such as Bingo, or getting her nails done. R.O. does not usually leave the nursing facility to attend community events or activities, and has little opportunity to interact with other people outside the nursing facility who live in the community, except for her family members who visit her several times a week.

R.O. did not receive a comprehensive functional assessment that accurately identified all of her strengths and needs. Rather, there were portions of assessments in various records, such as R.O.'s MDS, physical examination report, 2004 psycho-social assessment, etc., but they are not current or were not performed near or at the same time by an interdisciplinary team as part of a single, complete, assessment with recommendations for planned interventions to meet R.O.'s desired outcomes. Also, although R.O.'s nursing facility records indicated a number of physical and behavioral areas where she suffered decline, she did not receive a comprehensive re-assessment.

R.O. was not receiving nursing facility or LIDDA specialized services. R.O.'s PE failed to recommend any nursing facility specialized services, and R.O.'s LIDDA records revealed that R.O.'s guardian had declined LIDDA Service Coordination. In 2015, R.O.'s Service Coordinator wrote, "SC will be closed out to EHN [LIDDA] in regard to PASRR." R.O. 's sister-in-law indicated that she had one brief phone call with someone from the LIDDA and was unaware of the range of services she was declining. She believed that R.O. was only being offered community outings, and at the time of the phone call, she felt that R.O.'s health was too fragile. R.O.'s sister-in-law stated that she did not know she was declining services such as PT, OT, durable medical equipment, behavioral support, or ILST. When this reviewer met with her, R.O.'s sister in law stated that she believes R.O. would benefit from these services.

Thus, despite R.O.'s decline in ambulation, increased need for moderate to maximum assistance with activities of daily living (ADLs), increased frequency of falls, increased agitation and anxiety, and almost daily behavioral manifestations, including yelling, biting, hallucinating, cursing, and refusing care, at the time of my visit, R.O. was not receiving PASRR specialized habilitative services or behavior support services. R.O. has received short-term PT, but no long term specialized therapies to meet her habilitative needs. In addition, R.O. did not have a CMWC; rather, she had a wheelchair that was not

appropriate to meet her needs, and it appeared difficult, if not physically impossible, for R.O. to apply the brakes on her current nursing facility wheelchair. In this reviewer's opinion, those services would help R.O. maintain her safety and increase her independence in mobility.

R.O. was not receiving a continuous active treatment program that included aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services to prevent or decelerate R.O.'s regression and loss of current optimal functional status. R.O. is not receiving any services to promote her independence or self-determination. Moreover, it appears that the nursing facility staff have not been trained on how to care for people with IDD or how to meet R.O.'s habilitative needs.

At the time of my review, no ISP was completed for R.O. Rather, RO had a nursing facility Care Plan that referenced areas of focus, goals, and interventions/tasks that were general vague statements that could have applied to most of the other residents in the facility. It failed to reference specific planned interventions that were consistent with her preferences and would support her strengths while addressing her habilitative needs and taking steps to decrease her segregation from her community and increase opportunities for integration within her community and participation in community based activities and events.

Subsequent to my review, after 13 years in the nursing facility, in late August 2017, an ISP was developed for R.O. The only outcome listed in R.O.'s ISP is "I want to eat all my meals in the dining room." R.O.'s transition plan does not describe what the community would look like for R.O. or identify any steps to address barriers to her transition. Section 9, phases II and III of her transition plan are blank. There is no documentation of any discussion about services and supports she would need to transition.

During this reviewer's interview with R.O. and her sister-in-law, it became exceedingly clear that R.O.'s sister-in-law did not understand what she had refused when she declined PASRR service coordination. R.O.'s sister-in-law had no knowledge of the LIDDA or what the scope of service coordination was or how it may have potentially benefitted R.O. Despite the fact that she visits R.O. on a daily basis, she also had no understanding of the nursing facility care plan process, no knowledge of the role of the IDT or the SPT, and no current interactions with the LIDDA to explore options for services or settings appropriate to meet R.O.'s needs.

R.O. is appropriate for and would benefit from living in an integrated setting with appropriate community services and supports. R.O. may be served in the community and did not appear to need to continue to be confined in a nursing facility. Since her admission to the nursing facility R.O. has become increasingly isolated and withdrawn.

R.O. has not made an informed choice to remain in a segregated nursing facility. Rather, in the absence of information, R.O.'s sister in law has declined a waiver slot for R.O. and chose for R.O. to remain where she is, which is within walking distance of her sister in law's home. Neither R.O. nor her sister-in-law have received any individualized information about what the community might look like for R.O., taking into account her need, preferences, strengths, and weaknesses. There is no evidence in the record that any barriers to community living have been identified or addressed, or that there has been any effort to address any of her family's concerns about moving. R.O. has not had the opportunity to visit community providers, to spend time in the community regularly, or to speak with peers who have transitioned from the nursing facility to other settings.

When R.O.'s sister in law was asked where she thought R.O. would like to live, she became tearful and explained that R.O. would probably like to live with her. She acknowledged how hard this situation had been on her husband (R.O.'s brother) and other family members. R.O.'s sister-in-law proceeded to explain to this reviewer that if she were provided with more information and had the opportunity to visit some community living options that were close to her home, she might consider assisting R.O. to move from the nursing facility to a community home.

Attachment A

Natalie J. Russo, R.N., A.A.S., B.A., M.A.

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- ***Over 30 years of experience as a leader and member of executive management teams in government, nonprofit, and for-profit private sector health care and consulting companies;***

- ***Consulted with organizations across the country to help them successfully improve their quality of clinical supports and services to a variety of populations with varying health needs, including, but not limited to developmental, behavioral, medically fragile, and rare and expensive health needs;***

- **Expert in clinical policy and procedure development and evaluation, corporate compliance, quality and risk management data analysis and evaluation, oversight, monitoring, and ensuring the coordination of the delivery of clinical supports and services, especially to elders, people with intellectual and developmental disabilities, and behavioral health clients across the health care continuum;**

- **Results and success oriented leader and developer of excellence in service delivery in a variety of demanding and changing environments where multiple, and sometimes competing, priorities exist.**

- **Led organizations to attain and maintain 100% compliance with national accreditation organizations including TJC, URAC, and NCQA.**

- **Excels as an independent thinker, designer of data driven decision making systems and solutions, problem solver, and leader.**

- **Excellent written, computer, verbal, telephonic, and interpersonal skills**

E M P L O Y M E N T

RN Manager of Complex Care ***2017 – Present***

St Peter's Health Partners Medical Associates

Albany, NY 12208

St. Peter's Health Partners Medical Associates Albany Medical Center is one of the Capital Region's largest multi-specialty physician groups with more than 350 physicians and advanced practitioners, in more than 80 practice locations. SPHPMA is a full affiliate corporation of St. Peter's Health Partners.

SPHPMA offers patients improved coordination of care among their primary care providers, specialists, hospital and other health care providers. All team member work with patients and their families and caregivers to provide high quality, compassionate care and advanced treatment options in a supportive, healing environment. Headquartered in Albany, NY, the physician group practices represent more than 20 specialties, including: primary care; internal medicine; pediatrics; cardiology; clinical nutrition; endocrinology; obstetrics and gynecology; hematology, medical oncology and radiation oncology; neurology; neurosurgery; pulmonary and critical care; radiology; urology; bariatric care and surgery; general, hepatobiliary, neurological, orthopedic, spinal, thoracic, and esophageal surgeries; and urgent care.

- ✓ *Provides expert clinical coordination of the care of patients in the setting of primary care practices.*
- ✓ *Leads primary care practices to attain and maintain certification as Patient Centered Practices/Medical Homes and works with clinical teams to actualize the SPHPMA mission of achievement of patient focused outcomes and high quality professional practices.*
- ✓ *Consistently provides creative solutions to complex problems and maintains over 90% success with ensuring patients receive highly successful transitions of care across the care continuum.*
- ✓ *Successful management of complex care has resulted in improved patient adherence to medical/clinical recommendations and reduction in unnecessary emergency room use and inpatient hospital stays.*

Clinical Quality Specialist ***2016 – August 2017***
Albany Medical Center
43 New Scotland Avenue
Albany, NY 12208

Albany Medical Center is northeastern New York's only academic health sciences center and is one of the largest private employers in the Capital Region. It incorporates the 734-bed Albany Medical Center Hospital, which offers the widest range of medical and surgical services in the region, and the Albany Medical College, which trains the next generation of doctors, scientists and other healthcare professionals, and which also includes a biomedical research enterprise and the region's largest physicians practice with more than 450 doctors. Albany Medical Center works with dozens of community partners to improve the region's health and quality of life.

- ✓ *Successfully applied the Lean Six Sigma methodology on the clinical performance improvement strategies and outcomes in clinical departments including cardiology, cardiothoracic surgery, electrophysiology, and nursing.*

- ✓ *Key member of several Quality Improvement Teams seeking to improve the hospital's compliance with standards and quality of care re: 1) patients requiring mechanical ventilation and reducing VAEs, 2) patients transitioning to alternate levels of care, including, but not limited to, community-based outpatient services and rehabilitation facilities, 3) heart failure QIT, 4) nursing sensitive indicators QIT, and 5) Hospital Acquired Infection QIT*
- ✓ *A lead member of interdisciplinary clinical quality improvement teams that develop and implement strategies to attain and maintain specialty certification and accreditation in multiple areas, including, but not limited to, cardiology, cardiothoracic surgery, electrophysiology and cardiac catheterization labs, and AHA Mission Lifeline.*
- ✓ *Manager of the Medical Center's Quality Hospital Incentive Program (Q-HIP).*
- ✓ *Member of the Medical Center's Command Center for The Joint Commission (TJC) accreditation and re-accreditation surveys.*

President ***2010 – Present***
Care Counts, LLC.
35 Stafford's Crossing
Slingerlands, NY 12159

Care Counts is a national consulting company that brings expert consulting services to law offices, state and federal government, protection and advocacy groups, and physical and behavioral healthcare organizations. It specializes in evaluating and solving the problems of management teams, providers, and healthcare delivery systems who serve the elderly and people with behavioral health needs and/or intellectual/developmental disabilities.

- ✓ *All consultations involve a proven and successful methodology.*
- ✓ *In-depth real-time and retrospective expert reviews offer 1) exhaustive research, interpretation, and application of state and federal laws, regulations, rules, and organizational policies and procedures; 2) in-depth analyses of health, medical, and other data; 3) development of strategic plans, policies, and procedures; 4) define metrics/outcomes and establish quality assurance and performance improvement systems; and 5) provide recommendations and/or solutions to problems.*
- ✓ *Expert testimony results in agreements that are satisfactory to clients and their families and/or guardians, and many result in favorable decisions and settlements, which may avoid costly trials and prolonged litigation.*
- ✓ *Consultations jump start organizations' internal clinical, quality, and compliance programs, result in survey-readiness, help achieve accreditation or re-accreditation with organizations' national accreditation bodies, acceptance and approval of organizations' corrective action plans, and attain full compliance with the organizations' state/federal oversight agency's regulatory requirements.*

NOTE: A list of clients and expert consultations is available upon request.

Vice President & Chief Compliance Officer ***December, 2013 – December 2015***
Vanderheyden, Inc.
614 Cooper Hill Road
Wynantskill, NY 12198

Vanderheyden is a premier New York State, non-profit, 20-million dollar a year state and federally funded organization that provides services to thousands of New Yorkers and their families each year. It provides clinical, health, case coordination, speech and occupational therapy, 7-12th grade special education, and other services to older adults, adults, youth, and families who have serious emotional disturbances, chronic health and other special needs, including medical and behavioral health needs, intellectual disabilities, and/or developmental disabilities in residential, community, and home-based settings.

- ✓ *Led the redesign of the organization's annual operational plan to achieve quality outcomes.*
- ✓ *Reformed and improved the organization's system of quality improvement and auditing and monitoring to create the capacity for continuous quality improvement, efficiency of care, and desired outcomes for all service recipients.*
- ✓ *Led new initiatives and increased the organization's capacity for data based decision-making, monitoring of metrics for continuous improvement, transparency, and accountability to all stakeholders.*
- ✓ *Implemented strategic plans and programs that ensured that the organization met and exceeded all of its state oversight agencies standards and developed a culture of "first, quality" and embracing best practices.*
- ✓ *Developed the organization's Corporate Compliance Program and achieved the state's recognition as a top tier provider of services where continuous quality and clinical improvement systems were effectively joined with successful revenue cycle management.*

Director of Quality and Care Management *January 2005 – May 2010*
Medical Management & Rehabilitation Services, Inc.
723 S. Charles Street, Suite 104
Baltimore, MD 21230

Medical Management & Rehabilitation Services, Inc. (MMARS) is a 15-million dollar, URAC-accredited, nationally recognized case management and independent support coordination organization that provides comprehensive care management, utilization management, disease management, and clinical consulting services across the spectrum of age and special needs for a variety of health care providers located across the country. MMARS, Inc. maintains offices in Baltimore, Memphis, and Atlanta, and it is a company committed to providing customized, cost-effective, and comprehensive health care management services.

- ✓ *Ensured that quality client services were provided and client connections were attained and maintained at all points across the continuum of care management.*
- ✓ *Established measureable performance goals and outcomes and produced performance reports to all stakeholders, including state and federal government,*

other providers, and individual consumers to strengthen client engagement and satisfaction.

- ✓ *Collaborated with other members of the executive management team to achieve URAC accreditation and re-accreditation in case management and utilization management. Scored 100% compliance with regulatory and URAC standards and was recognized by URAC as one of the nation's leading quality management programs.*

Sr. Associate ***2001 - 2005***
NKR & Associates, Inc.
318 Delaware Avenue
Delmar, New York 12054

NKR & Associates, Inc. is a consultation corporation specializing in the provision of monitoring services in conjunction with class action lawsuits, administrative sanctions of state governments, and corporate integrity agreements issued by the U.S. Office of the Inspector General/Health and Human Services

- ✓ *Successfully assisted the Federal Court Monitor in managing a complex class action lawsuit that was in its remedial phase.*
- ✓ *Oversaw the state of Tennessee's implementation of the federal court's Remedial Orders that affected a class of several hundred named members and several thousand at-risk members.*
- ✓ *Ensured that the planned services and protections for health and safety of class members were in place for all, and especially for those who transitioned from institutional to community-based systems of care during 2001-2005.*
- ✓ *Collaborated across all providers and levels of government within the state of Tennessee to enable them to develop pathways to achieve compliance with the court's orders, to improve their systems of care, and to develop community based options for health care, housing, jobs, and leisure/recreational activities for people with intellectual and/or developmental disabilities in West Tennessee.*

Director, Outcomes Research & Risk Management ***1996 - 2001***
Four Winds - Saratoga
30 Crescent Avenue
Saratoga Springs, New York 12866

Four Winds – Saratoga (FWS) is a behavioral health service system located in upstate New York. FWS provides mental health services to children, adolescent, adults, and older adults, and offers four levels of treatment intensity: inpatient, partial hospital, intensive outpatient, and outpatient services.

- ✓ *Continuously measured FWS success using actionable analytics.*
- ✓ *Led all research activities that measured individuals' progress toward recovery and the achievement of their goals and captured individual and family/guardian satisfaction.*
- ✓ *Improved communication of performance and satisfaction of services via easy-to-read and understand reports.*

- ✓ *Reduced health risks, injuries, and other safety risks through successful application of risk management strategies and risk reduction plans.*
- ✓ *Led all internal investigations to ensure all relevant inquiries were conducted at the highest level of ethical procedure and provided the organization with recommendations for specific responses to specific risk(s) and to ultimately improve the quality of care across the organization.*

Director, Research Activities (1993-1996) ***1986 - 1996***
Policy Analysis and Development Specialist (1986-1992)
New York State Commission on Quality of Care for the Mentally Disabled
99 Washington Avenue
Albany, New York 12210

- ✓ *Fervently advocated on behalf of the people of New York State who were recipients of the state's mental hygiene and substance abuse services.*
- ✓ *Participated at the forefront of the state's initiatives to transition people with disabilities from institutions to community-based care.*
- ✓ *Answered the questions of the governor and the legislators regarding the state of affairs of mental hygiene services across New York State.*
- ✓ *Led all state policy and analysis research projects to ensure programmatic and fiscal responsibility across all of the state's mental hygiene service system.*
- ✓ *Communicated findings of significance to all stakeholders via multi-media approach, such as presentations, written reports, videos, newsletters, conferences, and letters to state officials, executive administrators of provider organizations, advocates, and all other stakeholders.*
- ✓ *Led the way for other states in the nation to follow in the transformation of care of people with disabilities.*

Nursing Supervisor/Charge Nurse ***1976-1986***
Mt. Loretto Nursing & Rehabilitation
Swart Hill Road
Amsterdam, New York 12010

- ✓ *Ensured that health, safety, and quality of care was maintained at all times and for all residents.*
- ✓ *Developed and oversaw the implementation of individualized care plans that reflected the wishes, desires, and goals of residents and their families.*
- ✓ *Played a key role in attaining the facility's JCAHO accreditation.*
- ✓ *Led the first intervention of its kind to reduce the use of physical interventions and psychoactive medications.*
- ✓ *Performed nursing care with kindness, respect, dignity, and excellence.*
- ✓ *Improve resident care through keen supervision of other nurses and assistants while promoting their positive performance and challenging them to constantly strive to do better.*

E D U C A T I O N

State University of New York at Albany

M.A., SOCIOLOGY — *1986*

State University of New York at Albany

B.A., DUAL MAJOR:
SOCIOLOGY/PSYCHOLOGY — *1984*

Fulton-Montgomery Community College

A.A.S., NURSING — *1979*

LICENSURE

REGISTERED PROFESSIONAL NURSE IN NY AND GA

AFFILIATIONS/ASSOCIATIONS

MEMBER OF AMERICAN ASSOCIATION OF NURSE COORDINATION

MEMBER OF DEVELOPMENTAL DISABILITIES NURSES ASSOCIATION

CERTIFICATIONS

CERTIFIED INVESTIGATOR OF SERIOUS INCIDENTS

Attachment B

Steward v. Smith
5:10-CV-1025-OLG
In the United States District Court for the Western District of Texas
San Antonio Division

CLIENT REVIEW REPORT OF NATALIE RUSSO
Attachment B

	Document	Bates No.
1.	Texas Health and Human Services Commission, Form 1039, Community Living Options and Instructions, *available at* https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1039-community-living-options	US00253559-253568
2.	Texas Health and Human Services Commission, Form 1041, Local Authorities (LA) Individual Service Plan/Transition Plan – NF and Instructions, *available at* https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1041-individual-service-plantransition-plan-nf	US00253775-253800
3.	42 C.F.R. § 483.440, Condition of participation: Active treatment services.	US00253366-253372
4.	TEX. HEALTH AND HUMAN SERVS. COMM'N, *PASRR Webinar: Specialized Services for Nursing Facility Residents with IDD*, April 25, 2017	US00253271-253365
5.	40 T.A.C., Part 1, Ch. 17, Subch. A-E, Preadmission Screening and Resident Review (PASRR)	US00253388-253401
6.	40 T.A.C., Part 1, Ch. 19. Subch. BB: NF responsibilities related to PASRR	US00253402-253410
7.	TEX. HEALTH AND HUMAN SERVS. COMM'N, (formerly, Texas Department of Aging and Disability Services), *Explanation of IDD Services and Supports*	US00253411-253423
8.	TEX. HEALTH AND HUMAN SERVS. COMM'N (formerly, Texas Department of Aging and Disability Services), *Making Informed Choices: Community Living Options Information Process for Nursing Facility Residents*, February 2016	US-00253424-253429
9.	2016 PASRR QSR Compliance Status Interim Report	DefE-00096540
10.	Information Letter No. 15-33, Prior Authorization for Preadmission Screening and Resident Review Specialized Services, Prior Authorization for Customized Power Wheelchairs and Rehabilitative Therapy Requests from Elisa Garza, Donna Jesse, and Mary Henderson to Nursing Facility Providers and LIDDAs (May 13, 2015), *available at* https://www.dads.state.tx.us/providers/communications/2015/letters/IL2015-33.pdf	US00253430-253432

11.	Information Letter No. 15-61, Preadmission Screening and Resident Review Habilitative Specialized Services from Michelle Martin and Elissa Garza to Nursing Facility Administrators (September 23, 2015) *Removed August 25, 2017*.	US00253433-253434
12.	Information Letter No. 15-84 Pre-Admission Screening and Resident Review – Reviewing and Requesting Changes to PL1s from Elissa Garza, Asst. Comm'r, Access and Intake to Nursing Facilities (December 31, 2015) *available at* https://www.dads.state.tx.us/providers/communications/2015/letters/IL2015-84.pdf	US00253435-253437
13.	Provider Letter No. 16-33 — Top Non-Compliance Trends with the Preadmission Screening and Resident Review (PASRR) Requirements from Mary Henderson, Asst. Comm'r, Regulatory Services to Nursing Facilities (August 31, 2016) *available at* https://www.dads.state.tx.us/providers/communications/2016/letters/PL2016-33.pdf	US00253503-253505
14.	Provider Letter No. 17-15 – Failure to Deliver PASRR Services from Mary Henderson, Asst. Comm'r, Regulatory Services to Nursing Facilities, (August 17, 2017), *available at* https://www.dads.state.tx.us/providers/communications/2017/letters/PL2017-15.pdf	US00253506
15.	Provider Letter No. 17-16 – Guidelines Regarding Plans of Correction Associated with a PASRR Violation from Mary Henderson, Asst. Comm'r, Regulatory Services (May 2, 2017), *available at* https://www.dads.state.tx.us/providers/communications/2017/letters/PL2017-16.pdf	US00253507
16.	Provider Letter No. 17-17 – Civil Money Penalty (CMP) Projects are Subject to Unannounced Visits to Ensure Project Implementation from Mary Henderson, Asst. Comm'r, Regulatory Services (June 21, 2017), *available at* https://www.dads.state.tx.us/providers/communications/2017/letters/PL2017-17.pdf	US00253508-253509
17.	PASRR TECHNICAL ASSISTANCE CENTER, Service Provider Promising Practices (Feb. 2013), *available at* https://www.pasrrassist.org/sites/default/files/attachments/PASRR_Service%2520Provider%2520Promising%2520Practices.pdf	US00253482
18.	42 C.F.R. 483, Requirements for States and Long Term Care Facilities	US00253483-253502

19.	TEX. HEALTH AND HUMAN SVCS. COMM'N, Local Authority for Intellectual and Developmental Disabilities Performance Contract, Attachment G (Amended Sept. 1, 2016)	US00253373-253387
20.	Tex. Health and Human Svcs. Comm'n, PASRR Level 1 Screening Form (May 2013, v. 1)	US00253470-253481
21.	Tex. Health and Human Svcs. Comm'n, PASRR Evaluation (June 2014, v. 3)	US00253438-243469
22.	PASRR Review Process and Service Coordination Participant Guide, July 2016	DefE-00055401-55459
23.	Nursing Facility records request letter	US00253268-253270
24.	LIDDA records request letter	US00253265-253267
25.	Spreadsheet: NF Transition Snapshot	DefE-01958693
26.	Nursing facility records for JA	US00109154-109465 US00159927-160030 US00174509-174774
27.	LIDDA records for JA	US00258378-258682
28.	Nursing facility records for RB	US00109831-110952 US00174042-174414
29.	LIDDA records for RB	US00173421-173484
30.	Nursing facility records for PC	US00099790-100224 US00125186-125620 US00171226-171399
31.	LIDDA records for PC	US00110999-111314 US00121531-121886 US00179965-180467
32.	Nursing facility records for LD	US00160538-161141 US00175030-175233
33.	LIDDA records for LD	US00151153-151214 US00161875-161887 US00163914-164032 US00182346-182364
34.	Nursing facility records for RF	US00093073-95325 US00176160-176571 US00182658-182674
35.	LIDDA records for RF	US00112111-112173 US00164217-164254 US00176783-176801
36.	LIDDA records for NF	US00100225-100577 US00127011-127363

		US00169683-169754 US00181278-181389
37.	Nursing facility records for NF	US00123172-124283 US00180869-181038
38.	Nursing facility records for LG	US0088813-90799 US00179422-179763
39.	LIDDA records for LG	US00100578-100750 US00127839-128011 US00161205-161301 US00169755-169772
40.	LIDDA records for MH	US00110187-110266 US00173195-173250
41.	Nursing facility records for MH	US00167240-168185 US00179764-179839
42.	LIDDA records for SC	US00111474-111705 US00169773-169801
43.	Nursing facility records for SC	US00151290-151677 US00174775-175029
44.	Nursing facility records for OL	US00087474-100830 US00128897-128976 US00178800-178896
45.	LIDDA records for OL	US00111361-111473 US00170050-170167
46.	Nursing facility records for RM	US00142366-142963 US00178615-178799 US00182655-182657
47.	LIDDA records for RM	US00164526-164693 US00170168-170343
48.	Nursing facility records for RO	US00091244-91365 US00132311-132528 US00135637-135764 US00143536-143663 US00172612-172742
49.	LIDDA records for RO	US00097070-97165 US00107642-107657 US00173329-173366
50.	LIDDA records for SP	US00141761-142096 US00174469-174494
51.	Nursing facility records for SP	US00160044-160483
52.	Nursing facility records for ABP	US00152234-153737
53.	LIDDA Records for ABP	US00164694-164902 US00174415-174445
54.	Nursing facility records for CS	US00109466-109830

		US00182234-182313
55.	LIDDA records for CS	US00142097-142365 US00174446-147468
56.	LIDDA records for RW	US00117422-117839 US00135219-135636 US00169802-169887
57.	Nursing facility records for RW	US00119728-120849 US00181039-181231
58.	Review of Individuals in Nursing Facilities Questions & Considerations	US00258739-258741