United States v. State of Texas

Monitoring Team Report

San Angelo State Supported Living Center

Dates of Onsite Review: March 14-18, 2016

Date of Report: May 25, 2016


| | |
|---|---|
| Submitted By: | Alan Harchik, Ph.D., BCBA-D<br>Maria Laurence, MPA<br>Independent Monitors |
| Monitoring Team: | Helen Badie, M.D., M.P.H, M.S.<br>Carly Crawford, M.S., OTR/L<br>Daphne Glindmeyer, M.D.<br>Marlenia Overholt, B.S., R.N.<br>Gary Pace, Ph.D., BCBA-D<br>Teri Towe, B.S.<br>Scott Umbreit, M.S. |

## Table of Contents

## Background

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

In 2009, the parties selected three Independent Monitors, each of whom was assigned responsibility to conduct reviews of an assigned group of the facilities every six months, and to detail findings as well as recommendations in written reports that were submitted to the parties. Each Monitor engaged an expert team for the conduct of these reviews.

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

Given the intent of the parties to focus upon outcomes experienced by individuals, some aspects of the monitoring process were revised, such that for a group of individuals, the Monitoring Teams' reviews now focus on outcomes first. For this group, if an individual is experiencing positive outcomes (e.g., meeting or making progress on personal goals), a review of the supports provided to the individual will not need to be conducted. If, on the other hand, the individual is not experiencing positive outcomes, a deeper review of the way his or her protections and supports were developed, implemented, and monitored will occur. In order to assist in ensuring positive outcomes are sustainable over time, a human services quality improvement system needs to ensure that solid protections, supports, and services are in place, and, therefore, for a group of individuals, these deeper reviews will be conducted regardless of the individuals' current outcomes.

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

Along with the change in the way the Settlement Agreement was to be monitored, the parties also moved to a system of having two Independent Monitors, each of whom had responsibility for monitoring approximately half of the provisions of

the Settlement Agreement using expert consultants. One Monitoring Team focuses on physical health and the other on behavioral health. A number of provisions, however, require monitoring by both Monitoring Teams, such as ISPs, management of risk, and quality assurance.

**Methodology**

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

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a facility's compliance with all provisions of the Settlement Agreement.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed. The amount of documentation requested by the Monitoring Teams decreased with the changes in the way monitoring was being conducted.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, Positive Behavior Support Plan (PBSP) and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Scoring** – The report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. The parties agreed that compliance determinations would not be made for the Domains or for the outcomes for this round of monitoring reviews. Therefore, none of the figures in this report should be construed as a statement regarding the Facility's compliance with the Settlement Agreement.

## Organization of Report

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

a. **Domains:** Each of the five domains heads a section of the report.
b. **Outcomes and indicators:** The outcomes and indicators are listed along with the Monitoring Teams' scoring of each indicator.
c. **Comments:** The Monitors have provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
d. **Individual numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers.
e. **Numbering of outcomes and indicators:** The outcomes and indicators under each of the domains are numbered, however, the numbering is not in sequence. Instead, the numbering corresponds to that used in the Monitors' audit tools, which include outcomes, indicators, data sources, and interpretive guidelines/procedures (described above). The Monitors have chosen to number the items in the report in this manner in order to assist the parties in matching the items in this report to the items in those documents. At a later time, a different numbering system may be put into place.

## Executive Summary

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at the San Angelo SSLC for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Teams during the onsite review. The Facility Director supported the work of the Monitoring Teams, and was available and responsive to all questions and concerns. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

**Status of Compliance with the Settlement Agreement**

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

## Restraint

| Outcome 1- Restraint use decreases at the facility and for individuals. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 1 | There has been an overall decrease in, or ongoing low usage of, restraints at the facility. | 92% 11/12 | This is a facility indicator. | | | | | | | | |
| 2 | There has been an overall decrease in, or ongoing low usage of, restraints for the individual. | 78% 7/9 | 0/1 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |

Comments:

1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (May 2015 through January 2016) were reviewed. The data showed that the overall use of crisis intervention restraint at San Angelo SSLC to be decreasing over the nine-month period, with the most recent five months being lower than the preceding four months. Moreover, the average across these nine months was lower than the average of the previous nine months (August 2014 to April 2015). That being said, the census-adjusted frequency of crisis intervention restraint usage at San Angelo SSLC was the second highest in the state, however, given the declining trend, it was scored positively for this indicator.

The frequency of physical crisis intervention restraints roughly paralleled the overall trend of crisis intervention restraints (because most crisis intervention restraints were physical restraints), that is, showing a downward trend. The average duration of physical restraints remained low and stable, at around five minutes. Crisis intervention chemical restraints showed a downward trend, with the most recent two months being the lowest usage of the nine months. There were zero uses of mechanical crisis intervention restraint.

Injuries during restraint showed a similar downward trend, with the most recent two months also being the lowest of the nine months. The number of individuals receiving crisis intervention restraint remained stable, but at a relatively high level, at around nine percent of the census. The number of individuals using protective mechanical restraint for self-injurious behavior remained constant at two, the same two individuals for whom this procedure was used at the time of the last review. While onsite, the Monitoring Team learned of continued efforts to reduce the amount of time, and the size of the mechanical restraint for both individuals and, therefore, this was scored positively for this indicator. The use of non-chemical and chemical restraint for medical and dental procedures was low or at zero.

Thus, state and facility data showed low usage and/or decreases in 11 of these 12 facility-wide measures (i.e., use of crisis intervention restraint, use and duration of physical crisis intervention restraints, use of mechanical and crisis intervention restraints, injuries during

restraint, use of protective mechanical restraint, use of chemical or non-chemical dental restraints, use of non-chemical medical restraints).

2. Five of the individuals reviewed by the Monitoring Team were subject to restraint. Four received crisis intervention physical restraints and crisis intervention chemical restraints (Individual #366, Individual #397, Individual #292, Individual #13) and one received only crisis intervention physical restraint (Individual #199). Data from state office and from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for three of the five (Individual #199, Individual #292, Individual #13).

The other four individuals did not have any occurrences of crisis intervention restraint or protective mechanical restraint for self-injurious behavior during this period (Individual #129, Individual #54, Individual #343, Individual #203). One of these four (Individual #129) had restraint in the prior nine-month period.

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 13 | | | | |
| 3 | There was no evidence of prone restraint used. | 100% 9/9 | 2/2 | 1/1 | 2/2 | 2/2 | 2/2 | | | | |
| 4 | The restraint was a method approved in facility policy. | 100% 9/9 | 2/2 | 1/1 | 2/2 | 2/2 | 2/2 | | | | |
| 5 | The individual posed an immediate and serious risk of harm to him/herself or others. | 100% 9/9 | 2/2 | 1/1 | 2/2 | 2/2 | 2/2 | | | | |
| 6 | If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others. | 80% 4/5 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | | | | |
| 7 | There was no injury to the individual as a result of implementation of the restraint. | 89% 8/9 | 2/2 | 1/1 | 2/2 | 1/2 | 2/2 | | | | |
| 8 | There was no evidence that the restraint was used for punishment or for the convenience of staff. | 100% 9/9 | 2/2 | 1/1 | 2/2 | 2/2 | 2/2 | | | | |
| 9 | There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment. | 50% 2/4 | 2/2 | Not rated | 0/2 | Not rated | Not rated | | | | |
| 10 | Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. | 100% 9/9 | 2/2 | 1/1 | 2/2 | 2/2 | 2/2 | | | | |
| 11 | The restraint was not in contradiction to the ISP, PBSP, or medical | 44% | 0/2 | 0/1 | 0/2 | 2/2 | 2/2 | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | orders. | 4/9 | | | | | | | | | |

Comments:
The Monitoring Team chose to review nine restraint incidents that occurred for five different individuals (Individual #366, Individual #199, Individual #397, Individual #292, Individual #13). Of these, five were crisis intervention physical restraints and four were crisis intervention chemical restraints. The crisis intervention restraints were for aggression to staff or other individuals, or self-injurious behavior. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

6. This indicator only applied to the five crisis intervention physical restraints. For Individual #397 11/23/15 the wrong release code was used. That is, a Y code was scored instead of the S code.

7. A non-serious injury was documented for the physical crisis intervention restraint for Individual #292 8/8/15.

9. Because criterion for indicator #2 was met for Individual #199, Individual #292, and Individual #13, this indicator was not scored for them. For Individual #366, the various aspects of programming and treatment implementation that the Monitoring Team looks for were in place. For Individual #397, however, treatment integrity was below criterion. Further, Individual #397's restraint occurred at a time he should have been at his day program workshop. Lack of engagement and participation was a factor in the exhibition of behavior that led to crisis restraint being needed.

11. The IRRF section of the ISP did not show a selection of one of the two options in the template to document restraint considerations for three of the individuals. This clerical task should be easy to correct for all individuals.

| Outcome 3- Individuals who are restrained receive that restraint from staff who are trained. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 13 | | | | |
| 12 | Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions. | 100% 3/3 | 1/1 | 1/1 | 1/1 | Not rated | Not rated | | | | |

Comments:
12. Because criterion for indicators #2 through #11 were met for Individual #292 and Individual #13, this indicator was not scored for them. Staff who worked with the other three individuals were able to answer the Monitoring Team's questions.

| Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 13 | | | | |
| 13 | A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor. | 89% 8/9 | 2/2 | 1/1 | 2/2 | 2/2 | 1/2 | | | | |
| 14 | There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities. | N/A | N/A | N/A | N/A | N/A | N/A | | | | |
| Comments:<br>13. One restraint did not meet criterion. It was for Individual #13 9/27/15. The restraint occurred at 5:40, the restraint monitor was notified at 6:28, and the restraint monitor arrived at 6:40 pm. | | | | | | | | | | | |

| Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 13 | | | | |
| a. | If the individual is restrained, nursing assessments (physical assessments) are performed. | 0% 0/9 | 0/2 | 0/1 | 0/2 | 0/2 | 0/2 | | | | |
| b. | The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects. | 50% 1/2 | N/A | N/A | 0/1 | 1/1 | N/A | | | | |
| c. | Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual. | 50% 1/2 | N/A | N/A | 0/1 | 1/1 | N/A | | | | |
| Comments: a. The crisis intervention restraints reviewed included those for: Individual #366 on 9/3/15 at 11:30 p.m. (chemical), and 12/13/15 at 9:30 p.m.; Individual #99 on 8/29/15 at 10:31 p.m.; Individual #397 on 10/28/15 at 9:14 p.m. (chemical), and 11/23/15 at 2:12 p.m.; Individual #292 on 7/7/15 at 12:50 p.m. (chemical), and 8/8/15 at 10:25 p.m.; and Individual #13 on 8/30/15 at 4:30 p.m. (chemical), and 9/27/15 at 5:40 p.m. For all of the applicable restraints, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint. However, for all restraints reviewed, problems were noted with regard to the documentation of vital signs, as well as documentation of mental status. The following provides a description of some of the problems noted: at times, respirations were marked as "refused," but the individual's cooperation is not needed to determine whether or not the individual is breathing; specifics regarding individuals' mental status or reactions to the chemical restraints often were not provided; and at times, nursing staff did not document whether or not pulse oximetry was attempted. | | | | | | | | | | | |

b. and c. Individual #397 was administered intramuscular (IM) Thorazine, for which a potential side effect is orthostatic hypotension. Individual #397 had four consecutive blood pressures taken at 15-minute intervals. On 10/28/15 at 10:10 p.m., his blood pressure was 89/42, followed by a reading at 10:25 p.m. at which time his blood pressure was 88/43. At 10:40 p.m. and 10:55 p.m., the nurse noted: "BP monitor would not register." There was no indication the nurse tried to obtain or document a manual blood pressure. The physician should have been notified regarding the low blood pressures.

Although the Crisis Intervention documentation indicated Individual #292 did not sustain an injury in relation to the restraint on 8/8/15, an injury report and nursing IPN described an injury.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 13 | | | | |
| 15 | Restraint was documented in compliance with Appendix A. | 100% 9/9 | 2/2 | 1/1 | 2/2 | 2/2 | 2/2 | | | | |

Comments:
15. Criteria were met for all five individuals. Documentation was done very well.

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 13 | | | | |
| 16 | For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy. | 40% 2/5 | 2/2 | 0/1 | 0/2 | Not rated | Not rated | | | | |
| 17 | If recommendations were made for revision of services and supports, it was evident that recommendations were implemented. | N/A | N/A | N/A | N/A | N/A | N/A | | | | |

Comments:
16. Because criterion for indicators #2 through #11 were met for Individual #292 and Individual #13, this indicator was not scored for them. DADS policy requires that when crisis intervention restraint occurs and the individual does not have a crisis intervention plan, the IDT must meet to review the restraint within one business day. Individual #199 and Individual #397 did not have a CIP, but there was no documentation (e.g., an ISPA) to demonstrate that this review occurred for any of their three restraints. Another potential source of documentation could be the dates in the Restraint Checklist Review section of the restraint, however, for these three, the dates indicated review after four days for two of the restraints and three weeks for the third.

**Abuse, Neglect, and Incident Management**

| Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 | |
| 1 | Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury. | 89% 8/9 | 1/1 | 1/1 | 2/2 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | |

Comments:

The Monitoring Team reviewed nine investigations that occurred for eight individuals. Of these nine investigations, eight were DFPS investigations of abuse-neglect allegations (one confirmed, seven unconfirmed). The other one was for a facility investigation of a sexual incident. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #199, unconfirmed physical abuse allegation, 439-13073, UIR 8006, 8/19/15
- Individual #397, unconfirmed physical abuse allegation, 439-41837, UIR 8041, 8/31/15
- Individual #292, unconfirmed physical abuse allegation, 438-14742, UIR 7864, 7/3/15
- Individual #292, sexual incident, UIR 8392, 12/26/15
- Individual #129, unconfirmed physical abuse allegation, 438-80092, UIR 7953, 8/4/15
- Individual #154, unconfirmed sexual abuse allegation, 440-04470, UIR 8140, 9/28/15
- Individual #343, unconfirmed physical abuse allegation, 441-18258, UIR 8268, 11/17/15
- Individual #13, unconfirmed physical abuse allegation, 439-53793, UIR 8064, 9/5/15
- Individual #203, unconfirmed neglect allegation, 441-71227, UIR 8421, 1/4/16

1. For all nine investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes (a) the occurrence of staff criminal background checks and signing of duty to report forms, (b) facility and IDT review of trends of prior incidents and related occurrences, and the (c) development, implementation, and (d) revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator and other facility staff met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

All criteria were met for eight of the nine investigations for this indicator. To be specific, background checks and signature sheets were done for all staff for all nine investigations. Two incidents did not have any prior occurrences and trends, so the other criteria did not apply (Individual #154 UIR 8140, Individual #203 UIR 8421). The remaining seven investigations were related to the individual's history of problem behaviors and, for six of the seven, the UIR included good discussion of the behavior problem, the PBSP, and data. That is, it was evident to the Monitoring Team that the facility was addressing the behaviors. Individual #343 (UIR 8268), however, had a PBSP in place to address sexual behavior, but sexual behavior was not related to this incident. According to the alleged perpetrator, she inappropriately restrained him because she was afraid of him because he had punched her in the past. During this same time

period, ISPAs noted that his aggression was increasing. The PBSP did not address aggression even though the team noted many concerns and an increasing trend.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 | |
| 2 | Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy. | 78% 7/9 | 1/1 | 1/1 | 2/2 | 1/1 | 1/1 | 0/1 | 0/1 | 1/1 | |

Comments:

2. The Monitoring Team rated seven of the investigations as being reported correctly. The other two were rated as being reported late or incorrectly reported. All were discussed with the facility Incident Management Coordinator while onsite. This discussion, along with additional information provided to the Monitoring Team, informed the scoring of this indicator. Those not meeting criterion are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

- Individual #343 UIR 8268: This late reporting was identified by the facility and actions were put into place. Per the DFPS report, the incident occurred at 9:30 am and was reported to DFPS at 11:40 am. The facility director was notified at 12:18 pm. The UIR contained two entries at 9:30 am, both of which include staff statements that should have generated a call to DFPS at that time or within an hour. Elsewhere in the UIR, it showed staff being placed in no direct contact status at 10:10 am, suggesting a determination was made at 10:10 am that the encounter represented possible abuse. UIR recommendations #4 and #5 acknowledged that this incident was reported late and that both employees were to be retrained.
- Individual #13 UIR 8064: Per DFPS, the incident occurred on 9/5/15 and was reported to them on 9/8/15. The first page of the UIR reported the same and also said that this was not a case of late reporting as the RMS reporter was conducting a standard quality assurance review of videos when this incident was discovered and immediately reported. This suggested that the review occurred on 9/8/15 late in the afternoon. This statement seemed contradicted by a UIR entry on page 5 that at 10:35 pm on 9/5/15, the AOD notified campus administrator that she had been notified by RMS that he had reported an allegation for the individual and that all three staff were placed on no direct contact. But, according to the DFPS report, they did not receive this reported allegation until 9/8/15 at 5:02 pm. These apparent contradictions should have been identified by the facility, reconciled in the UIR review process, and documented in the UIR.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 | |
| 3 | Staff who regularly work with the individual are knowledgeable | 100% | Not rated | Not rated | Not rated | Not rated | Not rated | 1/1 | Not rated | Not rated | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | about ANE and incident reporting | 1/1 | | | | | | | | | |
| 4 | The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | |
| 5 | If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | |
| Comments: | | | | | | | | | | | |

| Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 | |
| 6 | Following report of the incident the facility took immediate and appropriate action to protect the individual. | 100% 9/9 | 1/1 | 1/1 | 2/2 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | |
| Comments: | | | | | | | | | | | |

| Outcome 5– Staff cooperate with investigations. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 | |
| 7 | Facility staff cooperated with the investigation. | 100% 9/9 | 1/1 | 1/1 | 2/2 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | |
| Comments: | | | | | | | | | | | |

| Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 | |
| 8 | Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized. | 100% 9/9 | 1/1 | 1/1 | 2/2 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | |
| 9 | Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled. | 100% 9/9 | 1/1 | 1/1 | 2/2 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | |
| 10 | The analysis of the evidence was sufficient to support the findings | 100% | 1/1 | 1/1 | 2/2 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained) | 9/9 | | | | | | | | | |
| Comments: | | | | | | | | | | | |

| Outcome 7– Investigations are conducted and reviewed as required. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 | |
| 11 | Commenced within 24 hours of being reported. | 100% 9/9 | 1/1 | 1/1 | 2/2 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | |
| 12 | Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing). | 100% 9/9 | 1/1 | 1/1 | 2/2 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | |
| 13 | There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent. | 89% 8/9 | 1/1 | 1/1 | 2/2 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | |
| Comments:<br>13. For Individual #13 UIR 8064, the supervisory review did not identify and reconcile the conflicting data as to when the RMS actually determined that the incident be reported. | | | | | | | | | | | |

| Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 | |
| 14 | The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation. | 100% 9/9 | 1/1 | 1/1 | 2/2 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | |
| 15 | For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported. | 100% 1/1 | 1/1 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | |
| Comments: | | | | | | | | | | | |

| Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 | |
| 16 | The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case. | 100% 7/7 | N/A | 1/1 | 2/2 | N/A | 1/1 | 1/1 | 1/1 | 1/1 | |
| 17 | If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely. | 100% 5/5 | N/A | 1/1 | 1/1 | N/A | 1/1 | 1/1 | N/A | 1/1 | |
| 18 | If the investigation recommended programmatic and other actions, they occurred and they occurred timely. | 100% 4/4 | N/A | N/A | 1/1 | N/A | 1/1 | N/A | 1/1 | 1/1 | |
| Comments: | | | | | | | | | | | |

| Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | | | | | | | | | |
| 19 | For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending. | Yes | | | | | | | | | |
| 20 | Over the past two quarters, the facility's trend analyses contained the required content. | Yes | | | | | | | | | |
| 21 | When a negative pattern or trend was identified and an action plan was needed, action plans were developed. | Yes | | | | | | | | | |
| 22 | There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified. | Yes | | | | | | | | | |
| 23 | Action plans were appropriately developed, implemented, and tracked to completion. | Yes | | | | | | | | | |
| Comments:<br>19-23. The facility system for tracking, trending, and analyzing incident related data, and for developing follow-up plans, as noted in the last review, continued to be exemplary. | | | | | | | | | | | |

**Psychiatry**

| Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 397 | 292 | 13 | | | | | |
| 47 | The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint. | 0%<br>0/4 | 0/1 | 0/1 | 0/1 | 0/1 | | | | | |
| 48 | Multiple medications were not used during chemical restraint. | 50%<br>2/4 | 0/1 | 1/1 | 1/1 | 0/1 | | | | | |
| 49 | Psychiatry follow-up occurred following chemical restraint. | 50%<br>2/4 | 0/1 | 1/1 | 1/1 | 0/1 | | | | | |

Comments:
47-49. The review of the restraint episodes regarding Individual #397 on 10/28/15 and Individual #292 on 07/07/15 revealed that, while the restraint review was performed, the review was done outside of the allowable time limit. In both of these restraints, only one medication was utilized and there were interim psychiatric progress notes documenting contact with the individual.

For the restraint episodes regarding Individual #13 on 10/30/15 and Individual #366 on 09/30/15, there was no consult and review form provided for review, more than one medication was utilized in each episode, and there were no clinical or interim notes documenting psychiatric follow-up following the event.

**Pre-Treatment Sedation**

| Outcome 5 – Individuals receive dental pre-treatment sedation safely. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed. | 0%<br>0/2 | N/A | N/A | N/A | N/A | 0/1 | 0/1 | N/A | N/A | N/A |
| b. | If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed. | N/A | | | | | | | | | |

Comments: a. The State did not have a policy for determining whether or not individuals had proper medical clearance for the use of TIVA. On 6/12/14, the Facility implemented a TIVA policy. The policy described a number of requirements including "medical clearance." However, the policy did not provide guidance regarding perioperative clearance and which types of medical conditions

made individuals ineligible to have TIVA at the Facility (i.e., individuals who require hospital dentistry). PCPs were not required to review the medical condition of the individual prior to clearance. The anesthesiologist did this. The Facility should include a requirement for the PCP to conduct a "perioperative evaluation" in this operational procedure. There are numerous sources available to provide guidance in this area.

b. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation.

| Outcome 9 – Individuals receive medical pre-treatment sedation safely. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed. | N/A | | | | | | | | | |
| Comments: None. | | | | | | | | | | | |

| Outcome 1 - Individuals' need for pretreatment chemical restraint (PTCR) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTCR. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 129 | 343 | | | | | | |
| 1 | IDT identifies the need for PTCR and supports needed for the procedure, treatment, or assessment to be performed and discusses the five required items. | 0%<br>0/3 | 0/1 | 0/1 | 0/1 | | | | | | |
| 2 | If PTCR was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTCR, or (b) determined that any actions to reduce the use of PTCR would be counter-therapeutic for the individual. | 33%<br>1/3 | 0/1 | 0/1 | 1/1 | | | | | | |
| 3 | If treatments or strategies were developed to minimize or eliminate the need for PTCR, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTCR (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format. | N/A | N/A | N/A | N/A | | | | | | |
| 4 | Action plans were implemented. | N/A | N/A | N/A | N/A | | | | | | |
| 5 | If implemented, progress was monitored. | N/A | N/A | N/A | N/A | | | | | | |
| 6 | If implemented, the individual made progress or, if not, changes were made if no progress occurred. | N/A | N/A | N/A | N/A | | | | | | |

Comments:
1. Three individuals received pretreatment chemical restraint. Individual #366 for TIVA on 8/28/15, Individual #129 for TIVA on 9/17/15, and Individual #343 for colonoscopy in January 2016. None of their ISPs discussed the five required items. Individual #366's addressed one, Individual #343's two, and Individual #129's none.

2. An ISPA for Individual #343 provided documentation that the team determined that any actions to reduce the use of PTCR would be counter-therapeutic for him. The three required items were included.

**Mortality Reviews**

Outcome 10 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 288 | 90 | | | | | | | |
| a. | For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review. | 100% 2/2 | 1/1 | 1/1 | | | | | | | |
| b. | Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement. | 0% 0/2 | 0/1 | 0/1 | | | | | | | |
| c. | Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement. | 0% 0/2 | 0/1 | 0/1 | | | | | | | |
| d. | Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement. | 0% 0/2 | 0/1 | 0/1 | | | | | | | |
| e. | Recommendations are followed through to closure. | 0% 0/2 | 0/1 | 0/1 | | | | | | | |

Comments: a. Since the last review, three individuals died. The Monitoring Team reviewed two of these deaths. Individual #128 was in the group the Monitoring Team reviewed. He died a few days before the onsite review. The Facility had not yet conducted reviews of his death. Causes of death were listed as:

- For Individual #288, aspiration pneumonia, and sepsis;
- For Individual #90, cardiopulmonary failure, and multi-organ failure; and
- For Individual #128, the preliminary causes were listed as respiratory and cardiac arrest.

Of note, the Facility Director had not signed two of the official reports. The Monitoring Team reviewed this issue with the Settlement Agreement Coordinator.

b. through d. Some of the concerns with regard to recommendation included:

- Evidence was not submitted to show the Facility conducted thorough reviews of medical care. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews.
- For Individual #288, the mortality reviews included no recommendations related to the medical care provided. A physician should evaluate an individual with a history of a volvulus and small bowel obstruction who develops significant vomiting, a distended abdomen, and hypoactive or absent bowel sounds. A medical provider saw Individual #288 24 hours after the symptoms started. This was a delay in care, and it was not reflected in the clinical death review.
- For Individual #288's death, the Quality Assurance RN completed a Quality Improvement Clinical Death document that included six recommendations. The Clinical and/or Administrative Death Reviews included none of these recommendations, and no justification was provided for not including them. Examples of recommendations included: "Develop a system of oversight to ensure that Trigger Data Sheets are being completed, and signed by appropriate staff," or "Retraining nursing staff in regards to appropriate abdominal assessment, which should focus on timeframe for listening to bowel sounds."
- Similarly, for Individual #90's death, the Quality Assurance RN completed a Quality Improvement Clinical Death document that included seven recommendations. The Clinical and/or Administrative Death Review included none of these recommendations, and no justification was provided for not including them. An example of a recommendations was: "Retraining of nursing staff to ensure that all acute problems have an Acute Care Plan initiated within time frame outlined in the policy."

e. In response to the Monitoring Team's request for documentation showing the Facility followed the recommendations resulting from mortality reviews through to closure, the Facility submitted a series of charts listing each recommendation, the person responsible, the due date, evidence needed, and comments/updates. Attached to these charts were copies of meeting minutes, emails, etc. Closure of recommendations generally could not be confirmed for a number of reasons, including, for example:

- The charts submitted did not include a column for date of completion, and there was no indication on the charts that the recommendations had been followed through to closure.
- In some cases, recommendations were not measurable. For example, it was unclear how Facility staff could determine when the following recommendation was complete: "Documentation issues (Abbreviation's [sic] should not be used while documenting, also MARS [sic] and I&O and trigger data sheets where [sic] not being completed correctly.) Need to look at systems issues," or "Additional training from Hospice on pain management and end-of-life care. Quarterly would be good."
- In some cases, the documentation submitted with the charts did not confirm completion of the recommendations. For example, one of the recommendations read: "Clinical Work Group (CWG) to review and revise I&O [input and output] policy and forms to standardize and simplify (easier forms, add bowel movement specifications, colostomy bag care, etc.)" The Facility submitted copies of meeting minutes from the Clinical Work Group. However, these minutes did not provide evidence of closure of the recommendation. At each meeting, the group developed a set of action steps, and often raised questions that needed closure. The last minutes were from a meeting on 12/8/15, and the group included a list of action steps at the end of these minutes. However, no documentation was submitted to show that the various action steps were ever completed, or that the Clinical Work Group had successfully reviewed and revised the policy and forms.

- In addition, mortality review recommendations generally were not written in a way that ensured Facility practice had improved. Using the example in the bullet above this one, the recommendation required a group to meet to review and revise the input and output policy and forms. This in no way ensured that problematic practices changed. The recommendation should have been written in a manner that required closure to include monitoring to determine whether or not staff were following the revised input and output tracking requirements.

**Quality Assurance**

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | ADRs are reported immediately. | N/A | | | | | | | | | |
| b. | The Pharmacy and Therapeutics Committee thoroughly discusses the ADR. | N/A | | | | | | | | | |
| c. | Clinical follow-up action is taken, as necessary, with the individual. | N/A | | | | | | | | | |
| d. | Reportable ADRs are sent to MedWatch. | N/A | | | | | | | | | |

Comments: a. through d. Facility staff had not identified adverse drug reactions for any of the individuals reviewed.

It was unclear whether the Facility had mechanisms in place to ensure potential ADRs were reported. As part of the pre-review document request, the Facility submitted a list of the six potential ADRs that staff reported during the six months before the review. One of the Drug Utilization Reviews documented hyper-prolactinemia in several individuals. These should have been reported as ADRs if not previously done, but based on the list the Facility submitted, it did not appear they were.

Individual #148 had several prolactin levels greater than 200. Medical providers did not address this until the attending hospital psychiatrist documented that the individual was taking multiple psychotropic that were "significantly contraindicated." Significantly elevated prolactin levels warrant investigation for pituitary micoadenomas. This appeared to be done in the past. However, the DUE highlighted the adverse effects of elevated prolactin levels. As noted in the DUE, there were problems with lab monitoring for hyper-prolactinemia with Risperdal use and the Facility did not document a corrective action plan to address this issue.

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.

| # | Indicator | Score |
|---|---|---|
| a. | DUEs are completed in a timely manner based on the determined frequency but no less than quarterly. | 50%<br>1/2 |

| | | |
|---|---|---|
| b. | There is evidence of follow-up to closure of any recommendations generated by the DUE. | 0%<br>0/1 |
| Comments: a. Since the Monitoring Team's last review, the Facility completed one DUE in February 2016. The drug evaluated was Risperidone. The purpose of the DUE was to determine if appropriate lab monitoring occurred at the Facility. Eleven individuals were prescribed Risperidone, six of whom had received the drug continually. Three of six individuals were determined to have deficiencies related to lab monitoring. All three of the individuals had hyperprolactinemia.<br><br>b. The Facility did not submit a corrective action plan to address the deficiencies. Minutes from the Pharmacy and Therapeutics Committee were also not submitted as requested in the document request. It is unclear what if any actions were taken to address the problems with lab monitoring. | | |

**Domain** #2: Using its policies, training, and quality assurance systems to establish and maintain compliance, the State will provide individuals in the Target Population with service plans that are developed through an integrated individual support planning process that address the individual's strengths, preferences, choice of services, goals, and needs for protections, services, and supports.

**ISPs**

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 366 | 343 | 13 | 203 | 5 | 386 | | | |
| 1 | The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her. | 0%<br>0/6 | 3/6 | 2/6 | 2/6 | 0/6 | 3/6 | 0/6 | | | |
| 2 | The personal goals are measurable. | 0%<br>0/6 | 3/6 | 2/6 | 3/6 | 0/6 | 3/6 | 0/6 | | | |
| 3 | There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals. | 0%<br>0/6 | 0/6 | 0/6 | 0/6 | 0/6 | 0/6 | 0/6 | | | |

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #366, Individual #343, Individual #13, Individual #203, Individual #5, Individual #386). The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the San Angelo SSLC campus. The ISPs were developed between 7/14/15 and 10/22/15. There were no noticeable differences in quality between the ISPs developed in July 2015 and the ISPs developed in October 2015.

1. There was some improvement noted in the development of individualized personal goals based on preferences and strengths. The improvement was most evident in goals developed to address living options. For example, Individual #366's living option goal stated that he will move to an HCS group home in Killeen, TX. Individual #13's living option goal to be referred back home to live with her mother within 12 months was also individualized based on her preferences. These represented an improvement from the commonly used generic goal to live in the most integrated setting consistent with preferences, strengths, and needs.

Even though more individualized, there was still little evidence that goals were written to give individuals opportunities for greater exposure to new experiences or to develop new skills that might lead to a broader range of preferences. For example, relationship goals typically were written to increase contact with family or continue outings with peers. There were no goals written to encourage the development of new relationships, particularly in the community. Examples of individualized, measurable goals based on preferences included:

- Individual #13's goals to learn to tie her shoes and attend church in the community.
- Individual #5's goal to have a face-to-face visit with her mother at the facility.

- Individual #343's leisure goal to have a garden.

2. Most goals for individuals were not written in measurable terms, thus, it was not possible to determine if progress towards meeting goals had been achieved. Personal goals did not include a clear indicator that could be used to determine when the goals had been met. An example of a personal goal that was not measurable was Individual #386's employment goal "will sort recyclables." An example that did not define the skill to be learned was Individual #5's goal that stated, "will complete her money management SAP successfully." The examples above in #1 were also examples of measurable goals.

Personal goals should be aspirational statements of outcomes. Some personal goals may be readily achievable within the coming year, while some many will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and also need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

3. Review of data implementation sheets and QIDP monthly reviews indicated that consistent data were not collected for most ISP action plans. Monthly reviews of services and supports noted gaps in implementation and data collection for all of the individuals. In some cases, it was noted that action plans were never fully implemented during the ISP year. As noted, personal goals and many action plans were not measurable, therefore, there was no basis for assessing whether reliable and valid data were available.

The Monitoring Team observed Individual #203's ISP preparation meeting. Action plans were reviewed. There were no data available for the majority of her action plans, thus, the IDT was unable to determine if she had made progress towards her goals. Furthermore, there was confusion at the meeting regarding whether or not the action plans being reviewed were current or from her previous ISP.

| Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 343 | 13 | 203 | 5 | 386 | | | |
| 8 | ISP action plans support the individual's personal goals. | 0% 0/6 | 1/6 | 1/6 | 3/6 | 0/6 | 1/6 | 0/6 | | | |
| 9 | ISP action plans integrated individual preferences and opportunities for choice. | 50% 3/6 | 1/1 | 1/1 | 0/1 | 0/1 | 0/1 | 1/1 | | | |
| 10 | ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making. | 17% 1/6 | 0/1 | 1/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |
| 11 | ISP action plans supported the individual's overall enhanced independence. | 50% 3/6 | 1/1 | 0/1 | 0/1 | 0/1 | 1/1 | 1/1 | | | |
| 12 | ISP action plans integrated strategies to minimize risks. | 33% 2/6 | 1/1 | 0/1 | 1/1 | 0/1 | 0/1 | 0/1 | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 13 | ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs. | 17% 1/6 | 1/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |
| 14 | ISP action plans integrated encouragement of community participation and integration. | 0% 0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |
| 15 | The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. | 50% 3/6 | 1/1 | 0/1 | 1/1 | 0/1 | 1/1 | 0/1 | | | |
| 16 | ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs. | 67% 4/6 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 0/1 | | | |
| 17 | ISP action plans were developed to address any identified barriers to achieving goals. | 33% 2/6 | 0/1 | 0/1 | 1/1 | 0/1 | 1/1 | 0/1 | | | |
| 18 | Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur. | 0% 0/6 | 0/6 | 0/6 | 0/6 | 0/6 | 0/6 | 1/6 | | | |

Comments:

8. Personal goals were not well defined in the ISPs as indicated above.

9. Preferences and opportunities for choice were minimally addressed in three of six ISPs. These were Individual #343, Individual #366, and Individual #386. Individuals had limited opportunities to learn new skills based on identified preferences. For example, Individual #366 had an employment goal to work in the music industry. The ISP did not address his preferences in relation to specific types of jobs in the music industry or skills that might be beneficial in obtaining a job. Similarly, Individual #5 had a goal to work in the greenhouse. The ISP did not indicate how employment at the greenhouse related to her preferences or offered opportunities to learn new work skills based on her assessed needs. Individual #203 had a goal to attend the Suzy Crawford Center during the day. Her preferences for specific activities and skill building opportunities were not defined. None of the ISPs identified what work skills the individual might need to learn to succeed at employment other than behavioral goals that might relate to employment or a move into the community.

10. ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making for five of the individuals. One individual (Individual #343) had action plans related to informed decision-making. He had an action plan to address decision-making restrictions placed upon him by the court. It was also positive to learn that Individual #343's IDT had obtained a medical power of attorney for him, however, this was not noted in his ISP.

The self-advocacy committee remained an active and vibrant part of the San Angelo SSLC campus. Around 80 individuals attended the meeting that the Monitoring Team also attended. This was typical attendance. The committee addresses problems raised by individuals with the expectation that individuals themselves (with support from the human rights officer and his staff) will define the

problem, generate solutions, choose and implement actions, and evaluate them. A review of the agendas for the past nine months showed a variety of interesting topics: rights, transitioning, employment, and a presentation from the local national weather service. IDTs could consider developing action plans (and personal goals) related to self-advocacy committee activities, as well as related to individual and/or group problem solving.

11. Action plans for three of six individuals supported their enhanced independence, however, it was often difficult to determine how action plans to support independence were chosen as priorities based on preferences.

- For Individual #366, the IDT developed action plans for learning to drive, administering his medication, and living in the community.
- Individual #5 had SAPs for money management, making her bed, and cleaning her room.
- Individual #386's team had developed action plans to learn sign language to express his preferences and put away his clothing.
- Two of three SAPs for Individual #343 were maintenance activities rather than skill building. He had minimal action plans to increase his independence by learning new skills other than action plans to address behavior.
- Individual #203 did not have action plans for skill building and her IDT seemed to have little expectation for growth or skill development.
- Individual #13 had one SAP; it was for skill building related to deep breathing exercises.

12. Individual #366 and Individual #13's ISPs adequately integrated strategies to address risks. All individuals had an IHCP to address risks, however, not all risks were identified and supports to address risk were not typically integrated into other parts of the ISP. For example, outcomes and strategies to address falls for Individual #343 were not consistent throughout the ISP, IHCP, and PNMP. Individual #203's ISP did not include recommendation in her annual medical assessment for managing her asthma. Individual #5 had multiple falls during the ISP year. It was not evident that the IDT integrated strategies to address her falls into her ISP. See additional comments related to At-Risk outcomes.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were not well integrated. Examples included:

- Individual #203's PNMP strategies, communication strategies and psychiatric support plan were not integrated into her SAPs/action plans for day programming.
- There was no evidence that Individual #343's IDT met to review recommendations from his PNMT or neurological assessment. Recommendations were not integrated into his ISP. All recommendations from his medical assessments were not integrated into his IHCP. Supports for falls varied between his PNMP and IHCP.
- Individual #386's communication and behavioral strategies were not integrated into his SAPs.
- Recommendations from Individual #13's sensory assessment were not integrated into supports strategies.

14. Meaningful and substantial community integration was largely absent from the ISPs. There were no specific plans for community participation that would have promoted any meaningful integration for any individual.

15. Three of six IDTs considered opportunities for day programming in the most integrated setting, consistent with the individual's preferences and support needs. Although Individual #343 and Individual #386 had goals related to employment, it was not evident

how those goals were related to preferences or would support them to develop additional work skills. It was also not evident that Individual #203's day programming related to her skills and interest. Additionally, she had no opportunity to develop new skills.

A renewed focus on work opportunities on campus may help improve options available to individuals and their participation in those activities. Examples include the new apprenticeship program, a new employment director, and support from facility management.

16. Opportunities for functional engagement with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs were not evident for Individual #203 and Individual #386. They were both scheduled to attend the Suzy Crawford Center, however, functional skill building opportunities were not defined. Observations by the Monitoring Team did not support that ISPs were regularly implemented and that individuals were engaged in functional activity. Four of the six individuals were rarely engaged in meaningful activity during observations. Individual #13 and Individual #343 were both observed working at the sheltered workshop through most of the week. Individual #13 was on spring break from school and reported that she enjoyed working and making money during the break. Individual #343 reportedly attended work regularly. Individual #203, Individual #366, Individual #5, and Individual #386 were never observed participating in day programming.

17. Overall, individuals were making little progress towards outcomes, and barriers were not regularly identified and addressed in the ISP, and as noted in other sections of this report, particularly barriers related to health and participation in day programming. SAPs were often continued from the previous ISP without identifying barriers to consistent implementation.

18. For the most part, ISPs did not include collection of enough, or the right types of, data to make decisions regarding the efficacy of supports. SAPs often did not describe the behavioral objective. IHCP goals/objectives and interventions were often not measurable. In many cases, action plans were written to measure attendance without consideration of building skills to achieve the goal. For example,

- Individual #203 had goals to visit a group home in the community and attend the Suzy Crawford Center.
- Individual #366 had a goal to participate in an off campus activity once per month.
- Individual #13 had action plans to attend counseling and group sessions.
- Individual #343 had a goal to make a friend. It was not clear what would constitute successful completion of this goal or what he would need to do to make progress.

| Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 343 | 13 | 203 | 5 | 386 | 322 | | |
| 19 | The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities). | 67% 4/6 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 0/1 | N/A | | |
| 20 | If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner. | 100% 1/1 | N/A | N/A | N/A | N/A | N/A | N/A | 1/1 | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 21 | The ISP included the opinions and recommendation of the IDT's staff members. | 67%<br>4/6 | 0/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | N/A | | |
| 22 | The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR. | 100%<br>6/6 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A | | |
| 23 | The determination was based on a thorough examination of living options. | 50%<br>3/6 | 1/1 | 1/1 | 1/1 | 0/1 | 0/1 | 0/1 | N/A | | |
| 24 | The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community). | 67%<br>4/6 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 0/1 | N/A | | |
| 25 | For annual ISP meetings observed, a list of obstacles to referral was identified. | 100%<br>1/1 | N/A | N/A | N/A | N/A | N/A | N/A | 1/1 | | |
| 26 | IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition. | 67%<br>4/6 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 0/1 | N/A | | |
| 27 | For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles. | 0%<br>0/1 | N/A | N/A | N/A | N/A | N/A | N/A | 0/1 | | |
| 28 | ISP action plans included individualized measurable plans to educate the individual/LAR about community living options. | 0%<br>0/4 | N/A | N/A | 0/1 | 0/1 | 0/1 | 0/1 | N/A | | |
| 29 | The IDT developed action plans to facilitate the referral if no significant obstacles were identified. | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | | |

Comments:

19. Four of six ISPs included a description of the individual's preference and how that was determined. Individual #343, Individual #366, Individual #13, and Individual #5 had recently moved from the community, so were more aware of their options. For the remainder, preferences were largely unknown.

20. The Monitoring Team attended the annual ISP for Individual #322. There was good discussion about where he wanted to live. He said that he wanted to live with his parents, but then a number of IDT members (counseling, BHS, vocational, DSP) said that he had talked to them many times about wanting to explore foster care that is near his family, but not live with his family. His father said he'd love if Individual #322 lived with them, but he wanted whatever Individual #322 wanted, and that the family would be fine with foster care.

21. Four of six ISPs included a statement regarding the overall decision of the entire IDT, exclusive of the individual and LAR. The opinions of key staff members were not documented in assessments for Individual #366 (psychiatrist) and Individual #5 (nursing).

22. All ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR.

23. Three individuals had a thorough examination of living options based upon their preferences, needs, and strengths. Individual #203's preferences were unknown. Individual #5 was newly admitted and discussion was limited regarding her living preferences. Individual #386's team determined that his behavioral needs could not be met in the community, however, it was not clear which supports that IDT thought were not available in the community.

24. Four of six ISPs identified a thorough and comprehensive list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed. Individual #203's IDT noted that health was a barrier to placement and Individual #386's team identified behavioral needs as the barrier. In both cases, it was not clear why these were considered barriers to placement.

25. During the ISP meeting observed by the Monitoring Team, the IDT described a number of obstacles to referral, such as sexual behavior occurrences, day program and work attendance, attending SOTP sessions, and talking with the judge, who invited them to do so, once the individual made progress and participated regularly.

26. Individual #203 and Individual #386's ISPs did not include measurable action plans to address identified barriers to community placement.

27. During the ISP meeting observed by the Monitoring Team, no specific plan was put into place to support overcoming the obstacles to the individual's referral, other than telling that individual that he needed to do stop doing the problem behaviors and do better at attending work and therapy sessions.

28. None of the four ISPs included individualized measurable plans to educate the individual or when applicable the LAR.

| Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 343 | 13 | 203 | 5 | 386 | | | |
| 30 | The ISP was revised at least annually. | 100% 4/4 | 1/1 | 1/1 | N/A | 1/1 | N/A | 1/1 | | | |
| 31 | An ISP was developed within 30 days of admission if the individual was admitted in the past year. | 100% 2/2 | N/A | N/A | 1/1 | N/A | 1/1 | N/A | | | |
| 32 | The ISP was implemented within 30 days of the meeting or sooner if indicated. | 17% 1/6 | 0/1 | 0/1 | 1/1 | 0/1 | 0/1 | 0/1 | | | |
| 33 | The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able). | 83% 5/6 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | | | |
| 34 | The individual had an appropriately constituted IDT, based on the | 17% | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | individual's strengths, needs, and preferences, who participated in the planning process. | 1/6 | | | | | | | | | |

Comments:
30. ISPs were developed on a timely basis.

31. Individual #5 and Individual #13 were admitted to the facility in the past year. Their ISPs were developed within 30 days of admission.

32. Per QIDP monthly reviews, Individual #203, Individual #343, Individual #366, Individual #5, and Individual #386 had numerous action plans that were not implemented within 30 days of development.

33. Individual #203 did not attend her ISP meeting.

34. Five individuals did not have an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. Examples included:

- Individual #203's PCP did not attend her annual meeting. Health issues appeared to be the greatest barrier to her participation in functional programming.
- The psychiatrist did not attend Individual #343, Individual #366, Individual #13, or Individual #5's meetings. Psychiatry input was critical for all four.

When IDT members are unable to attend the meeting, more IDTs were seeking and documenting their input and comments prior to the meeting and bringing those comments forward at the meeting.

Outcome 6: ISP assessments are completed as per the individuals' needs.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 366 | 343 | 13 | 203 | 5 | 386 | | | |
| 35 | The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting. | 83% 5/6 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | | | |
| 36 | The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting. | 0% 0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |

Comments:
35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP Preparation meeting. Individual #386's team met, however, did not consider an updated communication assessment to assess progress towards communication goals from the previous year.

36. IDTs did not arrange for and obtain all needed assessments prior to the IDT meeting.

- Individual #203 did not have a QDRR, her psychiatry assessment used data from her 2014 behavioral assessment, and her annual nursing assessment was incomplete.
- Individual #343's QDRR, FSA, and annual medical assessment were not submitted 10 days prior to his annual IDT meeting.
- Individual #366's behavioral health assessment, annual medical assessment, and QDRR were not submitted 10 days prior to his ISP meeting.
- Individual #13's FSA and vision were submitted late.
- Individual #5's PSI and QDRR were not submitted 10 days prior to her ISP meeting.
- Individual #386 did not have an updated communication assessment following completion of his outcome to learn sign. The IDT continued his communication SAP without assessing his progress.

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

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 366 | 343 | 13 | 203 | 5 | 386 | | | |
| 37 | The IDT reviewed and revised the ISP as needed. | 0% 0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |
| 38 | The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports. | 0% 0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |

Comments:

37. IDTs generally met when the individual experienced some type of regression or change in status, but they rarely used data to make decisions about revising the ISP. As noted throughout this report, consistent reliable data were not available to help teams determine if supports were effective and if the individual was making progress. It was not evident that IDT members always reviewed supports and took action as needed when individuals failed to make progress on outcomes, experienced regression, or refused to participate.

38. QIDPs were not, for the most part, monitoring action plans on a monthly basis. Consistent implementation, progress, and/or regression could not be determined due to missing data for all individuals. As noted above, it was not evident that reviews resulted in action taken when ISPs were not implemented or not effective.

The QA department had been tracking the percentage completed on time and the percentage ultimately completed, even if late. Less than half completed on time, one third to half were never completed at all. The quality (content) of the reviews was monitored through November 2015 and was being re-started in March 2016. The indicators used in this facility-created tool were very good and appropriate. This tool should be a useful guide for QIDPs in improvement of the monthly review process. It was also good to see that San Angelo SSLC had this as part of their QA program.

| Outcome 1 – Individuals at-risk conditions are properly identified. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | The individual's risk rating is accurate. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| b. | The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs. | 78% 14/18 | 1/2 | 2/2 | 1/2 | 2/2 | 2/2 | 2/2 | 2/2 | 1/2 | 1/2 |

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #203 – urinary tract infections (UTIs), and constipation/bowel obstruction; Individual #343 – fluid imbalance, and infections; Individual #271 – gastrointestinal (GI) problems, and skin integrity; Individual #24 – constipation/bowel obstruction, and UTIs; Individual #5 – constipation/bowel obstruction, and seizures; Individual #386 – constipation/bowel obstruction, and skin integrity; Individual #288 – constipation/bowel obstruction, and UTIs; Individual #128 – GI problems, and infections; and Individual #148 – GI problems, and infections).

a. IDTs did not effectively use supporting clinical data when determining and documenting individuals' risk ratings.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs completed an IRRF for Individual #5, who was newly admitted, and updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs did not review the IRRFs, and make changes, as appropriate, including for Individual #203 – UTIs, Individual #271 – skin integrity, Individual #128 – infections, and Individual #148 – infections.

**Psychiatry**

| Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 4 | The individual has goals/objectives related to psychiatric status. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| 5 | The psychiatric goals/objectives are measurable. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| 6 | The goals/objectives are based upon the individual's assessment. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| 7 | Reliable and valid data are available that report/summarize the | 0% | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | individual's status and progress. | 0/9 | | | | | | | | | |

Comments:
4-7. Psychiatry related goals for individuals, when present, related to the reduction of problematic behaviors, such as aggression (e.g., Individual #13), or to the absence of medication side effects (e.g., Individual #203). Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric disorder and that provided measures of positive indicators related to the individual's functional status. All of the goals will need to be formulated in a manner that would make them measurable, based upon the individual's psychiatric assessment, and provide data so that the individual's status and progress can be determined. This will allow the psychiatrist to make data driven decisions regarding the efficacy of psychotropic medications.

For example, the goal in the IHCP for Individual #154 was to have no incidents of physical aggression for three months. This individual had a diagnosis of autism and he was prescribed Lithium and Geodon for indications of mood and psychosis, respectively. It is not clear how a reduction of physical aggression corresponded to these medication target symptoms. For Individual #366, there was one goal for him to have a reduction in psychiatric symptoms. Those symptoms, however, were not identified and the target behaviors monitored were physical aggression, verbal aggression, and property destruction. These do not correlate with the primary diagnosis of bipolar mood disorder.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 12 | The individual has a CPE. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 13 | CPE is formatted as per Appendix B | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 14 | CPE content is comprehensive. | 11% 1/9 | 0/1 | 0/1 | 0/1 | 1/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| 15 | If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission. | 100% 3/3 | 1/1 | N/A | 1/1 | N/A | N/A | N/A | N/A | 1/1 | N/A |
| 16 | All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |

Comments:
14. The Monitoring Team looks for 14 components in the CPE. While all components were included in the CPE, boiler plate/cut and paste information (i.e., not individualized or specific to the individual) was present in many of the CPEs. Bio-psycho-social formulations

were replete with information that was standard or consistently found across all evaluations. From one to three items did not meet criterion in the CPEs. These were the bio-psycho-social formulations in five of the CPEs, review of labs in three, and physical exam or treatment recommendations in one. The CPE for Individual #292, however, was an exception in that, while boiler plate information was present, the document also contained a great deal of individualized content.

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

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 17 | Status and treatment document was updated within past 12 months. | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A | 1/1 | 1/1 | 1/1 |
| 18 | Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP). | 0% 0/8 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | N/A | 0/1 | 0/1 | 0/1 |
| 19 | Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months. | 67% 6/9 | 0/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 |
| 20 | The psychiatrist or member of the psychiatric team attended the individual's ISP meeting. | 44% 4/9 | 0/1 | 1/1 | 1/1 | 0/1 | 1/1 | 0/1 | 0/1 | 0/1 | 1/1 |
| 21 | The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

Comments:

18. The Monitoring Team scores 16 aspects of the annual evaluation document. Overall, the annual evaluations were difficult to follow. They included a great deal of information cut and pasted from other sources. There was not a cogent summary that tied all of the information together in a summary to make the document a usable resource.

21. There was a need for improvement with regard to the documentation of the ISP discussion to include the rationale for determining that the proposed psychiatric treatment represented the least intrusive and most positive interventions, the integration of behavioral and psychiatric approaches, the signs and symptoms monitored to ensure that the interventions are effective and the incorporation of data into the discussion that would support the conclusions of these discussions, and a discussion of both the potential and realized side effects of the medication in addition to the benefits. The Monitoring Team looks for the above noted aspects of psychiatry participation. At the annual ISP meeting for Individual #322, observed by the Monitoring Team, the psychiatrist attended the entire meeting and actively participated when relevant questions and topics arose. The four components that comprise indicator #21 were not specifically discussed.

| Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 22 | If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided. | 100% 1/1 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 1/1 |

Comments:
22. One individual, Individual #203, had a PSP. While all the required items were technically present, the plan was scant, without much detail. It was concerning that the symptoms identified for monitoring of a mood disorder were designated as tension and excitement, which are factors included in the Brief Psychiatric Rating Scale. There are other rating scales normed for this population and mood symptoms that might be more indicative of a mood disorder. In addition, as the results of the Brief Psychiatric Rating Scale were not trended over time, it would be difficult to determine changes over time.

| Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 28 | There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 29 | The written information provided to individual and to the guardian was adequate and understandable. | 89% 8/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 |
| 30 | A risk versus benefit discussion is in the consent documentation. | 22% 2/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 | 1/1 | 0/1 | 0/1 |
| 31 | Written documentation contains reference to alternate and non-pharmacological interventions that were considered. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| 32 | HRC review was obtained prior to implementation and annually. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |

Comments:
29. There was detailed information regarding medication side effects included in the consent forms. The exception was one medication for Individual #13 that had incorrect side effect information, that is, for Thorazine rather than for imipramine.

30-31. There was a brief review of risks versus benefit in the consent documentation, with more detailed information included in the annual assessment or quarterly psychiatric reviews. Similar issues were noted with alternate and non-pharmacological interventions that were considered. There was a need for improvement with regard to the identification of alternate and non-pharmacological interventions. The consent forms stated that there were no alternatives to the recommended prescribed medication.

**Psychology/behavioral health**

| Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 1 | If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP. | 100% 13/13 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A |
| 2 | The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs. | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A |
| 3 | The psychological/behavioral goals/objectives are measurable. | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A |
| 4 | The goals/objectives were based upon the individual's assessments. | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A |
| 5 | Reliable and valid data are available that report/summarize the individual's status and progress. | 0% 0/8 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | N/A |

Comments:

1. Of the 14 individuals reviewed by both Monitoring Teams, 13 required a PBSP (eight of nine individuals reviewed by the behavioral health Monitoring Team and five of nine individuals reviewed by the physical health Monitoring Team). All 13 of those individuals had PBSPs.

2-3. All individuals with a PBSP had measurable behavioral objectives.

4. All of the PBSPs had behaviors targeted for increase and decrease that were based upon the individual's assessments.

5. Individual #397 and Individual #129 had interobserver agreement (IOA) assessments conducted in the last six months that were above 80%. They did not, however, have any measures of data collection timeliness. The remaining six individuals with PBSPs did not have either IOA or data collection timeliness measures. In order to ensure that target and replacement behavior data are reliable, it is critical that all individuals with PBSPs have regular IOA and data collection measures. Ensuring reliability of data should be a priority area for improvement for the behavioral health services department.

| Outcome 3 - All individuals have current and complete behavioral and functional assessments. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 10 | The individual has a current, and complete annual behavioral health update. | 78% 7/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 0/1 |
| 11 | The functional assessment is current (within the past 12 months). | 88% 7/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | N/A |
| 12 | The functional assessment is complete. | 88% 7/8 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A |

Comments:
10. All individuals had annual behavioral health assessments. Individual #203's, however, was more than one year old (dated 7/14/14), and Individual #343's was incomplete because it did not contain an adaptive functioning status.

11. Individual #154's functional assessment was more than 12 months old (dated 8/7/13).

12. All of the functional assessments contained all of the necessary components and, generally, were of excellent quality. Individual #397's functional assessment, however, was rated incomplete because of inconsistencies. Specifically, his direct assessment concluded that talking to him was an effective intervention for his target behaviors, however, the indirect assessment and summary indicated that the attention from staff was maintaining his target behaviors.

| Outcome 4 – All individuals have PBSPs that are current, complete, and implemented. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 13 | There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A |
| 14 | The PBSP was current (within the past 12 months). | 88% 7/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | N/A |
| 15 | The PBSP was complete, meeting all requirements for content and quality. | 62% 5/8 | 1/1 | 1/1 | 0/1 | 0/1 | 1/1 | 1/1 | 1/1 | 0/1 | N/A |

Comments:
14. Individual #154's PBSP was dated 8/22/16

15. The Monitoring Team reviews 13 components in the evaluation of an effective behavior support plan. Although only five PBSPs (Individual #366, Individual #199, Individual #129, Individual #154, Individual #343) were rated as having all 13 components, all eight PBSPs reviewed contained the majority of these components. Individual #397, Individual #292, and Individual #13's PBSPs were rated

| |
|---|
| as incomplete because the replacement behaviors were not functional and there was no rationale provided why a functional replacement behavior was not practical or functional. |

| Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 24 | If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service. | 100% 6/6 | 1/1 | 1/1 | 1/1 | 1/1 | N/A | N/A | 1/1 | 1/1 | N/A |
| 25 | If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes. | 100% 6/6 | 1/1 | 1/1 | 1/1 | 1/1 | N/A | N/A | 1/1 | 1/1 | N/A |
| Comments: 25. Individual #366, Individual #199, Individual #397, Individual #292, Individual #343, and Individual #13 received counseling services at the time of the onsite review. All five treatment plans and progress notes were judged to be complete. | | | | | | | | | | | |

**Medical**

| Outcome 2 – Individuals receive timely and quality routine medical assessments and care. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs. | 100% 1/1 | N/A | N/A | N/A | N/A | 1/1 | N/A | N/A | N/A | N/A |
| b. | Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days. | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | N/A | 1/1 | 1/1 | 1/1 | 1/1 |
| c. | Individual has timely quarterly reviews for the three quarters in which an annual review has not been completed. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| d. | Individual receives quality AMA. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| e. | Individual's diagnoses are justified by appropriate criteria. | 100% 18/18 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 |
| f. | Individual receives quality quarterly medical reviews. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| Comments: d. Problems varied across medical assessments. However, in all of the medical assessments reviewed, one to five | | | | | | | | | | | |

components were missing or incomplete. As applicable to the individuals reviewed, all annual medical assessments addressed:

- Social/smoking histories;
- Past medical histories;
- Interval histories;
- Allergies or severe side effects of medications;
- Lists of medications with dosages at the time of the AMA; and
- Pertinent laboratory information.

Moving forward, the Medical Department should focus on ensuring medical assessments include, as appropriate:

- Pre-natal histories;
- Family history;
- Childhood illnesses;
- Complete physical exams with vital signs;
- Updated active problem lists; and
- Plans of care for each active medical problem, when appropriate.

The recommendations for the active medical problems were based on a template for medical management. However, this section of the AMA was not person-specific. In other words, it provided guidelines for management that were not specific for the individual. Moreover, many AMAs included five to 10 pages related to the medications prescribed, listing all side effects, etc. The result was often an AMA that was 20 to 30 pages, and the unnecessary information would make the document cumbersome for a consultant to read as part of an evaluation.

e. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. It was good to see that clinical justification was present for the diagnoses reviewed.

Outcome 7 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations. | 6% 1/18 | 0/2 | 0/2 | 0/2 | 0/2 | 1/2 | 0/2 | 0/2 | 0/2 | 0/2 |

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #203 – respiratory compromise, and UTIs; Individual #343 – cardiac disease, and weight; Individual #271 – osteoporosis, and cardiac disease; Individual #24 – gastrointestinal problems, and cardiac disease; Individual #5 – gastrointestinal problems, and other: endocrine - hypothyroidism; Individual #386 – seizures, and cardiac disease; Individual #288 – osteoporosis, and seizures; Individual #128 – seizures, and osteoporosis; and Individual #148 – osteoporosis, and hypertension).

The ISP/IHCP that sufficiently identified the medical care necessary to address the individual's chronic care or at-risk condition was for Individual #5 – gastrointestinal problems.

The AMAs included a recommendation section that often provided a set of treatment guidelines, but not the specific plan for the individual. The assessment should clearly state the current status of the problem and the person-specific plan that will be implemented, not a generalized treatment template. As a result of these concerns with the AMAs, it was difficult for IDTs to include a complete and individualized medical plan in the IHCPs. The following provide examples of some of the problems noted:

- The IDT rated Individual #203 at high risk for UTIs. Although the AMA listed recurrent UTIs as an active problem, there was no plan or recommendation to address it, and thus, the IHCP did not include a plan for the medical management of UTIs.
- For Individual #343's cardiac disease, the goals in AMA and IHCP were not congruent. The IHCP cited a goal of maintaining a cholesterol level less than 200. The AMA documented a goal to decrease the 10-year atherosclerotic cardiovascular disease (ASCVD), risk but did not document the estimated risk using the Pooled Cohort Equations. The current American College of Cardiology/American Heart Association (ACC/AHA) guidelines no longer focus on low-density lipoprotein (LDL), targets but rather on a person's overall risk of developing ASCVD. The risk assessment is important in identifying individuals that might benefit from statin therapy. It also is important in helping to determine the intensity of statin therapy (high or moderate). The AMA should document an assessment and plan for each active medical problem, but did not.
- For Individual #271 – cardiac disease, the AMA documented the cardiac status as stable, but did not provide any further information such as the date of the last echocardiogram, the severity of the aortic regurgitation, or the last cardiology evaluation. Interestingly, the physical exam indicated the individual had no cardiac murmur. Even mild aortic regurgitation has a characteristic murmur. The AMA goal was to monitor for clinical or echocardiographic changes over the next 12 months. Monitoring of progression requires careful documentation of the baseline status for an individual with a history of aortic regurgitation. The IHCP goal was non-specific and provided no measures for monitoring this condition. In addition, according to the IHCP, action steps included monitoring of the electrocardiogram (EKG) with changes to be reported by the RN Case Manager to the PCP. This was not an appropriate action step, because RNs do not interpret 12-lead EKGs. The PCP must interpret the EKG with a cardiologist providing an over-read.
- For Individual #24, who was at high risk for cardiac disease, there was no plan for hypertension documented in the AMA, although the individual was treated with Metoprolol. The IHCP goal for the cardiac risk was to maintain blood pressure and heart rate within normal limits throughout the year. The IHCP did not include a goal related to the hyperlipidemia diagnosis. The AMA stated the goal for hyperlipidemia was to decrease the ASCV risk, but the current risk was not documented. Calculating this risk is a key factor in making further treatment decisions.
- Individual #386 had a history of seizure disorder. Although he had not had a documented seizure in two years, a low risk rating was not appropriate. Due to the low risk rating, there was no IHCP to address this individual who continues to be treated with anti-epileptic drugs.

**Dental**

| Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | Individual receives timely dental examination and summary: | | | | | | | | | | |
| | i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days. | 100% 1/1 | N/A | N/A | Not Rated (N/R) | N/A | 1/1 | N/A | N/A | N/A | N/A |
| | ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days. | 86% 6/7 | 1/1 | 1/1 | | 1/1 | N/A | 0/1 | 1/1 | 1/1 | 1/1 |
| | iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting. | 86% 6/7 | 1/1 | 1/1 | | 1/1 | N/A | 0/1 | 1/1 | 1/1 | 1/1 |
| b. | Individual receives a comprehensive dental examination. | 44% 4/9 | 1/1 | 1/1 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 | 1/1 | 0/1 |
| c. | Individual receives a comprehensive dental summary. | 63% 5/8 | 0/1 | 1/1 | N/R | 1/1 | 0/1 | 1/1 | 0/1 | 1/1 | 1/1 |

Comments: Because Individual #271 was a part of the outcome sample, and was at low risk for dental, some indicators were not rated for him (i.e., the "deeper review" indicators).

a. It was positive that for six of the individuals reviewed, dental examinations were completed within 365 days of the previous one, but no earlier than 90 days, and dental summaries were completed no later than 10 working days prior to the ISP meeting. It was also positive that Individual #5, who was newly admitted, had an exam completed within 30 days of admission.

b. It was positive that the dental exams of four individuals the Monitoring Team reviewed contained all of the necessary components. Of note, all four of these individuals were edentulous. It was good that all dental exams reviewed included, as applicable:

- A description of the individual's cooperation;
- An oral cancer screening;
- An oral hygiene rating completed prior to treatment;
- A description of sedation use;
- Information regarding last x-ray(s) and type of x-ray, including the date;
- A description of periodontal condition;
- The number of teeth present/missing;
- Caries risk;
- Periodontal risk;

- Specific treatment provided;
- The recall frequency; and
- A treatment plan.

However, staff in the Dental Department should focus on ensuring exams include, as applicable:

- Periodontal charting; and
- An odontogram (i.e., the odontograms were in black and white, so could not be interpreted, and did not include a narrative).

c. It was positive that five of the dental summaries reviewed contained all of the necessary components. As applicable, the following elements were included in all of the dental summaries reviewed:

- Recommendations related to the need for desensitization or other plan;
- Effectiveness of pre-treatment sedation;
- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health;
- Recommendations for the risk level for the IRRF;
- Dental care recommendations; and
- Treatment plan, including the recall frequency.

All but one included:

- The number of teeth present/missing; and
- A description of the treatment provided.

Three did not include:

- Provision of written oral hygiene instructions.

Of concern, the Dental Assistant completed two of the dental summaries. The Dental Assistant is not qualified to render professional opinions and/or make dental recommendations. This concern was raised during the last review, but it appeared the Dental Department was taking steps to correct this issue.

## Nursing

| Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | Individuals have timely nursing assessments: | | | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission. | 100% 1/1 | N/A | N/A | N/A | N/A | 1/1 | N/A | N/A | N/A | N/A |
| | ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting. | 75% 6/8 | 0/1 | 0/1 | 1/1 | 1/1 | N/A | 1/1 | 1/1 | 1/1 | 1/1 |
| | iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| b. | For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| c. | If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice. | 0% 0/8 | 0/2 | N/A | 0/1 | N/A | N/A | 0/1 | 0/1 | 0/2 | 0/1 |

Comments: a. It was positive that for most of the individuals reviewed, nurses completed timely new admission or annual comprehensive nursing reviews, as well as quarterly nursing record reviews. The exceptions were for Individual #203 for whom documentation was not present to show that a Physical Assessment for the annual review and/or Braden Scale were completed; and for Individual #343, whose Physical Assessment was completed two days prior to the ISP meeting.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #203 – UTIs, and constipation/bowel obstruction; Individual #343 – fluid imbalance, and infections; Individual #271 – gastrointestinal (GI) problems, and skin integrity; Individual #24 – constipation/bowel obstruction, and UTIs; Individual #5 –constipation/bowel obstruction, and seizures; Individual #386 – constipation/bowel obstruction, and skin integrity; Individual #288 – constipation/bowel obstruction, and UTIs; Individual #128 – GI problems, and infections; and Individual #148 – GI problems, and infections).

The annual comprehensive nursing assessments did not contain reviews of the risks reviewed that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

c. Nursing assessments were not completed in accordance with nursing protocols or current standards of practice for individuals' changes of status.

| Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| b. | The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| c. | The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working). | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| d. | The IHCP action steps support the goal/objective. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| e. | The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements). | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| f. | The individual's ISP/IHCP identifies the frequency of monitoring/review of progress. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| Comments: a. through f. Problems seen across all IHCPs were: missing nursing interventions to address the chronic/at-risk condition; a lack of individualization of nursing protocols to address the individuals' specific health care needs (i.e., often, IDTs repeated the same action steps for a number of different risks, and, as a result, the action steps had no correlation to the specific risk); a lack of focus on preventative measures; a lack of measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working); a lack of action steps that supported the goal/objective; a lack of specific clinical indicators to be monitored; and lack of identification of the frequency for monitoring of the individuals' health risks. | | | | | | | | | | |

**Physical and Nutritional Management**

| Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team | 40% 2/5 | 0/1 | 1/1 | 0/1 | N/A | N/A | N/A | N/A | 1/1 | 0/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | or PNMT. | | | | | | | | | | |
| b. | The PNMT review is completed within five days of the referral, but sooner if clinically indicated. | 40%<br>2/5 | 0/1 | 1/1 | 0/1 | | | | N/A | 1/1 | 0/1 |
| c. | For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely. | 20%<br>1/5 | 0/1 | 0/1 | 0/1 | | | | N/A | 1/1 | 0/1 |
| d. | Based on the identified issue, the type/level of review/assessment meets the needs of the individual. | 50%<br>3/6 | 0/1 | 1/1 | 0/1 | | | | 1/1 | 1/1 | 0/1 |
| e. | As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results. | 50%<br>1/2 | 0/1 | N/A | N/A | | | | N/A | N/A | 1/1 |
| f. | Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue. | 50%<br>3/6 | 0/1 | 1/1 | 0/1 | | | | 1/1 | 1/1 | 0/1 |
| g. | If only a PNMT review is required, the individual's PNMT review at a minimum discusses:<br>• Presenting problem;<br>• Pertinent diagnoses and medical history;<br>• Applicable risk ratings;<br>• Current health and physical status;<br>• Potential impact on and relevance to PNM needs; and<br>• Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan. | 25%<br>1/4 | 0/1 | N/A | 0/1 | | | | 1/1 | N/A | 0/1 |
| h. | Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary. | 20%<br>1/5 | 0/1 | 0/1 | 0/1 | | | | N/A | 1/1 | 0/1 |

Comments: a. through d., and f. For the five individuals that should have been referred to the PNMT:

- According to an OT/PT IPN dated 10/28/15, Individual #203 was diagnosed with aspiration pneumonia. However, the PNMT did not review/assess her.
- On 6/9/15, the PNMT initiated Individual #343's comprehensive assessment, but did not complete it until 8/28/15.
- For Individual #271, no evidence was found to show the IDT referred him to the PNMT, or that the PNMT made a self-referral. However, based on review of meeting minutes and ISPAs, he experienced choking incidents on 3/20/15, 7/23/15, 9/25/15, 10/14/15, and 11/23/15. Although three of these were determined not to be "true" choking, they were significant in light of the other choking incidents. A brief note in the IPNs indicated that PNMT consultation was not indicated, but this note did not provide sufficient clinical documentation for the IDT's decision.
- Individual #148's IDT did not refer her to the PNMT despite significant weight loss, a possible episode of aspiration pneumonia acquired in hospital while she had a naso-gastric tube secondary to aggression psychotic/catatonic state. This set of circumstances warranted at least a review by the PNMT. Although Individual #148 was mentioned in the PNMT minutes, dated 11/12/15, the discussion documented did not reflect a review of the depth and complexity necessary to address Individual

#148's needs.

In addition, since 3/26/14, Individual #288 had been on the PNMT caseload. As a result, the Monitoring Team did not assess indicators related to timeliness of referral, review, or assessment, and did not assess the quality of the assessment. However, the PNMT conducted ongoing review of his goals and action steps. He was admitted to the hospital on 9/14/15 for bowel obstruction, and possible aspiration pneumonia. On 9/22/15, he died during this hospitalization.

e. For Individual #203's hospitalization from 10/19/15 to 10/26/15, an RN Hospitalization Review was not completed in a timely manner.

h. It was positive that the PNMT conducted a thorough Comprehensive PNMT Assessment for Individual #128. As noted above, for Individual #271, Individual #148, and Individual #203, the PNMT should have conducted assessments, but did not.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP). | 6% 1/18 | 1/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| b. | The individual's plan includes preventative interventions to minimize the condition of risk. | 11% 2/18 | 1/2 | 0/2 | 1/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| c. | If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| d. | The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective. | 6% 1/18 | 0/2 | 0/2 | 1/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| e. | The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met. | 6% 1/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 1/2 | 0/2 |
| f. | Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable. | 6% 1/18 | 1/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| g. | The individual ISP/IHCP identifies the frequency of monitoring/review of progress. | 50% 9/18 | 2/2 | 2/2 | 2/2 | 1/2 | 0/2 | 1/2 | 1/2 | 0/2 | 0/2 |

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included goals/objectives related to: aspiration, and falls for Individual #203; choking, and falls for Individual #343; choking, and falls for Individual #271; falls, and choking for Individual #24; GI problems, and choking for Individual #5; weight, and choking for Individual #386; constipation/bowel obstruction, and weight for Individual #288; fluid

imbalance, and aspiration for Individual #128; and fractures, and choking for Individual #148.

a. ISPs/IHCPs reviewed generally did not sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or PNMP. The one that did was the IHCP for falls for Individual #203.

b. In addition, most ISPs IHCPs did not include preventative interventions to minimize the condition of risk. The exceptions were the IHCPs for falls for Individual #203, and choking for Individual #271.

c. Seven individuals reviewed had PNMPs, and the remaining two individuals (i.e., Individual #5, and Individual #148) had Dining Plans. All of the PNMPs and/or Dining Plans included most, but not all of the necessary components to meet the individuals' needs. None of the PNMPs included risk levels (i.e., not just the areas of risk, but the risk levels) related to supports. Other problems in some of the PNMPs included missing photographs (i.e., for Individual #5), photographs too small to serve as an adequate guide to staff (Individual #24), and inconsistency between the diet texture in the PNMP and those stated in the IPNs (i.e., for Individual #271).

d. The IHCP that identified the actions steps necessary to meet the identified objective was the one for choking for Individual #271.

e. The IHCP that identified the necessary clinical indicators was the one for fluid imbalance for Individual #128.

f. The IHCP that defined individualized triggers, and actions to take when they occur was the one for aspiration for Individual #203.

g. The IHCPs that defined the frequency of monitoring were those for aspiration, and falls for Individual #203; choking, and falls for Individual #343; choking, and falls for Individual #271; choking for Individual #24; choking for Individual #386; and constipation/bowel obstruction for Individual #288.

**Individuals that Are Enterally Nourished**

| Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake. | 0%<br>0/2 | 0/1 | N/A | N/A | N/A | N/A | N/A | N/A | 0/1 | N/A |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| b. | If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely. | 0%<br>0/2 | 0/1 | | | | | | | 0/1 | |

Comments: a. Clinical justification for total or supplemental enteral nutrition was not found in the IRRFs for Individual #203 or Individual #128.

b. For Individual #203, the IDT did not document discussion regarding the feasibility for her to progress along the continuum to oral intake. For Individual #128, although the IDT intended to start pleasure feedings, it was stated that these were not possible at the time of the ISP, dated 1/5/16, due to residuals. However, the IHCP did not include strategies to address the issues with residuals, or define a plan for when pleasure feeding might be possible. Goals related to residuals outlined in the PNMT evaluation/assessment were not included in the IHCP.

**Occupational and Physical Therapy (OT/PT)**

| Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | Individual receives timely screening and/or assessment: | | | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment. | N/A | N/A | N/A | N/A | N/A | Not Rated (N/R) | N/R | N/A | N/A | N/A |
| | ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days. | N/A | N/A | N/A | N/A | N/A | | | N/A | N/A | N/A |
| | iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs. | 71% 5/7 | 0/1 | 0/1 | 1/1 | 1/1 | | | 1/1 | 1/1 | 1/1 |
| b. | Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs. | 71% 5/7 | 0/1 | 0/1 | 1/1 | 1/1 | | | 1/1 | 1/1 | 1/1 |
| c. | Individual receives quality screening, including the following:<br>• Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills;<br>• Functional aspects of:<br>▪ Vision, hearing, and other sensory input;<br>▪ Posture;<br>▪ Strength;<br>▪ Range of movement;<br>▪ Assistive/adaptive equipment and supports;<br>• Medication history, risks, and medications known to have an impact on motor skills, balance, and gait;<br>• Participation in ADLs, if known; and<br>• Recommendations, including need for formal comprehensive assessment. | N/A | | | | | | | | | |
| d. | Individual receives quality Comprehensive Assessment. | 100% 1/1 | N/A | N/A | N/A | 1/1 | | | N/A | N/A | N/A |
| e. | Individual receives quality OT/PT Assessment of Current Status/Evaluation Update. | 50% 3/6 | 0/1 | 0/1 | 1/1 | N/A | | | 0/1 | 1/1 | 1/1 |
| | Comments: a. and b. Five of the seven individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status. The following concerns were noted: | | | | | | | | | | |

- Individual #203 did not have a current OT/PT assessment for the ISP meeting held on 7/14/15. On 10/18/15, she did have a post-hospitalization assessment completed as indicated.
- For Individual #343, no evidence was found that the OT/PT conducted a follow-up assessment in relationship to his falls, despite findings from program effectiveness monitoring, on 8/26/15, showing that supports were ineffective. An assessment was not completed until 9/30/15 for an ISP meeting held on 10/22/15.

d. and e. It was positive that the comprehensive assessment for Individual #24 included all of the necessary components, and provided her IDT with the information it needed to address her needs, taking into consideration her strengths and preferences. Similarly, the OT/PT Updates for Individual #271, Individual #128, and Individual #148 incorporated the necessary elements and provided an effective assessment for the IDT's use in planning. As noted above, Individual #203 should have had an OT/PT Update, but did not. The remaining updates included:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings;

They were missing one or more of the following elements:

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

| Outcome 3 – Individuals for whom OT/PT supports and services are indicated have ISPs that describe the individual's OT/PT-related strengths and needs, and the ISPs include plans or strategies to meet their needs. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | The individual's ISP includes a description of how the individual functions from an OT/PT perspective. | 86% 6/7 | 1/1 | 1/1 | 1/1 | 1/1 | N/R | N/R | 1/1 | 0/1 | 1/1 |
| b. | For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate. | 71% 5/7 | 1/1 | 1/1 | 1/1 | 0/1 | | | 1/1 | 1/1 | 0/1 |
| c. | Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment. | 30% 3/10 | 0/1 | 1/3 | 1/1 | 0/1 | | | 0/1 | 1/1 | 0/2 |
| d. | When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation. | N/A | | | | | | | | | |

Comments: a. Individual #128's ISP did not include a description of how he functioned from an OT/PT perspective.

b. Although Individual #24's ISP described the PNMP, there was no evidence the IDT discussed its continued relevance or approved the PNMP. Individual #148 had a dining plan, but there was no evidence the IDT reviewed or approved it at the most recent ISP meeting.

c. Individual #343's IDT converted a SAP for safe eating to a maintenance goal. Individual #271's IDT agreed with the OT/PT recommendations, though no active interventions were indicated. Individual #128's IDT incorporated into the ISP recommendations to modify his wheelchair.

**Communication**

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

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | Individual receives timely communication screening and/or assessment: | | | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment. | N/A | N/A | N/A | N/R | N/R | N/R | N/A | N/A | N/A | N/A |
| | ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission. | N/A | N/A | N/A | | | | N/A | N/A | N/A | N/A |
| | iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication. | 33%<br>2/6 | 1/1 | 0/1 | | | | 0/1 | 1/1 | 0/1 | 0/1 |
| b. | Individual receives assessment in accordance with their individualized needs related to communication. | 50%<br>3/6 | 1/1 | 0/1 | | | | 0/1 | 1/1 | 0/1 | 1/1 |
| c. | Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following:<br>• Pertinent diagnoses, if known at admission for newly-admitted individuals;<br>• Functional expressive (i.e., verbal and nonverbal) and receptive skills;<br>• Functional aspects of:<br>▪ Vision, hearing, and other sensory input;<br>▪ Assistive/augmentative devices and supports;<br>• Discussion of medications being taken with a known impact on communication;<br>• Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and<br>• Recommendations, including need for assessment. | 0%<br>0/2 | N/A | 0/1 | | | | N/A | N/A | N/A | 0/1 |
| d. | Individual receives quality Comprehensive Assessment. | 0%<br>0/1 | N/A | 0/1 | | | | N/A | N/A | N/A | N/A |
| e. | Individual receives quality Communication Assessment of Current Status/Evaluation Update. | 0%<br>0/4 | 0/1 | N/A | | | | 0/1 | 0/1 | 0/1 | N/A |
| Comments: a. and b. Individual #271, Individual #24, and Individual #5 did not require formal communication services and supports, and were part of the outcome group, so the Monitoring Team did not review these indicators for them. The following problems were noted:<br>• Individual #343 had a screening upon his admission in 2013, but did not have a comprehensive assessment despite a decline in mental status, and difficulty with communication according to an ISPA, dated 1/14/16. | | | | | | | | | | | |

- For Individual #386, the most current assessment submitted was dated 10/21/14, even though on 10/21/15, the IDT held an ISP meeting. He should have at least had an update.
- On 1/5/16, Individual #128's IDT held his ISP meeting, but the most recent assessment was completed on 1/12/15. He should have had at least an update.
- Individual #148's screening was completed on 10/13/15, but her ISP was held on 10/20/15.

d. and e. As noted above, Individual #343's IDT should have referred him for a comprehensive assessment based on his change of mental status, but they did not. Individual #386, and Individual #128's should have updates, but did not. Problems varied across updates for Individual #203 and Individual #288. On a positive note, both included:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services; and
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills.

However, in both updates reviewed, three or more of the key components were insufficient to address the individual's strengths, needs, and preferences. Based on the problems identified in the updates reviewed, moving forward, the Facility should ensure communication updates address, as appropriate:

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

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

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times. | 17% 1/6 | 0/1 | 0/1 | N/R | N/R | N/R | 0/1 | 0/1 | 1/1 | 0/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| b. | The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication. | 25% 1/4 | 0/1 | N/A | | | | 0/1 | 1/1 | 0/1 | N/A |
| c. | Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment. | 0% 0/4 | 0/1 | N/A | | | | 0/1 | 0/1 | 0/1 | N/A |
| d. | When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation. | N/A | | | | | | | | | |
| Comments: None. | | | | | | | | | | | |

**Skill Acquisition and Engagement**

| Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 1 | The individual has skill acquisition plans. | 89% 8/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 |
| 2 | The SAPs are measurable. | 93% 13/14 | 2/2 | 2/2 | 1/1 | 3/3 | 0/1 | 3/3 | 1/1 | 1/1 | N/A |
| 3 | The individual's SAPs were based on assessment results. | 93% 13/14 | 2/2 | 2/2 | 1/1 | 2/3 | 1/1 | 3/3 | 1/1 | 1/1 | N/A |
| 4 | SAPs are practical, functional, and meaningful. | 64% 9/14 | 2/2 | 2/2 | 0/1 | 1/3 | 1/1 | 3/3 | 0/1 | 0/1 | N/A |
| 5 | Reliable and valid data are available that report/summarize the individual's status and progress. | 36% 5/14 | 0/2 | 1/2 | 0/1 | 1/3 | 1/1 | 2/3 | 0/1 | 0/1 | N/A |

Comments:

1. The Monitoring Team chooses three current skill acquisition plans (SAPs) for each individual for review. There were only two SAPs available for review for Individual #366 and Individual #199; one SAP for Individual #397, Individual #343, Individual #129, and Individual #13; and none for Individual #203 for a total of 14 for this review. Typically, individuals have more than this number of skill acquisition plans because there are usually a number of skills that IDTs determine would be of benefit for the individual to acquire.

2. Ninety-three percent of the SAPs were judged to be measurable. Individual #129's correct responding SAP, however, was judged not be measurable because the overall objective was not clearly stated.

3. Ninety-three percent of the SAPs were based on assessment results. Individual #292's room cleaning SAP was scored as not based on assessment results because her FSA indicated she could independently clean her room.

4. Sixty-four percent of the SAPs appeared to be practical and functional (e.g., Individual #199's community transportation SAP). The SAPs that were judged not to be practical or functional typically appeared to represent a compliance issue rather than a new skill (e.g., Individual #13's deep breathing SAP).

5. Five of the 14 SAPs had interobserver agreement (IOA) demonstrating that the data were reliable. It was encouraging to learn that San Angelo SSLC was committed to ensuring that, in the future, every SAP will have an IOA assessment at least every six months.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 10 | The individual has a current FSA, PSI, and vocational assessment. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 11 | The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP. | 56% 5/9 | 0/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 0/1 | 1/1 |
| 12 | These assessments included recommendations for skill acquisition. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |

Comments:
11. Individual #366, Individual #199, Individual #343, and Individual #13's FSAs were not available to the IDT at least 10 days prior to their ISP.

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

**Restraints**

| Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 397 | 13 | | | | | | |
| 18 | If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint. | 100% 3/3 | 1/1 | 1/1 | 1/1 | | | | | | |
| 19 | If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days. | 100% 3/3 | 1/1 | 1/1 | 1/1 | | | | | | |
| 20 | The minutes from the individual's ISPA meeting reflected:<br>1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues,<br>2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them. | 100% 3/3 | 1/1 | 1/1 | 1/1 | | | | | | |
| 21 | The minutes from the individual's ISPA meeting reflected:<br>1. a discussion of contributing environmental variables,<br>2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them. | 100% 3/3 | 1/1 | 1/1 | 1/1 | | | | | | |
| 22 | Did the minutes from the individual's ISPA meeting reflect:<br>1. a discussion of potential environmental antecedents,<br>2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them? | 100% 3/3 | 1/1 | 1/1 | 1/1 | | | | | | |
| 23 | The minutes from the individual's ISPA meeting reflected:<br>1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint,<br>2. and if any were hypothesized to be relevant, a plan to address | 100% 3/3 | 1/1 | 1/1 | 1/1 | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | them. | | | | | | | | | | |
| 24 | If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP. | 100% 3/3 | 1/1 | 1/1 | 1/1 | | | | | | |
| 25 | If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP). | 100% 3/3 | 1/1 | 1/1 | 1/1 | | | | | | |
| 26 | The PBSP was complete. | N/A | N/A | N/A | N/A | | | | | | |
| 27 | The crisis intervention plan was complete. | 100% 3/3 | 1/1 | 1/1 | 1/1 | | | | | | |
| 28 | The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity. | 67% 2/3 | 1/1 | 1/1 | 0/1 | | | | | | |
| 29 | If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP. | 100% 3/3 | 1/1 | 1/1 | 1/1 | | | | | | |

Comments:
18-29. This outcome and its indicators applied to Individual #366, Individual #397, and Individual #13. It was encouraging to find that all three individuals had a sufficient number IDT meeting that addressed the necessary actions to better understand and implement plans to reduce future restraint.

28. Individual #366 and Individual #397 had a treatment integrity assessment at the time of their ISPA that indicated the PBSP was implemented as written. Individual #13 had her ISPA to address more than three restraints in 30 days on 9/14/15, however, she did not have a treatment integrity assessment until 10/23/15.

**Psychiatry**

| Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 1 | If not receiving psychiatric services, a Reiss was conducted. | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 2 | If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted. | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 3 | If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral. | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

Comments:
1-3. For the 15 individuals reviewed by both Monitoring Teams, all individuals were receiving psychiatric services.

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 8 | The individual is making progress and/or maintaining stability. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| 9 | If goals/objectives were met, the IDT updated or made new goals/objectives. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| 10 | If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made. | 71% 5/7 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | N/A | N/A |
| 11 | Activity and/or revisions to treatment were implemented. | 71% 5/7 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | N/A | N/A |

Comments:
8-9. Without measurable goals and objectives, progress could not be determined. Thus, the first two indicators are scored at 0%. There were, however, two individuals, Individual #203 and Individual #13, who were making progress based upon anecdotal reports, observations by and interactions with the Monitoring Team, and reduction in overt problem behaviors managed through the PBSP. For example, although not evident based on goal acquisition, Individual #13 had not engaged in self-injury in over six weeks, and she was very proud of her accomplishment.

10-11. Despite the absence of measurable goals, it was apparent that when some individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments) were developed and implemented. For example, for Individual #292, it was noted that antidepressant medications had been added with anecdotal reports of positive benefit. In the case of Individual #129, however, there was cause for concern because she was experiencing what appeared to be significant side effects related to her psychotropic medication regimen. This was discussed during the psychiatry clinical encounter regarding Individual #129 that was observed during the monitoring visit and at which time her medications were adjusted.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 23 | The derivation of the target behaviors was consistent in both the structural/ functional behavioral assessment and the psychiatric documentation. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 24 | The psychiatrist participated in the development of the PBSP. | 0%<br>0/8 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | N/A |
| Comments:<br>23. Although the derivation was consistent in both the structural/functional behavioral assessment and the psychiatric documentation, there were concerns regarding the validity of target symptoms identified. That is, the target symptoms did not correspond with specific diagnoses. | | | | | | | | | | | |

| Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 25 | There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use. | 67%<br>2/3 | N/A | 1/1 | N/A | N/A | N/A | 0/1 | N/A | N/A | 1/1 |
| 26 | Frequency was at least annual. | 100%<br>3/3 | N/A | 1/1 | N/A | N/A | N/A | 1/1 | N/A | N/A | 1/1 |
| 27 | There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken. | 67%<br>2/3 | N/A | 1/1 | N/A | N/A | N/A | 0/1 | N/A | N/A | 1/1 |
| Comments:<br>25-27. This outcome addresses the coordination between psychiatry and neurology. These indicators applied to three of the individuals. In two of the three cases, there was documentation, both in psychiatry and neurology notes, regarding information from the other discipline. It should be noted that this process was hampered by the fact that neurology clinics were conducted offsite. | | | | | | | | | | | |

| Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 33 | Quarterly reviews were completed quarterly. | 89%<br>8/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 |
| 34 | Quarterly reviews contained required content. | 0%<br>0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| 35 | The individual's psychiatric clinic, as observed, included the standard components. | 100%<br>2/2 | N/A | 1/1 | N/A | N/A | 1/1 | N/A | N/A | N/A | N/A |
| Comments:<br>33. Individuals were generally seen quarterly in a timely manner. The document request for Individual #13 revealed that there was no quarterly documentation available. | | | | | | | | | | | |

34. The Monitoring Team looks for nine components of the quarterly review. In general, reviews were missing two components: the review of the implementation of non-pharmacological interventions and the description of symptoms that support the psychiatric diagnosis.

35. Psychiatry clinic was observed for Individual #129 and Individual #199. In general, the psychiatry clinics were thorough and detailed, including the review of the pertinent laboratory examinations and other assessments. One issue noted was the lack of trending data regarding the Brief Psychiatric Rating Scale. This was the only symptom-specific information that psychiatrists received. Over time, it would be important for psychiatry and behavioral health staff to collaboratively identify appropriate target symptoms for monitoring that are specific to the individual's diagnosis.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 36 | A MOSES & DISCUS/MOSES was completed as required based upon the medication received. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

Comments:
36. These assessments were all done in a timely manner, however, the documents were reportedly reviewed and signed on the paper form, but not in the Avatar system. As such, the clinical correlation documentation was not included.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 37 | Emergency/urgent and follow-up/interim clinics were available if needed. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 38 | If an emergency/urgent or follow-up/interim clinic was requested, did it occur? | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A |
| 39 | Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information? | 87% 7/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | N/A |

Comments:
37-39. There was evidence of additional psychiatric reviews occurring when an individual was clinically unstable. These documents were generally handwritten.

| Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 40 | Daily medications indicate dosages not so excessive as to suggest goal of sedation. | 89% 8/9 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 41 | There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 42 | There is a treatment program in the record of individual who receives psychiatric medication. | 89% 8/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 |
| 43 | If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy. | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

Comments:

40. There was concern regarding Individual #129. She was experiencing what appeared to be side effects of her psychotropic medication regimen, specifically sedation. This was discussed in detail with psychiatry staff during the monitoring visit. In December 2015, she was lethargic, including sleeping an average of 14 hours nightly. Her medication regimen included an antidepressant medication at bedtime (Remeron) that has a side effect of sedation. Quarterly drug regimen reviews and polypharmacy committee review might have provided additional support for this individual, but as indicated elsewhere in this report, neither were occurring at San Angelo SSLC. At the psychiatry clinic during the onsite review week, her medications were adjusted/decreased.

41. There was no indication that the facility used psychotropic medication to sedate individuals for the convenience of staff or for punishment.

42. Individual #203's treatment program was questioned because she rarely attended day program, and alternative programming should be considered.

43. The facility did not use PEMA.

| Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 44 | There is empirical justification of clinical utility of polypharmacy medication regimen. | 0% 0/7 | 0/1 | N/A | 0/1 | 0/1 | 0/1 | N/A | 0/1 | 0/1 | 0/1 |
| 45 | There is a tapering plan, or rationale for why not. | 86% | 1/1 | N/A | 1/1 | 1/1 | 1/1 | N/A | 1/1 | 0/1 | 1/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 6/7 | | | | | | | | | |
| 46 | The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified. | 0%<br>0/7 | 0/1 | N/A | 0/1 | 0/1 | 0/1 | N/A | 0/1 | 0/1 | 0/1 |

Comments:
44 and 46. These indicators applied to seven individuals. Polypharmacy justification was not documented. There was currently no oversight of psychiatry prescribing practices (e.g., quarterly drug regimen reviews by pharmacy staff or a functioning polypharmacy committee). As a result, there was no systematic review of justifications occurring. The facility needs to implement polypharmacy committee activities and ensure that QDRRs are completed.

45. Individual #13's medications had been reduced since admission, but a current tapering plan was not evident because of the lack of documentation.

**Psychology/behavioral health**

| Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 6 | The individual is making expected progress | 0%<br>0/8 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | N/A |
| 7 | If the goal/objective was met, the IDT updated or made new goals/objectives. | 0%<br>0/2 | N/A | N/A | N/A | N/A | N/A | 0/1 | 0/1 | N/A | N/A |
| 8 | If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested. | 100%<br>2/2 | 1/1 | N/A | N/A | N/A | N/A | N/A | N/A | 1/1 | N/A |
| 9 | Activity and/or revisions to treatment were implemented. | 100%<br>2/2 | 1/1 | N/A | N/A | N/A | N/A | N/A | N/A | 1/1 | N/A |

Comments:
6. Available data indicated that Individual #366 and Individual #13 were not making progress. Individual #199, Individual #397, Individual #292, Individual #129, Individual #154, and Individual #343's progress notes indicated that they were making progress (or continued at a low rate of target behaviors) on one or more objectives in the PBSP, however, the data were not demonstrated to be reliable (see indicator #5), so these individuals were not scored as progressing.

Ensuring the reliability of the data collection should be a priority area for improvement for the behavioral health services department.

7. A target behavior objective appeared to be achieved for Individual #154 and Individual #343, however, a new objective was not

established.

8-9. Individual #366 and Individual #13 were not making progress, however, their progress notes included actions to address the absence of progress. Additionally, there was evidence that these actions were implemented.

| Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 16 | All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP. | 0% 0/8 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | N/A |
| 17 | There was a PBSP summary for float staff. | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A |
| 18 | The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework. | 88% 7/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | N/A |

Comments:
16. None of the eight individual's had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) implementing their PBSP were trained on the its implementation.

17. San Angelo SSLC utilized a brief PBSP for all individuals.

18. Seven individuals' functional assessments and PBSPs were written by a behavioral specialist who was enrolled in, or had completed BCBA coursework, and all were signed off by a BCBA. The exception was Individual #13's functional assessment and PBSP which were written by a behavioral specialist who had not completed or was enrolled in BCBA coursework.

| Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 19 | The individual's progress note comments on the progress of the individual. | 0% 0/8 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | N/A |
| 20 | The graphs are useful for making data based treatment decisions. | 88% 7/8 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A |
| 21 | In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions. | 100% 1/1 | N/A | N/A | N/A | N/A | 1/1 | N/A | N/A | N/A | N/A |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 22 | If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review. | 100% 1/1 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 23 | This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months. | 100% | | | | | | | | | |

Comments:

19. Progress notes were completed, but were not placed into the active record for each individual. This is part of the agreed upon criterion for this indicator. Therefore, this indicator was scored 0 for each individual.

20. All progress notes had graphs. Seven individual's graphs included indications of the occurrence of important environmental changes (e.g., medication changes), and were judged to be useful for making data based treatment decisions. The usefulness of Individual #366's graphs, however, was limited because they did not include recent medication changes.

21. In order to score this indicator, the Monitoring Team observed Individual #129's psychiatric clinic meeting and peer review meetings. In both meetings, the Monitoring Team found that current data were presented and graphed, which encouraged data based decisions by the team.

22. None of the nine individuals had peer review in the last six months, so Individual #319 was reviewed in order to score this indicator. There was evidence of follow-up/implementation of recommendations from her peer review.

23. The Monitoring Team observed Individual #129's external peer review. Individual #129 was reviewed because she had not been progressing as expected. Her peer review included the review of her functional assessment and PBSP. There was participation and discussion by the behavioral health services team to improve her PBSP. Additionally, San Angelo SSLC had documentation that internal peer review meetings were consistently occurring weekly, and that external peer review meetings were occurring monthly.

| Outcome 8 – Data are collected correctly and reliably. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 26 | If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites. | 0% 0/8 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | N/A |
| 27 | If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites. | 0% 0/8 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | N/A |
| 28 | If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity. | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 29 | If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be). | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A |
| 30 | If the individual has a PBSP, goal frequencies and levels are achieved. | 0% 0/8 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | N/A |

Comments:
26-27. The data collection system for measuring undesired (target) behaviors was an ABC system for all individuals and for all target behaviors. This system, that requires the DSP to record antecedents and consequences for each target behavior, is generally used for low frequency behaviors. For higher frequency target behaviors, however, it represents a substantial recording burden for DSPs and, therefore, is often found to be associated with underreported data.

Moreover, the occurrences of replacement/alternative behaviors were measured as SAP generalization data. Many of the SAP data sheets reviewed, however, confused the occurrence of replacement/alternative behaviors with the training of the behavior. In general, the data system was not sensitive to individual needs and did not adequately measure either undesired (target) or replacement/alternative behaviors.

In addition to ensuring reliability of data collection, the behavioral health services department should prioritize this area for improvement.

28. There were acceptable measures of IOA, data collection timeliness, and treatment integrity for all individuals.

29. San Angelo SSLC had established a monthly or quarterly schedule of IOA, data collection reliability, and treatment integrity for each individual based on his or her level of behavioral risk. The minimum acceptable level of IOA, data collection timeliness, and treatment integrity was 80%.

30. Goal frequencies and levels of data collection timeliness, IOA, and treatment integrity were not achieved for any individual. No individual had data collection timeliness assessments. Only Individual #397 and Individual #129 had an IOA measure. All individuals had treatment integrity at monthly or quarterly intervals and Individual #366, Individual #199, Individual #292, Individual #154, Individual #343, and Individual #13 had treatment integrity measures above 80%. Individual #397 and Individual #129 had treatment integrity levels below 80% for their most recent assessment.

## Medical

| Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | Individual has a specific goal(s)/objective(s) that is clinically relevant | 17% | 1/2 | 0/2 | 0/2 | 0/2 | 1/2 | 0/2 | 0/2 | 0/2 | 1/2 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | and achievable to measure the efficacy of interventions. | 3/18 | | | | | | | | | |
| b. | Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions. | 17% 3/18 | 1/2 | 0/2 | 0/2 | 0/2 | 1/2 | 0/2 | 0/2 | 0/2 | 1/2 |
| c. | Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s). | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| d. | Individual has made progress on his/her goal(s)/objective(s). | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| e. | When there is a lack of progress, the discipline member or IDT takes necessary action. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review [i.e., Individual #203 – respiratory compromise, and urinary tract infections (UTIs); Individual #343 – cardiac disease, and weight; Individual #271 – osteoporosis, and cardiac disease; Individual #24 – gastrointestinal problems, and cardiac disease; Individual #5 – gastrointestinal problems, and other: endocrine - hypothyroidism; Individual #386 – seizures, and cardiac disease; Individual #288 – osteoporosis, and seizures; Individual #128 – seizures, and osteoporosis; and Individual #148 – osteoporosis, and hypertension]. From a medical perspective, three of the goals/objectives were clinically relevant and achievable, and measurable, including those for Individual #203 – UTIs, Individual #5 – gastrointestinal problems, and Individual #148 – hypertension.

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

| Outcome 2 – Individuals receive timely and quality routine medical assessments and care. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| g. | Individual receives timely preventative care: | | | | | | | | | | |
| | i. Immunizations | 56% 5/9 | 1/1 | 1/1 | 1/1 | 0/1 | 0/1 | 1/1 | 0/1 | 0/1 | 1/1 |
| | ii. Colorectal cancer screening | 40% 2/5 | 0/1 | 1/1 | N/A | 1/1 | N/A | N/A | N/A | 0/1 | 0/1 |
| | iii. Breast cancer screening | 67% 2/3 | 0/1 | N/A | N/A | N/A | 1/1 | N/A | N/A | N/A | 1/1 |
| | iv. Vision screen | 89% 8/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | v. Hearing screen | 100%<br>9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| | vi. Osteoporosis | 13%<br>1/8 | 0/1 | 0/1 | 0/1 | 1/1 | N/A | 0/1 | 0/1 | 0/1 | 0/1 |
| | vii. Cervical cancer screening | 50%<br>2/4 | 0/1 | N/A | N/A | 0/1 | 1/1 | N/A | N/A | N/A | 1/1 |
| h. | The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. | 0%<br>0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

Comments: g. The following concerns were noted with regard to preventative care for the individuals reviewed:

- For Individual #203, a fecal occult blood (FOB) test was used for colorectal cancer screening. However, this was not high sensitivity testing the United States Preventive Services Task Force (USPSTF) recommends, and only a single specimen was documented in the records. In addition, the annual medical assessment indicated that breast and cervical cancer screening and bone mineral density (BMD) testing were suspended due to "disability and need for sedation." This did not provide sufficient justification for not completing preventative care. Moreover, the annual medical assessment later stated that she did not require pre-treatment sedation. The most recent dates for these studies were not provided.
- Osteoporosis screening was not completed for Individual #343, who had several risk factors, including long-term use of anti-epileptic drugs and a history of thyrotoxicosis.
- Individual #271 had a decrease in BMD, but the PCP had not addressed this finding.
- For Individual #24, discrepancies were found in the justification provided for not completing cervical cancer screening, and the prescription of medication for contraception. In addition, her records documented Hepatitis B vaccination in 2012 with no surface antibody production. She was identified as a non-responder. However, it was not clearly documented if the 2012 vaccine series was the primary or second vaccine series. There was no discussion of the non-responder status in the AMA.
- For Individual #5, the AMA stated that several immunizations were ordered, but there was no documentation that most of these were given, including pneumococcal, varicella, and TDap.
- For Individual #386, no DEXA scan was documented, even though he had a Vitamin D deficiency and maintained a borderline Vitamin D level of 30 with supplementation. He also had other risk factors, including long-term use of multiple anti-epileptic drugs.
- For Individual #288, no DEXA scan was documented even though he received alendronate. The eye consultation, dated 5/30/14, indicated follow-up was needed in one year, but documentation of follow-up was not submitted. In addition, there was no documentation that the pneumococcal conjugate vaccine (PVC13) was administered in accordance with the CDC guidelines.
- For Individual #128, a FOB test was used for colorectal cancer screening. However, this was not the high sensitivity testing the USPSTF recommends. He did not receive the pneumococcal conjugate vaccine (PVC13) per the Centers for Disease Control (CDC) guidelines. Osteoporosis screening also was not completed, and documentation noted that he "would not tolerate" without any specifics or a plan to address the issue.
- For Individual #148, the 2014 colorectal cancer screening was incomplete due to poor preparation. The individual was

referred back for a "complete colonoscopy" in 2015. However, there was no record of a repeat study. In addition, according to the AMA, a repeat DEXA was needed to clarify her status, but there was no documentation in the record of a repeat study.

h. For a number of individuals reviewed, documentation was not present to show that the PCP had fully considered the risks related to benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable, and/or addressed them. The following are examples:

- For Individual #24, the current IRRF did not accurately assess the risk for metabolic syndrome and the individual was rated at low risk for diabetes mellitus, even though the AMA noted metabolic syndrome and a strong family history. The AMA did not list metabolic syndrome as an active problem, and there was no plan to address it. The AMA also did not address components of the metabolic syndrome under the recommendations.
- Individual #5 was prescribed Zyprexa, but was rated at low risk for diabetes mellitus. The AMA medication list noted the contribution of Loratadine and Geodon to the anticholinergic burden, but the significant anti-cholinergic burden of Benztropine was not documented. Additionally, the PCP did not note if the individual actually experienced any of the many side effects that were listed in the medication list. The MOSES evaluation completed by nursing would provide an objective evaluation of the presence or absence of medication side effects.
- Individual #128 received several drugs with a significant anticholinergic burden. In several instances, the AMA medication list did not note the anti-cholinergic burden. Even when the anti-cholinergic burden was noted for the drug quetiapine, there was no documentation of the presence or absence of side effects. The MOSES evaluation would be instrumental in identifying medication side effects related to new generation psychotropics and medications with a significant anti-cholinergic burden. The results of both the MOSES and DISCUS evaluations are usually summarized in the QDRRs. However, there was no current QDRR for this individual.

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | Individual with DNR that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines. | 0% 0/2 | 0/1 | N/A | N/A | N/A | N/A | N/A | N/A | 0/1 | N/A |

Comments: For Individual #203, a DNR was implemented in 2010. Two Facility physicians signed it. Section D of the form, which was the section that needed completion if two physicians were making the decision on behalf of a person who was incompetent and did not have a qualified representative, was not appropriately completed. More specifically, neither of the following options was selected: 1) I attest to issuance of an Out-of-Hospital DNR by the patient by nonwritten communication; or 2) The patient's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgment, considered ineffective in these circumstances or are otherwise not in the best interest of the patient. On 1/14/16, the PCP made an IPN entry stating: "IDT has requested DNR status. [Individual #203] has profound IDD baseline. She has encephalomalacia. She is wheelchair bound and totally dependent for all ADLs. She also has osteoporosis. Will renew order for DNR."

For Individual #128, the DNR signed on 3/2/12 is not a properly executed DNR, and, therefore, did not appear to be valid. Section B was signed, which is the section that needs completion if a person acting on behalf of an individual who is incompetent is completing the form, but a box(es) were not checked as required. Moreover, per the form instructions, a physician must sign a statement if Section B is completed. There was no signature on the form in the section for the physician statement. A PCP note, dated 9/3/15, stated the DNR remained in effect.

| Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice. | 9% 1/11 | 1/2 | 0/2 | 0/2 | 0/1 | 0/1 | 0/2 | N/A | 0/1 | N/A |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| b. | If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes. | 9%<br>1/11 | 0/2 | 0/2 | 0/2 | 0/1 | 0/1 | 0/2 | | 1/1 | |
| c. | If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition. | 33%<br>1/3 | 1/1 | N/A | N/A | N/A | N/A | N/A | 0/1 | N/A | 0/1 |
| d. | As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN. | 67%<br>2/3 | 1/1 | | | | | | 0/1 | | 1/1 |
| e. | Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care. | 33%<br>1/3 | 1/1 | | | | | | 0/1 | | 0/1 |
| f. | If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff. | 100%<br>3/3 | 1/1 | | | | | | 1/1 | | 1/1 |
| g. | Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate. | 50%<br>1/2 | 1/1 | | | | | | N/A | | 0/1 |
| h. | Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness. | 50%<br>1/2 | 1/1 | | | | | | N/A | | 0/1 |

Comments: a. and b. For seven of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 11 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #203 (candida infection on 9/18/15, and upper respiratory infection on 10/17/15), Individual #343 (fall on 2/3/16, and eczema on 12/29/15), Individual #271 (excoriation on 8/4/15, and choking episode on 9/25/15), Individual #24 (knee injury on 9/24/15), Individual #5 (pressure ulcer on 1/7/16), Individual #386 (contusion on 8/12/15, and hypotension on 8/12/15), and Individual #128 (kidney injury on 12/4/15).

For the following acute issue, the medical provider at San Angelo SSLC followed accepted clinical practice in assessing it: Individual #203 (candida infection on 9/18/15). For the following individual, documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem has resolved or stabilized: Individual #128 (kidney injury on 12/4/15).

The following provide examples of some of the problems noted with regard to the assessment and/or treatment of individuals at San Angelo SSLC:

- On 10/15/15, the PCP evaluated Individual #203 due to a report of copious nasal drainage. Per the PCP, there was no observed respiratory distress, but secretions were increased. The PCP prescribed oral atropine drops to control secretions. The next follow-up occurred on 10/19/15, prior to the individual's transfer to the ED for respiratory distress. Of note, atropine drops given orally may result in a significant increase in the anti-cholinergic burden. When prescribed for control of secretions, atropine drops are usually administered sublingually.
- On 8/4/15, the PCP saw Individual #271 and documented that the individual scraped his foot on the swimming pool and had an excoriation of the right first toe. The assessment lacked the appropriate documentation of a physical examination of the foot. On 8/12/15, the individual had a wound consult and was diagnosed with a neuropathic ulcer of the same area. The individual had subsequent appointments with wound care. While the IPNs showed documentation of the PCP's review of wound consults, the PCP never documented further assessment of the wound.
- On 9/25/15, Individual #271 had a choking episode that required the Abdominal Thrust. On the same day, the PCP evaluated the individual and ordered a chest x-ray, and speech language pathology evaluation. The individual subsequently had a barium swallow study and dysphagiagram, which gastroenterology (GI) reported were unremarkable. The individual also had an abnormal chest x-ray that showed chronic obstructive pulmonary disease (COPD). On 9/30/15, the PCP documented the abnormal chest x-ray, noting that the individual never smoked. The plan was to obtain a repeat chest x-ray. The PCP never documented a repeat chest x-ray, nor did the PCP offer a differential diagnosis for these x-ray findings in a young non-smoker.
- On 9/29/15, the PCP documented that Individual #24 "hurt r [right] knee while with mom." The entire assessment was limited to nine words with the physical exam described in less than five words, and there was no plan related to the assessment. There also was no follow-up.
- On 8/12/15, the PCP noted that Individual #386 was examined due to a fall. The PCP's exam noted the individual's blood pressure was 100/60 and heart rate was 70. An EKG was done and showed bradycardia with a heart rate of 54 and an interpretation of borderline EKG. There was no documentation of the significant bruise another provider noted a few hours earlier. The PCP noted there was no change from the previous EKG. The dose of Lisinopril was decreased and orders were written to check the individual's blood pressure daily. The PCP documented no follow-up to determine if the medication dose change was effective.
- On approximately 12/14/15, a PCP noted that Individual #128's white blood cell counts were increased and his abdomen was distended. It appears that an abdominal ultrasound was ordered to rule out liver disease and it was normal. On 12/18/15, a series of abnormal labs were documented including a sodium level of 156. On 12/21/15, an extensive IPN detailed multiple problems. Overall, this individual had multiple documented lab abnormalities, including, for example, a blood urea nitrogen (BUN) count of 90, sodium of 56, and carbon dioxide (Co2) of 38. His creatinine increased from 0.9 to 1.7. Eventually, on 1/25/16, the PCP referred the individual to nephrology for evaluation. Per the IPN consult report, nephrology gave a new diagnosis of chronic kidney disease, possibly acute due to over diuresis. It would have been prudent to refer this individual for evaluation by a specialist prior to the end of January. Of note, on 4/22/15, this individual had an abnormal urine micro-albumin that the PCP did not address in the AMA.

The Monitoring Team reviewed three acute illnesses requiring hospital admission, including the following with dates of occurrence:

Individual #203 (hospital admission for aspiration on 10/19/15), Individual #288 (hospitalization for emesis/ileus on 9/13/15), and Individual #148 (hospitalization for catatonia and aspiration pneumonia on 11/5/15).

c. For Individual #148, there was a seven-hour delay between the time of her injury and the PCP/provider assessment and transfer.

d. The assessment completed for Individual #288 did not include recent vital signs, and also did not include pertinent history, focused physical findings, lab tests reviewed, and/or pending labs/tests listed.

f. It was also positive that for the individuals reviewed that were transferred to the hospital, the PCP or nurse communicated necessary clinical information with hospital staff.

g. Individual #288 died while in the hospital, so this indicator was not applicable.

h. As noted above, Individual #288 died while in the hospital, so this indicator was not applicable.

The following summarizes concerns:

- Individual #288 had a history of volvulus resulting in a colostomy and a small bowel obstruction resulting in bowl resection. On 9/13/15 at approximately 11 a.m., the individual began having emesis. Nursing staff implemented the vomiting protocol. The PCP was notified after the third episode of vomiting. At that time, nursing staff reported to the MD that the individual had abdominal distention. Bisacodyl was ordered. The individual continued to experience emesis and was noted to have a distended abdomen with no stool in the colostomy bag. The MD was contacted again and ordered an x-ray of the kidneys, ureters, and bladder (KUB) for the following day. The individual was ordered to have bowel rest, however, the direct support professionals gave the individual thickened liquids, which was followed by a large amount of emesis. The PCP was contacted, and gave no new orders. Nursing staff continued to document that the individual had a distended abdomen, no subsequent oral intake, and appeared uncomfortable. On 9/14/15, a PCP documented that the individual had no bowel movement for two days, had emesis for 24 hours, and had a distended abdomen with hypoactive bowel sounds. The individual was transported to the ED for evaluation. On 9/22/15, Individual #288 died at the age of 66 with cause of death listed as aspiration pneumonia and sepsis. The Facility did not provide any record of the hospitalization.
- For Individual #148, on 11/4/15, nursing staff documented agitated behavior and the individual was given an intramuscular (IM) injection of Thorazine. On 11/5/15, nursing documented at 8 a.m. that the individual fell and was bleeding from the right eyebrow. The PCP assessed the individual at 3 p.m., noting combative behavior for three days, decreased level of consciousness, and dehydration. The individual was transferred to the hospital. The attending psychiatrist at the hospital noted that the prolactin was greater than 200, and documented that the individual was treated with Invega "which was one of only two or three medications that are significantly contraindicated in patients with hyperprolactinemia." Of note, the Facility lab reports documented a prolactin level greater than 200 on 10/9/15, but there was no IPN documentation of a markedly elevated prolactin level, nor was there an assessment of the individual to determine if she had signs and symptoms of hyperprolactinemia. On 11/10/15, following Individual #148's return from the hospital, a medical evaluation was completed. The assessment was catatonia, poorly controlled hypertension, and aspiration pneumonia. The PCP documented no follow-up related to this evaluation. In fact, there were no additional PCP evaluations documented in the IPNs other than a consult review

for an ophthalmology clinic appointment on 12/14/15. It should be noted that hyperprolactinemia should have been reported as an ADR.

Outcome 5 – Individuals' care and treatment is informed through non-Facility consultations.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement. | 63% 10/16 | 1/2 | 1/2 | 1/2 | 1/1 | 1/2 | 1/2 | 0/1 | 2/2 | 2/2 |
| b. | PCP completes review within five business days, or sooner if clinically indicated. | 88% 14/16 | 1/2 | 2/2 | 2/2 | 1/1 | 1/2 | 2/2 | 1/1 | 2/2 | 2/2 |
| c. | The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT. | 38% 6/16 | 1/2 | 0/2 | 0/2 | 0/1 | 0/2 | 1/2 | 0/1 | 2/2 | 2/2 |
| d. | If PCP agrees with consultation recommendation(s), there is evidence it was ordered. | 91% 10/11 | 1/1 | 1/1 | 1/2 | 1/1 | 1/1 | N/A | 1/1 | 2/2 | 2/2 |
| e. | As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans. | 0% 0/2 | N/A | 0/1 | N/A | N/A | N/A | N/A | N/A | N/A | 0/1 |

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 16 consultations. The consultations reviewed included those for Individual #203 for neurology on 11/16/15, and ophthalmology on 12/11/15; Individual #343 for ophthalmology on 9/23/15, and gastroenterology (GI) on 1/27/16; Individual #271 for GI on 12/8/15, and endocrinology on 9/4/15; Individual #24 for orthopedics on 8/31/15; Individual #5 for neurology on 9/10/15, and ophthalmology on 8/21/15; Individual #386 for ear, nose, and throat (ENT) on 1/29/16, and neurology on 1/15/16; Individual #288 for orthopedics on 8/13/15; Individual #128 for renal on 1/25/16, and neurology on 11/24/15; and Individual #148 for ophthalmology on 12/14/15, and GI on 9/1/15.

a. The consultations reviewed for which PCPs did not review and initialed the reports, and/or indicate agreement or disagreement with the recommendations were those for: Individual #203 for ophthalmology on 12/11/15; Individual #343 for ophthalmology on 9/23/15; Individual #271 for endocrinology on 9/4/15; Individual #5 for ophthalmology on 8/21/15; Individual #386 for neurology on 1/15/16; and Individual #288 for orthopedics on 8/13/15.

b. The reviews for which documentation was not present to show they were completed timely were those for Individual #203 for ophthalmology on 12/11/15, and Individual #5 for ophthalmology on 8/21/15.

c. The consultations for which the PCP wrote a corresponding IPN that included the information that State Office policy requires were for Individual #203 for neurology on 11/16/15; Individual #386 for ENT on 1/29/16; Individual #128 for renal on 1/25/16, and

neurology on 11/24/15; and Individual #148 for ophthalmology on 12/14/15, and GI on 9/1/15.

d. When PCPs agreed with consultation recommendations, evidence was generally submitted to show they were ordered. The exception was for Individual #271 for endocrinology on 9/4/15. The PCP documented that the recommendations would need to be discussed with the Medical Director. There was no documentation of such discussion, and no further documentation regarding the recommendations in question.

e. For the following, the IDT referral portion of the IPN was blank and/or evidence of IDT review was not found:

- For Individual #343 for GI on 1/27/16, the PCP documented that the individual had four non-malignant polyps and diverticulosis. The pathology report indicated that the polyps were hyperplastic, tubular, and tubulovillous. Adenomatous polyps such as tubular, villous, and tubulovillous are neoplastic polyps and require close follow-up. The IDT should have been informed of these facts, but rather the PCP simply stated the individual had non-malignant polyps.
- For Individual #148 for GI on 9/1/15, the IDT referral section of the IPN was blank. The colonoscopy was being done due to the fact that the 2014 colonoscopy was incomplete due to poor preparation. It would seem prudent to refer this to the IDT for assistance with the preparation process.

Outcome 6 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care. | 44% 8/18 | 0/2 | 1/2 | 0/2 | 0/2 | 2/2 | 2/2 | 2/2 | 0/2 | 1/2 |

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #203 – respiratory compromise, and UTIs; Individual #343 – cardiac disease, and weight; Individual #271 – osteoporosis, and cardiac disease; Individual #24 – gastrointestinal problems, and cardiac disease; Individual #5 – gastrointestinal problems, and other: endocrine - hypothyroidism; Individual #386 – seizures, and cardiac disease; Individual #288 – osteoporosis, and seizures; Individual #128 – seizures, and osteoporosis; and Individual #148 – osteoporosis, and hypertension).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #343 – cardiac disease; Individual #5 – gastrointestinal problems, and other: endocrine - hypothyroidism; Individual #386 – seizures, and cardiac disease; Individual #288 – osteoporosis, and seizures; and Individual #148 – osteoporosis.

The following provide examples of concerns noted regarding medical assessment, tests, and evaluations:

- For Individual #203, the IRRF and AMA risk ratings for respiratory compromise were both high. The AMA outlined the management goals for treatment of asthma. The individual was maintained on oral corticosteroids (OCS). Generally accepted asthma treatment guidelines/algorithms note that because of the side effects, chronic administration of oral corticosteroids

should be prescribed by highly trained asthma specialists and only under strict circumstances. These algorithms include the use of chronic OCSs as a last measure after the institution of all other therapeutic options. The decision to use long-term steroids should be made in conjunction with a pulmonologist. While the management guidelines listed pulmonary consultation, there was no documentation of recent consultation with a pulmonologist.

- In addition, for Individual #203, it was documented that a urine culture grew Proteus mirabalis during her hospitalization. However, there was no discussion of the need to rule out structural abnormalities in this individual with recurrent UTIs and a history of previous Proteus UTI. Proteus infections are associated with neurogenic bladder and urinary stones. When identified in the urine, imaging should be done to look for stones. This individual was at increased risk for stones due to chronic topirimate use.
- For Individual #343, in the IPNs from August 2015 to February 2016, the PCP did not include any documentation regarding the etiology or evaluation of this individual's 25-pound weight loss. There also was no discussion of this in the September 2015 AMA.
- For Individual #271's risk related to osteoporosis, the DEXA scan done on 8/21/15 showed a decrease in hip bone mineral density of 23% and a decrease of spine bone mineral density of 10.9%. The PCP did not acknowledge in the IPNs that there was a significant decrease in bone mineral density, and there was no change in therapy to address this decrease.
- Individual #24's IRRF and AMA identified her as being at high risk for gastrointestinal problems. The IRRF identified her family history of colon cancer and the AMA documented several first and second-degree family members with cancer, including colon cancer, cervical cancer and endometrial cancer. However, the AMA did not include any discussion related to multiple family members with cancer. Hereditary non-polyposis cancer syndromes (HNPCC) increase the risk of colorectal, endometrial, and other cancers (documented in her family) usually under the age of 50. There was no documentation that this issue had been further explored. Additionally, the preventive care component of the AMA documented that a colonoscopy in 2009 was normal. However, the IRRF indicated the individual had removal of benign polyps in 2009, for which there was no documentation or plan for follow-up in the AMA. The specific histology should be documented. The date for the next exam should be based on the number and type of polyps removed and that date should be clearly noted as part of the surveillance plan. This individual is at higher risk for colon cancer due to the diagnosis in a parent at a young age.
- On 11/24/15, the neurologist saw Individual #128 and documented that the individual was tolerating Dilantin, but there had been no lab work done in a year. Per a PCP IPN entry, labs had been done. (This might mean that the Facility did not send the available lab results to the consultant for review or document that information on the consult request.) On 2/5/16, the neurologist noted that the individual had hematologic abnormalities most likely due to Dilantin. These were long-standing abnormalities that were documented in the AMA. Recommendations were made for further evaluation and to discontinue the Dilantin and start Keppra. Orders were written for lab evaluation, but the results were not in the record. This should have been reported as an ADR.
- For Individual #148, the post-hospital IPN and pharmacy WORx documentation identified poorly controlled hypertension. However, there was no referral to a specialist for assistance with management of poorly controlled hypertension. It was also not clear how the medication management was determined, because it was not consistent with Joint National Committee (JNC) 8 guidelines.

| Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions. | 22% 4/18 | 0/2 | 1/2 | 0/2 | 0/2 | 1/2 | 2/2 | 0/2 | 0/2 | 0/2 |
| Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address their medical needs. However, based on review of those action steps assigned to the PCPs that were identified for the individuals reviewed, the ones for the following risk areas or chronic conditions were implemented: Individual #343 – cardiac disease; Individual #5 – gastrointestinal problems; and Individual #386 – seizures, and cardiac disease. | | | | | | | | | | | |

**Pharmacy**

| Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; any necessary additional laboratory testing is completed regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and | 100% 16/16 | 2/2 | 1/1 | 2/2 | 2/2 | 2/2 | 2/2 | 1/1 | 2/2 | 2/2 |
| b. | If an intervention was necessary, the pharmacy notified the prescribing practitioner. | 0% 0/2 | N/A | N/A | N/A | N/A | 0/1 | N/A | N/A | 0/1 | N/A |
| Comments: b. For new medication orders, the Pharmacy Department should have issued the following interventions, but did not:<br>• For Individual #5, an Acetaminophen order was written for dosing every four hours as needed with total dose 3,900 milligrams (mg) within 24 hours. The Federal Drug Administration (FDA) has issued guidance stating the maximum dose is 4000mg/day. Numerous organizations have issued guidelines that limit the total dose to 3000 mg per day and 2000 mg per day in elderly patients.<br>• For Individual 128, an order was written to taper Dilantin to extinction, and then start Keppra. There was no intervention for this order, which failed to start Keppra prior to terminal taper of Dilantin. This would decrease the seizure threshold for this individual. | | | | | | | | | | | |

| Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | QDRRs are completed quarterly by the pharmacist. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| b. | The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to: | | | | | | | | | | |
| | i. Laboratory results, including sub-therapeutic medication values; | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| | ii. Benzodiazepine use; | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| | iii. Medication polypharmacy; | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| | iv. New generation antipsychotic use; and | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| | v. Anticholinergic burden. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| c. | The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement: | | | | | | | | | | |
| | i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| | ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| d. | Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions. | Not Rated | | | | | | | | | |

Comments: a. through b. The Monitoring Team requested the last two QDRRs for nine individuals. It was extremely concerning that none of the nine individuals reviewed had QDRRs completed in 2015 or to-date in 2016. The QDRRs from 2013 and 2014 that the Facility submitted no longer had any clinical significance, so they were not reviewed.

d. Based on the information provided, the Monitoring Team could not rate this indicator. As noted with regard to Outcome #1, interventions were not issued for some individuals for whom they should have been. In addition, without timely QDRRs, the Monitoring

Team could not determine how many recommendations prescribers should have considered and/or addressed.

The Monitoring Team identified a number of concerns related to the dispensing of ongoing prescribed medications. The need to generate appropriate drug alerts was even more important because none of the individuals had QDRRs completed in 2015, and several had not had an evaluation in more than two years. The identification of medication interactions and lab monitoring is a fundamental component of the QDRR process. A number of examples were found where the Pharmacy should have issued interventions (e.g., drug alerts, drug interactions, etc.), but did not. The following provide a few examples:

- On 8/18/15, Individual #5 had a change in levothyroxine dose. There was no follow-up thyroid stimulating hormone level and the Pharmacy continued to dispense the medication. There were also potential interactions between Trazodone, Divalproex, and Zyprexa that should have resulted in an interaction alert.
- The Pharmacy continued to dispense Individual #148 psychotropic medication without warning the prescriber, even though her prolactin level was markedly elevated (>200).
- Individual #24's drug regimen included lithium, Fazaclo, levothyroxine, metoprolol, ipatropium, cetirizine, Quasense, pregabalin, and atorvastatin. There was the potential for multiple interactions, but no drug alerts were issued.
- There were no interventions for individuals who received calcium carbonate and proton pump inhibitors (calcium citrate does not require an acidic environment, but calcium carbonate does).

**Dental**

| Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions; | 0%<br>0/3 | N/A | N/A | N/A | 0/1 | 0/1 | 0/1 | N/A | N/A | N/A |
| b. | Individual has a measurable goal(s)/objective(s), including timeframes for completion; | 33%<br>1/3 | | | | 1/1 | 0/1 | 0/1 | | | |
| c. | Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s); | 0%<br>0/3 | | | | 0/1 | 0/1 | 0/1 | | | |
| d. | Individual has made progress on his/her dental goal(s)/objective(s); and | 0%<br>0/3 | | | | 0/1 | 0/1 | 0/1 | | | |
| e. | When there is a lack of progress, the IDT takes necessary action. | 0%<br>0/3 | | | | 0/1 | 0/1 | 0/1 | | | |
| Comments: a. and b. The Monitoring Team reviewed three individuals with medium or high dental risk ratings. Most goals/objectives | | | | | | | | | | | |

focused on a change or maintenance of oral hygiene ratings, which were only completed once or twice a year. Goals/objectives focusing on the causes of the medium or high risk dental rating and/or goals/objectives with more incremental measures would allow IDTs to determine whether or not the individual was progressing, regressing, or maintaining his/her status.

c. through e. Without clinically relevant, achievable, and measurable goals, meaningful assessment of individuals' progress could not occur. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services to these three individuals, as well as the individuals in the core sample for whom this indicator was marked N/A (i.e., Individual #203, Individual #343, Individual #288, Individual #128, and Individual #148). For Individual #271 who was at low risk for dental and was in the outcome group, the "deep review" items were not scored, but other items were scored.

Outcome 4 – Individuals maintain optimal oral hygiene.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs. | 80% 4/5 | N/A | N/A | 1/1 | 1/1 | 1/1 | 0/1 | N/A | N/A | 1/1 |
| b. | At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff. | 100% 5/5 | N/A | N/A | 1/1 | 1/1 | 1/1 | 1/1 | N/A | N/A | 1/1 |
| c. | Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays. | 100% 5/5 | N/A | N/A | 1/1 | 1/1 | 1/1 | 1/1 | N/A | N/A | 1/1 |
| d. | If the individual has a fair or poor oral hygiene rating, individual receives at least two topical fluoride applications per year. | 50% 2/4 | N/A | N/A | 0/1 | 1/1 | 1/1 | 0/1 | N/A | N/A | N/A |
| e. | If the individual has need for restorative work, it is completed in a timely manner. | 50% 2/4 | N/A | N/A | 1/1 | 0/1 | N/A | 0/1 | N/A | N/A | 1/1 |
| f. | If the individual requires an extraction, it is done only when restorative options are exhausted. | 100% 2/2 | N/A | N/A | N/A | N/A | 1/1 | 1/1 | N/A | N/A | N/A |

Comments: a. Individual #203, Individual #343, Individual #288, and Individual #128 were edentulous.

It was concerning that two out of four individuals did not have timely restorative treatment completed.

| Outcome 6 – Individuals receive timely, complete emergency dental care. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary. | 100% 2/2 | N/A | 1/1 | 1/1 | N/A | N/A | N/A | N/A | N/A | N/A |
| b. | If the dental emergency requires dental treatment, the treatment is provided. | 100% 2/2 | | 1/1 | 1/1 | | | | | | |
| c. | In the case of a dental emergency, the individual receives pain management consistent with her/his needs. | 100% 1/1 | | N/A | 1/1 | | | | | | |
| Comments: a. through c. It was positive that for the two dental emergencies reviewed, individuals had dental services initiated within 24 hours or sooner, treatment was provided as needed, and they received pain management consistent with their needs. | | | | | | | | | | | |

| Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing. | 0% 0/1 | 0/1 | N/A | N/R | N/A | N/A | N/A | N/A | N/A | N/A |
| b. | The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP. | N/A | N/A | | | | | | | | |
| c. | If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique. | N/A | N/A | | | | | | | | |
| d. | At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing. | N/A | N/A | | | | | | | | |
| Comments: Because Individual #271 was a part of the outcome sample, and was at low risk for dental, some indicators were not rated for him (i.e., the "deeper review" indicators), including these related to suction tooth brushing.<br><br>The annual dental summary recommended suction tooth brushing for Individual #203, but it was unclear whether or not it was implemented. | | | | | | | | | | | |

| Outcome 8 – Individuals who need them have dentures. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s). | 83% 5/6 | 1/1 | N/A | 1/1 | N/A | N/A | 1/1 | 0/1 | 1/1 | 1/1 |
| b. | If dentures are recommended, the individual receives them in a timely manner. | 100% 1/1 | N/A | | N/A | | | N/A | N/A | N/A | 1/1 |
| Comments: None. | | | | | | | | | | | |

**Nursing**

| Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed. | 38% 3/8 | 0/1 | N/A | 1/2 | N/A | 1/1 | 0/1 | N/A | 0/1 | 1/2 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| b. | For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions. | 44%<br>4/9 | 0/1 | | 1/2 | | 0/1 | 1/1 | | 1/2 | 1/2 |
| c. | For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments. | 14%<br>1/7 | N/A | | 0/2 | | 0/1 | 0/1 | | 1/2 | 0/1 |
| d. | For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments. | 50%<br>1/2 | 1/1 | | N/A | | N/A | N/A | | N/A | 0/1 |
| e. | The individual has an acute care plan that meets his/her needs. | 0%<br>0/9 | 0/1 | | 0/2 | | 0/1 | 0/1 | | 0/2 | 0/2 |
| f. | The individual's acute care plan is implemented. | 0%<br>0/9 | 0/1 | | 0/2 | | 0/1 | 0/1 | | 0/2 | 0/2 |

Comments: The Monitoring Team reviewed nine acute illnesses and/or acute occurrences for six individuals, including Individual #203 – aspiration and urinary tract infection (UTI) on 10/19/15; Individual #271 – lesion on right medial first toe on 8/4/15, and bilateral conjunctivitis on 9/19/15; Individual #5 – pressure ulcer on left lateral malleolus on 1/6/16; Individual #386 – scalp lesion on 2/2/16; Individual #128 – UTI on 1/3/16, and UTI on 1/20/16; and Individual #148 – fall with moderate head injury on 11/5/15, and increase in blood pressure, dehydration, and change in mental status on 11/5/15.

a. The acute illnesses/occurrences for which nursing assessments were performed in alignment with nursing protocols and the individual's needs included: Individual #271 – lesion on right medial first toe on 8/4/15, Individual #5 – pressure ulcer on left lateral malleolus on 1/6/16, and Individual #148 – increase in blood pressure, dehydration, and change in mental status on 11/5/15. This was not applicable to Individual #128's UTI on 1/20/16, because it was identified as a result of a urine culture.

b. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms were: Individual #271 – lesion on right medial first toe on 8/4/15, Individual #386 – scalp lesion on 2/2/16, Individual #128 – UTI on 1/20/16, and Individual #148 – increase in blood pressure, dehydration, and change in mental status on 11/5/15.

c. For Individual #128's UTI on 1/3/16, licensed nursing staff conducted ongoing assessments in alignment with the applicable nursing protocols and the individual's health status.

d. Nursing staff conducted pre- and post-hospitalization assessments consistent with nursing protocols or standards of care for Individual #203 – aspiration and urinary tract infection (UTI) on 10/19/15.

e. In some cases, an acute care plan should have been developed, but was not. For those that were developed, problems noted included that they lacked instructions regarding follow-up nursing assessments; were not in alignment with nursing protocols; did not include specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; did not define the clinical indicators nursing would measure; and did not define the frequency with which monitoring should occur.

The following provide a couple of examples of concerns noted with regard to this outcome:

- On 8/4/15, Individual #271 had a lesion on his right medial first toe. Nursing staff appropriately notified the PCP. However, after the nursing IPN on 8/4/15, the next nursing entry related to the skin integrity issue was on 8/13/15, when direct support professional staff brought Individual #271 to the nurse for a dressing change.
- Similarly, for Individual #5's Stage I Pressure Ulcer, ongoing nursing assessments were not in alignment with nursing protocols or standards of care. For example, the nurse's initial assessment occurred on 1/7/16, followed by IPNs on 1/8/16, and 1/9/16, which did not address whether or not the size of the ulcer had decreased or increased, and did not address whether or not the individual experienced pain. The next recorded entries specific to the skin integrity issue were on 1/21/16, and 2/2/16. On 2/4/16, the PNMT nurse entered the final documentation related to the skin integrity issues, stating the Pressure Ulcer was resolved. A corresponding review by the physician to confirm that problem was resolved was not found.

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

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| b. | Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions. | 33% 6/18 | 2/2 | 0/2 | 1/2 | 0/2 | 1/2 | 1/2 | 0/2 | 1/2 | 0/2 |
| c. | Integrated ISP progress reports include specific data reflective of the measurable goal/objective. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| d. | Individual has made progress on his/her goal/objective. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| e. | When there is a lack of progress, the discipline member or the IDT takes necessary action. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #203 – UTIs, and constipation/bowel obstruction; Individual #343 – fluid imbalance, and infections; Individual #271 – gastrointestinal (GI) problems, and skin integrity; Individual #24 – constipation/bowel obstruction, and UTIs; Individual #5 – constipation/bowel obstruction, and seizures; Individual #386 – constipation/bowel obstruction, and skin integrity; Individual #288 – constipation/bowel obstruction, and UTIs; Individual #128 – GI problems, and infections; and Individual #148 – GI problems, and infections).

None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #203 – UTIs, and constipation/bowel obstruction; Individual #271 – GI problems; Individual #5 –

constipation/bowel obstruction; Individual #386 – skin integrity; and Individual #128 – GI problems.

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

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| b. | When the risk to the individual warranted, there is evidence the team took immediate action. | 0% 0/3 | N/A | N/A | 0/1 | N/A | N/A | N/A | N/A | 0/2 | N/A |
| c. | The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets). | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |

Comments: As noted above, the Monitoring Team reviewed a total of 18 IHCPs for nine individuals addressing specific risk areas.

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

c. Generally, for the individuals reviewed, documentation was not available to show their nursing interventions were implemented thoroughly.

Outcome 6 – Individuals receive medications prescribed in a safe manner.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | Individual receives prescribed medications in accordance with applicable standards of care. | 94% 15/16 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 1/1 | 0/1 | 2/2 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| b. | Medications that are not administered or the individual does not accept are explained. | 88% 7/8 | 1/1 | 1/1 | 1/1 | 1/1 | N/A | 1/1 | 1/1 | 0/1 | 1/1 |
| c. | The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation). | 100% 7/7 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A | N/A | 1/1 |
| d. | If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| e. | Individual's PNMP plan is followed during medication administration. | 100% 6/6 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | N/A | N/A | N/A |
| f. | Infection Control Practices are followed before, during, and after the administration of the individual's medications. | 86% 6/7 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | N/A | N/A | 1/1 |
| g. | Instructions are provided to the individual and staff regarding new orders or when orders change. | 0% 0/8 | 0/1 | N/A | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| h. | When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions. | 0% 0/8 | 0/1 | N/A | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| i. | If an ADR occurs, the individual's reactions are reported in the IPNs. | N/A | | | | | | | | | |
| j. | If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician. | N/A | | | | | | | | | |
| k. | If the individual is subject to a medication variance, there is proper reporting of the variance. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| l. | If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician. | 100% 1/1 | N/A | N/A | 1/1 | N/A | N/A | N/A | N/A | N/A | N/A |

Comments: The Monitoring Team conducted record reviews for nine individuals and observations of seven individuals, including Individual #203, Individual #343, Individual #271, Individual #24, Individual #5, Individual #386, Individual #288 (deceased so no observation), Individual #128 (deceased so no observation), and Individual #148.

a. and b. Problems noted included:

- The Medication Administration Records (MARs) for Individual #128 showed omissions and/or MAR blanks.

c. It was positive to see that for the individuals the Monitoring Team member observed during medication passes, nursing staff followed the nine rights of medication administration.

d. Nursing staff administered PRN medication, but at times, did not document the reason, route, and/or the individual's reaction or the effectiveness of the medication.

e. It was positive that for the individuals with PNMPs that the Monitoring Team observed, nursing staff followed the PNMPs.

f. With one exception, for the individuals observed, nursing staff followed infection control practices. The exception was for Individual #24, for whom the nurse did not conduct hand hygiene before or after touching objects, such as keys, and used non-sanitized scissors to open packaged medication.

g. For the records reviewed, evidence was not present to show that nursing staff provided instructions to the individuals and their staff regarding new orders or when orders changed.

h. When a new medication was initiated, when there was a change in dosage, and after discontinuing a medication, documentation was not present to show individuals were monitored for possible adverse drug reactions.

i. and j. For the individuals reviewed, Facility staff did not identify any ADRs.

k. Numerous problems were noted with regard to medication variances, including, for example:

- Individual #24 was prescribed cranberry juice to take with medication, but treatment sheets documented many days on which cranberry juice was "not available." A member of the Monitoring Team discussed this with the Chief Nurse Executive (CNE) during the onsite review. The CNE indicated she would take steps to correct this issue, because cranberry juice is available at the Facility.
- The Monitoring Team member also reviewed the multiple MAR blanks for Individual #128 with the CNE. The CNE reported she was aware of the problems associated with topical applications.
- Based on review of several MARs, when nurses transcribed new orders, the handwritten MARs did not include some of the required components (e.g., administration period, route, determination of whether or not the individual had an allergy, etc.). The Monitoring Team also reviewed this concern with the CNE.
- Overall, when Facility staff identified medication variances, very limited corrective action was documented.

## Physical and Nutritional Management

| Outcome 1 – Individuals' at-risk conditions are minimized. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have | | | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | taken reasonable action to effectuate progress: | | | | | | | | | | |
| | i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions; | 8% 1/13 | 0/2 | 0/1 | 0/2 | 0/2 | 1/2 | 0/2 | N/A | N/A | 0/2 |
| | ii. Individual has a measurable goal/objective, including timeframes for completion; | 46% 6/13 | 0/2 | 0/1 | 1/2 | 1/2 | 1/2 | 1/2 | | | 2/2 |
| | iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective; | 8% 1/13 | 0/2 | 0/1 | 0/2 | 1/2 | 0/2 | 0/2 | | | 0/2 |
| | iv. Individual has made progress on his/her goal/objective; and | 0% 0/13 | 0/2 | 0/1 | 0/2 | 0/2 | 0/2 | 0/2 | | | 0/2 |
| | v. When there is a lack of progress, the IDT takes necessary action. | 0% 0/13 | 0/2 | 0/1 | 0/2 | 0/2 | 0/2 | 0/2 | | | 0/2 |
| b. | Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress: | | | | | | | | | | |
| | i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate; | 100% 3/3 | N/A | 1/1 | N/A | N/A | N/A | N/A | N/A | 2/2 | N/A |
| | ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions; | 0% 0/5 | | 0/1 | | | | | 0/2 | 0/2 | |
| | iii. Individual has a measurable goal/objective, including timeframes for completion; | 20% 1/5 | | 0/1 | | | | | 1/2 | 0/2 | |
| | iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective; | 0% 0/3 | | 0/1 | | | | | 0/2 | N/A | |
| | v. Individual has made progress on his/her goal/objective; and | 0% 0/3 | | 0/1 | | | | | 0/2 | N/A | |
| | vi. When there is a lack of progress, the IDT takes necessary action. | 0% 0/3 | | 0/1 | | | | | 0/2 | N/A | |

Comments: The Monitoring Team reviewed 13 goals/objectives related to PNM issues that seven individuals' IDTs were responsible for developing. These included goals/objectives related to: aspiration, and falls for Individual #203; choking for Individual #343; choking, and falls for Individual #271; falls, and choking for Individual #24; GI problems, and choking for Individual #5; weight, and choking for Individual #386; and fractures, and choking for Individual #148.

a.i. and a.ii. The goal that was clinically relevant, achievable, and measurable was the one for GI problems for Individual #5. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: falls for Individual #271, choking for Individual #24, choking for Individual #386; and

fractures, and choking for Individual #148.

b.i. The Monitoring Team reviewed five areas of need for three individuals that met criteria for PNMT involvement, including: falls for Individual #343, constipation/bowel obstruction, and weight for Individual #288, and fluid imbalance, and aspiration for Individual #128. Individual #288 had been on the active caseload of the PNMT since 2014.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT had not developed clinically relevant and achievable goals/objectives for these individuals. The goal that was measurable was the one for constipation/bowel obstruction for Individual #288, but because it was not clinically relevant, the data it generated could not be used to measure progress.

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

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps. | 6% 1/18 | 0/2 | 0/2 | 0/2 | 1/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| b. | When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action. | 25% 2/8 | 0/1 | 1/1 | 0/2 | 1/1 | N/A | N/A | 0/2 | N/A | 0/1 |
| c. | If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT. | 50% 1/2 | N/A | 0/1 | N/A | 1/1 | N/A | N/A | N/A | N/A | N/A |

Comments: a. As noted above, most IHCPs did not include all of the necessary PNM action steps to meet individuals' needs. In addition, the timeframes and/or criteria for the completion of actions steps were often vague, and, as a result, there was no way to measure their completion. The IHCP for which documentation was found to confirm the implementation of the PNM action steps was the one for choking for Individual #24.

b. The following are examples of some of the concerns related to IDTs' responses to changes in individuals' PNM status:

- As discussed above, Individual #203's IDT did not refer her to the PNMT despite information that she had aspiration pneumonia. In addition, at the post-hospitalization ISPA meeting held on 11/3/15, over a week after her discharge back to SGSSLC, the IDT did not conduct a review of her PNMP, and no PNMT or Habilitation Therapy staff were present.

- Individual #271's choking events did not result in referral to the PNMT, and no evidence was presented to show the IDT held an ISPA meeting for the choking event in September. On 5/28/15, the IDT held his ISP meeting, but there was no evidence of revision of his IHCP after subsequent choking events. Program effectiveness monitoring identified that the program was ineffective, but the IDT did not implement meaningful interventions to address this problem. The OT/PT IPN, dated 11/12/15, stated that an action plan was due on 12/31/15, and IDT and the Speech Language Pathologist was to follow-up in relation to the choking events and Modified Barium Swallow Study (MBSS) findings.
- For Individual #271's, an ISPA, dated 8/31/15, indicated that custom shoes/foot orthotics were needed due to a neuropathic ulcer and pes planus, which placed him at risk for amputation. On 9/1/15, the physician wrote an order. The custom shoes/foot orthotics were not mentioned in his IHCP, and no Change of Status (COS) IHCP was developed in August/September 2015 to address the neuropathic ulcer. The only PNMP submitted made no reference to the custom shoes/foot orthotics. As a result, it was unclear whether or not he received the shoes and was using them.

c. For Individual #343, an IPN, dated 12/17/15, indicated the PNMT discharged him, but no evidence was found of an ISPA meeting with the IDT.

| Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately. | | |
|---|---|---|
| # | Indicator | Overall Score |
| a. | Individuals' PNMPs are implemented as written. | 57%<br>27/47 |
| b. | Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP. | 71%<br>5/7 |
| Comments: a. The Monitoring Team conducted 47 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 11 out of 17 observations (65%). Staff followed individuals' dining plans during 12 out of 23 mealtime observations (52%). Transfers were completed according to the PNMPs in one of three observations (33%). Staff followed the oral care instructions on individuals' PNMPs during three out of four observation (75%). | | |

**Individuals that Are Enterally Nourished**

| Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented. | N/A | N/A | | | | | | | N/A | |

| Comments: This indicator was not applicable to the individuals reviewed with enteral nutrition. |
|---|

**OT/PT**

| Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions. | 0% 0/8 | 0/1 | 0/2 | 0/1 | 0/1 | N/A | N/A | 0/1 | N/A | 0/2 |
| b. | Individual has a measurable goal(s)/objective(s), including timeframes for completion. | 0% 0/8 | 0/1 | 0/2 | 0/1 | 0/1 | | | 0/1 | | 0/2 |
| c. | Integrated ISP progress reports include specific data reflective of the measurable goal. | 0% 0/8 | 0/1 | 0/2 | 0/1 | 0/1 | | | 0/1 | | 0/2 |
| d. | Individual has made progress on his/her OT/PT goal. | 0% 0/8 | 0/1 | 0/2 | 0/1 | 0/1 | | | 0/1 | | 0/2 |
| e. | When there is a lack of progress or criteria have been achieved, the IDT takes necessary action. | 0% 0/8 | 0/1 | 0/2 | 0/1 | 0/1 | | | 0/1 | | 0/2 |
| Comments: a. and b. The Monitoring Team reviewed eight areas of OT/PT need for six individuals. IDTs had not included clinically relevant, achievable, and measurable goals/objectives in the individuals ISPs/IHCPs to address these needs.<br><br>c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Individual #5, Individual #386, and Individual #128 did not require OT/PT supports beyond PNMPs. Individual #5 and Individual #386 were part of the outcome sample, so further review was not conducted. Individual #128 was part of the core sample, so a full review was conducted. Full reviews were conducted for the remaining six individuals. | | | | | | | | | | |

| Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented. | 0% 0/8 | 0/1 | 0/3 | N/A | 0/1 | N/R | N/R | N/A | 0/1 | 0/2 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| b. | When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change. | 0%<br>0/1 | N/A | N/A | N/A | 0/1 | | | N/A | N/A | N/A |

Comments: a. Some examples of the problems noted include:

- Individual #148 had SAPs for safe eating and community awareness, but the Facility did not submit documentation to show they were implemented.
- Individual #128's IDT included an action step for wheelchair modifications with a due date of 2/3/16, but the IPNs did not include documentation showing the changes were made.
- Individual #24 had a SAP for a home exercise program, but the Facility did not submit evidence to show staff implemented it.
- Individual #203's range of motion goal/objective was not included in her ISP/IHCP.
- Individual #343 had a gardening goal/objective, but it was not implemented (i.e., an area was designated for his garden, but it was not ready for planting). In addition, he had maintenance goals/objectives for bathing and safe eating, but based on the information submitted, it was unclear what the IDT was measuring.

b. For Individual #24, no ISPA documentation was found for January 2016 showing IDT discussion and/or approval of her discharge from direct therapy intervention.

| Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 40 | 344 | 384 | 217 | 383 | 59 | 25 | 66 | 38 |
| a. | Assistive/adaptive equipment identified in the individual's PNMP is clean. | 100%<br>14/14 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| b. | Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition. | 100%<br>14/14 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| c. | Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual. | 93%<br>13/14 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 |
| | | Individuals: | | | | | | | | | |
| # | Indicator | | 7 | 98 | 202 | 146 | 126 | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Assistive/adaptive equipment identified in the individual's PNMP is clean. | | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | | | | |
| b. | Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition. | | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | | | | |
| c. | Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual. | | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | | | | |

Comments: a. and b. The Monitoring Team conducted observations of 14 pieces of adaptive equipment. The individuals the Monitoring Team observed had clean adaptive equipment that was in working condition, which was good to see.

c. An issue with proper fit of Individual #25's wheelchair was noted. Based on observation of this individual in her wheelchair, the outcome was that she was not positioned correctly. It is the Facility's responsibility to determine whether or not this was due to the equipment, or staff not positioning her correctly, or other factors.

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

**ISPs**

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

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 366 | 343 | 13 | 203 | 5 | 386 | | | |
| 4 | The individual met, or is making progress towards achieving his/her overall personal goals. | 0% 0/6 | 0/6 | 0/6 | 1/6 | 0/6 | 0/6 | 0/6 | | | |
| 5 | If personal goals were met, the IDT updated or made new personal goals. | 0% 0/6 | 0/6 | 0/6 | 0/6 | 0/6 | 0/6 | 0/6 | | | |
| 6 | If the individual was not making progress, activity and/or revisions were made. | 0% 0/6 | 0/6 | 0/6 | 0/6 | 0/6 | 0/6 | 0/6 | | | |
| 7 | Activity and/or revisions to supports were implemented. | 0% 0/6 | 0/6 | 0/6 | 0/6 | 0/6 | 0/6 | 0/6 | | | |

Comments:
4-7. Overall, personal goals were not defined, therefore, there was no basis for assessing progress in these areas. See Outcome 7, Indicator 37 for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans.

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

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 366 | 343 | 13 | 203 | 5 | 386 | | | |
| 39 | Staff exhibited a level of competence to ensure implementation of the ISP. | 0% 0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |
| 40 | Action steps in the ISP were consistently implemented. | 0% 0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |

Comments:
39-40. Documentation indicated that action steps were not consistently implemented as noted in examples throughout this report. For the most part, observations and staff interviews indicated that staff were familiar with individual's ISPs and ancillary plans, however, due to lack of consistent implementation, it was difficult to assess staff competency.

**Skill Acquisition and Engagement**

| Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 6 | The individual is progressing on his/her SAPS | 8% 1/12 | 0/2 | 0/1 | 0/1 | 0/3 | 1/1 | 0/2 | 0/1 | 0/1 | N/A |
| 7 | If the goal/objective was met, a new or updated goal/objective was introduced. | 100% 1/1 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 1/1 | N/A |
| 8 | If the individual was not making progress, actions were taken. | 25% 1/4 | N/A | N/A | N/A | 0/2 | N/A | 1/2 | N/A | N/A | N/A |
| 9 | Decisions to continue, discontinue, or modify SAPs were data based. | 57% 4/7 | 1/1 | N/A | N/A | 0/2 | 1/1 | 1/2 | N/A | 1/1 | N/A |

Comments:
6. Individual #129's SAP of correct reporting was rated as progressing. Individual #154's community safety and Individual #199's community transportation SAPs were scored N/A because they had reliable data, but not yet a sufficient amount of data to determine progress. Some SAPs (e.g., Individual #154's vending machine SAP) were scored 0 because they were not making progress. Some SAP data did indicate progress, but were scored as not making progress because they did not have reliable data (e.g., Individual #366's medication education SAP).

7-9. Step 1 of Individual #13's deep breathing SAP was achieved and step 2 was initiated. On the other hand, four SAPs (e.g., Individual #154's safe eating and operating a vending machine SAPs, and Individual #292's gain attention and room cleaning SAPs) were judged as not progressing. However, only Individual #154's safe eating SAP had evidence that action was taken to address the lack of progress (e.g., retrain staff, modify the SAP, discontinue the SAP). Overall, there was evidence of data based decisions to continue, discontinue, or modify SAPs for 57% of SAPs (seven SAPs had insufficient data to determine the use of data based decisions).

| Outcome 4- All individuals have SAPs that contain the required components. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 13 | The individual's SAPs are complete. | 0% 0/14 | 0/2 | 0/2 | 0/1 | 0/3 | 0/1 | 0/3 | 0/1 | 0/1 | N/A |

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Although none of the SAPs contained all of these components, all SAPs had the majority of these components.

All SAPs were missing a description of the documentation methodology. Another common missing component was ambiguous instructions that did not clearly state if the training session included all steps of the SAP or just the training step (e.g., Individual #199's community transportation SAP).

Outcome 5- SAPs are implemented with integrity.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 14 | SAPs are implemented as written. | 50% 1/2 | 0/1 | 1/1 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 15 | A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved. | 36% 5/14 | 0/2 | 1/2 | 0/1 | 1/3 | 1/1 | 2/3 | 1/1 | 1/1 | N/A |

Comments:
14. The Monitoring Team observed the implementation of two SAPs. Individual #199's community transportation SAP was judged to be implemented and recorded as written. The DSP implementing Individual #366's rules of the road SAP, however, did not implement it as written.

15. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. It was encouraging to learn that San Angelo SSLC did conduct regular and thorough SAP integrity checks. Their goal was to have an integrity check on every SAP, and they established a minimum level of acceptable integrity score of 80%.

They did not, however, include replacement behavior SAPs in their integrity assessment. It is suggested that the facility ensure integrity checks of each SAP (including replacement behavior SAPs) at least once every six months. Additionally, it is suggested that DSPs be immediately retrained and reassessed if they do not achieve the minimal acceptable integrity score.

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 16 | There is evidence that SAPs are reviewed monthly. | 92% 11/12 | 2/2 | N/A | 1/1 | 3/3 | 1/1 | 2/3 | 1/1 | 1/1 | N/A |
| 17 | SAP outcomes are graphed. | 50% 6/12 | 0/2 | N/A | 0/1 | 2/3 | 1/1 | 3/3 | 0/1 | 0/1 | N/A |

Comments:
16. The majority of SAPs were reviewed in QIDP monthly reports and included a data based review. Individual #199's community transportation and medication education SAPs were recently developed, so were not included in this indicator. Individual #154's

community safety SAP was not reviewed.

17. Half of the SAPs reviewed had graphed data. Some of those graphs were in the QIDP reports (e.g., Individual #154's SAPs), however, most of the six graphs were only found with the completed SAP data sheets (e.g., Individual #129's correct reporting SAP). In order to encourage data based decisions concerning the continuation, discontinuation, or modification of SAPs, it is suggested that all SAP data be graphed and presented in the QIDP monthly review.

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

| | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 18 | The individual is meaningfully engaged in residential and treatment sites. | 22% 2/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 | 1/1 | 0/1 |
| 19 | The facility regularly measures engagement in all of the individual's treatment sites. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 20 | The day and treatment sites of the individual have goal engagement level scores. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 21 | The facility's goal levels of engagement in the individual's day and treatment sites are achieved. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |

Comments:

18. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found two individuals (Individual #13, Individual #343) consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

19-20. San Angelo SSLC regularly measured engagement in all residential and day programming sites. They established 80% as their engagement goal level.

21. Available facility engagement data were aggregated across all home and treatment sites, and indicated that the average engagement in the residences over the last six months was 70%. The facility reported engagement in the treatment sites was regularly above 80%. Contributing to the challenge of ensuring individual engagement at San Angelo SSLC was the observation that the majority of individuals did not attend scheduled treatment activities. Therefore, an engagement measure of sites (e.g., day programming) would likely not capture the behavior of the majority of individuals who are not consistently attending programming, and who were usually not engaged in any other productive activity at all.

| Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 366 | 199 | 397 | 292 | 129 | 154 | 343 | 13 | 203 |
| 22 | For the individual, goal frequencies of community recreational activities are established and achieved. | 78% 7/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 0/1 |
| 23 | For the individual, goal frequencies of SAP training in the community are established and achieved. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| 24 | If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct. | 0% 0/9 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| Comments:<br>22-24. San Angelo SSLC established that each individual would attend at least three community outings every month. Seven individuals achieved that goal; the exceptions were Individual #203 and Individual #343. There was evidence that eight individuals participated in SAP training in the community (Individual #203 was the exception), however, there were no established goals for this activity. The facility should establish a goal frequency of SAP training in the community for each individual, and demonstrate that the goal was achieved. | | | | | | | | | | | |

| Outcome 9 – Students receive educational services and these services are integrated into the ISP. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 13 | | | | | | | | |
| 25 | The student receives educational services that are integrated with the ISP. | 100% 1/1 | 1/1 | | | | | | | | |
| Comments:<br>25. Individual #13 was under 22 years of age and attended public school. She was receiving services from the local independent school. Additionally, the IDT worked with the school district to provide appropriate educational services. In addition, Individual #13's QIDP monthly review included public school information and action plans that supported her IEP. | | | | | | | | | | | |

**Dental**

| Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action. | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions; | N/A | | | | | | | | | |
| b. | Individual has a measurable goal(s)/objective(s), including timeframes for completion; | N/A | | | | | | | | | |
| c. | Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s); | N/A | | | | | | | | | |
| d. | Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and | N/A | | | | | | | | | |
| e. | When there is a lack of progress, the IDT takes necessary action. | N/A | | | | | | | | | |
| Comments: These indicators were not applicable to any of the individuals the Monitoring Team responsible for reviewing physical health reviewed. | | | | | | | | | | | |

**Communication**

| Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions. | 0% 0/4 | 0/1 | N/A | N/A | N/A | N/A | 0/1 | 0/1 | 0/1 | N/A |
| b. | Individual has a measurable goal(s)/objective(s), including timeframes for completion | 0% 0/4 | 0/1 | | | | | 0/1 | 0/1 | 0/1 | |
| c. | Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s). | 0% 0/4 | 0/1 | | | | | 0/1 | 0/1 | 0/1 | |
| d. | Individual has made progress on his/her communication goal(s)/objective(s). | 0% 0/4 | 0/1 | | | | | 0/1 | 0/1 | 0/1 | |
| e. | When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action. | 0% 0/4 | 0/1 | | | | | 0/1 | 0/1 | 0/1 | |
| Comments: a. and b. Based on review of screening/assessment information as well as the Monitoring Team's observations, Individual #343, Individual #271, Individual #24, Individual #5, and Individual #148 could communicate functionally, and many of them showed high level verbal skills. For the remaining individuals, assessments were not current (e.g., Individual #386, and Individual #128), or IDTs had not developed clinically relevant, achievable and measurable goals/objectives.<br><br>c. through e. As noted above, Individual #343, Individual #271, Individual #24, Individual #5, and Individual #148 did not require formal communication services and supports. Because Individual #271, Individual #24, and Individual #5 were part of the outcome | | | | | | | | | | | |

group, no further review was conducted. Individual #343, and Individual #148 were part of the core group, so full reviews were conducted for them. For the remaining four individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of integrated ISP progress reports showing the individuals' progress on their goals/objectives.

| Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 203 | 343 | 271 | 24 | 5 | 386 | 288 | 128 | 148 |
| a. | There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented. | 0% 0/3 | 0/1 | N/A | N/R | N/R | N/R | 0/1 | N/A | 0/1 | N/A |
| b. | When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination. | N/A | | | | | | | | | |
| Comments: None. | | | | | | | | | | | |

| Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 154 | Home 502 | 65 | 253 | 151 | 194 | 211 | | |
| a. | The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual. | 86% 6/7 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | | |
| b. | Individual is noted to be using the device or language-based support in a functional manner in each observed setting. | 50% 3/6 | 0/1 | 1/1 | 1/1 | N/A | 0/1 | 0/1 | 1/1 | | |
| c. | Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times. | Not rated. | | | | | | | | | |
| Comments: In Home 502, for medication administration, each man selected his picture, said his name, and handed the picture to the nurse. They also use a Voice-Output Device with pictures for "sick" or "hurt." | | | | | | | | | | | |

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

Outcomes, indicators, and scores for this Domain will be included in the next Monitoring Team Report.

## APPENDIX A – Interviews and Documents Reviewed

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

**Documents:**

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

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

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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