United States v. State of Texas

Monitoring Team Report

San Angelo State Supported Living Center

Dates of Onsite Review: December 5-9, 2016

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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.
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. **Monitoring Report** – The monitoring report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. A summary paragraph is also provided for each outcome. In this paragraph, the Monitor provides some details about the indicators that comprise the outcome, including a determination of whether any indicators will be moved to the category of requiring less oversight. Indicators that are moved to this category will not be monitored at the next review, but may be monitored at future reviews if the Monitor has concerns about the facility's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the facility's plans for continued quality assurance and improvement.

Organization of Report

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

a. **Domains:** Each of the five domains heads a section of the report.
b. **Outcomes and indicators:** The outcomes and indicators are listed along with the Monitoring Teams' scoring of each indicator.
c. **Summary:** The Monitors have provided a summary of the facility's performance on the indicators in the outcome, as well as a determination of whether each indicator will move to the category of requiring less oversight or remain in active monitoring.
d. **Comments:** The Monitors have provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
e. **Individual numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers.
f. **Numbering of outcomes and indicators:** The outcomes and indicators under each of the domains are numbered, however, the numbering is not in sequence. Instead, the numbering corresponds to that used in the Monitors' audit tools, which include outcomes, indicators, data sources, and interpretive guidelines/procedures (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

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

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at 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.

This Domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, mortality review, and quality assurance. Twenty-four of these indicators had sustained high performance scores and will be moved to the category of requiring less oversight. This included four outcomes: outcome 3 related to restraint, and outcomes 3, 5, and 10 related to abuse, neglect, and incident management.

With the agreement of the parties, the Monitors have largely deferred the development and monitoring of quality improvement outcomes and indicators to provide the State with the opportunity to redesign its quality improvement system. Additional outcomes and indicators will be added to this Domain during upcoming rounds of reviews.

The identification and management of risk is an important part of protection from harm. Risk is also monitored via a number of outcomes and indicators in the other four domains throughout this report. These outcomes and indicators may be added to this domain or cross-referenced with this domain in future reports.

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

Restraint

San Angelo SSLC had the highest rate of crisis intervention restraint compared with other facilities. The facility, however, had a strong management system for restraint implementation, oversight, and reduction. This was reflected in nine indicators being moved to the category of requiring less oversight. Thus, it was good to see that the facility with the most restraints had one of the strongest systems for monitoring and managing restraint usage. Overall, frequency, duration, and other measures showed declining trends across the past nine months. Some increases may have been due to usage of a new psychotropic medication that has since been discontinued for some individuals. There were zero uses of crisis intervention mechanical restraint. The three crisis intervention chemical restraint indicators related to psychiatry's role met criteria only one-third of the time.

It was positive that for the restraints reviewed, nurses initiated monitoring timely. However, as part of restraint monitoring, nursing staff need to improve their documentation of individuals' vital signs and mental status. Nurses need to provide more detailed descriptions of mental status, including specific comparisons to the individual's baseline. In addition, nurses should complete and document assessment of any restraint-related injures or other negative effects, and follow-up actions.

Abuse, Neglect, and Incident Management

The occurrence of abuse and neglect and the conduct of investigations at San Angelo SSLC continued to be overall well managed by the incident management coordinator and the facility. As a result, 15 indicators moved to the category of requiring less oversight. Other indicators had improved since previous reviews (e.g., indicators 2, 6, 8, and 16). That being said, some important areas of incident management require focus. One is to ensure that protections are in place to reduce the likelihood of the incidents occurring in the first place. Many investigations did not meet the related indicator (#1). Some were due to outdated annual duty to report forms, some to problems with implementation of PBSPs, and some absence of follow-up to various recommendations. Another area of focus was to correctly implement the DADS non-serious injury investigation procedure that has been used at other facilities for several years. The case of Individual #65 is highlighted within indicator 1.

Other

IDTs were not talking about the pretreatment chemical restraint needs of individuals. Overall, PTCR practices needed more focus in order to meet the outcomes and indicators evaluated by the Monitoring Teams.

The Center continued to lack an appropriate adverse drug report (ADR) reporting and monitoring system. Staff were not compliant with the Center policy and were not even familiar with the requirements outlined in the policy. Specifically, there was no objective process for making the determination about the occurrence of ADRs. Pharmacy staff was not familiar with the use of a probability scale. This requirement was included in the Center policy. Furthermore, the ADR module of IRIS includes all of the components of the Naranjo Probability Scale, but staff did not appear to be utilizing it. In its reports for the March 2016 review and June 2015 review, the Monitoring Team previously noted concerns related to the Center's failure to execute an ADR reporting and monitoring system. The Center should immediately implement an effective surveillance and response program for ADRs that is consistent with the current generally accepted standards.

In response to the Monitoring Team's document request, San Angelo SSLC submitted documentation for two activities, neither of which met the requirements of a DUE. State Office should provide San Angelo with direction regarding the completion of clinically significant DUEs.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.	
Summary: San Angelo SSLC had the highest rate of crisis intervention restraint compared with other facilities. The facility, however, had a strong management system for restraint implementation, oversight, and reduction. Overall, frequency, duration, and other measures showed declining trends across the past nine months. Some increases may have been due to usage of a new psychotropic medication that	Individuals:

has since been discontinued for some individuals. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74
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.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (February 2016 through October 2016) were reviewed. Due to the changeover to the electronic record (IRIS), state office was unable to provide these data and graphs. Instead, the facility provided the graphs for the nine-month period. The Monitoring Team calculated the 1000-bed-day number using the facility-provided average daily census.

The frequency of crisis intervention restraint at San Angelo SSLC as the highest rate of crisis intervention restraints of all 13 facilities, when census controlled. Examination of the data trend, however, showed a declining trend over the nine month period, due, in part, from a spike in the middle of the period that was reportedly correlated with the use of a new psychotropic medication, Vraylar, for some individuals. When it was found to be ineffective, it was discontinued and other medications were tried, which then correlated with decreases in the facility's frequency of crisis intervention restraint, resulting in a decreasing trend across the nine-month period. When looking at the sub-types of crisis intervention restraint, both physical and chemical restraints showed the same trending. There were zero uses of crisis intervention mechanical restraint. The average duration of a physical restraint also showed a decreasing trend, also likely due to the changes in the medications. Even so, the average duration was about six minutes, among the three highest across the facilities. Given the declining trend lines, the Monitoring Team rated the frequency and duration of crisis intervention restraint as meeting criteria with this indicator. Moreover, as evidenced in the indicators below, San Angelo SSLC had a strong system for managing and reviewing crisis intervention restraint usage. Thus, it was good to see that the facility with the most restraints had one of the strongest systems for monitoring and managing restraint usage. However, because of the relatively high frequency and duration of usage, restraint reduction should be a priority activity for the restraint manager, restraint management committee, and the QA department. The restraint reduction committee met regularly; their discussion included trying to understand the frequency of usage of restraint and to implement actions to continue to reduce/manage restraint.

There were very few injuries that occurred as a result of restraint application and all were deemed non-serious. The number of individuals who received crisis intervention restraint, however, remained high, that is from 15-25 per month.

Protective mechanical restraints for self-injurious behavior (PMR-SIB) were thoughtfully managed. There were three occurrences: one for a long time usage that the facility continued to successfully fade, for a very complicated individual. One was a temporary usage that had since been discontinued. The third was for an individual who had a successful fade, but then a serious violent incident that resulted in incarceration caused regression in the fade of the protective mechanical restraints.

There was extremely limited use of non-chemical restraints for medical procedures (one occurrence), healing (three individuals), or long-term usage (none), or for dental procedures. The use of chemical restraints for medical and dental procedures was also low.

Thus, facility data showed low/zero usage and/or decreases in 11 of these 12 facility-wide measures (i.e., use of crisis intervention restraint; use of crisis intervention physical, chemical, and mechanical restraint; the duration of physical restraints; injuries during restraint; the number of individuals with PMR-SIB; and the use of non-chemical restraints for medical and dental procedures.

2. Seven of the individuals reviewed by the Monitoring Team were subject to restraint. Five received crisis intervention physical restraints (Individual #358, Individual #116, Individual #187, Individual #404, Individual #74), three received crisis intervention chemical restraint (Individual #28, Individual #358, Individual #74), and two received non-chemical medical restraint for healing (Individual #65, Individual #74). Data from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for six (Individual #28, Individual #358, Individual #116, Individual #187, Individual #65, Individual #74). The other two individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this 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.

Summary: Restraints, when they occurred, were well-managed at San Angelo SSLC. A restraint manager was assigned to this task and was well-versed in the details of the Settlement Agreement requirements and these outcomes and indicators. The facility had an active restraint reduction committee, too. The facility's performance on seven of these indicators was at or near 100% for this review and the previous two reviews. Therefore, they will be moved to the category of requiring less oversight (indicators 3, 4, 5, 6, 7, 8, 10). Indicator 11 showed good progress and if high performance is sustained, might move to the category of requiring less oversight after the next review. Indicator 9 will require attention and documentation. These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	28	358	116	187	65	404	74		
3	There was no evidence of prone restraint used.	100% 10/10	1/1	2/2	2/2	1/1	1/1	1/1	2/2		
4	The restraint was a method approved in facility policy.	100% 10/10	1/1	2/2	2/2	1/1	1/1	1/1	2/2		
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 8/8	1/1	2/2	2/2	1/1	N/A	1/1	1/1		
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 5/5	N/A	1/1	2/2	1/1	N/A	1/1	N/A		
7	There was no injury to the individual as a result of implementation of	90%	1/1	2/2	2/2	1/1	1/1	1/1	1/2		

	the restraint.	9/10									
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 10/10	1/1	2/2	2/2	1/1	1/1	1/1	2/2		
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A		
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 8/8	1/1	2/2	2/2	1/1	N/A	1/1	1/1		
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 10/10	1/1	2/2	2/2	1/1	1/1	1/1	2/2		

Comments:
The Monitoring Team chose to review 10 restraint incidents that occurred for seven different individuals (Individual #28, Individual #358, Individual #116, Individual #187, Individual #65, Individual #404, Individual #74). Of these, six were crisis intervention physical restraints, two were crisis intervention chemical restraints, and two were a set of dates of non-chemical medical restraint for healing. 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.

7. For Individual #74 5/25/16-5/27/16, there was no entry marked regarding injury.

9. Because criterion for indicator #2 was met for six of the seven individuals, this indicator was not scored for them. For Individual #404 8/26/16, of the relevant sub-indicators, the Monitoring Team could not confirm that ISP or PBSP were being implemented.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.

Summary: Staff correctly answered questions about the usage of crisis intervention restraint. This indicator was scored at 100% for this review and the two previous reviews and, therefore, this indicator will move to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	28	358	116	187	65	404	74		
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A		

Comments:
12. Although criteria were met, some staff had some difficulty immediately identifying prone restraint as being prohibited.

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.											
Summary: Indicator 13 showed continued improvement across this and the previous two reviews. With sustained high performance, it might move to the category of requiring less oversight after the next review. Indicator 14 scored at 100% at this review and two reviews ago (there were no occurrences last time). Due to this high sustained performance, this indicator (14) will be move to the category of requiring less oversight. Indicator 13 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	28	358	116	187	65	404	74		
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 8/8	1/1	2/2	2/2	1/1	N/A	1/1	1/1		
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.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	1/1		
Comments:											

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
Summary: It was positive that for the restraints reviewed, nurses initiated monitoring timely. However, as part of restraint monitoring, nursing staff need to improve their documentation of individuals' vital signs and mental status. Nurses need to provide more detailed descriptions of mental status, including specific comparisons to the individual's baseline. In addition, nurses should complete and document assessment of any restraint-related injures or other negative effects, and follow-up actions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	28	358	116	187	65	404	74		
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	13% 1/8	0/1	0/2	1/1	0/1	0/1	0/1	0/1		
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	25% 2/8	0/1	1/2	1/1	0/1	0/1	0/1	0/1		
c.	Based on the results of the assessment, nursing staff take action, as	0%	0/1	0/1	N/A	0/1	0/1	0/1	0/1		

	applicable, to meet the needs of the individual.	0/6									

Comments: The restraints reviewed included those for: Individual #28 on 8/20/16 at 12:05 a.m. (chemical); Individual #358 on 7/30/16 at 9:15 p.m. (chemical), and 6/16/16 at 1:17 a.m.; Individual #116 on 6/24/16 at 4:53 p.m.; Individual #187 on 7/11/16 at 3:33 p.m.; Individual #65 from 7/31/16 to 8/2/16 (medical restraints); Individual #404 on 8/26/16 at 9:45 a.m.; and Individual #74 on 9/28/16 at 4:40 p.m. (chemical).

a. For Individual #65, no physician's order was submitted indicating the frequency with which monitoring of the medical restraints was to occur.

For the seven crisis intervention restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint.

For the restraints of Individual #116 on 6/24/16 at 4:53 p.m., and Individual #187 on 7/11/16 at 3:33 p.m., nursing staff monitored and documented vital signs. For the restraint of Individual #404 on 8/26/16 at 9:45 a.m., the vital sign record for pulse and respirations were noted as the individual experienced Tachypneic, and Tacpnea, but no nursing follow-up was noted in the IPNs. Approximately half the vital signs for Individual #74's chemical restraint on 9/28/16 at 4:40 p.m. were illegible. In addition, a potential side effect of Thorazine is orthostatic hypotension, but no nursing assessments were documented that assessed the individual for this possible side effect.

For the restraints of Individual #116 on 6/24/16 at 4:53 p.m., nursing staff documented and monitored mental status. In some instances, no mental status assessment was documented, and in other instances, sufficient description was not provided of the individual's mental status (e.g., "awake and alert," "calm").

b. and c. Some examples of problems noted included:

- For Individual #28's chemical restraint, the documentation did not include assessments for vital signs to assess for orthostatic hypotension, a potential side effect of Haldol. She also had a history of syncope. In addition, prior to her receiving the Haldol, she was engaged in property destruction: "she started throwing down the fans and attacking staff" and "banging on pictures and walls." No documentation was found of nursing assessments for skin integrity or other injuries.
- Similarly, documentation was not present to show nursing staff monitored Individual #358 for orthostatic hypotension after the administration of Haldol.
- For Individual #187, item 2.4 on the Crisis Intervention Face-to-Face Assessment and Debriefing Form that addressed: "Did the restraint cause injury to anyone?" had the peer block checked, but listed Individual #187. Under Comments/Actions, the form stated: "restraint resulted in re-opening [illegible] abrasion." However, no injury report was found, and the Nursing IPN, dated 7/11/16 at 3:45 p.m., documented no new "injuries at this time." Nursing staff documented a skin assessment, but did not follow standards of care when documenting skin integrity problems.
- Prior to Individual #74 receiving the chemical restraint, the record documented "[Individual #74] had pulled a fire alarm, ran off the home and broke a mirror on a truck, engaged in hitting staff, and bit one staff." No nursing assessments were documented.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary: San Angelo SSLC's restraints are documented very well, though including the administering staff for a chemical restraint needs to occur for all chemical restraints. This indicator will remain in active monitoring. With improvement in this area and maintenance of high performance on the other sub-indicators, this indicator might move to the category of less oversight after the next review.			Individuals:									
#	Indicator	Overall Score	28	358	116	187	65	404	74		
15	Restraint was documented in compliance with Appendix A.	90% 9/10	1/1	1/2	2/2	1/1	1/1	1/1	2/2		
Comments: 15. The crisis intervention chemical restraint for Individual #358 7/30/16 did not indicate the staff who administered the restraint. Presumably, it was a nurse, but this detail needs to be included, too, as it was for Individual #74's chemical restraint 9/28/16).												

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
Summary: A combination of documentation problems and implementation challenges need to be corrected so that these two indicators can move forward. Performance has been about the same for this review and the last two reviews, too. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	28	358	116	187	65	404	74		
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	50% 1/2	Not rated	Not rated	Not rated	Not rated	Not rated	1/1	0/1		
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	50% 1/2	Not rated	Not rated	Not rated	Not rated	Not rated	1/1	0/1		
Comments: 16-17. Because indicators 2-11 were scored positively for seven of the restraints for four of the individuals, these two indicators were not scored for those restraints. In addition, because Individual #65's restraint was not a crisis intervention restraint, it also was not scored. Criteria were not met for Individual #74 9/28/16 because the Monitoring Team could not find (on the new form) entries documenting review by the unit and by the IMRT.											

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.)	
Summary: These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	28	358	74						
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	33% 1/3	0/1	1/1	0/1						
48	Multiple medications were not used during chemical restraint.	33% 1/3	0/1	0/1	1/1						
49	Psychiatry follow-up occurred following chemical restraint.	33% 1/3	1/1	0/1	0/1						

Comments:
47-49. These indicators applied to chemical restraints for Individual #28, Individual #358, and Individual #74. In the case of Individual #358, the psychiatric review was performed within the 10-day time frame. A psychiatric follow-up was documented in Individual #28's record. There was no documentation of psychiatric follow-up regarding Individual #28 or Individual #74.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.

Summary: San Angelo SSLC's performance declined since the last review on this important indicator. Some of the decline was due solely due to there being outdated duty to report forms for staff who worked with three individuals. For the others, there were problems in IDTs' development, implementation, and revision of supports to reduce the likelihood of incidents occurring. While the Incident Management Department did a good job of tracking recommendations, IDT members were not documenting when supports were implemented or monitor those supports for effectiveness. This is a priority area for the facility, especially given the number of incidents, injuries, and investigations that occur. And, given the seriousness of the case of Individual #65. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	28	358	116	187	269	65	404	74	
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	36% 4/11	0/1	2/2	0/1	1/2	0/1	0/2	1/1	0/1	

Comments:
The Monitoring Team reviewed 11 investigations that occurred for eight individuals. Of these 11 investigations, seven were DFPS investigations of abuse-neglect allegations (one confirmed, five unconfirmed, one inconclusive). The other four were for facility investigations of a discovered ankle fracture, discovered leg fracture, suicide threat, and 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 #28, UIR 8828, DFPS 442-94148, unconfirmed allegations of abuse, 4/6/16
- Individual #358, UIR 9399, DFPS 446-06204, unconfirmed allegations of abuse, 8/4/16
- Individual #358, UIR 9313, sexual incident, 7/19/16
- Individual #116, UIR 9554, DFPS 447-78950, confirmed allegation of neglect, 9/17/16
- Individual #187, UIR 9050, DFPS 443-48187, inconclusive allegation of abuse, 5/12/16
- Individual #187, UIR 9428, unauthorized departure, 8/11/16
- Individual #269, UIR 8812, DFPS 442-89229, referred allegation of neglect, 4/2/16
- Individual #65, UIR 9456, DFPS 446-63853, confirmed allegation of neglect, 8/19/16
- Individual #65, UIR 9284, discovered arm injury, 7/5/2016
- Individual #404, UIR 9407, DFPS 446-13691, inconclusive/unconfirmed allegation of abuse, 8/5/16
- Individual #74, UIR 9166, DFPS 443-82646, unconfirmed allegation of abuse, 6/5/16

1. For all 11 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.

2. Four of the investigations met criteria with all four sub-indicators a-d. Of the seven that did not meet criteria, three did not meet criteria solely because of there being outdated standard protection of employee annual signatures on the 1020 duty to report form (Individual #28 URI 8828, Individual #116 UIR 9554, Individual #74 UIR 9166).

For two of the other four, problems with implementation, documentation, and data collection of their PBSPs did not meet criteria (Individual #187 UIR 9428, Individual #269 UIR 8812). This was surprising to see at San Angelo, where these basics of behavioral programming were typically implemented in the past. The remaining two of the other four were two investigations for Individual #65 (UIRs 9456 and 9284). He had a broken arm, eventually leading to infection, and amputation.

Some comments about Individual #65's case are below. In the weeks following the onsite review, the Monitoring Team requested additional information about this case. The facility and State Office were very responsive to this request, including putting a number of additional protocols in place to address future occurrences of this type of serious medical situation for Individual #65 as well as for any other individuals at San Angelo SSLC.

Overall, Individual #65 received a lot of attention from the IDT and from the facility. He was frequently seen by psychiatry and his IDT met often. There were, however, numerous lapses in documentation, including submitting documentation to the Monitoring Team. For instance, while onsite the Monitoring Team made a second request to the facility for any additional ISPAs and was told that there were none. In addition to that, the Monitoring Team interviewed the QIDP who said that there were no additional ISPAs. Yet, the post-onsite

submissions of documents included some additional ISPAs. Moreover, much of the documentation, there was a description of what actions were to occur (which was good to see), but no summary of current status, no review of supports, and no indication of team discussion.

In the post-onsite documents, document 2 included a number of policy revisions, protocols, and actions to be taken. The Monitoring Team appreciated seeing that the facility has taken a look at what occurred for Individual #65 and is taking steps to prevent similar situations. Another positive was that the guardianship process was completed for Individual #65.

- The Monitoring Team acknowledges that Individual #65 presented a particularly complicated case. He had challenging behavior problems, was difficult to supervise, and had numerous medical disorders. Moreover, he was a relatively new admission to the facility.

- Individual #65 had numerous injuries, including at least two serious injuries prior breaking his arm on 6/21/16 (4/19/16 broken finger, 4/20/16 nose fracture). After that:
    - 7/6/16, discovered bone punctured skin.
    - 7/10/16, discovered bone punctured skin again.
    - 7/25/16, surgery to place hardware in arm to immobilize fracture.
    - 8/16/16, re-admitted to hospital with infection to arm.
    - 8/22/16, re-admitted to hospital via emergency room; hospital found that hardware had damaged an artery.
    - 8/28/16, re-admitted to hospital due to infection/MRSA at wound site. The hospital report noted that the splint got wet, and the facility put a fan on it to dry, however, there was no documentation of this by nursing staff. When the splint was removed at hospital five/six days later, there was significant infection that required draining. The infection/lesion was not in proximity of wet spot and the physician changed his dressing.
    - 8/31/16, at hospital, amputation of arm due to infection.

  In the post-onsite documents, document 6 was a calendar of various medical-clinical reviews, injuries, etc. for Individual #65. This was helpful. To aid in the evaluation of supports, this type of calendar or other timeline would likely be useful to IDTs in planning actions for individuals with complex, constantly changing, needs.

- Individual #65 was subject to six DFPS investigations in a six-month period, including two confirmed for neglect. These two investigations did not reflect that the facility reviewed all prior incidents and investigations and it was not evident that the IDT, at any point, reviewed these incidents in a meaningful way to determine if supports were sufficient. In its post-onsite document submission, document 2 provided some additional information, stating that the IDT did meet, but overall acknowledged that they were missing evidence of implementation of recommendations or implementation of changes agreed upon as an IDT. As a result, the facility stated that the incident management department will include the discussion related to the relevance of prior incidents in the analysis section of investigative reports, including the ISPA discussion, too.

- Previous serious injuries were determined by the facility to be due to behavior problems. The team did not document or meet to discuss behaviors that might have put him at risk either before the broken arm, or in the three-week period between

breaking his arm and the subsequent serious injuries.

- Individual #65 was identified as being at high risk for incidents and injuries by the Executive Safety Committee. He was also referred to the Critical Incident Team for review. Neither of these processes resulted in aggressive action being taken to protect him from harm. Executive Safety Committee notes from May 2016 through October 2016 had little updated data and said to continue to monitor. The Critical Incident Team made many recommendations, but then failed to ensure recommendations were completed, consistently implemented, or revised when not effective.

  In post-onsite document 2, the facility stated that "the Executive Safety Committee (ESC) will begin to attempt systemic improvements for risk areas by using of trend data and patterns within the facility. This will be an additional, new direction for the committee aimed at overall occurrences in order to reduce total numbers as well as lessen intensity of unusual incidents. The ESC will continue to review ISPAs for individuals reviewed in ESC and identified as high risk for incidents of injuries and will conduct follow-ups on progress an effectiveness of plans, as well as ensure action plans are kept up to date, timelines are met, etc. Accountability will be tracked through minutes." The Monitoring Team agrees with this approach.

  Similarly, regarding the Critical Incident Team, the facility stated that, "Recommendation monitoring/follow up for effectiveness will be completed through the IMRT recommendation tracking process. All recommendations resulting from a Critical Incident Team meeting will have a 3-month and 6-month ISPA discussing the effectiveness/lack of effectiveness. This ISPA is to be sent to Incident Management to be filed in the investigative case file and tracked for completion in the IMRT meeting notes. When lack of effectiveness is indicated, the ISPA will need to include adjustments being made to acquire the desired results and/or justification for discontinuing." The Monitoring Team agrees with this approach, too.

  Regarding other specific supports:
  - Update communication dictionary/cards: Monitoring Team onsite interviews with staff found that staff were not using communication cards. There was no documentation that staff ever consistently used communication cards. In the post-onsite documents, the facility stated that a re-evaluation of his communication needs was completed (1/17/17) and a new device of some sort was being ordered.
  - Bolt furniture to wall: Monitoring Team observation found that there was no furniture in his room and no documentation regarding removal of his furniture. In the post-onsite documents, the facility referenced completed work orders for bolting his furniture as well as there not being a need for HRC review, though this did not address the question of there being no furniture in his room.
  - Have TV on at all times: Monitoring Team observation found no TV in his room. In the post-onsite documents, the facility noted that the recommendation to have a TV (and have it on) was postponed, but that there was no documentation of this.
  - Sensory activities: Monitoring Team found numerous notes about this recommendation, which went back to 4/11/16. In the post-onsite documents, the facility reported that there was a sensory program in place (weighted blanket, compression garments), a sensory room, and documentation that many staff were trained. The facility noted that this was described in his PBSP and PNMP, however, information about its implementation and efficacy were not done (or the information was not available).

- Instruction sheet to be provided to staff for things that calm him: Monitoring Team did observe this.

- In the weeks following the onsite review, the Monitoring Team requested that the facility respond to the above, specifically, as to (a) what will be done to ensure that Individual #65 receives the needed protections and supports, and (b) what might be done differently in the future in these types of cases at San Angelo SSLC. The facility and State Office responded in a timely and thorough manner with more information about supports that were in place for Individual #65 as well as those that needed to be improved (and the need for improvement in documentation).

  In addition to the ESC and Critical Incident Team protocol changes described above, the facility noted the following protocol addition: "Unit directors (UD) will begin monitoring weekly IDT meetings and providing oversight and guidance (1 IDT per week per UD). They will then follow-up to ensure the ISPA is complete and actions are captured and reflected as discussed. The UDs, QC, and DRS will begin randomly selecting 1 action plan per week, 2-3 months following an ISP, to ensure plans are progressing and progress is being documented and plans are kept up to date. Results of this monitoring and oversight will be discussed in a monthly meeting between ADOP, DRS, UDs, and QC, and then plans will be developed to improve processes.

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

Summary: Overall, reporting procedures were followed and this indicator showed continued improvement from the last two reviews. It will remain in active monitoring and with sustained high performance, might move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	28	358	116	187	269	65	404	74	
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	10/11 91%	1/1	2/2	0/1	2/2	1/1	2/2	1/1	1/1	

Comments:
2. For Individual #116 UIR 9554, per DFPS, the incident occurred at 3:15 pm and was reported to them at 4:35 pm. Video review confirmed that two staff were trying to redirect/restrain Individual #116 from self-injury and one staff (the alleged perpetrator) failed to intervene. Presumably, one of the other two staff who was present was the reporter and did not immediately report. Circumstances that could have justified this were not provided in 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.

Summary: These indicators showed 100% performance for this review and the previous two reviews, too (with one exception of one staff answer in June 2015). Therefore, all three indicators will be moved to the category of requiring less oversight.	Individuals:

#	Indicator	Overall Score	28	358	116	187	269	65	404	74	
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 6/6	1/1	Not rated	1/1	1/1	1/1	1/1	Not rated	1/1	
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 8/8	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% 11/11	1/1	2/2	1/1	2/2	1/1	2/2	1/1	1/1	

Comments:
3. Because indicator 1 was met for two individuals, this indicator was not scored for them. The indicator was scored for the other six individuals and criteria were met.

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.

Summary: Performance at the last review was 100% for this indicator and 92% at the review prior to that one. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	28	358	116	187	269	65	404	74	
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	82% 9/11	1/1	1/2	1/1	2/2	1/1	1/2	1/1	1/1	

Comments:
6. For Individual #358 UIR 9313, the UIR did not note that immediate actions were taken in the general information section (as was the case with other UIRs). For Individual #65 UIR 9284, sub-indicator .3 requires that additional protections be implemented following the incident. The Monitoring Team could not confirm that protections were implemented, though the facility indicated in its post-onsite documents that many were in place.

Outcome 5– Staff cooperate with investigations.

Summary: The facility met criteria for 100% of the investigations during this and also during the previous two reviews. Therefore, this indicator will move to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	28	358	116	187	269	65	404	74	
7	Facility staff cooperated with the investigation.	100% 11/11	1/1	2/2	1/1	2/2	1/1	2/2	1/1	1/1	

Comments:

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
Summary: For the most part, investigations were complete at San Angelo SSLC. The complicated and serious nature of Individual #65's injury, though should have resulted in a more thorough review of previous history. All three indicators were scored at 100% for the past review. Given this past and sustained performance, indicators 9 and 10 will be moved to the category of requiring less oversight. Indicator 8 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	28	358	116	187	269	65	404	74	
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	10/11 91%	1/1	2/2	1/1	2/2	1/1	1/2	1/1	1/1	
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 11/11	1/1	2/2	1/1	2/2	1/1	2/2	1/1	1/1	
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	100% 11/11	1/1	2/2	1/1	2/2	1/1	2/2	1/1	1/1	
Comments: 8. For Individual #65 UIR 9284, the original injury that resulted in a broken bone was not included in the relevant history, though it was noted in comments as having occurred.											

Outcome 7– Investigations are conducted and reviewed as required.											
Summary: Investigations were, and have been, commenced within 24 hours of report, therefore, indicator 11 will move to the category of requiring less oversight. Indicators 12 and 13 will remain in active oversight, but with focus and improved high performance, might move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	28	358	116	187	269	65	404	74	
11	Commenced within 24 hours of being reported.	100% 11/11	1/1	2/2	1/1	2/2	1/1	2/2	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).	10/11 91%	1/1	2/2	1/1	2/2	1/1	2/2	0/1	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.	83% 8/11	1/1	1/2	0/1	2/2	1/1	2/2	0/1	1/1	

Comments:
12. Individual #404 UIR 9394 was signed as a completed investigation on 9/1/16. Approved extension requests were up until 8/26/16.

13. Supervisory review did not detect absence of immediate action (Individual #358 UIR 9313), late reporting (Individual #116 UIR 9554), and lack of extension (Individual #404 UIR 9394). The expectation is that the facility's supervisory review process will identify the same types of issues that are identified by the Monitoring Team. In other words, a score of zero regarding late reporting or interviewing of all involved staff does not result in an automatic zero score for this indicator. Identifying, correcting, and/or explaining errors and inconsistencies contributes to the scoring determination for this indicator.

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.

Summary: San Angelo SSLC conducted audit activity regarding significant injuries that met criteria at 100% for this review and for the last two reviews, too. Therefore, indicator 14 will move to the category of requiring less oversight. This review revealed that San Angelo SSLC was not implementing the DADS non-serious injury investigation procedure that has been used at other facilities for several years. This is easily correctable and the facility began to respond to this before the onsite week had ended. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	28	358	116	187	269	65	404	74	
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 8/8	1/1	1/1	1/1	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.	25% 2/8	0/1	0/1	0/1	0/1	1/1	0/1	1/1	0/1	

Comments:
15. Non-serious injury investigations were not occurring even though were several discovered non-serious injuries listed (for six of the individuals), that based on their location, should have been investigated via the typical DADS process for doing so. In post-onsite documents submitted to the Monitoring Team, document 3 described protocols being put in place to address non-serious injuries and their investigation.

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
Summary: These indicators scored at 100% at the two reviews prior to this review. Indicators 17 and 18 will be moved to the category of requiring less oversight. Indicator 16 will remain in active oversight and with sustained high performance may move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	28	358	116	187	269	65	404	74	
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	88% 7/8	1/1	1/1	1/1	0/1	N/A	2/2	1/1	1/1	
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 3/3	N/A	N/A	1/1	N/A	N/A	1/1	1/1	N/A	
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 3/3	1/1	1/1	N/A	N/A	N/A	1/1	N/A	N/A	

Comments:
16. Three investigations had no specific recommendations, however, Executive Safety Committee minutes showed regular review/follow-up related to two of these regarding injuries (Individual #358 UIR 9399, Individual #116 UIR 9554). This was very good to see.

For Individual #187 UIR 9428, the UIR noted that the fence the individual climbed over was eight feet high with small mesh and was not effective for deterring climbing among the facility's younger population. There was nothing in the UIR that addressed if, or how, this identified client protection issue would be addressed.

17. The actions for Individual #404 UIR 9394 were documented very well.

During this review period, 10 investigations included a confirmation of staff physical abuse level 2. In all 10 cases, the staff who were confirmed were terminated from employment.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
Summary: This outcome consists of facility indicators. Performance at criteria for this and for the last two reviews, too, puts this set of five indicators into the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations,	Yes									

	the facility had a system that allowed tracking and trending.											
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: 19-23. The facility system for tracking, trending, and analyzing incident related data, and for developing follow-up plans, as noted in the last two reviews, too, continued to be exemplary. In addition, San Angelo SSLC conducted thorough review of circumstances surrounding each investigation during incident management review team daily meetings. The investigations (and updates) were presented by the investigators.												

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	0% 0/1				N/A					0/1
Comments: a. The Center continued to conduct TIVA clinics using both a medical anesthesiologist and a dental anesthesiologist. The Center did not have any arrangements with regards to those individuals who required treatment in a hospital setting. The Center policy did not define which individuals were suitable for on-campus anesthesia and which required anesthesia in hospital setting. Moreover, there was no medical policy related to the need for peri-operative evaluations. Perioperative evaluations (medical clearance) must be thoroughly done, but were not. The Center utilized a template for all dental procedures. However, the notes of the dentist did not include the vital information typically seen such as: preoperative diagnosis, postoperative diagnosis, procedures performed, and description of procedure. The description of the procedure typically would note that informed consent was obtained in addition to the condition of the individual prior to the procedure, the type of anesthesia that was being utilized, a description of the procedure, and the condition of the individual after the procedure.											

Individual #328 had rheumatoid arthritis requiring the use of disease-modifying anti-rheumatic drugs. The pre-operative evaluation did not include any evaluation of the cervical spine by any providers involved in the care of this individual. Generally acceptable clinical guidelines for the management of rheumatoid arthritis include the assessment of cervical instability with flexion/ extension radiographs prior to procedures that may require general anesthesia and intubation. The consequences of failure to detect this have the potential to be devastating. On a positive note, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, and post-operative vital sign flow sheets were submitted.

b. For Individual #217, in response to the Monitoring Team's Document Request #46 (i.e., For individuals who received TIVA or medical and/or dental pre-treatment sedation, copy of informed consent, documentation of committee or group discussion related to use of medication/anesthesia, and Medical/Dental Restraint Checklist, as applicable), the Center submitted a statement that no information was required, because the individual did not receive this service. The Center provided no information related to Document Request #44 (i.e., 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). However, on 8/18/16, Individual #217 received oral pre-treatment sedation 1.5 hours prior to a dental appointment. The dental IPN did not state what medication was administered for pre-treatment sedation. The Registered Dental Hygienist wrote the only note related to the procedure. The Dentist provided no documentation for this individual who was sedated. Only one set of vital signs were documented in IPNs upon her return home.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									
Comments: Based on documentation the Center submitted, in the six months prior to the onsite review, none of the individuals the Monitoring Team responsible for physical health reviewed had medical pre-treatment sedation.											

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.											
Summary: These protection from harm aspects of PTCR were not being addressed by the facility, but need to be. This was especially important given that there were 75 instances of TIVA usage over the past year. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	404								
1	IDT identifies the need for PTCR and supports needed for the procedure, treatment, or assessment to be performed and discusses	0% 0/1	0/1								

	the five topics.										
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.	0% 0/1	0/1								
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								
4	Action plans were implemented.	N/A	N/A								
5	If implemented, progress was monitored.	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								
Comments: 1-6. This outcome and its indicators applied to Individual #404 who had TIVA in November of 2015 and September of 2016. There was no documentation in Individual #404's ISP, ISPAs, or QIDP monthly reviews/reports that the IDT identified the need for TIVA, or that treatments/strategies to minimize the future need for TIVA were considered.											

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	379	128	145	104					
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 4/4	1/1	1/1	1/1	1/1					
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					

d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1					

Comments: a. Since the last review, four individuals died. The Monitoring Team reviewed all four deaths:

- On 3/8/16, Individual #379 died at the age of 80 with causes of death listed as cardiopulmonary failure, multi-organ failure, and dementia;
- On 3/12/16, Individual #128 died at the age of 72 with cause of death listed as pneumonia;
- On 6/4/16, Individual #145 died at the age of 49 with causes of death listed as cardiac arrest, acute respiratory failure, recurrent aspiration, and dysphagia; and
- On 7/19/16, Individual #104 died at the age of 63 with causes of death listed as cardiac arrest, pulmonary arrest, aspiration, and dysphagia.

b. through d. Overall, the QA RN highlighted several deficiencies related to documentation of medical care. For example, it was noted that physician orders were frequently not timed, QDRR recommendations were not implemented, lab monitoring was not consistent with the Center's lab matrix, and consults were not always properly reviewed. These issues were repeatedly seen in the QA death reviews but there was no overarching plan to address these deficiencies. As discussed in other sections of this report, the Monitoring Team identified similar deficiencies in the records reviewed.

On a positive note, in the two most recent death reviews, the QA RN also identified issues related to nursing care (e.g., nursing guidelines not being followed, acute care plans not implemented), and with some exceptions, recommendations were included to address these issues. One notable exception was for Individual #104's death review. Specifically, the individual experienced respiratory distress with an oxygen saturation of 65% even after a treatment was given. No recommendations were included for training on recognizing signs and symptoms of respiratory distress/hypoxia, and/or reviewing whether or not the Center's Emergency Policy should have been implemented.

e. The recommendations generally were not written in a way that ensured that Center practice had improved. For example, a recommendation that read: "Retrain nursing staff to ensure that a daily report is obtained for an individual who is an inpatient in an acute care hospital over the weekends and holidays. This also should include documentation within the patient's medical record at the facility" resulted in retraining of staff on an existing procedure. This in no way ensured that concerning practices changed. The recommendation should have been written in a manner that required monitoring to determine whether or not nursing staff were obtaining reports on weekends and holidays for hospitalized individuals and documenting the information in the individuals' records.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: The Center should immediately implement an effective surveillance and response program for ADRs that is consistent with the current generally accepted standards.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	ADRs are reported immediately.	0% 0/2	N/A	N/A	0/1	N/A	N/A	0/1	N/A	N/A	N/A
b.	Clinical follow-up action is completed, as necessary, with the individual.	0% 0/2			0/1			0/1			
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	0% 0/2			0/1			0/1			
d.	Reportable ADRs are sent to MedWatch.	N/A			N/A			N/A			

Comments: a. through c. For Individual #251 and Individual #329, the Center identified possible ADRs in its response to the Monitoring Team's Tier I document request. Center policy requires that staff report all suspected ADRs. However, in response to the Tier II document request, the Center did not submit any ADR reporting forms, but rather submitted documents describing the possible ADRs. More specifically:

- For Individual #329, a note indicated that on 5/26/16: "possible irritation/itching after haloperidon injection. Had received same injection prior to and after. No treatment given." Without using a probability scale, Center staff determined this was not an ADR.
- For Individual #251, the Center submitted a chart that described on 5/27/16: "Hypotension after gentamycin bladder irrigation solution administered. Route of administration via catheter thought to be the cause of the hypotension. Received 2 more 3-day treatments in July without problem." Without an objective tool to determine the probability that an ADR occurred, the Pharmacy Director indicated that the PCP made the determination that it was not an ADR.

In sum, for neither of these possible ADRs did the Center submit ADR forms, follow-up documentation, and/or Pharmacy and Therapeutics Committee minutes. Overall, the Center continued to lack an appropriate ADR reporting and monitoring system. Staff were not compliant with the Center policy and were not even familiar with the requirements outlined in the policy. Specifically, there was no objective process for making the determination about the occurrence of ADRs. Staff was not familiar with the use of a probability scale. This requirement was included in the Center policy. Furthermore, the ADR module of IRIS includes all of the components of the Naranjo Probability Scale, but staff did not appear to be utilizing it. In its reports for the March 2016 review and June 2015 review, the Monitoring Team also noted concerns related to the Center's failure to execute an ADR reporting and monitoring system.

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.		
Summary: State Office should provide San Angelo with direction regarding the completion of clinically significant DUEs.		Individuals:
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	0% 0/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/2

Comments: a. and b. In response to the Monitoring Team's document request, San Angelo SSLC submitted documentation for two activities, neither of which met the requirements of a DUE:

- On 5/1/16, Center staff completed a review of Vraylar and CYP3A4. The objective and methodology of the DUE were not stated. There was no analysis of data. There was no plan to address the recommendations of the study.
- On 9/1/16, Center staff developed a PowerPoint presentation entitled: "Medications that Lower the Seizure Threshold." The Pharmacy Director acknowledged that this was an educational presentation and not a DUE.

Organizations such as the American Society of Health Systems Pharmacists provide guidelines for the completion of Drug Utilization/ Medication Use Evaluations. The guidelines detail how medications for evaluation should be selected, the steps for completing the review, the use of data, and the development/implementation of corrective actions plans.

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.

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Eleven of these indicators, in psychiatry, behavioral health, medical, and dental had sustained high performance scores and will be moved the category of requiring less oversight. This included one entire outcome: outcome 7 for behavioral health.

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

Assessments

For the individuals' risks reviewed, only one of the IDTs effectively used supporting clinical data (including comparisons from year to year), used the risk guidelines when determining a risk level, and/or as appropriate, provided clinical justification for exceptions to the guidelines. As a result, it was not clear that the risk ratings were accurate. In addition, when individuals experience changes in status, IDTs need to timely review related risk ratings, and make changes, as appropriate.

The IDT considered what assessments the individual needed for some, but not all, individuals. Even so, IDTs did not arrange for and obtained these needed, relevant assessments prior to the IDT meeting.

IDTs did not consistently meet to review progress or revise supports and services as needed. Reliable and valid data were not available to guide decision-making.

For this review and the previous two reviews, Medical Department staff completed the medical assessments in a timely manner. As a result, the related indicators will be placed in the category of requiring less oversight.

They cited a great deal of data, but failed to synthesize the data in a cogent manner that produced valuable clinical information. Moving forward, the Medical Department should focus on ensuring medical assessments, as appropriate, describe pre-natal histories, family history, childhood illnesses, past medical histories, complete interval histories, and include updated active problem lists, and plans of care for each active medical problem, when appropriate.

Over the last two reviews, improvement was noted with regard to the timely completion of annual dental exams. Annual dental summaries had been consistently completed timely, so the related indicator will move to the category requiring less oversight. Work was still needed with regard to the quality of dental exams and summaries.

Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas 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. In addition, often, when individuals experienced changes of status, nurses did not complete assessments consistent with current standards of practice.

Much like the other SSLCs, there were no individualized psychiatric goals for individuals. That is, those that focused upon the individual's psychiatric disorder via what have come to be called psychiatric indicators. Individuals had CPEs, but CPE content was not comprehensive. The psychiatric treatment document was updated within past 12 months, but wasn't fully complete.

Behavioral health services, however, created measurable goals, but surprisingly little data were not being collected reliably. The department's behavioral health assessments, functional assessments, and PBSPs were updated, but were incomplete, missing many standard components. Similarly, SAPs existed, but no reliable useful data were provided regarding implementation, performance, or progress.

For a number of individuals reviewed, the PNMT did not complete an assessment and/or provide justification for not completing an assessment, and/or the referral and assessment should have occurred sooner.

The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied, and some regression was noted during this review. The quality of these assessments also needs improvement.

It was very positive that four of the five individuals' communication updates addressed their communication strengths, preferences, and needs. This was a significant improvement from the last two reviews, and the Center should focus on maintaining this important progress. Improvement also was noted with regard to timeliness of communication assessments.

Individualized Support Plans

For the most part, staff with whom the Monitoring Teams interacted during the onsite week were very familiar with the supports included in individual's ISPs.

The development of individualized, meaningful personal goals in six different areas was not yet at criteria, but progress was evident. All six ISPs, for instance, included at least one goal that met criteria, and three ISPs had three goal areas that met criteria. But, many of the goals had not been implemented, and most were discontinued. The facility needs to focus on barriers that are

preventing individuals from achieving their goals and develop plans to address those barriers. In addition, a focus area for the facility (and its QA and QIDP departments) is to ensure the actions plans meet these various 11 items of ISP outcome #3.

Overall, the IHCPs of the individuals reviewed were not sufficient to meet their needs. Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs, as well as nursing and physical and nutritional support interventions.

The Monitoring Team observed an annual ISP meeting. For the most part, much of the nearly two hour meeting was spent reading the draft ISP. There was little discussion and often little agreement on how the team would support the individual to achieve her goals.

As a positive, San Angelo SSLC had two standard activities (self-advocacy committee, home meetings) that could be incorporated into individuals' ISPs, perhaps to help them improve their skills at individual problem solving and decision-making, as well as their group problem solving and decision-making skills.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: The development of individualized, meaningful personal goals in six different areas, based on the individual's preferences, strengths, and needs was not yet at criteria, but progress was evident as described below. All six ISPs, for instance, included at least one goal that met criteria, and three ISPs had three goal areas that met criteria. This was very good progress since the last review. Focus is needed to ensure that goals are written in a way that can be measured (i.e., its achievement can be determined) and that plans are implemented and data are collected. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	28	65	404	236	328	338			
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% 0/6	3/6	2/6	3/6	1/6	1/6	3/6			
2	The personal goals are measurable.	0% 0/6	2/6	1/6	3/6	1/6	1/6	1/6			
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% 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 #28, Individual #65,											

Individual #404, Individual #236, Individual #328, and Individual #338. 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.

1. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some 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.

None of the six individuals had individualized goals in all six areas, therefore, none had a comprehensive set of goals that met criterion. Outcomes for the six ISPs remained very limited in scope and provided few opportunities to learn new skills or ensure that the individual would be involved in meaningful activity. Thus, it was unlikely that personal goals developed by the IDT would have a significant impact on their day.

That being said, there was some improvement in the individualization of personal goals. Each individual had at least one goal in one area that met criterion with this indicator. Three individuals had goals that met criterion in three of the six areas.

To be specific, these goals met criterion:

- Individual #65's goals to establish a relationship with his nephew and use his communication book to let staff know when he wanted to go outside.
- Individual #28's goals to get physically fit with water aerobics, become a member of a church in the community, and live in a group home in Amarillo.
- Individual #236's goal to volunteer her time working with animals.
- Individual #404's goals to attend a Tejano concert, have an AA sponsor in the community, and live in the community near his family.
- Individual #328's goal to choose what he wants to eat.
- Individual #338's goals to swim, work at the greenhouse, and toilet independently.

Although IDTs had established the above goals that were more individualized (and based on known preferences), none of the goals listed had been implemented, and most were discontinued. Thus, individuals did not have person-centered ISPs that were leading towards individuals achieving their personal goals. The facility needs to focus on barriers that are preventing individuals from achieving their goals and develop plans to address those barriers.

Examples of goals that did not meet criterion because they were not aspirational, individualized, and/or based on preferences included:

- Individual #28's work/day goal was not based on an assessment that provided the opportunity to explore new opportunities and assess her preferences, strengths, and interests.

- Individual #236's relationship goal to make a new friend was not individualized.
- Individual #65, Individual #236, Individual #328, and Individual #338 had the living option goal to remain at San Angelo SSLC. This goal was not individualized or aspirational.
- Individual #328's recreation goal to communicate with staff when he wanted to go outside would increase his independence, however, it was unlikely to lead to participation in new activities based on his preferences.

2. Overall, personal goals for the ISPs did not meet the criterion described above in indicator 1. When a personal goal does not meet criterion, there can be no basis for assessing compliance with measurability or the individual's progress towards its achievement. The presence of a personal goal that meets criterion is a prerequisite to this process. Nine of the 13 personal goals that met criterion for indicator 1 also met criterion for measurability. Those that were not measurable included:

- Individual #65's goal to establish a relationship with his nephew.
- Individual #28's goal to get physically fit through water aerobics.
- Individual #338's goals to learn to swim and work in the greenhouse did not describe specific skills that he would need to learn to be considered successful.

3. For the nine goals that were determined to be measurable, none had reliable and valid data available to determine if the individual met, or was making progress towards achieving, his/her overall personal goals. As noted throughout this report, it was not possible to determine if ISP supports and services were being consistently implemented or determine the status of goals due to the lack of data and documentation provided by the facility. It appeared that few goals were consistently implemented and were often discontinued without the IDT establishing replacement goals.

The Monitoring Team observed Individual #236's annual ISP meeting during the onsite week. For the most part, much of the nearly two hour meeting was spent reading the draft ISP. There was little discussion and often little agreement on how the team would support Individual #236 to achieve her goals. The team did not have access to all relevant assessments and her PCP and psychiatrist did not attend the meeting, thus, the IDT could not address many of her risks and support needs.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.

Summary: When considering the full set of ISP action plans, the various criteria included in the set of 11 indicators in this outcome were not met, but in a handful of cases. A focus area for the facility (and its QA and QIDP departments) is to ensure the actions plans meet these various 11 items. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	28	65	404	236	328	338			
8	ISP action plans support the individual's personal goals.	0% 0/6	1/6	0/6	1/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities	33%	1/1	0/1	1/1	0/1	0/1	0/1			

	for choice.	2/6									
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	33% 2/6	1/1	0/1	1/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	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.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	33% 2/6	1/1	0/1	1/1	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.	17% 1/6	1/1	0/1	0/1	0/1	0/1	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.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	1/6	0/6	0/6	0/6	0/6	0/6			

8. Many personal goals did not meet criterion in the ISPs, as described above in indicator 1, therefore, action plans could not be evaluated in this context. A personal goal that meets criterion is a prerequisite for such an evaluation. Action plans are evaluated further below in terms of how they may address other requirements of the ISP process.

For the 13 personal goals that met criterion under indicator 1, only two had action plans that were likely to lead to the accomplishment of the goal. These were:

- Individual #28's action plans to support her relationship goal.
- Individual #404's action plans to support his living option goal.

Examples of action plans that were unlikely to support achievement of personal goals included:

- Individual #65's action plans for his communication and relationship goals were not detailed enough to support consistent implementation.
- Individual #28's goal to get physically fit through water aerobics was not measurable. Her action plans to support her living

option goal were not individualized.

- Individual #236's action plan to volunteer working with animals was a restatement of her goal without any specific implementation strategies.
- A SAP was never developed to provide teaching strategies for consistent implementation for Individual #404's goal for greater independence goal. Action plans to support his relationship goal did not include enough information to ensure consistent implementation.
- A SAP was not developed to support Individual #328's goal for greater independence.
- SAPs were not developed to support Individual #338's recreation, greater independence, or living option goals. Skills to be acquired were not defined.

9. Preferences and opportunities for choice were not routinely integrated in the individuals' ISP action plans. The exceptions were Individual #28 and Individual #328's ISP.

10. ISP action plans comprehensively addressed identified strengths, needs, and barriers related to informed decision-making for one individual (Individual #404). No action plans were identified that clearly supported decision-making skills.

San Angelo SSLC had two standard activities (self-advocacy committee, home meetings) that could be incorporated into individuals' ISPs, perhaps to help them improve their skills at individual problem solving and decision-making, as well as their group problem solving and decision-making skills. Many of the individuals at San Angelo SSLC would benefit from improving their decision-making skills, in fact, many had made serious poor decisions in their pre-facility lives as well as in the months or years that they've lived at the Center.

- The Monitoring Team attended the self-advocacy committee meeting. As usual, attendance was about 80 individuals, there was good engagement, and it remained a real part of the culture at the facility. There was information sharing, presentations, and problem solving. The HRO office continued to remain active and interested in continuing to improve the quality of this forum. The HRO also worked closely with the individuals in leadership positions of the committee, as well as with the assistant independent ombudsman and the facility's incident management coordinator.
- The facility also required each home to hold a meeting with individuals each week to discuss issues in the home, planning for activities, and so forth. These meetings could benefit from input from the HRO and his staff to, for instance, set up real problem solving activities for the individuals.

11. Two individuals had action plans to support greater independence.

- Individual #28 had action plans to shop, wash clothes, tell time, and work.
- Individual #404 had action plans for cooking, reading, math, and paying his phone bill.

For the other individuals:

- Individual #65's Functional Skills Assessment and Functional Behavioral Assessment were not completed prior to his ISP meeting, so skills for greater independence were not prioritized based on assessment results. It was likely that his communication goal might lead to greater independence, however, as noted above, it was not written in measurable terms.
- Individual #236 had a greater independence goal for medication administration. Her Functional Skills Assessment was not

completed prior to development of her ISP. It was not evident that this goal was a priority based on her preferences.

- Individual #338's IDT developed goals to address increased independence, however, the IDT failed to develop action plans and/or SAPs that were likely to lead to the accomplishment of goals.
- Individual #328's FSA recommended that the team develop skill acquisition plans for increased independence in bathing, medication administration, and money management. Additionally, the IDT developed a goal to choose his snack. Skill acquisition plans were not developed, therefore, it was unlikely that action plans would lead to acquisition of skills to enhance his independence.

12. IDTs did not fully integrate strategies to minimize risks in ISP action plans. Further discussion regarding the quality of strategies to reduce risks can be found throughout this report. In most cases, IDTs did not have updated assessments and data available for review prior to the ISP meeting to adequately determine risk ratings. Examples where strategies were not integrated in the ISP included:

- Individual #65's IRRF did not include updated fall data. His ISP did not address his risks due to side effects of multiple medications.
- Individual #236's action plans to address risk were not integrated throughout her ISP. For example, strategies to address risk associated with safe eating and diet were not integrated into skill acquisition plans for greater independence to choose her snack. At her recent ISP meeting, the team acknowledged that her communication SAP for choosing a snack could not be implemented because it conflicted with her diet.
- Similarly, Individual #328's safe eating strategies were not integrated into his skill acquisition plan for choosing a snack.
- Individual #404's team did not develop skill acquisition plans that should have integrated his behavioral and nutritional strategies to address risks into teaching strategies for his cooking goal.
- Individual #338's ISP did not integrated strategies to reduce his risk for falls into his goal to work in the greenhouse.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated in ISPs. In particular, psychiatry and medical supports were rarely integrated into support plans developed by other disciplines. In addition to the examples provided in #11 and #12 above:

- Individual #328's mobility strategies were not integrated into his community outing action.
- Individual #338's communication and behavioral recommendations were not integrated into teaching strategies because the IDT failed to develop skill acquisition plans.
- Individual #28's psychiatry supports were not integrated into her work and community living action plans by addressing barriers to implementation.
- Individual #65 experienced a number of significant and serious injuries throughout the year. It was noted that behavior, communication, psychiatry, habilitation therapy, and medical issues all contributed to his risk for injury. It was not evident that the team took an integrated approach to addressing his support needs to protect him from further injury.

14. Meaningful and substantial community integration was largely absent from the ISPs. There were few specific plans for community participation that would have promoted any meaningful integration for any individual. The exceptions were Individual #28's action plans to swim at the YMCA and attend church in the community and Individual #404's action plan to participate in an AA program in the community. These action plans for community integration, however, were never implemented. IDTs did not address barriers to implementation.

15. One of six ISPs considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Individual #28's ISP met criterion for this indicator, however, it was unlikely that action plans to support this goal would lead to achievement of her goal to work in the community. There was no clear rationale for action plans developed to support her vocational goal.

San Angelo SSLC had a vocational apprenticeship program. It was initiated at the time of the last onsite review, had stalled in the months after that, and was recently re-initiated. This program, however, can provide opportunities for individuals that could be incorporated into their ISPs. One individual (not chosen by the Monitoring Team) was very positive about the program and spoke about it at the self-advocacy committee meeting (Individual #190).

16. One of six ISPs (Individual #338) had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Observations did not support that individuals had opportunities to spend a majority of their day engaged in functional or meaningful activities. Day programming was rarely based on an adequate assessment of preferences or skills, but rather chosen from a limited list of opportunities for programming offered by the facility. When individuals did not attend day programming consistently, IDTs were not addressing barriers to attendance or considering other options for day programming based on the individual's preferences.

The facility offered a range of activities and programming for meaningful engagement, including cooking, computer, and arts and craft classes. More attention needs to be paid to individuals participating in these offerings as well as an additional focus on opportunities for skill building in the community.

17. Barriers to various outcomes were not consistently identified and addressed in ISPs. None of the ISPs had been consistently implemented. IDTs did not meet to address barriers to implementation. Often goals were continued from previous ISPs without addressing barriers to implementation. For example, at Individual #236's annual ISP meeting observed during the onsite review week, the IDT agreed to continue her communication SAP that had never been implemented without addressing barriers to implementation. She had not made progress towards her work or living option goals. Both were continued without addressing barriers to progress from the previous ISP year.

18. ISPs did not consistently include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action plans were broadly stated and as noted above, in many cases, skill acquisition plans were never developed to ensure consistent training would occur. Living options action plans generally had no measurable outcomes related to awareness.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.	
Summary: For one individual, all but one indicator met criteria. Other criteria were met for some indicators for some individuals, but overall, more work was needed to ensure that all of the activities occurred related to supporting most integrated setting practices within the ISP. Most indicators had at least one individual who met criteria. This shows that the facility has the capability to meet criteria, which should	Individuals:

be applied to all individuals. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	28	65	404	236	328	338			
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	0/1	1/1	1/1	0/1	1/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	33% 2/6	1/1	0/1	0/1	0/1	1/1	0/1			
23	The determination was based on a thorough examination of living options.	33% 2/6	1/1	0/1	1/1	0/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	67% 4/6	1/1	1/1	0/1	0/1	1/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	50% 3/6	1/1	0/1	1/1	0/1	0/1	1/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A			
28	ISP action plans included individualized measurable plans to educate the individual/LAR about community living options.	33% 2/6	1/1	0/1	1/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	100% 1/1	1/1	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. The exceptions were;
    - Individual #65's ISP did not include specific living preferences. It was noted that he liked where he lived, but there was no documentation that he was aware of other living options. His behavior over the past year did not support the IDT's opinion that he liked where he lived.
    - Individual #328's ISP noted that his preferences were unknown.

20. Individual #236's annual ISP meeting was observed. The IDT did not discuss her preferences for living options.

21. None of the ISPs met criterion for this indicator. Five of six ISPs did not have access to a number of relevant assessments prior to the ISP meeting, therefore, opinions and recommendation of the IDT's staff members was not available for review. Individual #236's ISP did not include a summary statement with a rationale for the IDT's decision.

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

- Individual #65 did not have a LAR and it was not evident that he understood his living options.
- Individual #236's ISP did not include a rationale for the IDT decision regarding her living option.
- Individual #404's consensus statement repeated the staff opinion statement without including his preferences.
- Individual #338's consensus statement did not include his or his LAR's preferences.

23. Two of the individuals (Individual #28, Individual #404) had a thorough examination of living options based upon their preferences, needs, and strengths. Both were able to express their preferences and had some knowledge of living options. For other individuals that were either unable to express their preferences or were unaware of their living options, it was not clear that IDTs considered other options that might support their individualized needs.

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 #236's team did not identify supports that could not be provided in the community. The team noted that she was "safer at the facility" and that she would "not understand" living in the community.
- Barriers to Individual #404 living in the community were not clearly defined. His ISP noted that "physical aggression and being a bully" were barriers to referral.

25. At Individual #236's annual ISP meeting observed, her behavior was identified as a barrier to referral, however, the IDT did not identify specific behaviors that could not be supported in the community.

26. One of the five individuals had individualized, measurable action plans to address obstacles to referral (Individual #28 was already referred.) Individual #338's PBSP addressed behaviors that were described as barriers to referral.

27. Specific plans to address obstacles to referral were not developed at Individual #236's ISP meeting observed by the Monitoring Team. The team developed plans for her to visit community providers, however, IDT members agreed that these visits would probably have no meaning to her.

28. Two of six ISPs (Individual #28, Individual #404) included specific action plans to educate individuals on living options.

29. Individual #28 had been referred to the community. Her ISP included specific action plans to move forward with the referral.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
Summary: ISPs were revised annually, but not implemented in a timely manner, and some aspects were not implemented at all. Not all individuals participated in their ISP preparation and annual meetings, and not all IDT members participated in the important annual meeting. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	28	65	404	236	328	338			
30	The ISP was revised at least annually.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	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).	67% 4/6	1/1	0/1	1/1	0/1	1/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			

Comments:

30. ISPs were developed on a timely basis.

32. Documentation was not submitted that would support that all action plans were implemented on a timely basis. The facility reported that the implementation of IRIS resulted in a gap in reporting data, however, consistent data were not available for individuals from July 2016 through November 2016. Examples in which timeliness criteria were not documented included:

- For Individual #28, the Monitoring Team was not able to confirm implementation of the ISP within 30 days due to the lack of data for her action plans to swim, bowl, attend animal science sessions, and go shopping.
- Individual #236's action plans to volunteer with animals were never implemented, and then were discontinued eight months after development.
- Individual #65 did not have implementation data for any of his goals.
- Individual #338 only had implementation data for one skill acquisition plan for one month (September 2016).

33. Four of six individuals participated in their ISP meetings. Individual #65 and Individual #28 did not attend their meetings.

34. Five of six individuals did not have an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. Individual #338 was the only individual who had consistent QIDP monthly reviews to indicate that his services and supports were routinely monitored and reviewed. Overall, there was a lack of participation in the

planning process by relevant disciplines:

- For Individual #65, no participation by his PCP, psychiatry, or day program staff.
- For Individual #236, no participation by her PCP or day program staff.
- For Individual #328, no participation by his LAR, PCP, or day program staff.
- Individual #28 did not have a consistent QIDP who coordinated her services. The QIDP position was vacant. Other QIDPs rotated weekly responsibility for coordinating her services resulting in a lack of consistent service coordination.
- Individual #404's assessments were not submitted in a timely manner to allow for a review of supports and services prior to the ISP meeting. It was not evident that his team routinely reviewed and revised supports.

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

Summary: Assessments that were needed were considered and identified by the IDTs for four of the six individuals. For all individuals, assessments were not always obtained prior to the ISP meeting. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	28	65	404	236	328	338			
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.	67% 4/6	0/1	0/1	1/1	1/1	1/1	1/1			
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, for four of six individuals.

- For Individual #28, the IDT did not adequately identify assessments related to syncope and related falls that were identified as a problem for over a year.
- For Individual #236, the team did not identify the need for an updated vocational assessment that would identify her work preferences.

36. IDTs did not arrange for and obtained needed, relevant assessments prior to the IDT meeting per the QIDP assessment submission data. Without relevant assessments available to IDTs prior to the annual ISP meeting, it was unlikely that all needed supports and services were included in the ISP. Assessments that were either not submitted or submitted late included:

- For Individual #65, his nursing, behavioral, functional skills, QDRR and audiological assessments.
- For Individual #28, her nursing, annual medical QDRR, and psychiatry assessments.
- For Individual #236, her functional skills, speech, and QDRR.
- For Individual #404, his nursing, behavioral, functional skills, QDRR and ICA.
- For Individual #328, his nursing and behavioral assessments.

- For Individual #338, his behavioral, psychiatry, QDRR, and audiological.

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

Summary: IDT and QIDP reviews were not occurring regularly, were not based on data, and did not result in actions when needed. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 28	65	404	236	328	338			
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 did not consistently meet to review progress or revise supports and services as needed. Reliable and valid data were not available to guide decision-making, in any event. As noted throughout this report, little progress was made towards achieving personal goals.

For all individuals, the IDTs did not meet to discuss lack of progress and address barriers or revise supports. When additional assessments were completed during the ISP year, there was rarely documentation that the team met to discuss recommendations from the assessment. For example,

- Individual #65's team did not meet and document changes in supports and services following his broken arm. He was seen at the hospital at least three additional times in a two-month period including undergoing two surgeries due to further complications from his broken arm. The IDT did not document discussion by the team or any revision to supports to protect him from further harm. In August 2016, his arm was amputated due to infection. There was no documentation to support that the IDT met to review supports either prior to amputation or following amputation. Behavior and communication were suspected to be contributing factors to his injuries. Recommendations were made during incident reviews to implement new communication and behavioral supports, however, there was not documentation to support that action plans were consistently implemented and reviewed for efficacy in reducing his risk of injury.
    - This case is also discussed, in much detail, under abuse/neglect incident management indicator #1.
- Individual #28 had three documented falls, two resulting in head injuries, between June 2016 and September 2016. The team did not meet to discuss the efficacy of supports in her ISP.
- Individual #236's action plans for volunteering, swimming, bowling, using Skype to contact her family, and attendance at day programming were not consistently implemented. There was no documentation that the IDT met to address barriers to implementation. In most cases, action plans were discontinued without evidence of team consensus.
- Individual #404, Individual #338, and Individual #328's teams did not meet to address lack of progress towards accomplishing goals.

38. Overall, QIDPs were not consistently completing monthly reviews. IDTs did not meet when there was a lack of progress or inconsistent implementation.

In addition, during the last onsite review, the Monitoring Team attended an ISP meeting that included some interesting goals and action plans for an individual. This individual was not selected for review this time, but the Monitoring Team asked to see his most recent QIDP monthly review to see how he was doing and how these new goals and action plans were unfolding for him an affecting his life (Individual #322). It turned out that he had no QIDP review since June 2016. That review was filled with indications that action plans had not been implemented, no data were available, or there was regression with no actions planned or taken. As a result of the Monitoring Team's inquiry, an ISPA was held to review his status during the week of the onsite review.

Also, QIDPs recently began using the IRIS system to populate monthly reviews of services. There was still quite a bit of inconsistency in how this information was being used. The QIDPs will need to be sure that they are gathering data for the month, summarizing progress, and revising the ISP as needed. Many individuals remained needlessly at risk due to the failure of IDTs to analyze data and revise supports when needed.

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

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

Individuals:

#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	The individual's risk rating is accurate.	6% 1/18	0/2	0/2	0/2	0/2	1/2	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.	22% 4/18	0/2	0/2	1/2	0/2	1/2	0/2	0/2	0/2	2/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #65 – fractures, and skin integrity; Individual #28 – dental, and falls; Individual #251 – constipation/bowel obstruction, and skin integrity; Individual #328 – gastrointestinal problems, and other: pain due to rheumatoid arthritis; Individual #233 – falls, and infections; Individual #329 – constipation/bowel obstruction, and infections; Individual #145 – aspiration, and hypothermia; Individual #338 – constipation/bowel obstruction, and fractures; and Individual #217 – respiratory compromise, and infections).

a. The IDT that effectively used supporting clinical data, and used the risk guidelines when determining a risk level was for Individual #233 – falls.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs 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 often did not review the IRRFs, and make changes, as appropriate.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.

Summary: The development of individualized psychiatric goals was being addressed by state office. Over the next few months, those activities should impact San Angelo SSLC's psychiatric goals and move them towards meeting criteria with these indicators. The ongoing changes in the psychiatric provider staff also competed with the ability for the facility to make progress on these indicators. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74
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 individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

4-7. Psychiatry related goals for individuals, when present, related to the reduction of problematic behaviors, such as aggression. 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. The data will allow the psychiatrist to make data driven decisions regarding the efficacy of psychotropic medications.

In other words, much like the other SSLCs, there were no individualized psychiatric goals for individuals. That is, those that focused upon the individual's psychiatric disorder and monitored progress via what have come to be called psychiatric indicators. Psychiatric providers attended ISP meetings. This was good to see and sets the occasion for presentation and discussion, as needed, of psychiatric indicators and psychiatry-related personal goals.

In addition to collecting data regarding problematic behaviors, the BPRS (Brief Psychiatric Rating Scale) was performed for all individuals prior to each psychiatry clinic. While this scale provided information regarding symptom experience at the time of the

administration of the scale, there was no cumulative or comparative review of the BPRS results over time. Comparison of BPRS results would make these data more useful in monitoring psychiatric symptoms.

Psychiatric progress notes did not routinely document review of data. In the psychiatric clinical encounters observed during this monitoring visit, data were not always available for review. Per the psychiatric clinicians, issues with IRIS had further complicated their receipt of data. For example, psychiatry clinic was held in the individual's home. Internet access was not available in all locations, impeding access to data.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: CPEs were done for all individuals and were in proper format, therefore, with sustained high performance, these two indicators might move to the category of less oversight after the next review. CPEs, however, were missing various content and the facility should consider updating them so that criteria can be met. Indicators 15 and 16 are primarily documentation problems that, with focused attention, can be corrected and improved. All five indicators of this outcome will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 28	358	116	187	269	65	404	236	74
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.	22% 2/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1	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.	17% 1/6	N/A	0/1	0/1	0/1	N/A	1/1	0/1	N/A	0/1
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.	78% 7/9	1/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1

Comments:
14. The Monitoring Team looks for 14 components in the CPE. This was the case for Individual #116 and Individual #236. Six of the other evaluations lacked sufficient bio-psycho-social formulation. This was the most common deficiency. One evaluation was lacking sufficient information in a total of four elements, two evaluations were lacking sufficient information in three elements, two evaluations

were lacking sufficient information in two elements, and two evaluations were lacking sufficient information in one element.

15. For the six individuals admitted since 1/1/14, all had psychiatric evaluations performed within 30 days of admission. Five individuals were lacking an integrated progress note from either the primary care provider or nursing documenting the admission assessment within the first business day after admission.

16. There was a need for improvement with regard to the consistency of diagnoses for Individual #116 (the annual medical assessment did not include the diagnosis of generalized anxiety disorder) and for Individual #269 (psychiatry documentation had a diagnosis of schizoaffective disorder, primary care has a diagnosis of schizophrenia, disorganized type).

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

Summary: Annual psychiatric treatment documentation was updated within the past 12 months for all individuals and had been for the past two reviews, too. Therefore, indicator 17 will be moved to the category of requiring less oversight. The other indicators maintained about the same performance as during the past two reviews and require additional focus. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 28	358	116	187	269	65	404	236	74
17	Status and treatment document was updated within past 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	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% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	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.	75% 6/8	0/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	0/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	72% 5/7	1/1	1/1	1/1	N/A	1/1	0/1	N/A	1/1	0/1
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:

17-18. The Monitoring Team scores 16 aspects of the annual evaluation document. Nine individuals required annual evaluations. The annual comprehensive psychiatric evaluations generally included information from previous evaluations. What was missing in the majority of the evaluations was a description of the derivation of the identified target symptoms, the combined behavioral health review/formulation, a review of the individual's non-pharmacological treatment, and the risk versus benefit discussion regarding treatment with psychotropic medication. In addition, the evaluations, while including large amounts of historical information, did not state the evaluator's summary and opinion as to the diagnosis and treatment.

19-20. Given the dates of the annual ISPs and the Monitoring Team's document request, information for some individuals was not

presented and, therefore, the scoring for those situations was given N/A.

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.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.

Summary: This indicator will remain in active monitoring. The quality of PSPs should be reviewed, perhaps by the QA department and/or psychiatry support staff.

#	Indicator	Overall Score	Individuals: 28	358	116	187	269	65	404	236	74
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A

Comments:
22. One individual, Individual #269, had a PSP in effect. The PSP was not detailed and did not indicate how, other than with the BPRS performed prior to psychiatry clinic, symptoms would be monitored.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.

Summary: San Angelo SSLC had signed consent forms for all medications and ensured HRC review. These two indicators had 100% scores for this review and the last two reviews and, therefore, indicators 28 and 32 will move to the category of requiring less oversight. Performance had improved for side effect information (indicator 29) and with sustained high performance might move to the category of requiring less oversight after the next review. The other two aspects of the consent information need improvement and focus. These three indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 28	358	116	187	269	65	404	236	74
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 regarding medication side effects was adequate and understandable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

		0/9									
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. The facility had transitioned to a revised version of the consent form. These consent forms included adequate side effect information.

30-31. The risk versus benefit discussion was not included in the consent form. Alternate and non-pharmacological interventions were not included. Most examples indicated that there were no alternatives to the medication.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: San Angelo SSLC ensured that every individual who needed a PBSP had a PBSP and that the PBSPs had goals/objectives as per criteria and that goals/objectives were measurable. This had been the case at the facility for a number of consecutive reviews and, therefore, indicators 1, 2, and 3 will move to the category of requiring less oversight. At this point, the facility should also have made more progress on indicators 4 and 5. More work will need to be done for indicators 4 and 5 to also move to this category. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74
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% 12/12	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
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	N/A	1/1	1/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	50%	1/1	0/1	1/1	0/1	N/A	0/1	1/1	1/1	0/1

		4/8									
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	N/A	0/1	0/1	0/1	0/1

Comments:
1. Of the 16 individuals reviewed by both Monitoring Teams, 12 required and had a PBSP (eight of the individuals reviewed by the behavioral health Monitoring Team and four individuals reviewed by the physical health Monitoring Team).

4. Individual #187 and Individual #358 had target behaviors in their PBSPs that were not addressed in their functional assessments. Individual #65 and Individual #74 had behavioral objectives in their PBSPs that were different from those in their functional assessments.

5. No individuals had evidence of interobserver agreement (IOA). Every individual had data collection timeliness assessments in the last six months, however, the most recent assessments were below 80% for Individual #116, Individual #358, Individual #28, Individual #65, Individual #404, and Individual #74. 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 that are at or above 80%.

Ensuring reliability of data should be a priority area for improvement for the behavioral health services department. At this point, these aspects of behavioral health services should be at criteria.

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

Summary: All individuals had current and complete annual behavioral health updates and their functional assessments were current, too. This was an improvement from the last review and with sustained high performance, these two indicators (10 and 11) might move to the category of requiring less oversight after the next review. The completeness/quality of the functional assessments, however, had deteriorated compared with the past two reviews and requires focus from the facility's behavioral health services leadership. All three indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74
10	The individual has a current, and complete annual behavioral health update.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The functional assessment is current (within the past 12 months).	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
12	The functional assessment is complete.	50% 4/8	0/1	0/1	1/1	1/1	N/A	0/1	1/1	1/1	0/1

Comments:

12. The direct assessment component of Individual #358 and Individual #74's functional assessments were not useful because they did not include target behaviors, or a rationale why they were not included. Individual #28 and Individual #65's functional assessments did not have a clear summary statement.

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

Summary: PBSPs were all current within the past 12 months. This was an improvement from the previous review and with sustained high performance, this indicator may move to the category of requiring less oversight after the next review. PBSP implementation within 14 of attaining consent did not occur for all individuals. Three of the eight PBSPs were missing components regarding content and quality. These indicators should be managed by behavioral health services leadership. All three will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 28	358	116	187	269	65	404	236	74
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	75% 6/8	0/1	1/1	0/1	1/1	N/A	1/1	1/1	1/1	1/1
14	The PBSP was current (within the past 12 months).	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	62% 5/8	1/1	0/1	1/1	1/1	N/A	0/1	0/1	1/1	1/1

Comments:

13. There was no information concerning consents/approvals of Individual #28's PBSP. Individual #116's PBSP was implemented prior to having consents.

15. The Monitoring Team reviews 13 components in the evaluation of an effective positive behavior support plan. Five of the eight PBSPs contained all of those components. Individual #358, Individual #65, and Individual #404's PBSPs specified the training of the replacement behavior, but did not clearly specify the reinforcement of replacement behaviors. Additionally, Individual #358's PBSP stated that the functions of her target behaviors were unknown, and the functions identified in Individual #65's functional assessment were different than those in his PBSP. There was little improvement since the last review on this indicator. Given the facility's behavioral health services resources, higher performance was expected.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.

Summary: These indicators were at 100% performance for this review as well as for the previous two reviews. Both indicators will be moved to the category of requiring less oversight.

#	Indicator	Overall	Individuals: 28	358	116	187	269	65	404	236	74

		Score									
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 2/2	N/A	1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 2/2	N/A	1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A
Comments: 24-25. Individual #358 and Individual #404 received counseling services at the time of the onsite review. Both treatment plans and progress notes were judged to be complete.											

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.										
Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely medical assessments (Round 9 – 89%, Round 10 – 100%, and Round 11 -100%), Indicators a and b will move to the category requiring less oversight. Indicator c for this Outcome will be assessed once the ISPs reviewed integrate the revised periodic assessment process.		Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
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.	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% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	Not Rated (N/R)									
Comments: c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.											

Outcome 3 – Individuals receive quality routine medical assessments and care.	
Summary: Much improvement was needed with regard to the quality of medical assessments. Given that over the last two review periods and during this review, individuals reviewed generally had diagnoses justified by appropriate criteria (Round 9 – 83% for Indicator 2.e, Round 10 – 100% for Indicator 2.e, and Round 11	Individuals:

-100% for Indicator 3.b), Indicator b will move to the category requiring less oversight. Indicator c for this Outcome will be assessed once the ISPs reviewed integrate the revised periodic assessment process.											
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	Individual receives quality AMA.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
b.	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
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	N/R									

Comments: a. It was positive to see that Individual #338's annual medical assessment included all of the necessary components to assess his needs. Problems varied across the remaining medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed social/smoking histories, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Most, but not all included allergies or severe side effects of medications. Moving forward, the Medical Department should focus on ensuring medical assessments, as appropriate, describe pre-natal histories, family history, childhood illnesses, past medical histories, complete interval histories, and include updated active problem lists, and plans of care for each active medical problem, when appropriate.

The AMAs were often lengthy documents, which cited a great deal of data, but failed to synthesize the data in a cogent manner that produced valuable clinical information. Some AMAs included four to five pages of the individuals' preferences, yet failed to note significant medical diagnoses and a plan to address those diagnoses.

b. 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.

c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
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	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	considerations.										
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #65 – osteoporosis, and seizures; Individual #28 – cardiac disease, and seizures; Individual #251 – cardiac disease, and seizures; Individual #328 – other: rheumatoid arthritis, and osteoporosis; Individual #233 – infections, and diabetes; Individual #329 – respiratory compromise, and constipation/bowel obstruction; Individual #145 – aspiration, and other: hypothyroidism; Individual #338 – cardiac disease, and seizures; and Individual #217 – respiratory compromise, and seizures).

b. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely dental summaries (Round 9 – 89%, Round 10 – 86%, and Round 11 - 89%), Indicator a.iii will move to the category requiring less oversight. For this review and the last one, improvement was noted with regard to the timely completion of dental exams. If the Center maintains this progress, then during the next review, indicator a.ii might move to the category requiring less oversight. The Center should continue to focus on the quality of dental exams and summaries.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
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.	N/A									
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	56% 5/9	1/1	1/1	0/1	1/1	0/1	1/1	0/1	1/1	0/1

c.	Individual receives a comprehensive dental summary.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. It was positive that with one exception, dental summaries were completed no later than 10 working days prior to the ISP meeting, and dental exams were completed timely.

b. It was positive that the dental exams for Individual #65 (edentulous), Individual #28, Individual #328, Individual #329, and Individual #338 (edentulous) addressed the required components. Problems varied across the remaining exams. On a positive note, all of those reviewed included an oral cancer screening, an oral hygiene rating completed prior to treatment, a description of periodontal condition, caries risk, periodontal risk, the recall frequency, and a treatment plan. Moving forward, the Center should focus on ensuring dental exams include, as applicable: a description of the individual's cooperation; a description of sedation use; information regarding last x-ray(s) and type of x-ray, including the date; periodontal charting; an odontogram; specific treatment provided; and a summary of the number of teeth present/missing.

c. The Center did not submit a dental summary for Individual #233. Within the remaining eight dental summaries, problems were noted in relation to two or more of the required elements. Moving forward the Facility should focus on ensuring dental summaries include the following, as applicable:

- Recommendations related to the need for desensitization or other plan;
- A summary of the number of teeth present/missing, which is important due to the fact that odontograms might be difficult for IDTs to interpret;
- Effectiveness of pre-treatment sedation;
- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health;
- Provision of written oral hygiene instructions;
- Recommendations for the risk level for the IRRF;
- Dental care recommendations;
- A description of the treatment provided; and
- Treatment plan, including the recall frequency.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.	
Summary: All of these indicators require continued focus to ensure nurses complete timely annual and quarterly reviews, and that nurses complete quality nursing assessments for the annual ISPs. It is essential that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice. For the individuals reviewed, a number of extremely concerning lapses were found in nursing assessments consistent with current	Individuals:

standards of care.											
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
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.	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.	78% 7/9	0/1	1/1	1/1	1/1	0/1	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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
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.	6% 1/16	0/2	0/2	0/2	0/2	0/2	0/1	1/2	0/2	0/1

Comments: a. None of the quarterly reviews were complete. For example, some were not completed at all (e.g., for Individual #329 and Individual #145). Others did not include required components (e.g., Braden scale, weight record, complete physical assessment, etc.).

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #65 – fractures, and skin integrity; Individual #28 – dental, and falls; Individual #251 – constipation/bowel obstruction, and skin integrity; Individual #328 – gastrointestinal problems, and other: pain due to rheumatoid arthritis; Individual #233 – falls, and infections; Individual #329 – constipation/bowel obstruction, and infections; Individual #145 – aspiration, and hypothermia; Individual #338 – constipation/bowel obstruction, and fractures; and Individual #217 – respiratory compromise, and infections).

None of the nursing assessments sufficiently addressed the risk areas reviewed. Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas 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. When individuals experienced changes of status, the risk for which nurses conducted assessments in accordance with nursing protocols or current standards of practice was for Individual #145 – aspiration. The following provide a few of examples of concerns

noted:

- On 8/28/16, Individual #65 was hospitalized for status post (S/P) infected open reduction internal fixation of humerus fracture with re-fracture status post left above elbow amputation on 8/31/16. Prior to this event, nurses did not assess him in accordance with current standards of practice, including, for example, for pain or circulation, and when assessments were completed, they were not done in a manner that allowed for comparison (e.g., for pain, sometimes the Faces scale was used, but sometimes it was not). In response to the Monitoring Team's request for IPN documentation, the Center provided IPNs in which nurses frequently referenced IView documentation in relation to vital signs. However, the Center did not provide IView documentation with the IPN documentation. Therefore, the Center did not present evidence that nurses were monitoring Individual #65's vital signs.

  The following provides a brief summary of concerns noted with regard to nurses' role in the days shortly before Individual #65's 8/28/16 hospitalization, which culminated in the amputation of his lower arm. On 8/26/16, a two-line nursing assessment stated: "indicates some pain in left arm. Notified… LVN and she will medicate when time. Able to squeeze with left hand but grip is weak. See IView." No Faces scale was used and no IView information was provided. No information was provided regarded whether or not nursing staff notified the physician of what appeared to be a breakthrough of pain occurring outside his prescribed medication times. In addition, the significance of the left hand grip weakness was not further explored (i.e., circulation). On 8/28/16 at 1:48 a.m., a nursing IPN denoted increased edema, and stated: "won't allow full assessment from this nurse." This provided no observations of circulatory status, and no indication that the nurse notified the physician. Nursing staff did not follow current standards of care with regard to these changes in status, and it did not appear the nurse re-attempted to perform assessments and/or conduct more frequent follow-up nursing assessments. The next IPN, dated 8/28/16 at 6:52 a.m., indicated he was transported via emergency medical staff (EMS) due to Serosanguinous drainage requiring pressure dressing with ice packs.
- On 4/5/16, Individual #28 went to the Dental Clinic for an emergency visit. Notes indicated she told the dentist all her teeth hurt. The Dentist noted: "OH [oral hygiene] -poor with thick plague coating on all her teeth and food debris… [Individual #28] had her teeth brushed by dental staff, which has not been happening for several days… Problem - today's toothache complaint is due to hygiene lapse." The Monitoring Team found no nursing IPNs prior to or after this dental emergency to show that nursing staff conducted any review/assessments of her teeth, dental pain, or dental care. It also did not appear that the IDT put any action steps in place to ensure she was working toward the goal the IDT established to improve her oral hygiene from poor to fair.
- On 7/16/16, Individual #28 was diagnosed with three rib fractures. The next nursing IPN was dated 7/18/16. Implementation of current standards of care would have resulted in nursing staff conducting assessments for early detection of respiratory decline, including the ability of the individual to take deep breaths, as well as assessment for pain. Without these assessments in the days following the diagnosis, it did not appear that San Angelo SSLC nurses understood the potential risk of rib fractures. No acute care plan was found in the records provided.
- On 6/22/16, a nursing IPN identified skin integrity issue for Individual #251: "gluteal fold coccyx noted light pink, blanches with dry peeling area and redness to the groin." Nursing staff provided no measurement, and no documentation of physician notification. According to a medical IPN, dated 6/28/16: "PCP notified due to unresolved fungal rash to groin, scrotum and buttocks and order for Nystatin." Nursing follow-up assessments did not follow current standards of care, such as documenting if the rash improved, stayed the same, or if the borders (not measured) had increased, or whether or not their

was odor or drainage.

- Individual #328 required pain management with the use of a narcotic prescribed three times a day, but nursing staff completed no IPNs related to the individual's response to pain medications.
- On 5/1/16, a nursing IPN documented: "staff had reported that [Individual #233] had fallen because of slippery stairs." No other history was taken, despite the fact that she had fallen a number of times. The IPN stated the individual refused assessment, but the nurse did not document any further attempts for assessments. The nurse did not even document respirations, which do not require the individual's cooperation. The next nursing IPN was dated 5/9/16. On 5/25/16, a nursing IPN documented that Individual #233 "tripped and fell on pavement," and refused vital signs, including no respiratory rate. The next nursing IPN, dated 5/26/16, was for new skin integrity problem.
- For Individual #217, an initial assessment, dated 8/18/16, documented a red rash approximately 3.5 inches long and approximately 1 inch wide to right side of neck. The PCP was notified "via email." No acute care plan was found, nor were follow-up nursing IPNs found regarding the rash, including whether or not it had decreased in size, or was responding to the medication. An 8/22/16 medical IPN indicated the rash had healed, but "she is wet from drooling."

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.

Summary: Given that over the last three review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 65	28	251	328	233	329	145	338	217
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: IHCPs at Lufkin SSLC need significant improvement with regard to the inclusion of nursing supports.

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
Summary: Improvement was seen with regard to completion of RN Post Hospitalization reviews and PNMT review of them. The Center should focus on sustaining its progress in this area, as well as improving the timeliness of referrals, and the completion of reviews and PNMT assessments for individuals that need them.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	50% 3/6	0/1	0/1	N/A	1/1	1/1	N/A	0/1	1/1	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	33% 2/6	1/1	0/1	N/A	1/1	0/1		0/1	0/1	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/5	0/1	0/1	N/A	0/1	N/A		0/1	0/1	
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	57% 4/7	0/1	0/1	1/1	0/1	1/1		1/1	1/1	
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 4/4	1/1	N/A	1/1	1/1	N/A		1/1	N/A	
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	57% 4/7	0/1	0/1	1/1	1/1	1/1		0/1	1/1	
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation	40% 2/5	N/A	0/1	1/1	0/1	1/1		N/A	0/1	

	for a full assessment plan.										
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4	0/1	0/1	N/A	0/1	N/A		0/1	N/A	

Comments: a. through d., and f. For the seven individuals that should have been referred to and/or reviewed by the PNMT:

- According to an ISPA, dated 3/24/16, Individual #65 had a pressure wound with methicillin-resistant Staphylococcus aureus (MRSA), but the IDT did not refer him to PNMT at that time. On 3/30/16, the PNMT/wound care RN evaluated him and described the wound as an abscess rather than a pressure wound. Individual #65 was hospitalized on that date. Subsequently, upon his return to San Angelo SSLC, the PNMT RN reviewed him and also noted weight loss. On 4/6/16, the IDT held an ISPA meeting and referred him to the PNMT. The evaluation was not completed until 5/11/16. The Center did not submit this evaluation as part of its response to the Monitoring Team's document request, but provided it in response to an onsite request. Individual #65 was on the PNMT caseload at time of his humeral fracture, but there was no evidence of reassessment for the long bone fracture.
- For Individual #28, no evidence was found of referral to the PNMT despite significant weight loss (i.e., 23 pounds over the last year according to the RN annual comprehensive assessment dated 9/29/16, when she was not on a weight reduction diet), and/or rib fracture on 7/16/16.
- On 12/23/14, Individual #251 was referred to the PNMT with the PNMT assessment initiated on that date. Referral was related to decubitus ulcers (i.e., two or more Stage 2 in one year), including delayed healing to the coccyx, and right and left gluteal pressure ulcers. As of 11/18/15, and again on 12/16/15, PNMT meeting minutes indicated that all goals had been met, with review scheduled in one month. In January 2016, Individual #251 was hospitalized, so review continued. On 1/20/16, the PNMT indicated it would continue to support the IDT relative to development of clinical indicators for urinary tract infections (UTIs) and respiratory compromise. On 3/30/16, regression was noted relative to documentation and skin care. Minutes, dated 6/8/16, indicated the PNMT planned to prepare for discharge in one month. However, in mid-June, Individual #251 was hospitalized with sepsis and a UTI. He was placed on hospice, so PNMT supports were modified to palliative care and development of plan with hospice and IDT. He was discharged on 8/30/16.
- For Individual #328, the PNMT initiated a review upon his return from a hospitalization on 3/3/16, and again on 4/8/16. On 3/31/16, and 4/11/16, the PNMT held meetings with his IDT. His pneumonia was categorized as bacterial pneumonia until the Pneumonia Committee reviewed it on 4/20/16, and made the determination that it was probable aspiration pneumonia. The PNMT did not provide a clear rationale regarding why a comprehensive assessment was not initiated.
- On 5/4/16, Individual #233 was referred to the PNMT, but the review was not completed until 5/18/16.
- On 3/23/16, Individual #145 was hospitalized. A swallow study revealed aspiration, although it was done when he was lethargic. On 4/1/16, while he was in the hospital, Individual #145 was placed on hospice care. Meetings with the IDT and RN occurred on 4/8/16, at which time the IDT reported that he was returning to baseline and they were recommending that he be removed from hospice at that time (the PNMT reported meeting with the IDT on 4/13/16, but no ISPA submitted). The PNMT review document indicated that a review was conducted on 4/8/16 and 4/13/16, but that the actual referral to the PNMT did not occur until 4/20/16. The PNMT review indicated that a PNMT assessment was indicated, but there was no evidence in PNMT meeting minutes that this occurred, and no Comprehensive Assessment was submitted despite Pneumonia Committee confirmation that he had aspiration pneumonia. The Center indicated it was not completed due to his death, which occurred on 6/4/16, a couple of weeks after the assessment was due using the 4/20/16 referral date, although referral should have occurred even sooner after his hospitalization.

- On 6/29/16, Individual #338 was referred to the PNMT and the Center submitted a review dated 7/13/16. The review included some recommendations, but also indicated that there were recommendations in an addendum from a meeting with the IDT on 10/27/16 (i.e. "See Addendum for 10/27/16 PNMT recommendations."). This gave the impression that this document was not finalized until after 10/27/16. Moreover, no evidence was presented of those recommendations or a meeting with the IDT. It was of concern that the PNMT did not meet with the IDT about resolution to Individual #338's assessment until 10/27/16, over three months after their initial review.

g. For the reviews that did not meet criterion, the biggest problem was that sufficient clinical justification was not present to substantiate the decision to do or not do a comprehensive assessment.

h. As noted above, until a second request was made, the Center did not submit a comprehensive PNMT assessment for Individual #65, and the PNMT did not complete an assessment and/or provide justification for not completing an assessment for Individual #28, or Individual #328. As also discussed above, Individual #145's referral and assessment should have occurred sooner, but he died before the PNMT completed it.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: No improvement and some regression were seen with regard to these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0% 0/18	0/2	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.	6% 1/18	0/2	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.	14% 1/7	0/1	N/A	0/1	0/1	N/A	1/1	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.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	1/2

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 IHCPs related to: skin integrity, and fractures for Individual #65; falls, and weight for Individual #28; respiratory compromise, and skin integrity for Individual #251; skin integrity, and aspiration for Individual #328; weight, and falls for Individual #233; choking, and falls for Individual #329; skin integrity, and aspiration for Individual #145; choking, and falls for Individual #338; and aspiration, and osteoporosis for Individual #217.

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

b. The IHCP that included preventative physical and nutritional management interventions to minimize the individual's risk was for skin integrity for Individual #251.

c. Individual #28 and Individual #233 did not have PNMPs and/or Dining Plans. The Dining Plans for Individual #329 included all of the necessary components to meet the individual's needs. Problems varied across the remaining PNMPs and/or Dining Plans. For example:

- For Individual #65, the risk levels were not listed;
- For Individual 251, the risk levels were not listed;
- For Individual #328, the risk levels were not listed, and the PNMP did not include photographs;
- For Individual #145, his PNMP was not reviewed/modified to address his change in status, and the risk levels were not listed;
- For Individual #338, the risk levels were not listed, and bathing was not addressed; and
- For Individual #217, the risk levels were not listed.

d. The IHCP that met this criterion was for skin integrity for Individual #251.

g. The IHCPs reviewed that defined monitoring were for aspiration for Individual #145, and osteoporosis for Individual #217.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: The Center had not made progress with these indicators.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
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% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1
b.	If it is clinically appropriate for an individual with enteral nutrition to	N/A									N/A

	progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.										
Comments: a. The only statement provided was that Individual #217 silently aspirated during a Modified Barium Swallow Study (MBSS) in 2011. This was not sufficient clinical justification for continued enteral nutrition.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied, and some regression was noted during this review. The quality of these assessments also needs improvement. The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
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/R						
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	38% 3/8	1/1	0/1		0/1	0/1	0/1	1/1	0/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	38% 3/8	0/1	0/1		1/1	0/1	0/1	1/1	0/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of:	N/A									

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

Comments: a. and b. The following concerns were noted:

- On 8/13/15, the OT and PT completed a comprehensive assessment for Individual #65. He should have had at least an update for his ISP meeting held on 8/11/16. He also had a significant change in status (above elbow amputation on 8/31/16, with multiple complications) that justified another comprehensive assessment. Consults were noted on 8/12/16, and 8/15/16 related to the humeral fracture with recommendations for direct therapy. On 9/16/16, a brief post-hospitalization assessment was completed with recommendations for bed positioning.
- Individual #28 had an increase in falls after her ISP meeting, which should have triggered an update to assess the etiology and need for supports.
- Individual #328's 5/11/16 post-hospitalization review occurred over a month after his hospitalization. It included recommendations for direct therapy due to deconditioning.
- No evidence was found of an OT/PT review of Individual #233's, or Individual #338's increases in falls.
- According to Individual #329's OT/PT assessment, dated 8/23/16, for the ISP meeting held on 9/13/16, she had 17 falls since the previous ISP meeting. However, there was no evidence of review of these falls in updates/consultations or the assessment, and the OT/PT offered no recommendations.

d. As noted above, the above the elbow amputation of Individual #65's arm should have resulted in a comprehensive assessment, but the OT/PT did not complete one.

e. Individual #28 and Individual #233 should have had updates, but did not. The following summaries some examples of concerns noted with regard to the required components of the remaining OT/PT updates:

- 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: For Individual #65, the OT/PT provided no analysis of the 32 reported falls other than to say they were related to impulsive behaviors and elopement;

- The individual's preferences and strengths are used in the development of OT/PT supports and services: Individual #65 and Individual #145's updates did not meet this requirement. For example, Individual #145's ISP stated that he wanted to be able to walk again. This was not addressed in the OT/PT assessment, nor did the IDT appear to address this in any way other than to state that he had been involved in direct therapy in the past without any increase in his strength or ability to walk. No standing program was developed nor was a clinical rationale provided for not developing one;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: As noted above, the assessment for Individual #65 did not analyze his multiple falls;
- 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): For Individual #329, the update provided no discussion of her knee braces. For Individual #65, it did not appear the OT/PT followed up on the use of the ankle foot orthoses (AFO) after skin breakdown occurred. He had stopped wearing this despite "dramatic improvement of foot drop";
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: Although assessments often referenced monitoring findings, which was positive, specific supports were not fully discussed, and/or monitoring findings were not complete;
- 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: Often, updates did not analyze specific data related to direct OT/PT goals/objectives (e.g., Individual #217, Individual #145, and Individual #328), and for other individuals, lack of analysis of existing health concerns/risks, resulted in a lack of clinical justification for decisions related to the provision or not of OT/PT supports and services (e.g., Individual #65); 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: A number of updates did not include a full set of recommendations to address the needs identified in the assessment (e.g., Individual #217, Individual #338, and Individual #145), and/or did not comment on the need to continue existing supports (e.g., Individual #328).

On a positive note, all of the completed updates provided:

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- 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; and
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments.

Outcome 3 – Individuals for whom OT/PT supports and services are indicated have ISPs that describe the individual's OT/PT-related strengths and needs, and the ISPs include plans or strategies to meet their needs.											
Summary: Over the last two reviews and this one, the Center's scores for these indicators varied. The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall	65	28	251	328	233	329	145	338	217

		Score									
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	50% 4/8	0/1	1/1	N/R	1/1	1/1	0/1	0/1	1/1	0/1
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.	57% 4/7	0/1	0/1		1/1	0/1	N/A	1/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	17% 1/6	0/1	N/A		0/1	N/A	0/1	N/A	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.	0% 0/10	0/3	N/A		0/1	N/A	0/2	0/2	N/A	0/2

Comments: b. Individual #28 and Individual #233 did not have PNMPs, but both individuals' IDTs had rated them at high risk for falls. No justification was provided for not developing PNMPs.

c. and d. Examples of concerns noted included:

- No evidence was found of an ISPA meeting to review and gain IDT approval for the implementation of OT/PT goals/objectives recommended in the consult for Individual #65. The same was true for Individual #329 for direct OT services recommended to address hand pain, and direct OT and PT services for Individual #145.
- On 5/11/16, Individual #328 had a consult/update that recommended a number of goals/objectives. Only one was included in the ISP without justification for not including others. No evidence was found of an ISPA to integrate the goals into the ISP. More specifically, the consult was done on 5/11/16, and the ISP meeting was held on 6/21/16. The annual assessment indicated that direct therapy was not indicated. The ISP stated that direct therapy would continue, but only listed one of the goals from the consult. Although direct therapy was initiated in May, there had not been an ISPA held to integrate that into the previous year/current ISP. Then, this year's ISP should have updated or continued the existing goals as indicated.
- Direct PT goals were recommended for Individual #217, but they were not integrated into her ISP through an ISPA.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.	
Summary: It was very positive that four of the five individuals' communication updates addressed their communication strengths, preferences, and needs. This was a significant improvement from the last two reviews, and the Center should focus on maintaining this important progress. Improvement also was noted with regard to timeliness of communication assessments. All of these indicators will	Individuals:

continue under active oversight.											
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
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/R	N/R			
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	83% 5/6	1/1	N/A	1/1	1/1			1/1	1/1	0/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	100% 7/7	1/1	1/1	1/1	1/1			1/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/1	N/A	N/A	N/A	N/A			0/1	N/A	N/A
e.	Individual receives quality Communication Assessment of Current	80%	0/1	N/A	1/1	1/1			N/A	1/1	1/1

	Status/Evaluation Update.	4/5									

Comments: Because Individual #233 and Individual #329 were part of the outcome group and had functional communication skills, the "deep review" indicators were not reviewed.

d. Individual #145's comprehensive communication assessment identified his preferences and strengths, but did not integrate them into supports; the speech language pathologist (SLP) referenced that historically he did not show an interest in AAC devices, but provided no evidence of current assessment related to AAC devices; the assessment merely described behavioral issues, indicated they were likely due to communication issues, and reported that he had a functional communication SAP as a replacement behavior without reviewing the SAP; no evidence was found in the assessment that the SLP and BHS staff collaborated in assessment or the development of supports; and due to issues with the assessment (e.g., regarding AAC, and communication issues impacting behavior), it was unclear if a full set of recommendations to address his needs were included.

e. It was very positive that four of the five individuals' communication updates addressed their communication strengths, preferences, and needs.

For Individual #65, the assessment mentioned effectiveness monitoring, but did not outline specific findings. The statement was made that supports were determined to be effective, but it was not clear on what objective data this determination was based. In addition, the justification for the use of a communication book versus a communication board was not clearly identified.

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

Summary: The Center showed some improvement with these indicators, which was good to see. All of them will continue under active oversight.

#	Indicator	Overall Score	Individuals: 65	28	251	328	233	329	145	338	217
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.	57% 4/7	0/1	0/1	1/1	0/1	N/R	N/R	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	100% 5/5	1/1	N/A	1/1	1/1			1/1	N/A	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	30% 3/10	0/2	N/A	1/1	0/2			0/1	0/2	2/2
d.	When a new communication service or support is initiated outside of	100%	1/1	N/A	N/A	N/A			N/A	N/A	N/A

	an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	1/1									
Comments: a. For three individuals, their ISPs did not provide functional descriptions of their communication skills, including examples.											

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.											
Summary: One individual had no SAPs and it was surprising that most individuals did not have more than one or two, especially given their potential for learning new skills. Given this, as well as the problems in data reporting and review, all five indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74
1	The individual has skill acquisition plans.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	94% 15/16	3/3	1/1	2/2	1/1	N/A	1/2	2/2	2/2	3/3
3	The individual's SAPs were based on assessment results.	81% 13/16	2/3	1/1	2/2	0/1	N/A	2/2	2/2	1/2	3/3
4	SAPs are practical, functional, and meaningful.	62% 10/16	2/3	1/1	2/2	0/1	N/A	1/2	2/2	1/2	1/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/16	0/3	0/1	0/2	0/1	N/A	0/2	0/2	0/2	0/3

Comments:

1. Individual #269 did not have any skill acquisition plans (SAPs). The Monitoring Team chooses three current SAPs for each individual for review. There was only one SAP available to review for Individual #187 and Individual #358, and two SAPs available for Individual #236, Individual #404, Individual #116, and Individual #65 for a total of 16 SAPs for this review. This was substantially lower than the 27 SAPs usually reviewed at a facility, was similar to last review, and lower than at the June 2015 review.

2. Ninety-four percent of the SAPs were judged to be measurable (e.g., Individual #358's identify her medications SAP). Individual #65's present his picture to the nurse SAP, however, did not specify how many verbal prompts should be presented and, therefore, was not judged as measurable.

3. Eighty-one percent of the SAPs were based on assessment results. Individual #236's identify her body parts SAP and Individual #187's identify numbers SAP were inconsistent with their functional skills assessments (FSAs) which indicated they could complete the

tasks at the training prompt level. Individual #28's oral care SAP was inconsistent with the FSA summary that indicated that she was independent in oral care.

4. Ten SAPs appeared to be practical and functional (e.g., Individual #116's count coins SAP). The SAPs that were judged not to be practical or functional typically represented more of a compliance issue rather than a new skill (e.g., Individual #74's functional communication SAPs), or assessment data indicated the individual already possessed the skill (e.g., Individual #187's identify numbers SAP).

5. Five of the 16 SAPs had interobserver agreement (IOA) demonstrating that the data were reliable. All of the SAP data, however, were reported to be uninterpretable due to the electronic data system not being able to identify the training step and, therefore, all 16 SAPs were rated as not having reliable data. It was encouraging, however, to learn that San Angelo SSLC was planning a data card to supplement the electronic system to ensure that SAP data were interpretable.

It is recommended that the demonstration of consistently reliable SAP data become priority for San Angelo SSLC.

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

Summary: With sustained high performance, indicator 10 might move to the category of requiring less oversight after the next review. All three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 28	358	116	187	269	65	404	236	74
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.	33% 3/9	1/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
12	These assessments included recommendations for skill acquisition.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1

Comments:

11. Individual #74, Individual #404, Individual #236, Individual #65, and Individual #269's FSAs were not available to the IDT at least 10 days prior to their ISP. Additionally, Individual #187's PSI was not available to the IDT at least 10 days prior to his ISP.

12. Individual #187's vocational assessment did not include a recommendation for a skill acquisition plan.

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.

This domain contains 40 outcomes and 176 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Nineteen of these, in restraint, psychiatry, psychology/behavioral health, dental, and OT/PT, had sustained high performance scores and will be moved the category of requiring less oversight. This included no full outcomes.

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

Goals/Objectives and Review of Progress

Variables that were identified as potentially playing a role in the occurrence of behaviors that often led to more than three restraints in any rolling 30-day period were identified and actions to address these variables were developed and taken, resulting in 11 of the 12 indicators moving to the category of requiring less oversight.

Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress with regard to individuals' physical and/or dental health. 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.

In psychiatry, without measurable goals and objectives, progress could not be determined. In behavioral health, given the absence of good, reliable data, progress could not be determined for all of the individuals. Neurology consultations were occurring at least annually, as required. Better coordination between psychiatry and behavioral health services clinicians was needed.

Behavioral health peer reviews were occurring as required. Psychiatric quarterly reviews were completed, but in general, reports were missing two to eight components. Side effect assessments were not routinely occurring in a timely manner, and there was need for improvement in polypharmacy committee to ensure a critical review of medication regimens.

Acute Illnesses/Occurrences

In psychiatry and behavioral health, it was apparent that when individuals were deteriorating and experiencing increases in their psychiatric and behavioral symptoms, changes to the treatment plan were developed and implemented for most, but not all, individuals. One example was the facility's use of the psychotropic medication Vraylar for a number of individuals. Its use corresponded with increases in problem behaviors and psychiatric symptoms for almost all of these individuals. Subsequently,

the medication was discontinued. Interim clinics were available and held, though implementation and follow-up of actions from those clinics was not evident for many individuals.

Nursing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis for acute illnesses/occurrences remained areas on which the Center needs to focus. It is also important that nursing staff timely notify the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification. Nursing staff were not developing acute care plans for all relevant acute care needs, and those that were developed needed improvement.

Overall, the quality of medical practitioners' assessment, treatment, and follow-up on acute issues treated at the Center and/or in other settings varied, and for some individuals reviewed, significant concerns were noted.

Implementation of Plans

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

Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. In addition, documentation often was not found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs. The Center needs to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessments, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible. These treatments, interventions, and strategies need to be included in IHCPs, and PCPs need to implement them timely and thoroughly.

Overall, the Center needs to improve its performance with regard to PCPs' review and response to consultations, as well as referral of recommendations to IDTs, as dictated by individuals' clinical need, for discussion and planning.

The Center also needs to focus on ensuring 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.

Individuals generally received x-rays in accordance with the applicable American Dental Association Guidelines, which was consistent with findings from the last two reviews, so the related indicator will move to the category requiring less oversight. During this review, the Dental Department generally provided the individuals reviewed with necessary prophylactic dental care, tooth-brushing instruction, x-rays, and treatment for periodontal disease. Improvements are needed with regard to the

provision of fluoride treatment as appropriate, the timely completion of restorative work, and the Dentist's assessment of the need for dentures for individuals with missing teeth. Assessment for and provision of suction tooth brushing also require attention.

There continued to be significant problems in the provision of pharmacy services. The Monitoring Team's last two reviews clearly documented problems with the completion of QDRRs. During the June 2015 review, none of the individuals reviewed had a current QDRR. During the March 2016 review, it was again noted that none of the individuals reviewed "had QDRRs completed in 2015 or to date in 2016." This review identified some improvement in this area. However, the Pharmacy Director reported that during the month of November, only 32% of QDRRs were completed. The failure to conduct QDRRs can adversely impact the clinical care and this was noted for some individuals.

Adaptive equipment was generally clean and in good working order. The two related indicators will be moved to the category of requiring less oversight. For a couple of individuals, proper fit was an issue.

It was positive that during observations of transfers, staff completed them correctly. While still needing improvement, the rate of implementation of Dining Plans was relatively high (81%). However, it was of significant concern that only 30 percent of individuals were positioned correctly during the Monitoring Team's observations. The Center should focus on positioning, and continue to improve compliance with Dining Plan implementation.

Staff training on PBSPs for regular and float staff was not occurring as it should have been and as typically occurs at most other facilities. Compared with the last review, performance showed a decrease.

Restraints

<table>
<tr><td colspan="12">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.</td></tr>
<tr><td colspan="3">Summary: San Angelo SSLC attended to the many indicators of this outcome for this review as well as for the past two reviews with scores of 100% for all indicators with but a few exceptions (indicator 28 at 67% at the last review, indicators 21-23 at 80% in June 2015). Given this sustained high level of performance as well as improvements in performance, 11 indicators (indicators 19-29) will be moved to the category of requiring less oversight. Indicator 18 did not meet full criteria because the facility's monitoring system did not identify one individual for whom these indicators should have been applied. Therefore, this indicator will remain in active monitoring.</td><td colspan="9">Individuals:</td></tr>
<tr><td>#</td><td>Indicator</td><td>Overall</td><td>358</td><td>116</td><td>74</td><td>404</td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

		Score									
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.	75% 3/4	1/1	1/1	1/1	0/1					
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	N/A					
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 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	N/A					
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 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	N/A					
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 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	N/A					
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	100% 3/3	1/1	1/1	1/1	N/A					
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	N/A					
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	N/A					
26	The PBSP was complete.	N/A	N/A	N/A	N/A	N/A					
27	The crisis intervention plan was complete.	100% 3/3	1/1	1/1	1/1	N/A					
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity	100% 3/3	1/1	1/1	1/1	N/A					

	data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.										
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	N/A					

Comments:
18-29. This outcome and its indicators applied to Individual #358, Individual #116, Individual #404, and Individual #74. It was encouraging that Individual #358, Individual #116, and Individual #74 had a sufficient number IDT meeting that addressed the necessary actions to better understand the factors affecting their restraints and reduce their future occurrence. This resulted in 100% scores for these three individuals.

18. Individual #404 had his fourth restraint in 30 days on 8/27/16, however, he did not have an ISPA to address those restraints. Individual #358, Individual #116, and Individual #74 had more than three restraints in 30 days and had ISPAs to address those restraints within 10 business days.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
Summary: This indicator might move to the category of requiring less oversight after the next review if high performance is sustained. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	217								
1	If not receiving psychiatric services, a Reiss was conducted.	100% 1/1	1/1								
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								
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								

Comments:
1. Of the 16 individuals reviewed by both Monitoring Teams, one individual was not receiving psychiatric services. This individual, Individual #217, was assessed in 2013 utilizing the REISS screen. Unfortunately, it was not possible to determine if this was an initial screening assessment or performed as a result of a change in status.

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledges that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
8-9. Without measurable goals and objectives, progress could not be determined. Thus, the first two indicators are scored at 0%.

10-11. Despite the absence of measurable goals, it was apparent that when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments) were developed and implemented.

As such, several individuals were prescribed the atypical antipsychotic medication Vraylar. This medication has a secondary metabolite that is active at approximately three weeks following the start of treatment. The secondary metabolite is strongly correlated with the development of akathisia (an internal feeling of restlessness). Several individuals were noted to experience increases in target symptoms during treatment with this medication, which also presented as increases in self-injurious and aggressive behaviors, some of which also required crisis intervention restraint (see that section of this report, too). Adjustments were subsequently made on an individual basis.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary: Performance on these two indicators was low at this review and at the last two reviews, too. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target	11% 1/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1

	behaviors.										
24	The psychiatrist participated in the development of the PBSP.	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1

Comments:
23. While the target behaviors (e.g., behavioral challenges) identified for monitoring were consistent, what was generally lacking was how these behaviors related to the specific psychiatric diagnosis. Only one record, regarding Individual #116, indicated in the functional assessment that the identified target behaviors were the way that this individual coped with symptoms of anxiety.

24. There was no documentation or indication that the psychiatric providers participated in the development of the PBSP.

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.

Summary: Neurology consultations occurred for each individual at least annually. This had maintained for some time now and, therefore, indicator 26 will be moved to the category of requiring less oversight. Ensuring that that psychiatry and neurology coordinate and document this coordination is necessary for focus from the psychiatry department. These two indicators, 25 and 27, will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	20% 1/5	0/1	N/A	1/1	N/A	N/A	0/1	0/1	N/A	0/1
26	Frequency was at least annual.	100% 4/4	1/1	N/A	1/1	N/A	N/A	1/1	1/1	N/A	N/A
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	40% 2/5	1/1	N/A	1/1	N/A	N/A	0/1	0/1	N/A	0/1

Comments:
25 and 27. These indicators applied to five of the individuals. In one case, Individual #116, there was documentation of consultation/collaboration between psychiatry and neurology. In the other four cases requiring this consultation, there was no documentation of collaboration in the record, though in Individual #28's record there were cross referenced notes (resulting in a positive score for her for indicator 27).

26. This indicator applied to four individuals and met the annual criterion.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.												
Summary: San Angelo SSLC had no full time psychiatrists and relied upon locum tenens contracted psychiatrists for the many individuals who required psychiatric services. Even though one of these was a long-term contracted provider, this competed with the psychiatry department's ability to meet the indicators in this outcome, as well as many of the other psychiatry indicators and outcomes. These three indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74
33	Quarterly reviews were completed quarterly.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
34	Quarterly reviews contained required content.	0% 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.	0% 0/3	0/1	N/A	N/A	N/A	0/1	N/A	0/1	N/A	N/A

Comments:

33. In general, psychiatric quarterly reviews were completed as required by schedule. For Individual #74, there was one period of a five month gap.

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

35. Psychiatry clinic was observed for three individuals. In two of these examples (Individual #269, Individual #404), data were provided, but they were not specifically utilized in decision making for medication adjustments. For Individual #28, the QIDP was not in attendance. Further, due to reported issues with IRIS, data were not available for review during the clinic and the staff relied on anecdotal evidence and memory. Furthermore, this individual had issues with syncope and was being seen by cardiology the same day as psychiatry clinic, but syncope was not discussed.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74
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. Assessments were not routinely occurring in a timely manner. There also was a transition from the DISCUS to the AIMS. Often,

when the psychiatrist did review the document within the allotted time, the review consisted of the psychiatrist signing the paper assessment, not using the electronic system.

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

Summary: Emergency and interim psychiatry clinics were available for individuals and had been for some time. Therefore, indicator 37 will be moved to the category of requiring less oversight. Follow-up to these clinics, however, needs attention (and documentation). Therefore, indicators 38 and 39 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 28	358	116	187	269	65	404	236	74
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?	56% 5/9	0/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1

Comments:

37. There was documentation of emergency/interim clinics in all records reviewed. This was good to see.

38. However, in four examples, when follow up clinics were specifically requested, such as plans to follow up in clinic in two weeks, there was no documentation that these occurred.

39. Documentation for Individual #65 was not the typical IDT document.

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.

Summary: These indicators showed improvement from the last review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 28	358	116	187	269	65	404	236	74
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

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:											

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.											
Summary: Performance had not improved for these indicators. Management of polypharmacy, an important protection from harm, needs to be comprehensive, as required by this outcome. All three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	0% 0/8	0/1	0/1	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.	50% 4/8	1/1	1/1	0/1	1/1	0/1	N/A	1/1	0/1	0/1
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% 0/8	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1

Comments:

44. These indicators applied to eight individuals. Polypharmacy justification was not appropriately documented in any example.

45. There was documentation for four individuals showing a plan to taper various psychotropic medications.

46. When reviewing the polypharmacy committee meeting minutes, there was no documentation of committee review for any individuals selected by the Monitoring Team meeting criteria for polypharmacy. As discussed at length during the monitoring visit, there was need for improvement in polypharmacy committee to ensure a critical review of medication regimens meeting criteria for polypharmacy.

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.	
Summary: Given the absence of good, reliable data, progress could not be determined for all of the individuals. The Monitoring Team scored indicators 8 and 9 based upon the facility's report of progress/lack of progress as well as the ongoing	Individuals:

exhibition of problem target behaviors. The indicators in this outcome will remain in active monitoring.											
#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74
6	The individual is making expected progress	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	80% 4/5	1/1	1/1	1/1	N/A	N/A	N/A	1/1	0/1	N/A
9	Activity and/or revisions to treatment were implemented.	100% 4/4	1/1	1/1	1/1	N/A	N/A	N/A	1/1	N/A	N/A

Comments:
6. Individual #28, Individual #116, Individual #358, Individual #404, and Individual #236 were not making progress. Individual #74, Individual #65, and Individual #187 appeared to be progressing, however, they were scored as 0 because they did not have PBSP data that were demonstrated to be reliable (see indicator #5). Again, at this point, the facility should have reliable data for PBSPs, such that progress can be accurately evaluated.

8. Individual #28, Individual #116, Individual #358, and Individual #404 were not making progress, however, their progress note included actions to address the absence of progress. Individual #236 was also not making expected progress, however, her progress note did not include actions to address the absence of progress.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
Summary: These activities described by these three indicators were not occurring at San Angelo SSLC as they should have been and as they typically are at most other facilities. Compared with the last review, performance showed a decrease for indicators 17 and 18 and a slight increase from 0% for indicator 16. More focus and management needs to be applied so that these important activities occur regularly and for all individuals. All three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74
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.	25% 2/8	0/1	0/1	0/1	0/1	N/A	1/1	0/1	1/1	0/1
17	There was a PBSP summary for float staff.	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
18	The individual's functional assessment and PBSP were written by a	50%	1/1	1/1	1/1	1/1	N/A	0/1	0/1	0/1	0/1

	BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	4/8									

Comments:

16. Only Individual #65 and Individual #236 had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) working in their residence were trained on their PBSPs.

17. No individuals had a PBSP summary available for float staff.

18. Individual #28, Individual #358, Individual #116 and Individual #187's functional assessments and PBSPs were written by a behavioral specialist who had a BCBA. Individual #65, Individual #404, and Individual #74's functional assessments and/or PBSPs were written by behavioral specialists who were enrolled in BCBA coursework, however, they were not signed off by a BCBA. Individual #236's PBSP was written by a behavior 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.											
Summary: Three of these review-related indicators were at 100% performance for this review and the two previous reviews and, therefore, will be moved to the category of requiring less oversight (indicators 19, 22, and 23). Graphing had improved and with sustained high performance might move to the category of requiring less oversight after the next review. Ensuring that data are presented in clinical meetings (indicator 21), should occur in all instances. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74
19	The individual's progress note comments on the progress of the individual.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
20	The graphs are useful for making data based treatment decisions.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	50% 1/2	0/1	N/A	N/A	N/A	N/A	N/A	1/1	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:
19-20. All individuals had progress notes and graphed PBSP data that lent themselves to visual interpretation, and included indications of the occurrence of important environmental changes (e.g., medication changes).

21. In order to score this indicator, the Monitoring Team observed Individual #404 and Individual #28's psychiatric clinic meetings. In Individual #404's meeting, current PBSP data were presented and graphed, which encouraged data based decisions by the IDT. In Individual #28's meeting, however, behavioral data were verbally presented, but not graphed.

22. None of the individuals reviewed had a previous peer review. In order to score this indicator, the Monitoring Team reviewed Individual #201's peer review. There was evidence that changes suggested in his peer review were implemented.

23. In order to score this indicator, the Monitoring Team observed Individual #65's peer review. Individual #65 was reviewed because he was not making expected improvements. His peer review included the review of his functional assessment, PBSP, and most recent behavioral data. There was participation and discussion by the behavioral health services team. Additionally, San Angelo SSLC had documentation that internal peer review meetings were consistently occurring weekly, and external peer review meetings were occurring monthly.

Outcome 8 – Data are collected correctly and reliably.

Summary: There was improvement in indicators 26 and 27, maintenance of 100% performance for indicators 28 and 29, and no improvement from 0% for indicator 39 compared with the last review. Given the recently implemented electronic health record, the need for sustained performance across some of these indicators, and the need for indicator 30 to show some improvement, all five will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	38% 3/8	0/1	0/1	0/1	0/1	N/A	1/1	0/1	1/1	1/1
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	N/A	1/1	1/1	1/1	1/1
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	N/A	1/1	1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1

Comments:

26. At the time of the onsite review, the data collection system for target behaviors consisted of a data card system (that was also used to provide data to the electronic data system) that was found to be individualized and flexible.

27. At the time of the onsite review, there were no replacement data for Individual #28, Individual #358, Individual #116, Individual #187, and Individual #404 because the data were collected as skill acquisition plans (SAPs) and the electronic data system was not tracking the training step. The Monitoring Team was encouraged to learn that the San Angelo SSLC was planning to add data cards to the electronic system to address this data collection problem.

28. There were established 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 established as 80%.

30. San Angelo established goal frequencies and levels of data collection timeliness, IOA, and treatment integrity were not achieved for any individual. No individual had IOA. All individuals had data collection timeliness and treatment integrity measures. Only Individual #236 and Individual #187, however, achieved the data collection timeliness goal levels, while Individual #74, Individual #236, Individual #404, Individual #187, Individual #116, and Individual #358 achieved the treatment integrity goal levels.

It is critical that San Angelo SSLC ensure that PBSP data are consistently reliable, and PBSPs are implemented with integrity.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs generally did not have a way to measure outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	Individual has a specific goal(s)/objective(s) 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(s)/objective(s) to measure the efficacy of interventions.	11% 2/18	0/2	0/2	0/2	0/2	0/2	2/2	0/2	0/2	0/2
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%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

		0/18									
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 #65 – osteoporosis, and seizures; Individual #28 – cardiac disease, and seizures; Individual #251 – cardiac disease, and seizures; Individual #328 – other: rheumatoid arthritis, and osteoporosis; Individual #233 – infections, and diabetes; Individual #329 – respiratory compromise, and constipation/bowel obstruction; Individual #145 – aspiration, and other: hypothyroidism; Individual #338 – cardiac disease, and seizures; and Individual #217 – respiratory compromise, and seizures).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #329 – respiratory compromise, and constipation/bowel obstruction.

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 4 – Individuals receive preventative care.

Summary: None of the nine individuals reviewed received the preventative care they needed. The Center continues to need to focus on improving the preventative care it provides the individuals it supports. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to preventative care can be assessed, and are deemed to meet the requirements of the Settlement Agreement. In addition, the Facility needs to focus on ensuring 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.

Individuals:

#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	Individual receives timely preventative care:										
	i. Immunizations	78% 7/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	50% 2/4	N/A	1/1	0/1	1/1	N/A	N/A	N/A	N/A	0/1
	iii. Breast cancer screening	67%	N/A	1/1	N/A	N/A	0/1	N/A	N/A	N/A	1/1

		2/3									
	iv. Vision screen	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	14% 1/7	1/1	N/A	0/1	0/1	0/1	N/A	0/1	0/1	0/1
	vii. Cervical cancer screening	33% 1/3	N/A	1/1	N/A	N/A	0/1	0/1	N/A	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. The following problems were noted:

- According to the AMA, Individual #65's varicella status was left blank.
- For Individual #28, the Center's response to the document request for a vision screening indicated one was not needed, and no report was submitted. However, according to the Center's lab matrix a vision exam was needed, and the PCP indicated one was done.
- According to Individual #251's AMA, the risk of sedation for a colonoscopy was too great. For the years 2014 to 2016, the Preventative Care Flow Sheet documented that a colonoscopy was not applicable. However, there was also no colorectal cancer screening, such as a high sensitivity fecal occult blood testing done. There was no documentation of Prevnar 13 administration. No DEXA scan was completed for Individual #251 due to concerns about sedation. However, there did not appear to be consideration given to portable methods as previously done for this individual.
- For Individual #328, bone mineral density testing should have been repeated in 2015.
- Individual #233's last mammogram was completed in July 2015. She had a history of an abnormal Pap screening in 2014. Although the February 2015 Pap appeared to be normal, there was no follow-up despite an increased risk of cervical dysplasia. She also was at increased risk for osteoporosis due to her medication regimen.
- Individual #329 did not meet the age requirements for a Pap smear. However, she was prescribed oral contraceptives, and the gynecologist indicated that an exam was due in April 2016. Documentation of such an exam was not found in the records.
- For Individual #145, the IRRF stated he was at high risk for osteoporosis, but a DEXA could not be completed. A DEXA was actually done on 8/7/15, and showed osteopenia. The AMA included the diagnosis of osteopenia in the active problem list section. However, there was no plan to address it, and there was no FRAX score to determine if treatment was indicated.
- Individual #338 had not had a DEXA scan, even though he received long-term treatment with anti-epileptic drugs, and was prescribed Valproic Acid.
- Individual #217 had a consult related to coffee ground emesis noting that gastroenterology (GI) did not recommend an upper endoscopy at the time. However, there was no evidence of screening for colorectal cancer. She had a diagnosis of osteoporosis and was prescribed medication to treat it. There was no explanation for the last DEXA being in 2006. At the age of 66, she did

not require cervical cancer screening. However, the AMA noted the last screening was in 2002.

Comments: b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	100% 2/2	N/A	N/A	1/1	N/A	N/A	N/A	1/1	N/A	N/A
Comments: On 5/19/16, the Ethics Committee discussed Individual #145. It was good to see that in addition to the Medical Director, and Chief Nurse Executive (CNE), participants included an outside physician, outside legal representative, rights protection, and the individual's guardian.											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Overall, the quality of medical practitioners' assessment, treatment, and follow-up on acute issues treated at the Facility and/or in other settings varied, and for some individuals reviewed, significant concerns were noted. The Monitoring Team will continue to review all of these indicators.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
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.	0% 0/8	N/A	0/1	0/1	0/1	N/A	0/2	N/A	0/2	0/1
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.	13% 1/8		0/1	0/1	0/1		0/2		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	73% 8/11	2/2	1/1	1/2	1/1	1/1	1/1	1/2	0/1	N/A

	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.										
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	67% 2/3	N/A	N/A	1/1	1/1	N/A	N/A	0/1	N/A	
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.	82% 9/11	1/2	1/1	1/2	1/1	1/1	1/1	2/2	1/1	
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	73% 8/11	1/2	1/1	1/2	1/1	1/1	1/1	1/2	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.	0% 0/8	0/2	0/1	0/2	0/1	N/A	N/A	0/2	N/A	
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	27% 3/11	1/2	0/1	0/2	0/1	1/1	0/1	1/2	0/1	

Comments: a. and b. For six of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed eight acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #28 (rib fractures on 7/16/16), Individual #251 (skin lesion on 9/21/16), Individual #328 (lethargy on 7/22/16), Individual #329 (possible foreign body on 4/22/16, and fall with possible elbow injury on 5/11/16), Individual #338 (olecranon bursitis on 4/19/16, and right hand fracture on 6/28/16), and Individual #217 (dermatitis on 8/18/16).

The acute illness/occurrence reviewed for which follow-up was needed, and 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 resolved or stabilized was for Individual #217 (dermatitis on 8/18/16).

The following describe some of the concerns noted:

- On 7/16/16, nursing staff documented that Individual #28 had a large bruise on her right hip and she reported that another individual pushed her. It was subsequently noted that the individual's "vital signs [were] elevated" and she complained of right rib pain. An addendum (to the Nursing Progress Note) by the PCP, dated 7/26/16, noted that three rib fractures were seen on x-ray, and "This is an unknown serious injury." The PCP never documented any medical assessment or plan of care for this individual with three rib fractures.
- On 7/22/16, Individual #328's PCP documented the staff reported he was lethargic and had low oxygen saturations. This individual recently had been diagnosed with pneumonia that was slowly resolving. The chest x-ray showed mild central vascular congestion, and the PCP's assessment was daytime lethargy probably due to staying awake at night. The plan was to

check labs, but "no further fu [follow-up] indicated at this time." The PCP did not document any follow-up or the results of the labs.

- On 4/27/16, at 10 a.m., the PCP noted that an attempt was made to see Individual #329 due to the possibility of a foreign body in the thumb, but the individual was off campus. At 1 p.m., the PCP documented an abnormal exam and that the recommendation was to "block and explore," due to the possibility of a glass foreign body. The PCP provided no additional documentation related to this. At 2 p.m., nursing staff documented that the individual soaked her finger and picked glass out. However, the PCP did not provide any follow-up assessment.
- On 5/11/16, the PCP indicated that Individual #329 fell down the stairs. The physical exam documented a tender radial head and some decreased range of motion. The assessment was "elbow pain." The plan was for the individual to use a sling and have an x-ray. There was no documentation related to pain control or follow-up. The physical assessment of the extremity was incomplete. The PCP determined there was a need to obtain an x-ray, presumably to rule out a fracture. Elbow fractures may be difficult to diagnose by x-ray. A thorough exam documenting tenderness, range of motion, and neurovascular status would have been important.
- On 6/28/16, per nursing notes (8:30 a.m.), Individual #338 complained of falling and injuring his right hand. According to a consult IPN, dated 7/1/16, the individual saw orthopedics on 6/30/16, and had a cast applied for a metacarpal fracture. Other than the review of the consult, there was no PCP documentation related to the hand fracture.
- On 8/18/16, Individual #217's PCP documented that the individual drooled and had a lot of skin contact to the right side of neck. The physical exam noted that drool was going to the right jaw and neck, and there was slight maceration of the skin fold. There were no other descriptors. The assessment was candidiasis and osteoporosis. The plan was to start nystatin. On 8/22/16, it was noted that the rash had healed and she was wet from drooling. The assessment/plan was "osteoporosis." The PCP documented no plan related to further prevention.

For eight of the nine individuals reviewed, the Monitoring Team reviewed 11 acute illnesses requiring hospital admission, or ED visit, including the following with dates of occurrence: Individual #65 (humeral fracture on 6/21/16, and amputation on 8/28/16), Individual #28 (syncope on 9/25/16), Individual #251 (sepsis on 4/18/16, and sepsis on 6/12/16), Individual #328 (pneumonia on 4/6/16), Individual #233 (lip laceration on 8/30/16), Individual #329 (back pain on 5/17/16), Individual #145 (pneumonia on 3/23/16, and pneumonia on 4/12/16), and Individual # 338 (laceration on 6/20/16).

c. For the following transfers that occurred after hours, no PCP/provider summary IPN was documented within one business day: Individual #251 (sepsis on 6/12/16), Individual #145 (pneumonia on 4/12/16), and Individual # 338 (laceration on 6/20/16).

d. Eight of the acute illnesses reviewed occurred after hours or on a weekend/holiday. Vital signs were not documented in the IPN for Individual #145 (pneumonia on 3/23/16).

e. For the acute illnesses reviewed, it was positive the individuals reviewed generally received timely treatment at the SSLC. The exceptions were Individual #65's humeral fracture on 6/21/16, for which the Center submitted no IPN documentation related to the transfer; and on 6/10/16, the PCP saw Individual #251, but did not follow-up even though the individual was sent to the ED on 6/12/16.

f. The individuals that were transferred to the hospital for whom documentation was not submitted to confirm that the PCP or nurse communicated necessary clinical information with hospital staff were Individual #65's humeral fracture on 6/21/16, for which the Center submitted no IPN documentation related to the transfer; Individual #251 (sepsis on 4/18/16), and Individual #145 (pneumonia on 4/12/16).

g. and h. The following provide examples, of concerns noted:

- On 6/18/16, nursing staff reported that Individual #65 cut the palm of his hand. The hand involved was not specified. On 6/20/16, nursing staff noted that the individual had an abrasion to the back of the head with scant bleeding. Trauma orders to conduct neurological checks were implemented. On 6/21/16, nursing staff documented that the individual complained of pain related to a fracture. At 11:05 a.m., the PCP noted that the individual had an injury, was seen in the ED, had his arm immobilized due to a fracture, and was scheduled to see orthopedics. Emergency Department records indicated the diagnosis was closed, displaced, moderately angulated fracture of the left humeral shaft. On 6/24/16, the PCP reviewed the orthopedic consult and documented that the plan was to "keep current splint in place at all times." The next PCP/provider documentation was on 6/27/16.

  On 7/5/16, Individual #65 developed an open fracture due to a puncture wound. On 7/10/16, he was seen in the ED again due to bleeding from a puncture wound. A single suture was placed for hemostasis. On 7/25/16, he underwent an open reduction internal fixation (ORIF). The radial nerve was interposed in the fracture and a radial-nerve palsy resulted. On 8/2/16, the individual was admitted again due to surgical site bleeding. On 8/7/16, he was noted to have a lacerated artery that required ligation. On 8/16/16, the individual required another hospital admission. Per the surgeon's report, the individual "jumped in a puddle and was splashing around in it reportedly and then was dry off with a fan and presented to clinic 5 or 6 days later. The cast was removed with significant purulence… The patient was taken to the OR [operating room] for incision and drainage due to an infected wound." On 8/28/16, the humerus was re-fractured dislodging the hardware. A decision to amputate was made based on the complicated history.

  On 9/16/16, Individual #65 was discharged, and on 9/17/16, the PCP saw him. The IDT held several ISPA meetings, but none related to Individual #65's return following the hospitalization for amputation. Of note, the dates for the event data discussed during the ISPAs reviewed showed some inconsistencies, such as the actual date for diagnosis of the initial fracture when compared to the hospital documents.

  It appeared problematic that the PCP did not discuss and/or document discussion with the orthopedic surgeon regarding implementation of conservative management via immobilization and splinting. Staff repeatedly documented the challenges in maintaining immobilization adequate for healing.
- On 4/18/16, Individual #251's PCP documented decreased mental status. The individual developed a tremor after starting nitrofurantoin for a urinary tract infection (UTI). The plan was to check labs and change the antibiotic. The individual was transferred to the ED after the white blood cell count returned at 24 thousand. He was admitted with urosepsis and pneumonia. On 4/22/16, a readmit note was entered in the IPNs. This very brief note provided little information regarding the four-day hospitalization. No additional follow-up was documented. On 4/26/16, the IDT met for an ISPA meeting, but the PCP did not attend. The next PCP entry was on 6/10/16.

On 6/10/16, Individual #251's PCP documented in a very brief note that the individual had decreased urine output. A repeat urinalysis was requested. The plan was to start Macrobid pending urine results. It was also noted that: "Gentamycin bladder flush still not started." The individual was sent to the ED for evaluation of a tremor, respiratory problems, and diaphoresis attributed to an adverse medication reaction (gentamycin) around 9:40 p.m., and returned several hours later. There was no physician follow-up upon return.

On 6/12/16, nursing staff documented that the individual was being transferred to the ED due to temperature, tachycardia, and lethargy. On 6/16/16, he returned following hospitalization for urosepsis. The PCP documented in a one-line assessment that the individual had an irregular heartbeat and an EKG was done. No interpretation of the EKG was documented in the note. On 6/18/16, another provider documented that the individual had new onset atrial fibrillation with a "spontaneously low" ventricular rate. Aspirin was prescribed for stroke prevention. On 6/30/16, the next PCP entry described the individual as "status quo." On 6/21/16, the IDT met for an ISPA meeting, but the PCP did not attend. It was not clear if the IDT was informed of the new diagnosis, the risk for thromboembolism (stroke), and the risks/benefits associated with the various medical management options.

- On 4/6/16 at 1:00 p.m., Individual #328's PCP noted the individual was diagnosed with pneumonia 10 days ago. The individual was pale with a blood pressure of 96/53 and oxygen saturation of 94% on three liters of oxygen following a nebulizer treatment. The impression was decreased oxygen saturation. The plan was to check a chest x-ray and labs and start antibiotics. Around 5:00 p.m., the PCP noted continued decreased oxygen saturation. The assessment was pneumonia. The individual was transferred to the ED for evaluation and admitted with "hypoxia following treatment for pneumonia." Individual #328 returned on 4/8/16. The PCP did not document any follow-up. The Center did not submit any evidence of a post-hospital ISPA meeting.
- On 5/16/16, nursing staff documented that Individual #329 was being sent to the ED for evaluation of back pain. On 5/17/16, the PCP documented in a non-SOAP format note that the individual "has back pain-fell down stairs 2 wk [weeks] ago." The note, which was largely illegible, consisted of four lines. The assessment/plan was "back pain, MS; OTC [over-the-counter] meds [medications]." It appeared that the individual was off campus and the PCP did not examine her. There was no follow-up for this acute issue.
- On 3/23/16 around noon, Individual #145's PCP noted the individual had scattered rhonchi and an oxygen saturation of 88%. The assessment was acute respiratory decline. The plan was to obtain a chest x-ray, check labs, and a prescribe Levaquin. The note did not include vital signs, such as blood pressure and respiratory rate. At 3:00 p.m., the PCP documented that the individual was transferred to the ED after the assessment revealed drowsiness, decreased appetite, and no improvement in respiratory status. Again, no vital signs were noted. On 3/31/16, the individual returned to the Center. The seven-word post hospital assessment indicated that the diagnosis was pneumonia.

  On 4/1/16, the assessment noted the diagnosis was left upper lobe pneumonia and two swallow studies completed during the individual's hospitalization documented silent aspiration. The guardian refused percutaneous endoscopic gastrostomy (PEG) tube placement and the individual was referred to hospice. Per the PCP, "His IDT disagrees with the decision to give comfort care alone." The IDT believed the swallow studies were not done under ideal circumstances. The plan was to obtain a third swallow study. On 4/3/16, the PCP documented resolving pneumonia. On 4/12/16, Individual #145 was sent to the ED for

respiratory problems, and on 4/13/16, returned. There was no physician assessment prior to or after the ED evaluation. The diagnosis per ED records was bronchopneumonia.

The IPN entry from the PCP documented on 5/19/16 that the Ethics Committee unanimously agreed to a DNR. There was no mention of a 3rd study. The guardian refused placement of a PEG tube. Per the PCP, the guardian "confirmed agreement with DNR."

- On 6/20/16, nursing staff documented that Individual #338 went to the ED for a repair of a laceration that occurred when he hit his head on a piece of metal. There was no physician documentation related to this acute event.

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

Summary: Overall, the Center needs to improve its performance with regard to PCPs' review and response to consultations, as well as referral of recommendations to IDTs, as dictated by individuals' clinical need, for discussion and planning.

#	Indicator	Overall Score	Individuals: 65	28	251	328	233	329	145	338	217
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	50% 8/16	1/2	0/2	0/1	1/2	1/2	1/2	1/1	2/2	1/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	63% 10/16	2/2	1/2	0/1	2/2	0/2	1/2	1/1	1/2	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.	31% 5/16	1/2	0/2	0/1	1/2	0/2	0/2	1/1	1/2	1/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	80% 8/10	1/1	N/A	N/A	1/1	1/2	1/2	1/1	2/2	1/1
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	25% 1/4	0/1	0/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 16 consultations. The consultations reviewed included those for Individual #65 for orthopedics on 7/7/16, and neurology on 6/6/16; Individual #28 for cardiology on 4/26/16, and neurology on 7/15/16; Individual #251 for urology on 5/19/16; Individual #328 for podiatry on 8/5/16, and rheumatology on 7/27/16; Individual #233 for nephrology on 6/14/16, and infectious disease on 2/19/16; Individual #329 for neurology on 5/6/16, and Modified Barium Swallow Study (MBSS) on 5/15/16; Individual #145 for radiology/dysphagogram on 4/28/16; Individual #338 for neurology on 5/6/16, and orthopedics on 7/19/16; and Individual #217 for neurology on 9/2/16, and dermatology on 5/23/16.

a. The consultation reports reviewed for which documentation was not found to show that the PCPs indicated agreement or disagreement with the recommendations, and provided rationale when they did not agree were for: Individual #65 for neurology on

6/6/16; Individual #28 for cardiology on 4/26/16, and neurology on 7/15/16; Individual #251 for urology on 5/19/16; Individual #328 for rheumatology on 7/27/16; Individual #233 for infectious disease on 2/19/16; Individual #329 for MBSS on 5/15/16; and Individual #217 for neurology on 9/2/16.

b. Reviews that were not completed timely were those for Individual #28 for neurology on 7/15/16; Individual #251 for urology on 5/19/16; Individual #233 for nephrology on 6/14/16, and infectious disease on 2/19/16; Individual #329 for neurology on 5/6/16; and Individual #338 for neurology on 5/6/16.

c. PCP IPNs that included all of the components State Office policy requires were submitted for the following consultations: Individual #65 for orthopedics on 7/7/16, Individual #328 for podiatry on 8/5/16, Individual #145 for radiology/dysphagogram on 4/28/16, Individual #338 for orthopedics on 7/19/16, and Individual #217 for dermatology on 5/23/16.

d. When PCPs agreed with consultation recommendations, evidence was generally submitted to show orders were written for all relevant recommendations, including follow-up appointments, with the following exceptions:

- Individual #233's consultation for infectious disease on 2/19/16, for whom there was no evidence that the yearly GYN evaluation was completed as recommended. It is also noteworthy that there was no evidence in the records reviewed that the recommendations for follow-up and laboratory monitoring were implemented; and
- Individual #329's consultation for MBSS on 5/15/16, for whom the form was incomplete, the findings were not cited, and the recommendations section said: "see report."

It is important to note, however, that without information about whether or not PCPs agreed with recommendations, the Monitoring Team often could not rate this indicator.

e. The following problems were noted:

- For Individual #65's consultation from orthopedics on 7/7/16, the PCP did not refer it to the IDT. However, it appeared that the IDT should have had knowledge of and discussed the treatment plan, which was difficult to implement.
- Given the ongoing issues related to falls/seizures/syncope for Individual #28, the information included in the cardiology consultation on 4/26/16 should have been referred to the IDT, but this section of the PCP IPN was left blank. Similarly, the neurology consultation on 7/15/16 noted another hard fall with blunt trauma to her face, cause unclear, but staff feel that falls are due to loss of balance. Previous brain MRI showed some focal encephalomalacia. The recommendation was to "Wear helmet; once tapered off lamictal 24 hour ambulatory eeg [electroencephalogram]; Revaluate after eeg." The IDT did not meet to discuss these recommendations and revise/formulate a plan.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.	
Summary: The Center needs to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessment, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible.	Individuals:

#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
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.	39% 7/18	1/2	1/2	1/2	0/2	0/2	0/2	1/2	2/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #65 – osteoporosis, and seizures; Individual #28 – cardiac disease, and seizures; Individual #251 – cardiac disease, and seizures; Individual #328 – other: rheumatoid arthritis, and osteoporosis; Individual #233 – infections, and diabetes; Individual #329 – respiratory compromise, and constipation/bowel obstruction; Individual #145 – aspiration, and other: hypothyroidism; Individual #338 – cardiac disease, and seizures; and Individual #217 – respiratory compromise, and seizures).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #65 – seizures; Individual #28 – seizures; Individual #251 – seizures; Individual #145 – other: hypothyroidism; Individual #338 – cardiac disease, and seizures; and Individual #217 – seizures. The following provide a few examples of concerns noted regarding medical assessment, tests, and evaluations, and/or identification of the necessary treatment(s), interventions, and strategies, as appropriate:

- For Individual #65's risk related to osteoporosis, the PCP made a referral to endocrine, who then recommended a rheumatology evaluation to determine the need for additional medical therapy. However, the PCP did not utilize tools such as the Fracture Risk Assessment Tool (FRAX) score to help determine the need for treatment. The interpretation of the DEXA scores clearly indicates that bone mineral density is not the only risk for future fragility fracture. Other clinical criteria must be considered including age, previous fractures, risk of falling, etc. The PCP had not addressed the May 2016 DEXA and the diagnosis of osteopenia in the AMA.
- Individual #28's PCP referred her to cardiology and neurology for evaluation. In October 2015, the cardiology evaluation documented some orthostatic changes. However, there was no evidence that this assessment was further evaluated. No orthostatic vital signs were documented. The PCP's physical exam did not document the cardiac murmur the cardiologist noted. The EKG showed mild tricuspid and mitral regurgitation and other findings, which might not require immediate treatment, but which the PCP never acknowledged.
- For Individual #251, while the PCP stated full agreement in the AMA with the IRRF risk assessment, the cardiac risk was low in the AMA and high in the IRRF. The DNR Order was based on the diagnoses of dementia and "extremely high ASCVD [atherosclerotic cardiovascular disease] risk score." The AMA did not discuss the diagnosis of hypertension, or hyperlipidemia. There was no documentation that the IDT was informed of the diagnosis of new onset atrial fibrillation and the risks/benefit of medical management. This was important given the risk for thromboembolism (stroke) and the decision not to anti-coagulate.
- Individual #328 had rheumatoid arthritis. His PCP referred him to a rheumatologist and followed the recommended treatment plans, but failed to mention the current status (disease activity), risks, strategies, or plans in the AMA other than "refer to rheumatology." The dental pre-operative evaluation did not include any evaluation of the cervical spine by any providers involved in the care of this individual. Generally acceptable clinical guidelines for the management of rheumatoid arthritis include the assessment of cervical instability with flexion/extension radiographs prior to procedures that may require general anesthesia and intubation. The consequences of failure to detect subluxation/cervical instability have the potential to be

devastating. Moreover, the IRRF did not discuss rheumatoid arthritis. This is a significant condition that requires aggressive treatment by a specialist. For example, Individual #328 receives immunosuppressive agents inclusive of biologic disease modifying anti-rheumatic drugs and azathioprine. Individuals receiving these drugs are at risk for a number of complications including infections. The IHCP should specify how to monitor for disease flairs as well as monitoring for drug use (clinical and labs). The fact that the rheumatologist provides treatment recommendations does not obviate the need for the PCP and IDT to closely monitor and be aware of risks/benefits of utilizing these agents.

- With regard to Individual #233's infection risk, the PCP deferred all care to the recommendations of the Infectious Disease specialist. The AMA and other assessments provided little to no information on the status of the disease. The last Infectious Disease consult was done on 2/19/16. Center staff had not followed several recommendations. The individual had not had yearly pap smears/gynecological evaluations (specific to management of the disease), and she did not have the important six-month follow-up documented in the records. Lab work had not been monitored as Infectious Disease requested.

  According to Individual #233's QDRRs, an order, dated 2/25/14, for fasting blood glucoses to be drawn monthly was not being done. It was noted that blood glucoses had been increasing and monitoring was needed. It was unclear why the IDT assessed the risk for diabetes mellitus as low. The individual receives multiple medications, several of which are associated with hyperglycemia and hyperlipidemia. The PCP did not address this in the AMA. The most recent two glucose values were greater than 100 and there was no Hemoglobin A1c drawn in the last six months.
- Individual #329's PCP did not provide any information on the status of her asthma or how it would be managed. In fact, the only comment was a goal to maintain good symptom control and prevent progression and complications. It was difficult to determine how often the PRN (pro re nata, or as needed) medications were used; however, the individual did not have a recent need for transfer to the ED for asthma management. Numerous professional organizations have published goals of asthma treatment. These are usually divided into two domains: reduction of impairment, and reduction of risk. These guidelines would provide some objective means of documenting asthma control. They also provide specific guidelines on monitoring individuals with asthma.

  With regard to constipation, Individual #329's IHCP included use of docusate, Miralax, and the need for abdominal assessment. There was no discussion of non-pharmacologic measures inclusive of fluids, activity, and use of fiber. The PCP did not list constipation as a diagnosis even though the individual received daily medication for management.
- Individual #145's AMA included no discussion or plan related to dysphagia even though it was listed as an active problem.
- Individual #217's AMA cited asthma as an active problem and she received inhaled corticosteroids for asthma daily. She also was treated with montelukast for asthma, and in February 2016, she was hospitalized for an asthma exacerbation. The AMA provided no assessment or management plan for this active problem.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.	
Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. In addition, documentation often was not found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs.	Individuals:

#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	50% 9/18	1/2	2/2	1/2	0/2	0/2	1/2	1/2		
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, documentation often was not found to show that those action steps assigned to the PCPs were implemented. Those that were implemented were those for Individual #65 – seizures; Individual #28 – cardiac disease, and seizures; Individual #251 – seizures; Individual #329 – respiratory compromise; Individual #145 – other: hypothyroidism; Individual #338 – cardiac disease, and seizures; and Individual #217 – seizures.											

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; recommendations are made about any necessary additional laboratory testing 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.											
Summary: N/R			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	N/R									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.											

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.											
Summary: Although some improvement was noted, the Pharmacy Department needs to continue to focus on improving the timeliness as well as the quality of the QDRRs. In addition, prescribers need to review QDRRs timely, and implement the agreed upon recommendations timely and thoroughly.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	QDRRs are completed quarterly by the pharmacist.	56%	1/2	2/2	2/2	0/2	0/2	1/2	2/2	0/2	2/2

		10/18									
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;	77% 10/13	1/1	1/2	1/2	1/1	0/1	1/1	2/2	1/1	2/2
	ii. Benzodiazepine use;	75% 6/8	1/1	0/1	0/1	1/1	1/1	1/1	2/2	N/A	N/A
	iii. Medication polypharmacy;	71% 5/7	1/1	0/1	0/1	1/1	1/1	N/A	2/2	N/A	N/A
	iv. New generation antipsychotic use; and	80% 8/10	1/1	1/2	1/2	1/1	N/A	1/1	2/2	1/1	N/A
	v. Anticholinergic burden.	83% 10/12	1/1	1/2	1/2	1/1	1/1	N/A	2/2	1/1	2/2
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.	77% 10/13	1/1	1/2	2/2	0/1	1/1	1/1	2/2	1/1	1/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	46% 6/13	0/1	1/2	1/2	0/1	1/1	0/1	2/2	1/1	0/2
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	33% 4/12	1/1	1/2	0/2	N/A	0/1	0/1	1/2	1/1	0/2
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	N/R									

Comments: a. There continued to be significant problems in the provision of pharmacy services. The Monitoring Team's last two reviews clearly documented problems with the completion of QDRRs. During the June 2015 review, none of the individuals reviewed had a current QDRR. During the March 2016 review, it was again noted that none of the individuals reviewed "had QDRRs completed in 2015 or to date in 2016." This review identified some improvement in this area. However, the Pharmacy Director reported that during the month of November, only 32% of QDRRs were completed. The failure to conduct QDRRs can adversely impact the clinical care and this was noted for some individuals.

b. Of note, Center staff did not submit drug profiles for several of the QDRRs reviewed. In those instances, the Monitoring Team used the current pharmacy profile and/or most recent QDRR profile available. The following describe some of the problems noted with

regard to the quality of the QDRRs:

- For Individual #28, information/pages were missing for the QDRR, dated 6/30/16.
- Similarly, Individual #251's QDRR, dated 8/18/16, had blank spaces.
- Individual #233 was prescribed a medication for which the Clinical Pharmacist should have made recommendations regarding specific laboratory monitoring, but did not.

c. For the individuals reviewed, it was concerning to see that prescribers, particularly psychiatrists, were not consistently reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations.

d. When prescribers agreed to recommendations for the individuals reviewed, they frequently did not implement them. Some examples included:

- Individual #28's 6/30/16 QDRR included a recommendation that an eye exam was due in June. The PCP agreed. The PCP noted that the evaluation was completed on 8/26/16, but the Center's response to the Monitoring Team's document request indicated it was not needed and no documentation was submitted to show it was completed.
- For Individual #251, the Clinical Pharmacist made a number of recommendations related to the need for follow-up on abnormal lab values and drug monitoring. While the PCP agreed, there was no evidence that any of these were done (e.g., elevated urine micro-albumin, elevated Hemoglobin A1c, need for echocardiogram, low vitamin D of 18.9, and three risks for metabolic syndrome).
- For Individual #233, the Clinical Pharmacist noted that a 2014 order required monthly blood glucoses, but this lab monitoring was not being done. The PCP commented that this was excessive and the last fasting blood sugar was 105. It should be noted that several of the medications included in the protocol Individual #233 was prescribed increase the risk for hyperglycemia and the individual's blood glucoses were trending upward as the Clinical Pharmacist noted. A repeat fasting glucose or Hemoglobin A1c would be appropriate. There also was no follow-up for the recommendation to assess urinary protein.
- For Individual #217, outstanding issues were addressed in the QDRR recommendations. The PCP made no comments and several issues remained outstanding at the time of the review, including the need for eye evaluations and repeating lab studies.

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.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7	N/A	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including	0%		0/1	0/1	0/1	0/1	0/1	0/1		0/1

	timeframes for completion;	0/7									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/7		0/1	0/1	0/1	0/1	0/1	0/1		0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/7		0/1	0/1	0/1	0/1	0/1	0/1		0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/7		0/1	0/1	0/1	0/1	0/1	0/1		0/1

Comments: a. and b. Individual #65 (i.e., edentulous), Individual #329, and Individual #338's (i.e., edentulous) IDTs rated them at low risk with regard to dental health. However, Individual #329 had fair oral hygiene, and although she tolerated some dental care well, she required TIVA for the completion of fillings, and she regularly ground her teeth. Her IDT had not provided clinical justification for a low risk rating for dental. The Monitoring Team reviewed six individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, progress reports on existing 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. For Individual #28, Individual #251, Individual #328, Individual #233, Individual #329, Individual #145, and Individual #217, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services. Individual #65, and Individual #338 were in the core group, so complete reviews were completed for them as well.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: These are new indicators, which the Monitoring Team will continue to review.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	Individuals have no diagnosed or untreated dental caries.	57% 4/7	N/A	0/1	0/1	0/1	1/1	1/1	1/1	N/A	1/1
b.	Since the last exam:										
	i. If the individual had gingivitis (i.e., the mildest form of periodontal disease), improvement occurred, or the disease did not worsen.	100% 2/2	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/1
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	60% 3/5	N/A	0/1	1/1	1/1	1/1	N/A	0/1	N/A	N/A
c.	Since the last exam, the individual's fair or good oral hygiene score was maintained or improved.	N/R									

Comments: Individual #65 and Individual #338 were edentulous.

c. As indicated in the dental audit tool, this indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will be marked "N/R." At the time of the review, State Office had not yet developed a process to ensure inter-rater reliability with the Centers.

However, it is important to note that some of the individuals reviewed had significant problems with oral hygiene. Even though some individuals were seen in the Dental Clinic for tooth brushing instruction, it did not appear that IDTs were identifying and addressing the underlying cause of the problem (e.g., lack of focus on oral hygiene in the homes, individuals' refusals to participate in oral hygiene routines, etc.). The following provide a few examples of concerns noted:

- For Individual #233, who had weekly tooth brushing instruction at the Dental Clinic since January 2016, dental notes indicated: poor oral hygiene with bleeding upon brushing (8/29/16), poor oral hygiene with inflamed gums (8/22/16), strong mouth odor (6/16/16), and odor and bleeding (3/22/16).
- For Individual #145, who had weekly tooth brushing instruction at the Dental Clinic, dental notes indicated: "has a strong perio odor. His gums bleed upon brushing. You could tell he hadn't brushed his teeth in a while" (5/26/16), and poor oral hygiene with plaques on all surfaces, and "has not brushed in a while" (5/16/16).
- On 4/20/16, Individual #338 was referred for halitosis and poor oral hygiene. His dentures were also in poor repair.

Outcome 5 – Individuals receive necessary dental treatment.

Summary: Given that over the last two review periods and during this review, individuals generally received x-rays in accordance with the applicable American Dental Association Guidelines, or justification was provided (Round 9 – 89%, Round 10 – 100%, and Round 11 - 86%), Indicator c will move to the category requiring less oversight. The remaining indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
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, unless clinically justified.	100% 7/7	N/A	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	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.	86% 6/7	N/A	1/1	0/1	1/1	1/1	1/1	1/1	N/A	1/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	75% 3/4	N/A	1/1	N/A	1/1	1/1	N/A	0/1	N/A	N/A
e.	If the individual has periodontal disease, the individual has a	100%	N/A	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1

	treatment plan that meets his/her needs, and the plan is implemented.	7/7									
f.	If the individual has need for restorative work, it is completed in a timely manner.	50% 2/3	N/A	1/1	0/1	0/1	1/1	N/A	N/A	N/A	N/A
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A									

Comments: Individual #65 and Individual #338 were edentulous.

b. Individual #338 had a full set of dentures, but Dental Department staff did not document the provision of instructions for denture care.

c. For Individual #251, the last documented x-rays (except for tooth #6) were completed in 2014.

d. Individual #145's caries risk changed from low in October 2015 to medium in November 2015. No reasonable explanation was provided for the original score for an individual with documented poor oral hygiene.

f. For Individual #251, the treatment record, dated 3/11/15, documented that tooth #6 was non-restorable. It was not clear why the tooth was not extracted.

For Individual #328, the Dentist's documentation was not sufficient to explain whether 10 teeth developed the need for fillings over a one-year period (i.e., on 7/26/16, four fillings completed, and on 8/25/15, six fillings completed), or if treatment was delayed for some reason.

Outcome 7 – Individuals receive timely, complete emergency dental care.

Summary: Given that the Center attained 100% scores for Indicator a during this review and Indicators a through c during the Round 10 review (i.e., these indicators were N/A in Round 9), with sustained performance during the next review, indicators a through c will likely move to the category requiring less oversight.

#	Indicator	Overall Score	Individuals: 65	28	251	328	233	329	145	338	217
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 2/2	N/A	2/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A		N/A							
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A		N/A							

Comments: a. through c. On 4/5/16 and 4/12/16, Individual #28 complained that all her teeth were hurting. The Dentist's assessment

was tooth pain due to lapses in oral hygiene.

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: All of these indicators require the Center's focused attention. They will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
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% 0/3	N/A	N/A	0/1	N/A	N/A	N/A	0/1	N/A	0/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/1			N/A				0/1		N/A
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/1			N/A				0/1		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.	0% 0/1			N/A				0/1		N/A
Comments: a. The assessment section in the annual dental exam for suction tooth brushing was blank for Individual #251. Likewise, the assessment section for suction tooth brushing was blank for Individual #217. She received all of her nutrition enterally, and Dental Department staff noted she had rapid accumulation of calculus on her teeth from the enteral nutrition. b. through c. Based on the Center's response to the document request, Individual #145 did not receive suction tooth brushing. However, the Registered Dental Hygienist indicated he did.											

Outcome 9 – Individuals who need them have dentures.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	75% 6/8	0/1	1/1	1/1	1/1	0/1	1/1	1/1	N/A	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. Individual #65's assessment merely stated: "too uncooperative," which did not provide clinical justification for not pursuing dentures (i.e., more detail was needed describing with what he would not cooperate). He was edentulous.											

The Center did not submit an Annual Dental Summary for Individual #233, and the related section on the Annual Dental Exam form was blank. However, according to the IRRF, she had 20 missing teeth.

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Nursing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis for acute illnesses/occurrences remained areas on which the Center needs to focus. It is also important that nursing staff timely notify the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification. Nursing staff were not developing acute care plans for all relevant acute care needs, and those that were developed needed improvement. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	54% 7/13	2/2	1/2	1/2	1/1	0/1	1/2	0/1	1/2	N/A
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.	69% 9/13	2/2	1/2	1/2	1/1	0/1	2/2	1/1	1/2	
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/5	0/1	0/1	N/A	0/1	N/A	0/1	N/A	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.	0% 0/8	0/1	0/1	0/2	N/A	0/1	0/1	0/1	0/1	
e.	The individual has an acute care plan that meets his/her needs.	0% 0/13	0/2	0/2	0/2	0/1	0/1	0/2	0/1	0/2	
f.	The individual's acute care plan is implemented.	0% 0/13	0/2	0/2	0/2	0/1	0/1	0/2	0/1	0/2	
Comments: The Monitoring Team reviewed 13 acute illnesses and/or acute occurrences for eight individuals, including Individual #65 – fractures of proximal phalanx, bilateral ring fingers, and nose on 4/19/16, and acute bleeding from surgical wound on 8/2/16; Individual #28 – mild head injury on 6/28/16, and syncope on 9/25/16; Individual #251 – urosepsis on 4/18/16, and post-pallor and											

diaphoresis on 6/10/16; Individual #328 – Stage I decubitus on 4/15/16; Individual #233 – lip laceration due to peer-to-peer aggression on 8/30/16; Individual #329 – fall with injury to mid-back on 5/16/16, and cellulitis to left upper arm on 5/20/16; Individual #145 – bronchopneumonia with hypoxemia on 4/12/16; and Individual #338 – repair of laceration to right ear on 6/20/16, and mild head injury on 9/26/16.

a. When individuals displayed signs and symptoms of an acute/illness/occurrence, nursing staff conducted assessments for Individual #65 – fractures of proximal phalanx, bilateral ring fingers, and nose on 4/19/16, and acute bleeding from surgical wound on 8/2/16; Individual #28 – syncope on 9/25/16; Individual #251 – post-pallor and diaphoresis on 6/10/16; Individual #328 – Stage I decubitus on 4/15/16; Individual #329 – cellulitis to left upper arm on 5/20/16; and Individual #338 – mild head injury on 9/26/16.

b. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms were: Individual #65 – fractures of proximal phalanx, bilateral ring fingers, and nose on 4/19/16, and acute bleeding from surgical wound on 8/2/16; Individual #28 – syncope on 9/25/16; Individual #251 – post-pallor and diaphoresis on 6/10/16; Individual #328 – Stage I decubitus on 4/15/16; Individual #329 – fall with injury to mid-back on 5/16/16, and cellulitis to left upper arm on 5/20/16; Individual #145 – bronchopneumonia with hypoxemia on 4/12/16; and Individual #338 – mild head injury on 9/26/16.

e. For nine of the acute illnesses/occurrences the Monitoring Team reviewed, no acute plans were found. For some of the more recent illnesses/occurrences, it appeared that issues with the production of documentation from IRIS might have contributed to this finding. In addition, though, for some acute illnesses/occurrences that occurred prior to the implementation of IRIS (i.e., San Angelo's "go-live" date was 7/11/16), the Center did not produce acute care plans (e.g., Individual #65 – fractures of proximal phalanx, bilateral ring fingers, and nose on 4/19/16; Individual #28 – mild head injury on 6/28/16; Individual #329 – fall with injury to mid-back on 5/16/16, and cellulitis to left upper arm on 5/20/16; Individual #145 – bronchopneumonia with hypoxemia on 4/12/16; and Individual #217 – repair of laceration to right ear on 6/20/16). Common problems with the acute care plans reviewed included a lack of: instructions regarding follow-up nursing assessments that were consistent with the individuals' needs; alignment with nursing protocols; specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; clinical indicators nursing would measure; and the frequency with which monitoring should occur.

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

- Upon Individual #65's return from the hospital for acute bleeding on 8/2/16, the majority of nursing entries did not provide consistent assessment of vitals signs, or when vital signs were documented as elevated, reporting or following up with additional assessments and vital signs. Nurses did not consistently document care, or circulatory status, which are basic standards of care for an individual with an orthotic device that provides or performs functions of support and immobilization. As is discussed in greater detail in the medical acute care section of this report, on 8/2/16, the individual was admitted to the hospital due to surgical site bleeding. On 8/7/16, he was noted to have a lacerated artery that required ligation. On 8/16/16, the individual required another hospital admission. Per the surgeon's report, the individual "jumped in a puddle and was splashing around in it reportedly and then was dry off with a fan and presented to clinic 5 or 6 days later. The cast was removed with significant purulence… The patient was taken to the OR [operating room] for incision and drainage due to an infected wound." On 8/28/16, the humerus was re-fractured dislodging the hardware. The individual's orthopedic surgeon made the decision to amputate based on the complicated history.

- When Individual #251 returned from the hospital on 6/11/16, two different RNs conducted post-hospitalization assessments, but documented notably different results. For example, the most significant difference was the skin assessment, for which one RN identified seven areas of concern, but the other assessment documented "none" on the physical assessment form. Nursing assessments are the first step in gathering information to formulate a plan of care. The Center should have quality checks in place to ensure the accuracy of post-hospital assessments.
- On 4/15/16, direct support professional staff reported that Individual #328 had a "red mark on buttock." On a positive note, the nurse followed the nursing protocol/standard of care for assessing the site, taking measurements, and notifying the physician. San Angelo SSLC has a certified wound care nurse on staff, and she documented it as a Stage I decubitus. On the same day, a corresponding medical IPN included the recommendations from the Certified Wound RN, and rehabilitation consult for pressure mapping the wheelchair, recliner, and bed. Physician orders read: "Clean wound M-W-F on 6-2 shift and PRN in IPN on 2-10 verifies dressing in place in IPN until healed." On 4/18/16, the 6-2 shift nurse noted "tx completed to coccyx," but provided no information regarding whether or not the wound was improving. No 2-10 documentation was found for 4/18/16. The 4/20/16 nursing, medical, and Certified Wound RN IPNs documented the Stage I decubitus was resolved. Although it was noted as resolved, the nursing IPNs did not consistently show evidence the orders were followed.
- Individual #329 developed cellulitis to the left upper arm, and the medical IPN indicated this was the site that Haldol injections were often given every two weeks. Nursing IPNs did not consistently include an assessment of the left arm for changes to determine if the site was responding to the medication, or if the compresses were routinely being used, and their effectiveness. No information was provided regarding whether nursing staff reviewed the dates of the recent Haldol injections to determine if the sites were being rotated for the chemical restraints. Although an IPN on 5/24/16 indicated an acute care plan was written and staff were trained, no acute care plan was found in the records.

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

Summary: For individuals reviewed, IDTs did not have a way to measure outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 65	28	251	328	233	329	145	338	217
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.	61% 11/18	2/2	1/2	2/2	0/2	0/2	2/2	1/2	2/2	1/2
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	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	takes necessary action.	0/18									

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #65 – fractures, and skin integrity; Individual #28 – dental, and falls; Individual #251 – constipation/bowel obstruction, and skin integrity; Individual #328 – gastrointestinal problems, and other: pain due to rheumatoid arthritis; Individual #233 – falls, and infections; Individual #329 – constipation/bowel obstruction, and infections; Individual #145 – aspiration, and hypothermia; Individual #338 – constipation/bowel obstruction, and fractures; and Individual #217 – respiratory compromise, and infections).

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 #65 – fractures, and skin integrity; Individual #28 – falls; Individual #251 – constipation/bowel obstruction, and skin integrity; Individual #329 – constipation/bowel obstruction, and infections; Individual #145 – aspiration; Individual #338 – constipation/bowel obstruction, and fractures; and Individual #217 – respiratory compromise.

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 provision 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.

Summary: This is an area that requires focused efforts. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 65	28	251	328	233	329	145	338	217
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.	12% 2/17	0/2	0/2	0/2	0/2	1/2	0/2	0/2	1/2	0/1
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 specific risk areas for nine individuals, and as available, the IHCPs to address them.

a. through c. 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 generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, IDTs took immediate action in response to risk (i.e., the exceptions were Individual #233 - falls, and Individual #338 - fractures), or that nursing interventions were implemented thoroughly.

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
Summary: For the two previous reviews, as well as this review, the Center did well with the indicators related to administering medications according to the nine rights (c), and nurses following the PNMP during medication administration (f, and previously e). However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review them until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will remain in active oversight as well.			Individuals:								
#	Indicator	Overall Score	251	328	329	217	346	52			
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R									
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	N/R									
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an	N/R									

	enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.										
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	80% 4/5	0/1	1/1	N/A	1/1	1/1	1/1			
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of six individuals, including Individual #251, Individual #328, Individual #329, Individual #217, Individual #346, and Individual #52.

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. This indicator was not assessed during this review, but will be during upcoming reviews. The Center had just recently obtained the curriculum State Office provided to assist the Centers in complying with these requirements.

f. Individual #251's PNMP indicated he should use a weighted mug with a straw for liquids. During the observed medication pass, he used the mug, but not the straw. In addition, his diet was ground texture, but as a strategy to decrease his medication refusals, he received a cupcake if he took his medications. The Monitoring Team member discussed these issues with Nursing Administration, who

indicated they would work with Habilitation Therapies to clarify the PNMP.

g. For the individuals observed, nursing staff followed infection control practices, which was good to see.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Overall, IDTs and/or the PNMT did not have a way to measure outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
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;	0% 0/12	0/2	0/2	N/A	0/1	0/1	0/2	0/1	0/1	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	8% 1/12	0/2	1/2		0/1	0/1	0/2	0/1	0/1	0/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/12	0/2	0/2		0/1	0/1	0/2	0/1	0/1	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/12	0/2	0/2		0/1	0/1	0/2	0/1	0/1	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/12	0/2	0/2		0/1	0/1	0/2	0/1	0/1	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;	75% 6/8	2/2	0/2	N/A	1/1	1/1	N/A	1/1	1/1	N/A
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/10	0/2	0/2	0/2	0/1	0/1		0/1	0/1	
	iii. Individual has a measurable goal/objective, including	10%	0/2	0/2	1/2	0/1	0/1		0/1	0/1	

		timeframes for completion;	1/10									
	iv.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/10	0/2	0/2	0/2	0/1	0/1		0/1	0/1	
	v.	Individual has made progress on his/her goal/objective; and	0% 0/10	0/2	0/2	0/2	0/1	0/1		0/1	0/1	
	vi.	When there is a lack of progress, the IDT takes necessary action.	0% 0/10	0/2	0/2	0/2	0/1	0/1		0/1	0/1	

Comments: The Monitoring Team reviewed 12 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: skin integrity, and fractures for Individual #65; falls, and weight for Individual #28; skin integrity for Individual #328; weight for Individual #233; choking, and falls for Individual #329; skin integrity for Individual #145; choking for Individual #338; and aspiration, and osteoporosis for Individual #217.

a.i. and a.ii. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: falls for Individual #28.

b.i. The Monitoring Team reviewed 10 areas of need for seven individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goals/objectives were included. These areas of need included: skin integrity, and weight for Individual #65; fractures, and weight for Individual #28; respiratory compromise, and skin integrity for Individual #251; aspiration for Individual #328; falls for Individual #233; aspiration for Individual #145; and falls for Individual #338.

Individual #251 was referred to the PNMT in 2014, so this indicator was not applicable.

For Individual #28, no evidence was found of referral to the PNMT despite significant weight loss (i.e., 23 pounds over the last year according to the RN annual comprehensive assessment dated 9/29/16). In addition, Individual #28 experienced a rib fracture on 7/16/16, which is a significant fracture. From the documentation provided, it was not clear that the PNMT was aware of or had reviewed the weight loss or fracture.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT did not develop clinically relevant, achievable, and measurable goals/objectives for the individuals reviewed. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: skin integrity for Individual #251.

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, 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.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18	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 increased or there was a change in status, there is evidence the team took immediate action.	25% 3/12	0/2	0/2	0/2	1/2	1/2	N/A	N/A	1/1	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.	0% 0/2	N/A	N/A	0/2	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, documentation generally was not found to confirm implementation of the action steps that were included in IHCPs.

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

- Individual #251's IDT made no change to his IHCP when he was placed on hospice or when he was removed from hospice care. In fact, after 7/28/16, no evidence was found of ISPA meetings.
- On a positive note, in April 2016, the PNMT nurse conducted an assessment and provided an intervention for Individual #328's Stage I decubitus ulcer.
- On a positive note, Individual #233's IDT referred her to the PNMT in relation to her weight.
- Individual #217 was hospitalized for sepsis, and asthma, which potentially could increase her risk of aspiration. However, no evidence was found of an ISPA meeting to discuss this hospitalization and the possible changes in support needs.

c. For Individual #251, no evidence was found via IHCP or ISPA that discharge from the PNMT occurred, despite the fact that Individual #251 was on the list of individuals the PNMT had discharged (i.e., 9/13/16). The Monitoring Team found no evidence of plan development with transition to the IDT from PNMT services.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.	
Summary: It was positive that during observations of transfers, staff completed them correctly. While still needing improvement, the rate of implementation of Dining Plans was relatively high. However, it was of significant concern that only 30 percent of individuals were positioned correctly during the Monitoring Team's	

observations. The Center should focus on positioning, and continue to improve compliance with Dining Plan implementation.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	72% 33/46
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.	54% 7/13
Comments: a. The Monitoring Team conducted 46 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during three out of 10 observations (30%). Staff followed individuals' dining plans during 26 out of 32 mealtime observations (81%). Transfers were completed correctly four out of four times (100%).		

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
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
Comments: None.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Overall, for individuals reviewed, IDTs did not have a way to measure outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	25% 3/12	0/3	0/1	N/A	0/1	0/1	0/2	1/2	N/A	2/2
b.	Individual has a measurable goal(s)/objective(s), including	8%	0/3	0/1		1/1	0/1	0/2	0/2		0/2

	timeframes for completion.	1/12									
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 1/12	0/3	0/1		0/1	0/1	0/2	0/2		0/2
d.	Individual has made progress on his/her OT/PT goal.	0% 1/12	0/3	0/1		0/1	0/1	0/2	0/2		0/2
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 1/12	0/3	0/1		0/1	0/1	0/2	0/2		0/2

Comments: a. and b. At the time of his annual ISP meeting, Individual #251 had functional motor and self-help skills, so a goal/objective was not indicated. Individual #338 also had functional motor and self-help skills that had not changed. The goals/objectives that were clinically relevant and achievable, but not measurable were those for Individual #145 (i.e., improving inhalation and breath control), and Individual #217 (i.e., maintaining head at midline, and initiating head rotation to the right).

The goal/objective that was measurable, but not clinically relevant was the standing goal for Individual #328.

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 generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Individual #251 was in the outcome group, so the remaining "deep review" items were not rated. Individual #338 was part of the core group, and so the Monitoring Team conducted full monitoring of his supports and services. For the remaining seven individuals, full reviews were conducted due to a lack of clinically relevant, achievable, and measurable goals/objectives to address areas of OT/PT need.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/10	0/3	N/A	N/R	0/1	N/A	0/2	0/2	N/A	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.	25% 2/8	0/3	N/A		0/1	N/A	2/2	0/2	N/A	N/A

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

- Lack of evidence in integrated ISP reviews that supports were implemented.
- For Individual #328, the QIDP monthly summary indicated there were no OT/PT progress notes to assess progress. The Monitoring Team found two monthly IPNs (i.e., dated 5/11/16, and 6/10/16), and a third, dated 7/11/16, which indicated that

he had plateaued and would be discharged from direct therapy. These notes did not report the frequency of intervention provided, though three times a week for eight weeks had been recommended. He was discharged with the only rationale being he plateaued without adequate data to substantiate this conclusion. No data sheets were submitted.

- After Individual #65's amputation, while no ISPA specifically related to terminating OT services for treatment of his left upper extremity would necessarily be expected, at least a progress note from the therapist should have been documented to provide a rationale for discontinuing the interventions with new recommendations. A comprehensive assessment and/or thorough update would have addressed this as well (there was only a brief progress note for post-hospitalization on 9/16/16). An ISPA meeting to discuss new needs across all areas of support relative to this a significant change in status secondary to left above elbow amputation was clearly necessary. The IDT did not appear to recognize the significance of the changes to this man's life from the end of June through mid-September, and appeared to view these as naturally occurring consequences of the initial fracture.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.

Summary: Given that over the last two review periods and during this review, individuals observed generally had clean adaptive equipment (Round 9 – 100%, Round 10 – 100%, and Round 11 - 100%) that was in working order (Round 9 – 94%, Round 10 – 100%, and Round 11 - 100%), Indicators a and b will move to the category of requiring less oversight. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's varying scores (Round 9 – 78%, Round 10 – 93%, and Round 11 - 89%), this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators.

[**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]

#	Indicator	Overall Score	Individuals: 40	369	71	344	7	202	25	294	38
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	100% 19/19	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% 19/19	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.	89% 17/19	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		203	98	189	318	295	134	222	217	273

a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		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.		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.		1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		383								
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1								
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1								
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1								

Comments: a. The Monitoring Team conducted observations of 19 pieces of adaptive equipment. The individuals the Monitoring Team observed had clean adaptive equipment, which was good to see.

b. It was positive that the equipment observed was in working order.

c. Based on observation of Individual #71 (staff reported he was being assessed for a new wheelchair), and Individual #295 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.

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.

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition. One indicator, in communication, had sustained high performance scores to be moved the category of requiring less oversight.

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

More ISP personal goals were individualized than during the previous review. This was a significant accomplishment and an indication of the work the facility had done to improve goal development. This was good to see, however, none had data or sufficient implementation to allow progress to be assessed.

For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals.

Skill acquisition plans contained many of the required components, but were most commonly missing specific instructions to teach the skill. Further, available SAP data did not allow the evaluation of progress. Monitoring Team observations of the implementation of two SAPs showed that they were not implemented and documented as written. No SAP data were reviewed in the QIDP monthly reports.

Monthly engagement measures were taken, but goals were not established. Monitoring Team observations found 22% of individuals to be consistently engaged. Attendance at day activities continued to be a problem (e.g., employment, workshop, activities, therapy, sessions).

Educational services were not consistently integrated into the student's ISP. This was an area that was a strength over the past years, but with changes at San Angelo SSLC's unit and residential directors, as well as changes in the Water Valley ISD administration, renewed attention needs to be paid to this outcome and its indicators.

It was good to see clinically relevant communication goals/objectives for four of the individuals reviewed. The Center should focus on ensuring goals/objectives are measurable, and that IDTs implement the goals/objectives.

During the last two reviews, individuals generally had their AAC devices with them and readily available. As a result, the related indicator will receive less oversight. However, ensuring that staff are providing individuals with opportunities to use their AAC devices functionally is an area that requires improvement.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Given that most goals were not yet individualized and did not meet criterion with ISP indicators 1-3, the indicators of this outcome also did not meet criteria. The 13 goals that were developed did not have data to allow progress to be assessed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	28	65	404	236	328	338			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	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 did not meet criterion as described above, 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. For the personal goals that met criterion, there was no evidence that action plans to support those goals were consistently implemented because reliable and valid data were not available.

Moreover, at San Angelo SSLC attendance at day activities continued to be a problem (e.g., employment, workshop, activities, therapy, sessions). For instance, at Building Imaginations, attendance was 30% of those who were signed up for that program. Factors affecting attendance are likely a combination of the meaningfulness of the activities as well as aspects of the individuals' psychiatric and behavioral disorders.

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	28	65	404	236	328	338			
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%	0/1	0/1	0/1	0/1	0/1	0/1			

		0/6									

Comments:
39. Staff knowledge regarding individuals' ISPs was insufficient to ensure the implementation of the ISP, based on observations, interviews, and lack of consistent implementation.

40. The action steps were not consistently implemented for any goals and/or action plans.

Skill Acquisition and Engagement

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

Summary: Without an acceptable or useable data system to allow progress to be determined, these indicators did not meet criteria and all will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74
6	The individual is progressing on his/her SAPS	0% 0/16	0/3	0/1	0/2	0/1	N/A	0/2	0/2	0/2	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	0% 0/16	0/3	0/1	0/2	0/1	N/A	0/2	0/2	0/2	0/3
9	Decisions to continue, discontinue, or modify SAPs were data based.	0% 0/16	0/3	0/1	0/2	0/1	N/A	0/2	0/2	0/2	0/3

Comments:
6. Available SAP data did not allow the evaluation of progress (see indicator 5).

7-8. Available SAP data did not allow the evaluation of progress. Furthermore, actions were not taken.

9. Data based decisions were impossible to assess because available SAP data did not allow the evaluation of progress.

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

Summary: SAPs were missing many components; none had all of the required components, including the absence of clear training instructions. This will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74

13	The individual's SAPs are complete.	0% 0/16	0/3	0/1	0/2	0/1	N/A	0/2	0/2	0/2	0/3

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Although none of the 16 SAPs were found to be complete, the majority of components were present for the majority of SAPs.

The most common missing component was specific instructions to teach the skill. All of the SAP training sheets indicated that forward chaining or shaping methodologies should be used for training the SAP. In all of the SAPs, it was not clear how staff knew the training step.

Additionally, although the SAP instructions clarified that staff should expose individuals to all the steps of the task analysis when the training methodology was forward chaining, it was not clear that staff train on the training step, guide through new steps, and allow individuals to complete the steps they already mastered.

Ensuring that all SAPs have the necessary training components should be a priority for San Angelo SSLC.

Outcome 5- SAPs are implemented with integrity.

Summary: SAPs that were observed by the Monitoring Team were not done correctly and the facility had not implemented its own plan to regularly assess the quality of implementation. Without correct implementation, learning is not likely to occur and instead, valuable staff and individual personal time are wasted. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74
14	SAPs are implemented as written.	0% 0/2	N/A	N/A	0/1	0/1	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.	31% 5/16	2/3	0/1	1/2	0/1	N/A	1/2	1/2	0/2	0/3

Comments:
14. The Monitoring Team observed the implementation of two SAPs (Individual #116's count coins SAP, and Individual #187's identify numbers SAP). Neither was judged to be implemented and documented as written. Individual #116's count coins SAP used an old (obsolete) training sheet and, therefore, the staff did not follow the training steps as written. Individual #187's identify numbers SAPs was recorded incorrectly. The lead manager for the facility's SAPs and one of the staff who does SAP reliability checks observed these two implementations alongside the Monitoring Team. The Monitoring Team discussed these observations with them and they were in agreement with the above comments.

15. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. Five SAP integrity measures were documented (Individual #28's requesting a break, and requesting attention SAPs, Individual #116's multiply numbers SAP, Individual #65's personal hygiene SAP, and Individual #404's dinning etiquette SAP). San Angelo SSLC established a schedule of SAP integrity that would ensure that each SAP was observed at least once every six months.

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

Summary: The new electronic data system did not allow the documentation of the training step. Thus, there were no SAP data from July 2016 to the present review. The facility staff said they planned to reintroduce the SAP training sheet as a card so that they could collect those data. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 28	358	116	187	269	65	404	236	74
16	There is evidence that SAPs are reviewed monthly.	0% 0/16	0/3	0/1	0/2	0/1	N/A	0/2	0/2	0/2	0/3
17	SAP outcomes are graphed.	0% 0/16	0/3	0/1	0/2	0/1	N/A	0/2	0/2	0/2	0/3

Comments:
16. No SAP data were reviewed in the QIDP monthly reports.

17. No SAP data were graphed.

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

Summary: Performance remained the same for indicators 18, 19, and 21. Indicator 20 showed a large decrease. Engagement in activities, including attendance at day programming (e.g., employment, activities, therapy, classes) remained an ongoing challenge for the facility and the individuals. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 28	358	116	187	269	65	404	236	74
18	The individual is meaningfully engaged in residential and treatment sites.	22% 2/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

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 only Individual #28 and Individual #74 consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

19-21. San Angelo SSLC conducted monthly engagement measures across residential and treatment sites, but did not establish engagement goals.

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

Summary: Community outings occurred, but did not meet criteria for this indicator. Community SAP training occurred for some individuals, but also did not meet criteria. It was good to see that outings were occurring. With additional work, it is likely that the facility can make progress on these indicators. All three will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	28	358	116	187	269	65	404	236	74
22	For the individual, goal frequencies of community recreational activities are established and achieved.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1
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:
22-24. All individuals had goals of three community outings a month. Individual #74 and Individual #236 achieved those goals in at least five of the last six months. Several individuals had documentation of SAP training in the community, however, there were no established goals for this activity. A goal for the frequency of SAP training in the community should be established for each individual, and the facility needs to demonstrate that those goals are achieved.

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

Summary: Educational services were not integrated into the student's ISP. This was a strength over the past years, but with changes at San Angelo SSLC's unit and residential directors, as well as changes in the Water Valley ISD administration, this no longer met criteria and will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	358								
25	The student receives educational services that are integrated with the ISP.	0% 0/1	0/1								
Comments: 25. Individual #358 was under 22 years of age and attended public school. There was, however, no evidence that Individual #358's educational services were integrated into her ISP or ISPAs.											

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.										
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals. These indicators will remain in active oversight.			Individuals:							
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/2	N/A	0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/2		0/1			0/1				
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/2		0/1			0/1				
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/2		0/1			0/1				
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/2		0/1			0/1				
Comments: None.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.	
Summary: It was good to see clinically relevant communication goals/objectives for four of the individuals reviewed. The Center should focus on ensuring	Individuals:

goals/objectives are measurable, and that IDTs implement the goals/objectives. These indicators will remain under active oversight.											
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	67% 6/9	2/2	N/A	1/1	0/2	N/A	N/A	0/1	1/1	2/2
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/9	0/2		0/1	0/2			0/1	0/1	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/9	0/2		0/1	0/2			0/1	0/1	0/2
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/9	0/2		0/1	0/2			0/1	0/1	0/2
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/9	0/2		0/1	0/2			0/1	0/1	0/2

Comments: a. and b. Individual #28, Individual #233, and Individual #329 were able to functionally communicate, so goals/objectives were not necessary. The goals/objectives that were clinically relevant, but not measurable were Individual #65's goals/objectives to use his communication book to let staff know he wanted to go outside, and to use his voice output device during medication administration; Individual #251's social story goal/objective; Individual #338's goal/objective related to articulation; and Individual #217's goals/objectives related to initiating communication, and utilizing her voice output device to request preferred activities.

c. through e. Because Individual #233 and Individual #329 were part of the outcome group no further review was conducted. Individual #28 was part of the core group, so a full review was conducted for her. For the remaining six individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives, and/or a lack of IDT analysis and/or action when progress did not occur.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: Considerable work was needed to ensure that staff implemented agreed-upon communication programs and strategies.			Individuals:								
#	Indicator	Overall Score	65	28	251	328	233	329	145	338	217
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/8	0/2	N/A	0/1	0/2	N/R	N/R	0/1	0/1	0/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA	N/A									

	meeting is held to discuss and approve termination.											
Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. Evidence was not present to show that the strategies were implemented.												

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.												
Summary: Given that over the last two review periods and during this review, individuals observed generally had their AAC devices with them and readily available (Round 9 – 75%, Round 10 – 86%, and Round 11 - 100%), Indicator a will move to the category of requiring less oversight. Improvement is needed with regard to individuals using their AAC devices functionally. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators.			Individuals:									
#	Indicator	Overall Score	40	27	118	211	217	137	65		
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	100% 8/8	1/1	1/1	1/1	1/1	2/2	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% 4/8	0/1	1/1	0/1	1/1	1/2	1/1	0/1		
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	100% 5/5									
Comments: a. and b. It was positive that individuals the Monitoring Team observed had their AAC/EC devices present and readily available. Work is needed to ensure staff assist individuals to utilize the AAC/EC devices functionally.												

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

This Domain contains five outcomes and 20 underlying indicators. At this time, none will be moved to the category requiring less oversight. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. In addition, earlier this year, the Center just had begun to take on additional post-move monitoring responsibilities, and was beginning to follow individuals in the community for a year as opposed to 90 days.

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

Overall, there was progress in the way supports were worded in term of measurability and in the comprehensiveness of the list of supports. Even so, similar issues regarding training of provider staff remained since the last review. Also, continued focus on the comprehensiveness of the list of supports is required.

The facility continued to provide post move monitoring within required timelines and across the state, though improvements in actions and in documentation are required, especially for the important supports of community provider staff training and their expected resultant knowledge and competencies. Attention should also be paid to doing post move monitoring thoroughly, documenting all actions taken by the PMM during the post move monitoring review, and ensuring that all three prongs of evidence are explored for each support.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.												
Summary: Overall, San Angelo SSLC made progress in improving the way supports were worded in term of measurability and in the comprehensiveness of the list of supports. Similar issues regarding details in the training of provider staff remained since the last review. Continued focus on the comprehensiveness of the list of supports is required. These two indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	76	243								
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/2	0/2								

2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/2	0/2							

Comments:
Seven individuals transitioned from the facility to the community since the last monitoring review. Two were included in this review (Individual #76 and Individual #243). Both individuals transitioned to a group home that was part of the State's Home and Community-based Services (HCS) program. Individual #76 was reported to be doing well overall, although the Monitoring Team identified concerns about the lack of pre-move preparation of provider staff regarding his critical physical/nutritional management needs. Individual #243 had experienced two potentially disruptive events, which are described under Outcome 3 below. The Monitoring Team reviewed these two transitions and discussed them in detail with the San Angelo SSLC Admissions and Placement staff while onsite.

There were no returns from failed transitions to the community. This was great to see and may even be the first time that there hadn't been a failed community transition in the period between Settlement Agreement monitoring visits.

1. Many supports defined in the CLDPs for Individual #76 and Individual #243 were measurable, however, some were not, particularly in the area of pre-move training requirements. Overall, there were some positive findings.

- The IDT developed 12 pre-move supports for Individual #76. Six of them were measurable. Pre-move training supports, while improved to a degree, still lacked needed specificity, as described below:
  - Six of the pre-move supports were for inservices to be provided prior to the transition. Some pre-move training supports were more specific than many the Monitoring Team has reviewed, which was positive to see. All identified the provider staff to be trained, which was also positive.
  - It was also positive to see that some of these training supports included specific details about what the training should include and what provider staff should know. This was, however, not yet consistent across all pre-move training supports, which did not typically include any interviews or demonstration to confirm staff knowledge. The evidence required for all but one of the inservice supports called for signed rosters showing completion and completed competency quizzes, but did not clearly indicate what competency criteria would apply. For example, the nursing training included specific topics, but failed to specify any competency criteria for most.
  - It was particularly good to see a training support identified in the CLDP that required competency, through demonstration, for texture modifications for Individual #76's diet. This was very appropriate based on his critical needs in this area. It was, therefore, most unfortunate the IDT decided to modify this support prior to the move to remove the competency requirement and eliminate the need for habilitation therapy to participate in this training.
  - IDTs should carefully consider how competency can be assured for each and every support requiring staff implementation.
- Most of Individual #76's 38 post-move supports were measurable. Of note, the post-move staff knowledge supports expanded upon the pre-move training supports, providing more detail for the provider staff and the PMM to be able to understand the expectations. For the most part, the only post-move supports that were not measurable were four of the five that called for repeating the pre-move inservice training for any new staff. Of these four, (social history, nursing, equipment/dining plan instructions/dental hygiene instructions and the psychiatric support plan (PSP)), the latter two had companion post-move supports that detailed specific staff knowledge requirements and, therefore, met criterion.
- For Individual #243, the IDT developed 13 pre-move supports. Supports included provider staff to receive competency based

training on many topics, including her personal preferences, family dynamics, identified preferred family contact and social history, medical risks, diagnoses, medication purposes and side effects, diet, weight, ear plugs and self-administration program; her room cleaning, laundry care and cooking programs; and PSP prevention/intervention techniques, definitions of psychiatric behavior indicators and mental health diagnosis. There were few specific staff competencies defined for these training supports. It was positive that interviews were required as evidence for these, but the lack of clear competency expectations makes it difficult to measure whether staff were as knowledgeable as needed prior to her transition.

- Many post move supports for Individual #243 were measurable, but this was still not consistent. Examples of those that were not included:
    - A support to draw a Complete Blood Count (CBC) with differential and Clozaril levels every 28 days should have been more specific about how those were to be reported, particularly since the provider was not aware of this need/process at the CLDP meeting, per the discussion narrative.
    - Some supports, such as for her current medication regimen including side effects, called for interviews as evidence, but it was not clear which staff should be interviewed. For example, the support did not state whether direct support professionals (DSPs) should be interviewed as to the side effects they needed to monitor.
    - There were no staff interview requirements for a support that called for DSPs to implement the PSP. This was also true for staff implementation of room cleaning, laundry care, and cooking programs.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for this indicator to be scored as meeting criterion. Neither of these CLDPs met criterion overall, as described below:

- Past history, and recent and current behavioral and psychiatric problems: Neither the ISP or assessments provided sufficient history regarding behavioral and psychiatric needs for Individual #76 and Individual #243. This was reflected in the CLDP.
    - For Individual #76, on the positive side, there was a detailed support for the implementation of the PSP that clearly indicated what staff were expected to know and do. There were also supports for psychiatric care.
    - Examples of past history, and recent and current behavioral and psychiatric problems that were not addressed for Individual #76 included the following:
        - He had a long history of psychiatric hospitalizations and failed attempts at community living due to severe aggression, history of using weapons against family, and alcohol abuse, but there were no staff knowledge supports related to this history and potential signs to be aware of. This was of significance because his history indicated that decompensation typically occurred after each group home placement in the past.
        - There was no support for tracking of psychiatric symptoms, which had been recommended and would have provided some indication of any potential decompensation.
        - There was no support for the recommendation that in the event of behavioral changes, psychiatric medication changes should not be considered without first consulting with a medical or behavioral clinician.
        - The CLDP narrative stated that the Center psychiatrist would have a phone conference with the community physician prior to transition, but there was no pre-move support defined to track this for completion.
    - On a positive note for Individual #243, there was a good narrative description of her need for supervision in the CLDP. Unfortunately, this did not carry over to the support as defined. The description indicated the IDT recommended 24 hour awake staff to monitor for signs and symptoms of her psychiatric symptoms as well as trained staff to accompany

her for activities that occur away from home to assist with communication needs. It also indicated she should not be dropped off at any community activities without staff for her personal safety because she was considered to be a vulnerable individual. The IDT only defined one related support, a pre-move support calling for 24 hour awake staff due to history of psychiatric symptoms and PTSD.

- Per the ISP, Individual #243 had 18 placements since being removed from family home due to neglect and abuse, including sexual abuse. Her CPS worker explained she had a very difficult time transitioning to new places and will often display extreme aggressive behaviors. It was also noted there was a history of being jailed for assaulting foster parents and staff. The IDT did not develop supports that specifically considered and addressed her documented history of decompensation in new settings.
- In Individual #243's ISP, the psychiatrist expressed reservations regarding transition, attributing her recent behavioral gains to very structured environment that might not be sustained in a "socially challenging and high stimulus environment" of community placement. Per the behavioral health assessment, Individual #243 "had not displayed dangerous behaviors for six months," so this recency did indicate some reason to examine environmental structure and other supports. The vocational assessment also did not recommend community transition due to behaviors at her off campus work setting.
    - The IDT did not develop supports that considered her documented history of decompensation in new settings, the recency of her stable behaviors, including the psychiatrist's concerns in this regard just months prior to transition.
    - Her maintenance programs for problem-solving and deep breathing and weekly counseling, which could have been important supports for stability during the transition period, were discontinued.
- Individual #243 had a history of sexual abuse, PTSD and exploitation and there had also been a fairly recent allegation of neglect related to possible inappropriate sexual behavior with a peer. While a Center investigation determined this had not occurred, the IDT should have examined the circumstances and whether there was any concern related to her history. Training supports did not adequately emphasize this history or what impact this might have on her behavior. As noted above, the IDT also discontinued weekly counseling, which it later found necessary to re-instate following a Potentially Disrupted Community Transition (PDCT) event that was related to her relationship with a boyfriend.
- Training supports for her PSP had some positive components. The pre-move support for training indicated who would be trained and defined training topics to include prevention and intervention techniques, definition of her psychiatric behavior indicators, and her diagnosis of schizophrenia. Competency criteria were not clearly stated in that support, but a post-move support for implementation of the PSP did specify some expectations, which was positive to see. The latter still did not include staff interviews as evidence, but should have.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: For both individuals, supports for various follow-up appointments and consultations appeared to be comprehensive, which was positive. There were, however, a number of concerns identified by the Monitoring Team in the areas of safety, medical, healthcare, therapeutic, risk, and supervision needs, including the following:
    - One positive example for Individual #76 was the definition of his supervision level, including 24 hour awake staff availability with the specific purposes of monitoring for seizures, assisting with preparing meals due to modified diet texture, and to assist with safe eating during mealtimes. Another support also called for provider staff to accompany

him on any community outings or activities. These provided good detail, although there remained concern that the support did not address the specific level of supervision needed to assist with safe dining. This is further examined below.

- Supports related to Individual #76's dysphagia and potential for aspiration pneumonia were of significant concern. Two dysphagiagrams had determined that he experienced silent aspiration with all textures and liquids and recommended he not have any oral intake. The IDT, along with Individual #76 and his LAR/family, agreed that he would continue to receive oral intake, with appropriate supports built in to keep him healthy and safe. The IDT defined pre-move supports for training that included competency based training, to included competency demonstration, on how to correctly modify his foods to pureed and liquid to nectar for use with the Aladdin mug, which would have been appropriate. The IDT later modified this support, such that the training and competency demonstration would not be required, based on the RN's statement that provider staff already were familiar with such techniques.
    - The IDT should not rely on prior training of provider staff without also ensuring they are competent to meet each individual's needs.
- Additional concerns in this area included a lack of a staff knowledge support about the nature of his dysphagia and the critical importance of adhering to his diet and dining plan. While the dining plan was quite detailed, various transition assessments included specific instructions that were not clearly consistent with the support. For example, the nursing assessment indicated he should have 1:1 supervision when eating, but the support said only that staff should sit beside him. It should have clearly stated 1:1 to make clear that the designated staff could not also be supervising others at the table or otherwise engaged in mealtime activities. There was also no support for physical and nutritional management monitoring in the new setting.
- Examples of other needs for Individual #76 not addressed with supports included:
    - The nutrition assessment indicated fluids were to be encouraged and documented, but this was not addressed.
    - A local agency was preparing two pairs of orthopedic shoes to be finished after transition. Per the CLDP narrative, the Center's Rehabilitation Department was to provide the new home address for delivery, but there was no support to confirm the shoes were received. At the time of the Monitoring Team's onsite visit, Center staff were not able to verify the shoes had been delivered as needed.
- Individual #243's primary health risks included her weight, cardiac disease due to dyslipidemia, and side effects from her medication (Clozaril), requiring ongoing monthly labs and quarterly EKGs. Examples of areas of concern for Individual #243 included the following:
    - Individual #243 was morbidly obese and often chose unhealthy snacks, which would have negative impacts on her weight and cardiac status. At a pre-move ISPA meeting, the Center RN asked whether the provider could limit access to unhealthy snacks, but the provider indicated they could only encourage healthy choices. There was no support related to staff encouraging healthy food choices. The only support was for a "healthy cooking" program once per week, but this did not address the importance of staff supporting healthy choices throughout the week. In fact, the program itself did not address healthy cooking, only very basic steps for using the stove/oven.
    - It was also concerning that there was no support for her reproductive health needs. Per the medical assessment, her gynecological and clinical breast exams were deferred. Elsewhere in the medical assessment,

it indicated routine exams should be done annually until there had been three normal exams and then at last every three years. Her last exam was on 5/9/13, indicating her next exam was due within days after transition. This was also latest exam documented in nursing assessment. The nursing assessment noted that the Center would try to complete a well woman exam prior to the transition, but this was not identified as a pre-move support. There was no support identified for ensuring this care after transition, nor was this included in the support for care with the community primary care physician (PCP.)

- There was no support for staff knowledge regarding side effects from her psychiatric medications, even though staff training included an item on a post-training test indicating Individual #243 had a history of drooling related to side effects that should be reported to the nurse if observed.
- There was no support for staff knowledge regarding her diagnosis of tachycardia.
- Inservices provided by the Center suggested Individual #243 receive routine pedicures to help keep thick build-up on feet under control, but there was no specific support. Pedicures were only included as one of a number of possible, but not required, community outing options.
- Provider training also included other concerns related to cardiac and medication side effects that were supposed to be reported if observed. There was a pre-move support for training and a post move support for her to receive her medications, which listed the side effects, but no support specifically calling for staff to be aware of and report side effects.

- What was important to the individual was captured in the list of pre-/post-move supports. Neither of the CLDPs met criterion in this regard:
  - Family was noted to be important to Individual #76 and the CLDP indicated he wanted to see them more. He originally preferred a community transition to the Midland Odessa area to be closer to them, but no homes were available. A provider in San Angelo was selected instead, but there were no specific supports for facilitating family contact or visits. Per the ISP, working and earning money was also important, but no related supports were identified.
  - For Individual #243, work and earning money were very important and she had very specific interests in this regard. Work was only minimally addressed as described in more detail under the next set of bullets below. The CLDP did not address her interest in volunteering at an animal shelter. It was also noted in the ISP that her foster family was very important to her, and that she had a boyfriend and other friends at the Center she wanted to stay in touch with, but there were no supports to facilitate maintaining any relationships. The only reference to maintaining relationships was an IDT statement she would not need support for contacting friends at the Center because she could call them independently.

- Need/desire for employment, and/or other meaningful day activities:
  - Individual #76's ISP goal was to earn $30 per month and indicated he had worked sporadically since the age of 16 doing odd jobs, cleaning yards, and had worked in a hospital warehouse successfully with close supervision. He also participated in shredding at the Center. Despite his known interest in working, the only support was to attend a day habilitation program, Monday to Friday, with no detail about what he might engage in there either through employment or meaningful day activities in integrated community settings.
  - The CLDP noted Individual #243 stated her goal was to get a job and that this was an important outcome for her. Per

the ISP, she had many work related strengths, including good attendance, ability to work independently, good productivity, ability to do any job offered, and ability to read and write. Per her ISP, her goal was to clean houses in the community. She also had an action plan to volunteer at an animal shelter, based on her stated preferences. Her 45 Day vocational assessment update stated she recently completed a trial work program at Christians in Action and the job coach reported she did very well. She was also in an apprenticeship program for carpentry. These specific preferences and strengths should have been translated into CLDP supports, but were not. Examples included:

- The only CLDP supports were related to being transported to pick up job applications at least once every two weeks, to receive assistance in filling them out, and being transported to drop off applications. These were not specific to her stated job preferences.
- The support for attending day program did not include any specific training toward her goal or any opportunity to participate in job exploration, nor did it define any employment outcome for her.
- The IDT had discussed the possibility of a DARS referral in an ISPA, but indicated only that this was something Individual #243 had to do and that the IDT could help if needed. There was no support for such assistance.
- There was no support related to her interest in volunteering at an animal shelter.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success: Neither of the CLDPs addressed positive reinforcement, incentives, and other motivating components in a comprehensive fashion, but there were some positive components noted:
  - For Individual #76, CLDP supports did include the use of self-calming techniques, which was referenced in the behavioral health assessment. Supports also called for participation in preferred activities on a weekly basis. The PSI indicated he preferred Spanish speaking staff, and the BHA also indicated Spanish speaking staff were more likely to be able to direct him from dangerous situations he might not be aware of, but there were no supports about access to Spanish speaking staff.
  - For Individual #243, supports called for participation in preferred activities on a weekly basis and verbal praise was included in the skill maintenance programs. The post-move support for the implementation of the PSP also provided some strategies for intervention in the event of behavioral issues, such as avoiding over-prompting and using deep breathing and problem solving techniques. These were positive to see. On the other hand, the CLDP summary review of the behavioral health summary included some additional, more positive, approaches that were not included in supports, such as that she responded well to social positive interaction and reinforcement when not displaying challenging behavior and to be careful to praise her when teaching new skills. Also, opportunities to work and earn money were of considerable importance and motivating to her, per her assessments, Preferences and Strengths Inventory (PSI) and the ISP, but these were minimally addressed, as described above.

- Teaching, maintenance, participation, and acquisition of specific skills:
  - For Individual #76, there were no supports for teaching, maintenance, participation, and acquisition of specific skills based upon individual's needs and preferences. The Functional Skills Assessment (FSA) recommended an oral care maintenance program and a safe eating maintenance program, which were not included as supports for teaching, maintenance, participation or acquisition of specific skills. He also had a nighttime toileting SAP at the Center, but this was not included in the CLDP. The FSA also indicated Individual #76 was doing well with learning to cook and enjoyed

cooking, but there were no related supports. The ISP had an action plan for Individual #76 to learn to prepare his own snack by texturizing cookies, but there was no mention in the CLDP. The FSA further noted he needed verbal cues to dial telephone, which could have been helpful in maintaining family contact, but the IDT did not define a related support.

- This indicator met criterion for Individual #243. The CLDP included specific skill acquisition plans for cooking healthy meals, cleaning her room, self-administration of medication, and doing laundry, all of which were part of her ISP. She also had ISP goals for problem-solving and deep breathing skills, and these were included in the support for implementation of the PSP. Activities of daily living (ADLs) were addressed primarily as participation through verbal and physical prompting, rather than as skill acquisition or maintenance. There were still some missed opportunities for teaching, maintenance, participation and acquisition of specific skills. For example, the CLDP did not include any money management support, although she had an ISP goal for the use of a debit card in the community. The FSA Summary did not have current data and conflicted with other assessments regarding her relative independence, such as in telephone use. It was also documented in more than one place that she wanted to learn to sew, but this was not addressed.

- All recommendations from assessments are included, or if not, there is a rationale provided: Overall, the Center implemented a good process for reviewing CLDP assessments and making and documenting team decisions about recommendations. Still, there were recommendations that were either not addressed or did not have an adequate rationale provided for not being included.
  - For Individual #76, examples included:
    - The annual medical assessment (AMA) included a statement that he should not be referred for transition because his medical needs could not be met in the community. This was not discussed by the IDT to identify and address the specific issues that concerned the PCP.
    - The AMA also recommended Individual #76 may need further specialty follow-up with speech therapy or OT for further assistance with swallowing and eating. This recommendation was not addressed in the CLDP, nor any justification provided.
  - For Individual #243, examples included:
    - The BHA indicated she may need counseling to help her with adjustment to community living if issues arise. This was not addressed in the CLDP supports.
    - The dental assessment indicated prophylaxis was needed every three months, but the IDT changed it to six months, citing as a rationale that this was how it was done in the community. The IDT should provide a justification that this protocol was sufficient to meet the individual's needs, rather than simply stating this was how it was routinely done in the community.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.	
Summary: The Center continued to provide post move monitoring, though as indicated in the detail below, improvements in actions and in documentation are required in order to meet criteria with these indicators. This is especially true for	Individuals:

the important supports of community provider staff training and their expected resultant knowledge and competencies. Observation of post move monitoring indicated it was not being done as thoroughly as need be. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	76	243							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	0% 0/2	0/1	0/1							
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1							
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1							
6	The PMM's scoring is correct based on the evidence.	0% 0/2	0/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, the IDT/Facility implemented corrective actions in a timely manner.	0% 0/2	0/1	0/1							
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	0% 0/1	N/A	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	0% 0/1	N/A	N/A							

Comments:

3. Post-move monitoring had been completed for two post move monitoring periods for Individual #76 and for four periods for Individual #243. These were timely and included observations at all locations. This was good to see, especially given that the Center's transitions occurred all over the state. Post move monitoring reports were done in the proper format. They generally included comments regarding the provision of every support, but some were not thorough in addressing the support, which resulted in this indicator not meeting criteria.

- For Individual #76, the Post-Move Monitor (PMM) provided good detail for many supports and the overall summaries for each visit were helpful for understanding the status of the transition. Many supports included ample detail, but this was not consistent. For example, for the pre-move support for supervision level, the checklist indicated only that the support was in place, but evidence called for residential logs to be reviewed and staff interviewed regarding supervision needs. There was no

documentation that either of these had occurred.

- For Individual #243, the overall summaries for each visit were also helpful for understanding the status of the transition. Many supports had detailed comments, but some did not have enough detail to substantiate findings. For example, the PMM did not interview staff for knowledge of the PSP or regarding the purpose of 24-hour awake staff support.

4. Reliable and valid data that report/summarize the status regarding the individual's receipt of supports: In many cases, reliable and valid data were available that reported/summarized the status regarding the individual's receipt of supports, but this was not consistent.

- For Individual #76, it was not always possible to ascertain whether reliable and valid data were present, due in part to a lack of specificity and measurability of some supports. This was described under indicator #1. Other examples included:
  - The PMM did not interview staff for knowledge of how to implement PSP.
  - The 7 day post move monitoring checklist under-reported Individual #76's weight by approximately 30 pounds, but this was not discovered until the 45 day.
  - Evidence for a support for staff to be with Individual #76 for community outings, to ensure his personal safety due to limited awareness of surroundings, and to ensure his food was pureed was to include staff interview. Per the completed checklist, staff were interviewed as to presence of staff at all outings, but there was nothing noted about staff knowledge of the purpose of the support. It would be important for staff who accompany him to be aware of the needs that require their presence.
  - It was similarly not possible to assess whether he was remaining as independent as possible in toileting and dressing or receiving verbal prompts for ADLs due to a lack of data provided.
- For Individual #243, the PMM did not document interviewing staff for knowledge of the PSP, therefore, it was not feasible to make an accurate judgment as to whether the support was in place. There was also missing documentation for several supports including her self-administration program, community outings, and body weight.

5. Based on information the PMM collected, these individuals were not consistently receiving the supports described or listed in the CLDP and sufficient justification was not provided.

- For Individual #76, the PMM indicated many supports were being received as required, but there remained instances in which they were not, but should have been. Examples at the time of the 7 day PMM visit included:
  - The bowel movement (BM) log could not be located.
  - His dining plan was not being implemented as required and the food texture at the day habilitation was not pureed as required.
  - The shower bench was not present.
  - The spin toothbrush was not present and staff were not aware of the need for low foam toothpaste.
  - His PSP could not be located in the home/
  - There was no evidence provided that any new staff had received required training for the PSP and social history.
  - His PNMP could not be easily located for staff reference.
- For Individual #243, examples of supports not being received as required included:
  - At the time of the 7 day PMM visit, the following were not provided as required: documentation of her visit to the psychiatrist was unavailable, care with a podiatrist had not been established, it could not be confirmed the SAMs

program for Clozaril had been continued; it could not be confirmed her initial body weight was taken within 5 days, and it could not be confirmed her prescribed diet had been continued because it was not documented on the medication administration record (MAR) or the SSLC check-sheet provided.

- At the time of the 45 day PMM visit, examples of supports not being received as required included: Clozaril labs were late; Clozaril administration had lapsed for five and one-half days, with no plan in place to prevent recurrence; no job applications had been completed; SAMs documentation was not found; there was no documentation of community outings for the month of May; her psychiatric consult was missing important information, including medications and diagnoses; and there were incorrect diagnoses on the MAR.
- At the time of the 180 day PMM visit, the following were not provided as required: a quarterly EKG had not been ordered, the required optometry appointment was late by 45 days, and she was not engaging in much physical activity since changing day programs in September.

6. In many cases, PMM's scoring appeared to be correct, but this was not consistent. For example:

- For Individual #76, a support for the use of dining equipment, including an Aladdin mug, was marked as present at the time of the seven day PMM visit, but the provider did not actually have the mug until it was provided by Center on 10/10/16, after the visit occurred; and it was unclear if the PMM should have scored as present training for any new staff for health risks, assistive and mealtime equipment, dining plan, dental hygiene instructions and mobility, as these were not provided until after the seven day visit.
- For Individual #243, some supports were marked as in place, but the documentation was not available to substantiate these findings. Examples included supports requiring service logs as evidence at the 7 day visit as well as the day habilitation attendance log at the 45 day visit, and the lack of interviews and review of the residential log and check-sheets regarding the implementation of the PSP.

7-8. It was positive that the IDTs met routinely to review the results of each PMM visit, but the Center still needed improvement in consistent implementation of corrective actions in a timely manner. Example included:

- For Individual #76, there was evidence of good and timely response noted by PMM to ensure follow-up training by RN and SLP as to his nutritional management needs. Other follow-up was not as timely.
  - The 7 day PMM checklist noted there would be follow-up with the provider and the IDT regarding the lack of evidence of training for any new staff, but there was no documentation of such follow-up until the 45 day PMM visit.
  - The PMM also indicated follow-up would be completed regarding the PNMP not being readily available to staff at the 45 day PMM visit. This should have been more timely given his critical needs in this regard.
  - At the 45 day PMM visit, the PMM observed Individual #76 to have a very weak swallow. This should have brought to attention of the IDT given the criticality of this issue.
- For Individual #243, issues related to the lapse of her Clozaril medication and the inconsistent implementation of labs, as discussed above, needed to be addressed more assertively to ensure timely resolution. Examples included:
  - At the time of the 45 day PMM visit on 6/1/16, Clozaril labs were late and Clozaril administration had lapsed for five and one-half days, with no plan in place to prevent recurrence. Although the PMM requested some follow-up information on a timely basis, a provider plan of action to prevent recurrence was not requested until 6/14/16. The IDT did not meet to review the absence of this critical support until 6/17/16. At that time, the IDT agreed to refer to

DFPS as a neglect allegation, further reinforcing this should have been addressed immediately. On 7/18/16, the PMM reviewed a letter from the provider to Individual #243, stating the provider had "taken the following actions: Action will be taken with the nurse." This would not suffice as a plan to prevent recurrence.

- At the time of the 90 day PMM visit on 7/18/16, the PMM found that Clozaril levels had not been tested in June or July. On 7/25/16, the PMM contacted the provider and was told they did not generally do the Clozaril levels, just the CBC. The SSLC nurse was to follow-up to request lab results, but documentation on 10/17/16 indicated only that the identified nurse was no longer employed and that the PMM had reviewed an email dated 7/29/16 from the provider stating that all labs were now current. There was no evidence any IDT member or the PMM had viewed the actual lab results to ensure the support was present.
- At the time of the 180 day PMM visit on 10/17/16, the PMM reviewed Clozapine labs drawn on 8/11/16, calling into question whether the Clozapine lab had been current on 7/29/16 as the provider email described above had indicated. The results indicated both Norclozapine and Clozapine levels were high, with the latter noted to be in the toxic range. The PMM did not document taking follow-up action until 11/14/16.

9. The Center had two post move monitors. The Monitoring Team attended and observed conduct of post move monitoring at a day program and group home in San Angelo with one of the post move monitors. It was for Individual #240. The home was worn, not very homey, and there were no activities going on at the home during the afternoon/early evening hours of the observation. Post move monitoring was not done as thoroughly as it needs to be. For example, the check-sheet created by the facility for use by the provider was not asked for (until prompted by the Monitoring Team), all three types of evidence were not pursued, leading questions were used, and the interview of the individual should occur separate from the staff member in cases such as this where the individual was very verbally capable.

10. The written report showed some of what the Monitoring Team observed, as well as additional information obtained by the PMM from the day program and provider nurse. The report, however, did not detail some of what the Monitoring Team observed during conduct of the visit, especially regarding details of what evidence was looked at. Examples include interview with staff about pre move supports (which was good to see) but the report only said "same as above," nothing included about the staff's report that family was recently identified, and other examples of relevant information provided by the home staff member. These details should be included in future reports.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of preventable negative events following transition into the community.												
Summary: One individual had no negative events occur. The other had serious negative events that occurred shortly after her transition and, fortunately, did not result in a return to the facility. A review of the incidents, the CLDP, and the transition assessments showed that some supports were missing from the CLDP that would have reduced the likelihood of these incidents having occurred. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	76	243								

11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	50% 1/2	1/1	0/1							

Comments:

11. Individual #76 had not experienced any negative PDCT events as of the time of the monitoring visit. Individual #243 had experienced two PDCT events in quick succession in September 2016: on 9/10/16, she ran away from the home; and on 9/12/16, she assaulted two of her housemates and police were called. The precipitating event was described as breaking up with her boyfriend who, it was reported, may have been harassing her. The IDT met following the PDCT and determined the following:

- Individual #243 should potentially be enrolled in another day habilitation program to allow her to avoid what was considered to be an unhealthy relationship, as well as attend counseling once a week to include techniques on how to manage unwanted sexual attention.
- All new staff were to be trained on her history of sexual abuse and PTSD.
- The IDT considered what might have been done differently and identified provider issues, including deficiencies in the psychiatric consult, inconsistent administration of psychiatric meds, and undocumented challenging behaviors. All of these had been identified by the PMM.
- The inconsistent administration of Clozaril and late labs had not been resolved and was being reported to DFPS.
- The SSLC IDT indicated the problem was not anticipated prior to the move for the following reasons: she had not had challenging behaviors prior to the move, provider staff were competency-based trained on her PSP, and supports were identified to ensure she received her Clozaril as needed.

In addition to these findings and considerations, the IDT should have considered the following concerns that may have had implications for this event:

- Individual #243's documented history of decompensation in new settings and the recency of her stable behaviors, including the psychiatrist's concerns in this regard just months prior to transition.
- The IDT had discontinued her ongoing maintenance programs for problem-solving and deep breathing and did not include a support for weekly counseling. These actions may have removed important supports for stability during the transition period.
- The IDT should also have provided more emphasis/training as to her history of sexual abuse, PTSD, and exploitation.

IDTs should take guidance from the transition staff. They know the most about community providers, their strengths and weaknesses, what happens after an individual moves, and how to best ensure good continued support. They have experience with the minutiae of failed placements, PDCTs, and so forth. The transition department staff are a resource to teams and their recommendations and suggestions should be strongly considered and taken, unless there's strong reason not to.

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.												
Summary: This outcome focuses upon a variety of transition activities. San Angelo SSLC made progress on some of these indicators, though as detailed below, improvements in quality and detail are needed. The completion of all relevant assessments as well as the quality of transition assessments are areas of focus for the APC and his staff. Although Center staff provided training to community provider staff, the CLDPs did not define the training well, especially regarding staff competency. The facility staff worked very well with the local authority, which increases the likelihood of a successful transition for individuals. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	76	243								
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1								
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	0% 0/2	0/1	0/1								
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1								
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1								
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/2	0/1	0/1								
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/1	0/1								

18	The APC and transition department staff collaborates with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition.	50% 1/2	1/1	0/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

Comments:

12. The transition department held a meeting to review each transition assessment in preparation for drafting the CLDP and holding the CLDP meeting. This was long-standing, and very good, detailed review, one by one, of each assessment and its recommendations, ultimately turning them into supports to be included the CLDP. Doing this successful, however, was hampered because assessments did not consistently meet criteria for this indicator. The Monitoring Team considers four sub-indicators when evaluating this indicator.

- Updated with 45 days of transition: The Center did not review or update the Integrated Risk Rating Form (IRRF) for either of the individuals, but should have, or should have indicated that the IRRF was reviewed and no updates were required. The IRRF section of the ISP typically contains a great amount of information. The Admissions Placement Coordinator (APC) should ensure that the IDTs review the status of the IRRF as part of the transition assessment process.
  - For Individual #76, updated pharmacy, audiological, and speech assessments were not completed.
  - For Individual #243, the IDT did not obtain updated pharmacy, OT/PT, speech, functional skills, or audiological assessments, even though these were all requested. The Center should re-evaluate its protocol for requiring disciplines to be responsive to these requests, as some simply replied that Individual #243 received no active services and then did not submit an updated evaluation.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Assessments that were not available or updated had a negative impact on the scoring of this indicator for both individuals.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments that were not available or updated had a negative impact on the scoring of this indicator for both individuals.
  - For Individual #76, examples of other assessments that did not provide a comprehensive set of recommendations that would be adequate for planning or focus on the new settings included the medical and social work assessments.
  - For Individual #243, the social work, medical, nursing and psychiatric did not meet criterion.
- Assessments specifically address/focus on the new community home and day/work settings, and identify supports that might need to be provided differently or modified in a community setting: Assessments did not consistently meet criterion for this sub-indicator. For Individual #76, for example, the IDT itself identified that the AMA and nutrition assessment did not adequately address needs in the community setting. For Individual #243, several assessments noted a history of decompensation in a group home setting, but assessments did not provide sufficient detail or recommendations to allow the IDT to consider any supports that might be needed to prevent recurrence.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator.

- There was documentation to show IDT members actively participated in the transition planning process:
  - Criterion was not met for Individual #76's CLDP. It was very concerning that SSLC Rehabilitation Department staff did not routinely participate in ongoing transition ISPA and CLDP meetings for Individual #76, despite his critical needs

related to his dysphagia diagnosis and extremely high potential for aspiration.

- Two dysphagiagrams had determined that he experienced silent aspiration with all textures and liquids and recommended he take nothing by mouth. The IDT, along with Individual #76 and his LAR/family, agreed that he would continue to receive oral intake, but supports would be built in to keep him healthy and safe. OT/PT/SLP staff were frequently not present at the meetings in which these decisions were made, per the signature sheets. Their participation should have been considered essential.
- As mentioned above, the IDT defined pre-move supports for training that included competency demonstration on how to correctly modify Individual #76's foods to pureed and liquid to nectar for use with the Aladdin mug. The IDT later modified this support, such that the training and competency demonstration would not be required, based on the RN's statement that provider staff already were familiar with such techniques. Again, OT/PT/SLP staff were not represented at this meeting to discuss whether this would adequately address his needs.
- Following a PMM finding that staff were not consistently providing the appropriate texture, provider staff expressed concern that they did not receive training from the Center. According to the ISPA at that time, the IDT indicated the Rehab Department staff had been asked to be very involved in the transition, but had not participated as needed.
- Individual #76's transition was delayed due to a failure of the SLP to implement needed STEM therapy (related to his swallow function) on a timely basis. A CLDP was held on 5/7/16, but had to be postponed until further notice due to this delay in implementation. The final CLDP did not occur until 9/15/16.
- The Monitoring Team learned that some of this was due to staffing challenges, including an allegation that put habilitation therapy staff on no client contact for a period of time. But given all of the above, the absence of that clinical discipline in this individual's transition was evident.

  - For Individual #243, the CLDP narrative noted that IDT members were actively involved, including transporting her to overnight visits with the provider, touring both the home and day habilitation program and provided inservice to staff at both sites. The IDT also met to discuss the outcome of her provider visits.

- The CLDP specified the SSLC staff responsible for transition activities, and the timeframes in which such actions are to be completed:
  - For Individual #76, pre-move supports typically indicated the SSLC staff responsible, but post-move supports only identified provider staff. While it was important to identify the responsible provider staff, the CLDP should also clearly state the SSLC staff responsible for ensuring all supports are implemented as required.
  - For Individual #243, the CLDP did not consistently identify the SSLC employee to be responsible for completing or ensuring the completion or implementation of all supports, often identifying only a provider staff. The CLDP should clearly state at least the specific discipline or position assigned responsibility for each support.
- The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting: Criterion was met for this sub-indicator for both individuals.

14. Documentation did not indicate Center staff provided training of community provider staff that met the needs of these two individuals, including identification of the staff to be trained and method of training required. Training did not consistently define the training methodology or competency criteria for key supports or include any competency testing or demonstration. As described

above, it was particularly concerning that the Rehabilitation Department did not participate in pre-move training related to Individual #76's nutritional management needs, including training for his appropriate diet texture.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: Neither of these CLDPs met criterion. Individual #76's CLDP indicated that phone contact between the facility's psychiatrist and the community physician would occur in order to exchange essential information related to Individual #76's psychiatric medications. This was not included in pre-move supports, but should have been. The Center was not able to provide any evidence the needed collaboration occurred. For Individual #243, the IDT used a check sheet for supports that included such collaboration as an option, which was a positive strategy for ensuring consideration. This option was not checked, but the IDT did not specifically document any discussion as to why or why not. It should include in the CLDP a specific statement as whether any collaboration was needed, and if any completed, summarize findings and outcomes.

16. SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs: Neither of these CLDPs met criterion. They did not state, but should have, whether the IDT considered whether any assessments of setting were needed based on individual needs.

17. The CLDP should provide a specific statement about the types and level of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences. Examples include provider direct support staff spending time at the Facility, Facility direct support staff spending time with the individual in the community, and Facility and provider direct support staff meeting to discuss the individual's needs. The CLDPs for Individual #76 and Individual #243 did not address any of these examples. The IDT should consider whether any such collaboration specific to the individuals' needs would be in order and document their rationale.

18. Individual #76's CLDP met criterion for collaboration between SSLC staff and LIDDA staff, based upon his needs. LIDDA staff and the HCS Service Coordinator participated in his CLDP. For Individual #243, the LIDDA and HCS Service Coordinator participated in the CLDP, including 14 day meeting and the in PDCT ISPA. These were positive, but the IDT did not involve the LIDDA in the issues related to an ongoing failure of the provider to address her needs related to Clozaril administration. Given the critical nature of those supports and the length of time it took to resolve the related issues, the SSLC should have communicated these concerns to the LIDDA and requested assistance.

19. Neither of these CLDPs met criterion for pre-move supports being in place in the community settings on the day of the move. Overall, it was concerning that pre-move supports did not require the more detailed testing of staff knowledge and competence that was sometimes indicated in post-move supports. It is incumbent upon the SSLC to ensure staff competence to provide supports essential to health and safety prior to the move, rather than waiting seven days until the first PMM visit. The initial seven days after transition is a critical period, during which a lack of staff knowledge can lead to negative outcomes. For example, provider staff had not received needed training regarding diet texture for Individual #76, as described above. This had resulted in his being provided with food that did not meet his critical safety needs. Other examples of supports that were not in place included:

- For Individual #76:
    - The psychiatrist had not directly communicated with the community PCP as the CLDP indicated.
    - It was also not clearly documented that the PMM observed for the presence of the blender for pureeing food at the pre-

move site review. The PMM checklist stated the PMM was told in interview that both home and day habilitation had the equipment, but PMM only documented observing it at the day habilitation program.

- For Individual #243:
  - Per the CLDP, the evidence required for training supports included staff interviews, but the documentation did not include any interviews that would have confirmed staff knowledge and/or competence.
  - The PMM did not document observation of the cooking book available at home, but rather documented only that Home Manager emailed copies of book covers on 4/15/16 to be sent with her on the day of move. The day of move checklist did not reference whether this occurred as needed. The PMM should not rely on emails or interviews to ensure that needed items are available as indicated, but should observe for these directly.

Outcome 5 – Individuals have timely transition planning and implementation.

Summary: One individual did not move within a timely manner, due in large part to actions and inactions by the facility. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	76	243							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	50% 1/2	0/1	1/1							

Comments:

20. For Individual #76, transition was delayed due to a failure of the SLP to implement STEM therapy as indicated. A CLDP was held on 5/7/16, but had to be postponed until further notice due to this delay in implementation. The final CLDP did not occur until 9/15/16. For Individual #243, transition was timely. She was referred on 12/17/15 and transitioned on 4/25/16, within 180 days.

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