United States v. State of Texas

Monitoring Team Report

San Angelo State Supported Living Center

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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. In this report, any indicators that were moved to the category of less oversight during previous reviews are shown as shaded and no scores are provided. The Monitor may, however, include comments regarding these indicators.

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. At the last review, 24 of these indicators were moved to the category of requiring less oversight. During this review, one other indicator had sustained high performance scores and will be moved to the category of requiring less oversight. This was in the area of 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.

<u>Restraint</u>
San Angelo SSLC continued to have the highest census-adjusted rate of crisis intervention restraint of any of the Centers, at about 50% higher than the next two highest Centers. The restraint reduction committee was somewhat active, but it was good to hear that the facility director had, as of the last meeting, become a regular attendee. Even with this comparatively high rate of crisis intervention restraint, San Angelo SSLC also reported that 19 individuals, who had crisis intervention restraint in the past, had not had any occurrences in at least the previous nine months. This was good to see. It does, however, indicate the need for continued attention to crisis intervention restraint usage and continued data and trend analysis. For instance, it may be that the rate of restraints is affected by new admissions, change in housemates, or change in psychiatric status. Also, the Center was piloting the use of the Ukeru trauma-informed care and restraint-avoidance program in two homes. It was too early to tell if it was having any effect on the frequency of crisis intervention usage. A set of data that might suggest effects was being collected.

Overall, when crisis intervention restraint was used, it was appropriate to the presenting circumstance, and was applied within policy guidelines. Most documentation requirements met criteria. There were, however, some exceptions: the restraint

monitor's presence and/or activities, documenting of the name of the nurse who applied crisis intervention chemical restraint, and timely review by the unit and by the IMRT. The Center's restraint manager was well aware of these.

Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: monitoring individuals for potential side effects of chemical restraints and providing follow-up for abnormalities; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and clearly documenting an assessment for injuries.

<u>Abuse, Neglect, and Incident Management</u>
There was good evidence of supports being in place to reduce the likelihood of the incident having occurred in the first place. This was an improvement from the last review. San Angelo SSLC reported focusing on this outcome/indicator (1). DFPS and SSLC protocols for individuals designated for streamlined investigations were being followed. UIRs were well written, very descriptive, and for the most part, it was easy to follow the sequence of events and the logic behind the resultant conclusions and recommendations. Staff were knowledgeable about reporting requirements, though, that being said, two of the investigations did not meet all of the reporting criteria. Relevant evidence was utilized and the conclusions that were drawn were supported by the evidence. For those investigations with recommendations, disciplinary and/or programmatic recommendations were addressed and implemented in a timely manner.

The incident management department's analysis of incident-related data trends as well as resultant action development, implementation, and review continued to meet criteria. In addition, San Angelo SSLC conducted a thorough review of circumstances surrounding each investigation during incident management review team daily meetings. The investigations (and updates) were presented by the Center's investigators.

Non-serious injury investigations were now being conducted in accordance with state policy, however, they needed to also be carried out for certain types of non-serious discovered injuries, to explore the possibility of possible abuse or neglect.

The Center's long-time IMC recently transferred to be the state office discipline coordinator position for incident management. The Monitoring Team looks forward to working with her in this new role. It is likely that the new San Angelo IMC, whoever it is, will need a great deal of support and guidance from Center's administration in order to avoid any decrease in performance regarding incident management and the various criteria for the outcomes and indicators in this Domain.

<u>Other</u>
Although for one of the individuals reviewed a potential adverse drug reaction (ADR) was properly reported, the Pharmacy and Therapeutics Committee document for 7/26/17 under the ADR section states: "ADRs are not being reported properly. Has nursing started retraining?" The reporting of ADRs is of critical importance, and the Center needs to address the lack of reporting as soon as possible.

The Center made improvement with regard to the completion of clinically significant DUEs (i.e., at the time of the last review, the Center had completed none). Two of the DUEs identified significant problems with the completion of regular lab monitoring that was important to the health and safety of individuals the Center served. Due to issues with the documentation from the Pharmacy and Therapeutics Committee, the Monitoring Team could not determine whether or not recommendations from the DUEs were accepted, implemented, and/or closed to address these concerns that placed individuals at significant risk.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.												
Summary: San Angelo SSLC continued to have the highest census-adjusted rate of crisis intervention restraint in the state. Additional data and trend analysis was warranted as well as a more active restraint reduction committee. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	67% 8/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	78% 7/9	1/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (November 2016 through July 2017) were reviewed. San Angelo SSLC continued to have the highest census-adjusted rate of crisis intervention restraint of any of the Centers, at about 50% higher than the next two highest Centers (Lufkin SSLC and Mexia SSLC). Graphed monthly data points showed a fairly stable trend across the last four nine-month periods (i.e., back to August 2014). The usage of crisis intervention physical restraint paralleled the overall use of crisis intervention restraint because most crisis intervention restraints were crisis intervention physical restraints. The average duration of a crisis intervention physical restraint, however, was slightly lower than during any of the four nine-month periods. The usage of crisis intervention chemical restraint fluctuated from seven to 27 occurrences each month. There was usage of crisis intervention mechanical restraint for one individual in one month (March 2017), but it had been discontinued since then. The Center reported that 10 injuries occurred during restraint application, but all were deemed non-serious (e.g., abrasion).

The number of individuals who had crisis intervention restraint each month showed a slightly ascending trend over the nine-month period and, in addition, was higher than during the previous nine-month period. The number of individuals with PMR-SIB was at one.

Even with this comparatively high rate of crisis intervention restraint, San Angelo SSLC also reported that 19 individuals, who had crisis intervention restraint in the past, had not had any occurrences in at least the previous nine months. This was good to see. It does, however, indicate the need for continued attention to crisis intervention restraint usage and continued data and trend analysis. For

instance, it may be that the rate of restraints is affected by new admissions, change in housemates, or change in psychiatric status. These are examples of some variables that might be explored by the Center. In addition, the restraint reduction committee can play a role in the occurrence and management of crisis intervention restraint. A monthly meeting might be warranted. It was good to see that the facility director was now a regular member of the committee.

Also, the Center was piloting the use of the Ukeru trauma-informed care and restraint-avoidance program in two homes. It was too early to tell if it was having any effect on the frequency of crisis intervention usage. At the time of the onsite visit, there had been nine applications of the intervention. The Monitoring Team appreciated the demonstration by the three trainers. They were extremely enthusiastic and knowledgeable about the program. A group was meeting each month to review the usage of Ukeru. A set of data that might suggest effects was being collected.

The Center had a very low usage of non-medical restraints for medical or dental procedures, for healing post-procedures, or for long-term usage. The Center also had low usage of pretreatment sedation for medical or dental procedures, and a decreasing trend in the usage of TIVA for dental procedures.

Thus, facility data showed low/zero usage and/or decreases in eight of these 12 facility-wide measures (use of crisis intervention mechanical restraint, duration of crisis intervention physical restraint, restraint-related injuries, use of PMR-SIB, use of non-chemical restraints for medical or dental, and use of pretreatment sedation/TIVA).

2. Six of the individuals reviewed by the Monitoring Team were subject to restraint. Four received crisis intervention physical restraints (Individual #358, Individual #200, Individual #153, Individual #119), three received crisis intervention chemical restraint (Individual #316, Individual #358, Individual #227), and one received crisis intervention mechanical restraint (Individual #316). Data from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for four (Individual #316, Individual #227, Individual #153, Individual #119). The other three 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: The two indicators in active monitoring will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	316	358	200	227	153	119			
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The restraint was a method approved in facility policy.										
5	The individual posed an immediate and serious risk of harm to him/herself or others.										
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.										
7	There was no injury to the individual as a result of implementation of										

#	Indicator	Overall Score									
	the restraint.										
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.										
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/2	Not rated	0/1	0/1	Not rated	Not rated	Not rated			
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	83% 5/6	0/1	1/1	1/1	1/1	1/1	1/1			

Comments:
The Monitoring Team chose to review nine restraint incidents that occurred for six different individuals (Individual #316, Individual #358, Individual #200, Individual #227, Individual #153, Individual #119). Of these, five were crisis intervention physical restraints, three were crisis intervention chemical restraints, and one was a crisis intervention mechanical restraint. 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.

9. Because criterion for indicator #2 was met for four of the individuals, this indicator was not scored for them. For Individual #358 and Individual #200, there were problems with implementation of their PBSPs, complete comprehensive psychiatric evaluations, and/or ensuring active engagement opportunities.

11. For Individual #316, for usage of the mechanical restraint, an order was obtained and a crisis intervention plan written, but the IRRF was not updated.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
Summary:			Individuals:								
#	Indicator	Overall Score									
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

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: Assurance of restraint monitor presence and content of review needed	Individuals:

additional attention. This indicator will remain in active monitoring.											
#	Indicator	Overall Score	316	358	200	227	153	119			
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	67% 6/9	2/2	1/2	1/2	1/1	1/1	0/1			
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
13. Two restraints, Individual #358 3/23/17 and Individual #200 7/18/17, showed restraint monitor arrival (which was good), but it was beyond the maximum time allowed. For Individual #119 3/2/17, the typical information showing review of circumstances and consequences of restraint was not provided.

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
Summary: Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: monitoring individuals for potential side effects of chemical restraints and providing follow-up for abnormalities; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and clearly documenting an assessment for injuries. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	316	358	200	227	153	119			
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	11% 1/9	0/2	0/2	0/2	0/1	0/1	1/1			
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	0% 0/9	0/2	0/2	0/2	0/1	0/1	0/1			
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	0% 0/9	0/2	0/2	0/2	0/1	0/1	0/1			

Comments: The crisis intervention restraints reviewed included those for: Individual #316 on 3/7/17 at 6:45 p.m., and 3/16/17 at 1:30 p.m. (chemical); Individual #358 on 3/23/17 at 9:58 p.m., and 7/26/17 at 12:24 p.m. (chemical); Individual #200 on 5/1/17 at 5:57 p.m., and 7/18/17 at 6:50 p.m.; Individual #227 on 1/2/17 at 9:00 p.m. (chemical); Individual #153 on 5/25/17 at 11:53 a.m.; and Individual #119 on 3/2/17 at 12:21 p.m.

a. through c. The following provide some examples of problems noted:

- For some individuals, mental status was documented as "oriented x4" without an explanation of what the "x4" represented.
- A couple of hours after the nurse administered the chemical restraint to Individual #316, the individual's pulse rate was noted to be high (126). Subsequently, the individual refused vital signs, and then ran out of the home. Although the nurse documented a number of times that vital signs could not be taken because the individual was not in the home, no documentation was found as to when Individual #316 returned to the home, and whether or not the nurse made additional attempts to obtain vital signs.
- For Individual #358's restraint on 3/23/17, the Face-to-Face Checklist Comments noted: "while in horizontal, [Individual #358] started head-banging causing a bump on her head. Staff got a mat and assisted." This checklist contained no documentation of vital signs or mental status or head-to-toe assessments. No injury report or vital signs or assessments were found in the documents the Center provided. No physician order was submitted, and there was no related nursing IPN or flow sheets (e.g., IView) submitted.
- Nursing IPNs were sometimes missing. As a result, there was no documentation of whether or not nursing staff conducted a head-to-toe assessment to check for injuries.
- For Individual #200's restraint on 7/18/17, the Checklist contained no information regarding documentation of any vital signs or mental status. The Center did not submit any nursing IPNs or flow sheets in any of the folders related to this restraint.
- For Individual #153's restraint on 5/25/17, no documentation was found in the records provided of nursing assessments for vital signs, other than a respiratory rate. The records contained no assessment of mental status. No documentation was presented to show a nursing assessment was conducted to ascertain if any injuries occurred. Of note, the record did not indicate that the individual refused any assessments.

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

Summary: The name of the nurse applying crisis intervention chemical restraint was not included for one restraint and nursing reviews as required post crisis intervention chemical restraint were not documented. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 316	358	200	227	153	119			
15	Restraint was documented in compliance with Appendix A.	67% 6/9	1/2	1/2	2/2	0/1	1/1	1/1			

Comments:
15. The crisis intervention chemical restraint for Individual #227 1/2/17 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 the other crisis intervention chemical restraints. Documentation of required post crisis intervention chemical restraints were not done at criteria.

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

Summary: Performance remained about the same as last time and remains an area for the Center to ensure gets corrected. These two indicators will remain in active

Individuals:

#	Indicator	Overall Score	316	358	200	227	153	119			
monitoring.											
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	44% 4/9	2/2	2/2	0/2	0/1	0/1	0/1			
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	50% 1/2	N/A	N/A	N/A	0/1	1/1	N/A			

Comments:
16. The typical entries on the IRIS documentation showing date of review by unit and IMRT were not present for five of the restraints. The Center's restraint manager was aware of this and was putting a plan in place to correct/fix it.

17. For Individual #227 1/2/17, the recommendation to update her PBSP was not implemented.

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: Attention should be paid by the psychiatry department to ensure that psychiatry-related activities related to crisis intervention chemical restraint occur as required. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	316	358	227						
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	0% 0/3	0/1	0/1	0/1						
48	Multiple medications were not used during chemical restraint.	33% 1/3	0/1	1/1	0/1						
49	Psychiatry follow-up occurred following chemical restraint.	67% 2/3	1/1	1/1	0/1						

Comments:
47-49. The psychiatric providers were not reviewing the chemical restraint occurrences in a timely manner. There was clinical follow-up immediately following the chemical restraint in two of the three cases, regarding Individual #316 and Individual #358. Individual #227 was seen by psychiatry the day following a chemical restraint. The quarterly documentation did not review the restraint and incorrectly indicated that she had not experienced chemical restraints in the six months prior to the assessment

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.												
Summary: Performance increased since the last review. San Angelo SSLC reported focusing on this outcome/indicator. Also, at the last review, the Monitoring Team made a number of comments regarding Individual #65, including requests for follow-up information in the months between onsite reviews. The Center complied with those requests and, although he was not chosen as part of the review group for this review, anecdotal observations by Monitoring Team members occurred during the onsite week and reports were that he was engaged with his staff member in various locations on campus. Indicator 1 will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	322	316	358	200	227	153	119	72	55	38
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	92% 12/13	1/1	2/2	0/1	1/1	2/2	1/1	1/1	2/2	1/1	1/1

Comments:
The Monitoring Team reviewed 13 investigations that occurred for 10 individuals. Of these 13 investigations, 10 were DFPS investigations of abuse-neglect allegations (three confirmed, seven unconfirmed). One of these was designated as a streamlined investigation. The other three were for facility investigations of law enforcement contact, sexual activity, and a serious injury. A fourteenth investigation was also chosen for review, but the results from DFPS and OIG were pending at the time of this monitoring review so, therefore, it was excluded from this review (Individual #316, UIR 10475, DFPS 453-27352, allegation of physical abuse, 6/13/17).

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 #322, UIR 9997, DFPS 450-99692, unconfirmed allegation of verbal abuse, 1/15/17
- Individual #316, UIR 10194, encounter with law enforcement, 3/17/17
- Individual #316 Baker, UIR 10297, DFPS 452-43047, confirmed allegation of neglect, 4/18/17
- Individual #358, UIR 10633, DFPS 453-78669, streamlined investigation, unconfirmed allegation of neglect, 7/18/17
- Individual #200, UIR 10323, DFPS 452-56490, confirmed allegation of verbal abuse, 4/27/17
- Individual #227, UIR 10458, DFPS 453-23662, confirmed allegation of physical abuse, 6/11/17
- Individual #227, UIR 10313, unauthorized departure, date unknown
- Individual #153, UIR 10274, DFPS 452-35638, unconfirmed allegation of physical abuse, 4/12/17
- Individual #119, UIR 10336, DFPS 452-63046, unconfirmed allegation of neglect, 5/2/17
- Individual #72, UIR 10188, DFPS 451-98084, unconfirmed allegation of emotional abuse, 3/16/16

- Individual #72, UIR 10339, sexual incident, date unknown
- Individual #55, UIR 10528, DFPS 453-38984, administrative referral of sexual/physical abuse allegation, 6/21/17
- Individual #38, UIR 10655, discovered fracture, hand-wrist, 7/26/17

1. For all 13 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.

Criteria were met for 12 of the 13 investigations. For the one investigation that did not meet all criteria, a staff member was identified who had not signed the annual duty to report form. For nine of the 13, the investigation was regarding allegations of staff misconduct and for each of these, there were no relevant individual-related trends to be reviewed. For the other four, the behaviors exhibited by the individual had occurred before, had been trended, and were part of their treatment programs (e.g., PBSP, psychiatry, level of supervision). This was good to see. One investigation was conducted under streamlined investigation protocols and met the various criteria for this indicator, too, except for the one staff member regarding duty to report form.

Three individuals at San Angelo SSLC were deemed for streamlined investigations for certain types of allegations based on their histories of frequent reporting of unfounded allegations. None of the three were part of the above review group of individuals, so the Monitoring Team chose to review the status of one of these three, Individual #300. Two sets of protocols were relevant. One was DFPS' regarding assignment and maintenance of one's name on their list. This was being followed, including a review in July 2017. The other was DADS' protocols for there to be a plan in place, for it to be reviewed, and for that information to be put forward. A plan to address this behavior was part of her PBSP, including regular collection of data.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.												
Summary: Overall, reporting procedures continued to be followed. It will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	322	316	358	200	227	153	119	72	55	38
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	85% 11/13	1/1	1/2	1/1	1/1	1/2	1/1	1/1	2/2	1/1	1/1

Comments:
2. The Monitoring Team rated 11 of the investigations as being reported correctly. The other two were rated as being reported late or incorrectly reported. All were discussed with the facility Incident Management Coordinator while onsite. This discussion, along with additional information provided to the Monitoring Team, informed the scoring of this indicator.

Those not meeting criteria are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself

should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

- For Individual #316 UIR 10297, the UIR indicated that this was reported to DFPS by an unknown employee. The incident occurred at 10:15 am and the unknown employee reported it to DFPS at 10:49 am (within one hour). This unknown employee did not report it to the facility director/designee. The facility director/designee was notified after the Center was notified by DFPS, in other words, the facility director/designee was not notified within one hour of when the incident occurred.
- For Individual #227 UIR 10458, the UIR indicated that the incident was reported by the individual. During this incident (as described in the DFPS report), there were at least six staff on the scene who likely witnessed or participated in the incident and should have reported it earlier. The allegation was confirmed by DFPS.

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:

Individuals:

#	Indicator	Overall Score									
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.										
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.										

Comments:

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

Summary: Criteria were met for all investigations for all individuals. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	322	316	358	200	227	153	119	72	55	38
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 13/13	1/1	2/2	1/1	1/1	2/2	1/1	1/1	2/2	1/1	1/1

Comments:

Outcome 5– Staff cooperate with investigations.

Summary:

Individuals:

#	Indicator	Overall Score									
7	Facility staff cooperated with the investigation.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments:											

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.												
Summary: With sustained high performance, indicator 8 might be moved to the category of requiring less oversight after the next review.			Individuals:									
#	Indicator	Overall Score	322	316	358	200	227	153	119	72	55	38
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 13/13	1/1	2/2	1/1	1/1	2/2	1/1	1/1	2/2	1/1	1/1
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
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)											
Comments:												

Outcome 7– Investigations are conducted and reviewed as required.												
Summary: Some investigations were not completed within the required period of time allowed and did not have approved extension requests. These two indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	322	316	358	200	227	153	119	72	55	38
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
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).	85% 11/13	1/1	2/2	1/1	1/1	2/2	1/1	1/1	1/2	1/1	0/1
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	85% 11/13	1/1	2/2	1/1	1/1	2/2	1/1	1/1	1/2	1/1	0/1

	accurate, complete, and coherent.											

Comments:
12. Individual #72 UIR 10188 and Individual #38 UIR 10655 were completed in 12 days with no extension requests.

13. The supervisory review did not detect the late completion of the two investigations noted in indicator 12. 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 was now correctly conducting NSI investigations, but was not conducting them at all times when they should have been conducted. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	322	316	358	200	227	153	119	72	55	38
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	60% 6/10	1/1	1/1	0/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1

Comments:
15. For one individual, NSI investigations were appropriately conducted (Individual #200) and, for five individuals, NSI investigations were not needed because there were no discovered injuries that called for an NSI investigation. But for four individuals, various discovered injuries were identified and these were the types of non-serious injuries that warranted a NSI investigation.

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.

Summary: Indicator 16 showed sustained high performance and, therefore, will be moved to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	322	316	358	200	227	153	119	72	55	38
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 7/7	N/A	2/2	N/A	1/1	1/1	1/1	1/1	1/1	N/A	N/A

17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	
	Comments: 17. Five investigation cases in the tier 1 document request were labeled as including a confirmation for physical abuse category 2. In four of these cases, employment of the staff member was not maintained. In the fifth case, the confirmation was overturned and changed to unconfirmed upon appeal. Thus, in other words, there were no instances of maintained employment with a confirmation of physical abuse category 2.	

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
Summary: This outcome consists of facility indicators.			Individuals:								
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	Over the past two quarters, the facility's trend analyses contained the required content.										
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.										
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.										
23	Action plans were appropriately developed, implemented, and tracked to completion.										
	Comments:										

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A

	are followed.										
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. On a positive note, Center staff developed a policy entitled: "General Anesthesia Use in Dental Clinic," with an implementation date of 7/3/17. The implementation date was after the occurrence of the use of TIVA that the Monitoring Team reviewed. However, the policy represents a positive step forward. This document offers guidance regarding criteria for the use of TIVA, as well as the need for and type of preoperative evaluation of individuals prior to the use of general anesthesia in the dental clinic. In addition, it identifies classes of individuals for whom anesthesia should only be used in a hospital setting. However, the document was incomplete and required involvement of the Medical Director to add content to the medical components of the policy.

For Individual #144, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, and post-operative vital sign flow sheets were submitted. However, the operative did not comment on the condition of the individual after the procedure.

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

Outcome 11 – Individuals receive medical pre-treatment sedation safely.

Summary: The Monitoring Team will continue to assess this indicator.

#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A

Comments: a. Informed consent was not provided for the pre-treatment medical sedation of Individual #344 on 2/27/17. In addition, documentation was not submitted to show interdisciplinary input on the medication and dosage.

Of note, Tier I documentation indicated Individual #144 had pre-treatment medical sedation for an electrocardiogram, but the Center did not provide documentation for this use of pre-treatment sedation as part of its Tier II document request response.

Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.

Summary: One individual was selected for review for this outcome. The IDT reviewed the need for PTS and determined that no actions were needed. These indicators will remain in active monitoring.

#	Indicator	Overall Score	357								
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses	100% 1/1	1/1								

	the five topics.										
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	100% 1/1	1/1								
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (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. None of the individuals reviewed had PTS, therefore, Individual #357 was chosen to review to score this indicator. Individual #357 had TIVA on 7/25/17 for dental work. These scores are based on review of the 5/17/16 ISPA.										

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	222	134							
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 2/2	1/1	1/1							
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/2	0/1	0/1							
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/2	0/1	0/1							
d.	Based on the findings of the death review(s), necessary	0%	0/1	0/1							

	administrative/documentation recommendations identify areas across disciplines that require improvement.	0/2									
e.	Recommendations are followed through to closure.	0% 0/2	0/1	0/1							

Comments: a. Since the last review, two individuals died. The Monitoring Team reviewed both deaths. Causes of death were listed as:

- On 1/12/17, Individual #222 died at the age of 84 of end stage heart disease, and chronic obstructive lung disease; and
- On 2/1/17, Individual #134 died at the age of 81 of colitis with other complications.

b. through d. The Clinical Death review identified important action steps, for example, related to the need for the Medical and Pharmacy Directors to update the lab matrix, for PCPs to complete interval medical reviews, and for the Center to develop and implement oversight mechanism to track the completion of preventative care and medical consultations.

The nursing death reviews also included some valuable recommendations related to, for example, the need to improve acute care plans and IHCPs and their implementation, adherence to nursing guidelines, and assessment and follow-up related to pain and medications administered for pain. However, it was not clear that these recommendations were adopted, and included in the clinical and/or administrative death reviews for follow-up and tracking through to conclusion.

In addition, it was unclear that the recommendations developed were sufficient to address the concerns that the mortality reviews revealed with regard to the provision of health care services. For example, although the clinical death review included a couple of recommendations related to lab monitoring, the Monitoring Team's review continued to identify significant concerns with lab monitoring. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews.

e. The recommendations generally were not written in a way that ensured that Center practice had improved. For example, a recommendation required PCPs to review literature related to chronic kidney disease and inflammatory bowel disease. It was unclear how the Medical Director would determine whether or not these activities had any impact on medical care.

The Center also did not submit documentation to show that the recommendation related to IHCP/acute care nursing monitoring occurred. The nursing member of the Monitoring Team asked for clarification regarding the email and spreadsheet submitted. The Center's quality assurance staff reviewed the documents and agreed that the documentation did not satisfy the recommendation.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.	
Summary: Based on documentation the Center provided, Center staff did not believe that staff were reporting all potential adverse drug reactions. In reviewing individuals' records, the Monitoring Team identified potential adverse drug reactions that Center staff had not identified. The Center should take action to	Individuals:

ensure staff are trained on and report potential adverse drug reactions.											
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
a.	ADRs are reported immediately.	33% 1/3	N/A	N/A	N/A	N/A	N/A	N/A	1/1	0/1	0/1
b.	Clinical follow-up action is completed, as necessary, with the individual.	33% 1/3							1/1	0/1	0/1
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	33% 1/3							1/1	0/1	0/1
d.	Reportable ADRs are sent to MedWatch.	0% 0/2							N/A	0/1	0/1

Comments: a. through d. Individual #344 had a history of being allergic to Levaquin. According to the PCP, Individual #344 was referred to an allergy and immunology specialist and tested negative for a Levaquin allergy. On 4/2/17 at 12:17 p.m., the PCP diagnosed him with a lower respiratory infection, and prescribed Levaquin. At 9:51 p.m., the PCP was notified that the individual had swollen lips, was hypoxic, and had a temperature of 102.5. EMS transferred him to the ED, and he was admitted to the hospital with "sepsis presumably secondary to pneumonia" and urticaria due to Levaquin.

Two potential ADRs were not reported as such. These included:

- In April 2017, the blood pressure regimen was changed for Individual #98 due to a chronic cough. In May 2017, the PCP noted the cough had resolved. However, the PCP did not report this as a potential ADR; and
- On 3/3/17, the neurologist saw Individual #370, and documented: "I suspect that Depakote is at least partly responsible for her complaints. I would recommend that her psychiatrist taper her off of Depakote to see if the nausea and the weight gain resolve. The concern about Depakote is not only nausea but also pancreatitis or pancreatic pseudocyst which would be difficult to detect by clinical monitoring." On 3/21/17, the PCP reviewed the neurology consult. However, it did not appear the PCP reported this as a potential ADR. In addition, the PCP agreed with the Depakote taper, but did not refer the discontinuation of this mood stabilizer to the IDT for review. Further, it did not appear that the recommendation was addressed by psychiatry until 4/14/17.

Moreover, the Pharmacy and Therapeutics Committee document for 7/26/17 under the ADR section states: “ADRs are not being reported properly. Has nursing started retraining?” The reporting of ADRs is of critical importance, and the Center needs to address the lack of reporting as soon as possible.

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: The Center made improvement with regard to the completion of clinically significant DUEs (i.e., at the time of the last review, the Center had completed none). Two of the DUEs identified significant problems with the	Individuals:

completion of regular lab monitoring that was important to the health and safety of individuals the Center served. Due to issues with the documentation from the Pharmacy and Therapeutics Committee, the Monitoring Team could not determine whether or not recommendations from the DUEs were accepted, implemented, and/or closed to address these concerns that placed individuals at significant risk. These indicators will remain in active oversight.		
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 3/3
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/3

Comments: a. and b. Since the previous review, San Angelo SSLC completed three DUEs, including:

- A DUE on Lithium monitoring that was presented to the Pharmacy and Therapeutics (P&T) Committee on 1/25/17. The DUE concluded: "Based on results above, lithium level monitoring is not being completed as required by the facility lab matrix. It is unclear as to how or why appropriate lab monitoring is not occurring." Per the P&T minutes, dated 1/25/17: "The nurse CM [Case Managers] are supposed to be keeping track of these things. …SO [State Office] is not fond of the pharmacist ordering labs, review lab matrix and make changes if needed.";
- A DUE on Iron Supplementation in Iron Deficiency Anemia that was presented to the P&T Committee on 4/26/17, for which no substantive discussion occurred; and
- A DUE on Oxcarbamazepine that was presented to the P&T Committee on 7/26/17. This DUE noted that: "for the most part, SSLC monitoring matrix were not followed." The documentation from this meeting appeared to be an agenda rather than meeting minutes.

The Center submitted documents entitled Pharmacy and Therapeutics Committee. They included the date and the time. The documents were not identified as the agenda or the minutes. They provided very little information about this important Committee's meetings. With regards to the DUEs, it was not clear if corrective action plans were developed, or if the Committee members accepted the recommendations stated in the DUEs. The Committee chair was not identified as the documents were not signed or dated, nor did the Committee approve the content of the minutes. As a result, the Monitoring Team could not determine whether or not recommendations were accepted, implemented, and/or closed.

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. At the last review, 11 of these indicators were moved the category of requiring less oversight. For this review, five other indicators were moved to this category, in ISPs, psychiatry, and psychology/behavioral health. One indicator in medical, however, were returned to active monitoring.

The Monitoring Team had the opportunity to spend a number of hours with the psychiatrists at San Angelo SSLC during the onsite week as well as with the State's newly appointed statewide discipline coordinator for psychiatry. The Monitoring Team looks forward to working with him in this new role.

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

Two individuals were reviewed by both Monitoring Teams (Individual #153, Individual #119). Both individuals had complex psychiatric histories and psychotropic medication regimens. In addition, they each had health-related problems that required additional treatments and medications. The side effects and drug-drug interaction effects of their various psychotropic and physical health medications required an in-depth review and re-evaluation. The Monitoring Team discussed these two individuals with the facility director during the onsite week. For Individual #119, a root cause analysis meeting was held during the onsite week. Many team members had not adequately prepared for the discussion, and the meeting did not have focus or structure. Even so, a number of recommendations/actions were eventually generated by the team and sent to the Monitoring Team. This individual's case will require ongoing attention and likely modifications to the actions generated by the root cause analysis discussion.

For most individuals, the IDT did not consider what assessments the individual needed and would be relevant to the development of the ISP prior to the annual meeting. None of the IDTs arranged for and obtained all needed, relevant assessments prior to the IDT meeting.

For the individuals' risks reviewed, IDTs continued to struggle to effectively use supporting clinical data (including comparisons from year to year), use the risk guidelines when determining a risk level, and/or as appropriate, provide clinical justification for exceptions to the guidelines. As a result, for the great majority of the risk ratings reviewed, it was not clear whether or not 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.

QIDP monthly reviews were being conducted and IDTs were meeting routinely. This was good to see, however, the reviews did not adequately summarize progress, document implementation, and show that follow-up occurred.

Comprehensive psychiatry evaluations (CPE) existed for all individuals. Some documentation problems with the change to the electronic record led to criteria not being met some individuals.

Functional assessments were current. The completeness of the functional assessments showed continued improvement, but was not yet at criteria. None of the individuals had recommendations for SAPs in both their vocational and functional skills assessments.

Based on the Monitoring Team's review of annual medical assessments for other indicators, the Center regressed with regard to the completion of timely annual medical assessments. As a result, the related indicator will move back to active oversight.

In terms of the quality of annual medical assessments (AMA), it was positive that those reviewed included, as applicable, social/smoking histories, past medical histories, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. However, moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, pre-natal histories, family history, childhood illnesses, updated active problem lists, and plans of care for each active medical problem, when appropriate. All of these areas needed significant work. Overall, the AMAs reviewed did not include individualized plans of care consistent with current practice guidelines. This is an area on which the Medical Department should focus.

The IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. Moreover, the Center did not provide any interim reviews for any of the individuals reviewed. This is of significant concern. The Center should correct this longstanding issue immediately.

The Center should focus on completing timely annual dental exams that are within 365 days of the previous one, as well as no more than 90 days from the ISP meeting. Work also is needed to improve the quality of dental exams and summaries.

Due to issues with IRIS as well as concerns related to adherence to basic nursing standards, full nursing physical assessments were not documented for any of the individuals reviewed (e.g., missing weight graphs, fall assessments, and assessments of reproductive systems; lack of follow-up and/or analysis of abnormal findings; and incomplete mental status descriptions). In addition, 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, and when individuals experienced changes of status, nurses often did not complete assessments consistent with current standards of practice.

Some improvement was noted with regard to the quality of PNMT assessments. In addition to continuing its efforts to improve assessment quality, the Center should focus on the timely referral of individuals to the PNMT, timely completion of the PNMT initial review, completion of PNMT comprehensive assessments for individuals needing them, and involvement of the necessary disciplines in the review/assessment.

Over the past four reviews, 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 regressed. The quality of OT/PT assessments continues to be an area on which Center staff should focus as well.

It was good to see continued improvement with regard to the timeliness of communication screenings and assessments, as well as the provision of the correct type of assessment (i.e., a screening, comprehensive assessment, or update). Improvements are needed with regard to the quality of communication assessments and updates.

Individualized Support Plans

Continued progress was seen regarding the development of personal goals in all of the different ISP areas. All six ISPs, for instance, included two or more goals that met criteria, and one ISP had goals that met criteria in five of the six areas, for a total of 18 goals that met criteria. Further, 11 of these goals were written in measurable terms, also demonstrating good progress. Unfortunately, none had goals that met criteria in the health/wellness/IHCP area, and none were implemented sufficiently, correctly, and with adequately collected data to determine progress.

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.

Two of the goals had adequate action plans to support achievement of those goals. A focus area for the facility is to ensure the actions plans meet all of the various characteristics described across the 11 indicators of outcome 3.

Overall, ISPs included a good summary of discussion regarding living options. San Angelo SSLC held more thorough living options discussions for those individuals who were more able to participate in this type of discussion as compared to those individuals who were less able to participate and directly express their preferences.

ISPs were revised annually, however, they were not implemented in a timely manner, and some aspects were not implemented at all. There was improvement in the participation and attendance of the individual and other relevant interdisciplinary team members.

Regarding psychiatry, there remained the need for individualized diagnosis-specific personal goals that referenced/measured psychiatric indicators regarding problematic symptoms of the disorder, as well as psychiatric indicators regarding positive pro-social behaviors. Psychiatrists were continuing to attend most annual ISP meetings. Improvements were needed in the content of the annual psychiatric evaluation, timely submission to the IDT, and psychiatry information in the final ISP document.

In behavioral health services, indicator 5 (reliable data) is pivotal for the determination of many other indicators in behavioral health services. Criteria for this indicator were met for more than half of the individuals (compared with zero individuals at the last review). PBSPs were current. About half met criteria for content.

About half of the individuals at San Angelo SSLC had zero skill acquisition plans. This was surprising given that each individual had many areas of his or her life for which skill development would improve independence, satisfaction, and quality of life. The other individuals had some SAPs, but very few, also given their many needs. This was also the case at the last review, too.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: Continued progress was seen. Although the development of individualized, meaningful personal goals in all six different ISP areas was not yet at criteria, but much progress was evident. All six ISPs, for instance, included two or more goals that met criteria, and one ISP had goals that met criteria in five of the six areas, for a total of 18 goals that met criteria. This was very good progress since the last review. Further, 11 of these goals were written in measurable terms, also demonstrating good progress. Unfortunately, none had goals that met criteria in the health/wellness/IHCP area, and none were implemented sufficiently, correctly, and with adequately collected data to determine progress. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	316	200	153	119	144	77			
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	2/6	4/6	5/6	2/6	2/6	3/6			
2	The personal goals are measurable.	0%	2/6	3/6	2/6	1/6	1/6	2/6			

		0/6									
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 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 #153, Individual #119, Individual #200, Individual #316, Individual #144, Individual #77). The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the San Angelo SSLC campus.

The ISP relies on the development of personal goals as a foundation. 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 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 areas. Therefore, none had a comprehensive set of goals that met criterion. For these six individuals, however, the IDT had defined some personal goals that met criterion for being individualized based on the individual's preferences and strengths. Overall, 18 of 36 personal goals met criterion for this indicator. This was an improvement from the past review when 13 of 36 goals met criterion. Goals that met criterion were:

- Individual #153's goals for relationships, work/day programming, greater independence, and living options.
- Individual #119's goals for relationships, and living options.
- Individual #200's goals for relationships, work/day programming, greater independence, and living options.
- Individual #316's goal for greater independence and living options.
- Individual #144's goals for recreation and greater independence.
- Individual #77's goals for work/day programming, greater independence, and living options

Although IDTs had created the above goals (ones that were more individualized and based on known preferences than in the past), few had been fully implemented. Thus, individuals did not have person-centered ISPs that were really leading them towards 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.

2. Of the 18 personal goals that met criterion for indicator 1, 11 also met criterion for measurability. This was another sign of progress for the QIDPs and IDTs. Seven that did not meet criterion included:

- Individual #153's recreation, relationship, and work/day programming goals.
- Individual #119's relationship goal.
- Individual #200's relationship goal
- Individual #144's recreation goal.

- Individual #77's living option goal.

When personal goals for the ISPs did not meet the criterion described above in indicator 1, 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.

3. None of the goals had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals. As noted throughout this report, it was not possible to determine if ISP supports and services were being regularly implemented or to determine the status of goals because of the lack of data and documentation provided by the facility. It appeared that few action plans were regularly implemented. Some examples of goals where implementation data were not available to review progress monthly included:

- None of Individual #153's monthly reviews included enough data to determine progress towards goals. Monthly reviews indicated that a majority of his action plans were never implemented.
- Individual #119's monthly reviews did not include data regarding progress for any of his goals.
- Individual #144 did not have monthly reviews of progress from January 2017 through June 2017.
- For Individual #144, SAP data sheets indicated that his goal to operate his alarm clock was being consistently implemented, however, data integrity was questioned in the monthly summary and the QIDP failed to summarize progress in her monthly review.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: Overall, performance remained about the same as at the last review. Although about half of the goal areas had personal goals that met criteria (indicator 1), only two of the goals had adequate action plans to support achievement of those goals (indicator 8). The other indicators in this outcome refer to the total set of action plans across all goals and all areas of the ISP. A focus area for the facility (and its QIDP department) is to ensure the actions plans meet all of the various characteristics described across the 11 indicators. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	316	200	153	119	144	77			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	0/6	1/6	1/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	33% 2/6	1/1	0/1	0/1	0/1	0/1	1/1			
11	ISP action plans supported the individual's overall enhanced	50%	1/1	0/1	0/1	0/1	1/1	1/1			

	independence.	3/6									
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.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
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	0/1	0/1	0/1	0/1	0/1	1/1			
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.	17% 1/6	0/1	1/1	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	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
8. Half of the personal goals met criterion in the ISPs, as described above in indicator 1, therefore, those action plans could 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.

Action plans often did not support accomplishment of personal goals. They usually did not include staff instructions or implementation strategies that would ensure staff could consistently teach a new skill or accurately collect data on progress. IDTs need further guidance on developing action plans/ staff instructions that might lead to progress or achievement of goals.

For the 18 personal goals that met criterion under indicator 1, two had action plans that were likely to lead to the accomplishment of the goal. IDTs were struggling with developing action steps that would lead to measurable progress towards goals. Goals that met criterion were:

- Action plans for Individual #144's greater independence goal.
- Action plans for Individual #77's living option goal.

9. While all ISPs included action plans that integrated preferences, Individual #316's ISP was the only one that included opportunities to make choices.

10. Four ISPs' action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making. Individual #316's and Individual #77's action plans for money management and medication administration were developed by the IDT to address barriers to making informed decisions.

As noted in every previous report, the Monitoring Team attended the Center's monthly self-advocacy meeting. As usual, attendance was about 80 individuals, there was good engagement, and it remained a real part of the culture at the facility. Another standard activity at San Angelo SSLC was the weekly home meeting for individuals. As suggested in the last monitoring report, both of these activities set the occasion for decision-making and problem solving. One or both meetings activities 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. House managers lead these weekly meetings and likely would welcome guidance on how to teach group decision-making skills to the individuals. 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.

11. Three of six ISPs (Individual #316, Individual #144, Individual #77) met criterion for this indicator. Individual #316's ISP included action plans for money management and vocational skills. Individual #144's action plans included handwashing, oral care, and operating his alarm clock. Individual #77's ISP included action plans for money management and learning to ride the city bus.

12. ISPs did not integrate strategies to minimize risks in ISP action plans. As noted above, IDTs failed to develop specific teaching and support strategies to carry out action plans, thus they did not have an avenue to integrate support strategies to address risks into action plans. Specific support strategies should be included in staff instruction for implementing action plans, when relevant, to minimize risks in all settings. Further discussion regarding the quality of strategies to reduce risks can be found throughout this report.

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, communication, medical, and psychiatric supports were rarely integrated into support plans developed by other disciplines. In most cases, supports were fragmented, with little evidence that IDT members were sharing data and collaborating on developing supports. Examples where discipline assessments and recommendations were not fully integrated included:

- Individual #153's ISP did not document integrated supports (PNMT, medical, behavior, and psychiatry) to address his falls, though each discipline assessment included recommendations.
- Individual #119's IDT noted overall regression that was being addressed by his PCP, psychiatrist, behavioral health specialist, and habilitation therapy. There was little evidence of collaboration among team members and supports were not integrated throughout his ISP.
- During interviews, Individual #77's QIDP and support staff reported that disciplines were working together to develop supports to address her health care issues, however, action plans with strategies for implementation were not developed to ensure that supports were consistently implemented, and monitored for efficacy.

14. Meaningful and substantial community integration was absent from five ISPs. Although these individuals had opportunities to go into the community, only one of the individuals had formalized training with adequate teaching strategies that might lead to integration

into the community. Individual #77 had action plans for training that included going to the library, riding the city bus, attending church, and swimming in the community.

15. One of six ISPs included action plans to support opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Four ISPs included goals that supported opportunities for employment in the community, however, action plans were not developed to support accomplishment of the goal. Though still somewhat general in nature, Individual #77 did have some action plans to support her goal to work at Unique Creations. Individual #144 did not have a day/employment goal.

16. One of six ISPs (Individual #77) supported substantial opportunities for functional engagement described with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Based on observations, five individuals were rarely engaged in functional training during the day that might lead to gaining new skills and greater independence. Five of the ISPs did not integrate preferences for day programming into action plans. Action plans typically were written for compliance with attendance at programs with little consideration of what the individual wanted to learn or do during the day.

- Individual #153 was rarely observed engaged in functional activities. His ISP included one skill acquisition plan (to state kitchen safety rules). Individual #153 appeared to like going to one of the day activity programs, but his attendance and presence were limited, and sometimes he was sent away. The IDT might consider if there's a way for him to be present longer, or perhaps even have some work responsibilities there. The Monitoring Team understands that there are also various behavioral issues that need to be considered.
- Individual #119 had a goal for work at the sheltered workshop on campus. The IDT developed action plans to address attendance (which was historically low), but did not include specifics regarding what type of job he would do and what job skills would be taught.
- Individual #200 and Individual #316 had no measurable action plans to support their goal to work.
- Individual #144's team did not develop a work/day goal. His ISP noted that he spent three to four hours a day in scheduled classes and liked to walk around campus and sunbathe. The ISP did not identify his scheduled classes or what skills he would be learning.

17. Five ISPs did not adequately address barriers to achieving goals and learning new skills. The exception was Individual #200. His ISP identified behavior as a barrier to progress towards all goals. His PBSP included specific action plans to address those barriers. For five individuals, barriers to consistent implementation of action plans were not addressed. Individual #316's ISP preparation meeting was observed. The IDT reviewed her goals and noted that most of her action plans were never implemented. They did not address the previous year's barriers to implementation or to progress.

18. None of the action plans were found to describe detail about data collection and review. Overall, ISPs did not usually include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action plans were broadly stated and, in most cases, skill acquisition plans were not developed when needed to ensure consistent training strategies were implemented.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
Summary: Criterion was met for some indicators for some individuals and, overall, there was improvement in performance, with seven indicators scoring higher than at the last review. More focus was needed to ensure that all of the activities occurred related to supporting most integrated setting practices within the ISP. Primary areas of focus are meeting these indicators for those individuals who are less able to directly participate in living option discussions. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	316	200	153	119	144	77			
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).	83% 5/6	1/1	1/1	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	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	67% 4/6	1/1	1/1	1/1	1/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	83% 5/6	1/1	1/1	1/1	1/1	0/1	1/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	100% 6/6	1/1	1/1	1/1	1/1	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	N/A	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.	83% 5/6	1/1	1/1	1/1	1/1	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	N/A	N/A	N/A			
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	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	N/A	N/A	N/A	N/A	N/A	1/1			

Comments:
19. Five ISPs included a good description of the individual's preference and how that was determined. The exception was Individual #144. His ISP did not include his preferences related to his living environment.

20. The Monitoring Team attended the annual ISP meeting for Individual #308. Scoring for this indicator and for indicators 25 and 27 is based upon this observation. The IDT discussed that he seemed to like living at San Angelo SSLC, but there was no discussion about what his preference might be and how those preferences might be met in the community.

21. Four of the six ISPs fully included the opinions and recommendation of the IDT's staff members. According to QIDP assessment data, 67% of Individual #144's assessments and 47% of Individual #77's assessments were submitted 10 days prior to the annual IDT meeting for review by the IDT.

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

23. Five of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths. Individual #144's ISP did not document a thorough discussion of his preferences related to living options.

Overall, ISPs included a good summary of discussion regarding living options. This was positive. Five individuals were familiar with other living options and able to provide input to the IDT regarding their preferences. Goals were developed to support their preferences. IDTs were still struggling to develop individualized action plans that were likely to lead to the accomplishment of those goals, thus, little progress had not been made towards achieving living option goals.

24. All 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. Obstacles were primarily related to complex behavioral and medical needs.

25. Although progress was noted in indicator 23 above, this was not evident at the annual ISP meeting for Individual #308 that was observed by the Monitoring Team. At this meeting, there was discussion of his behavioral problems, but little discussion of any positives that might accrue to him if he lived in the right type of community setting. IDT members did not give their individual opinions and recommendations regarding referral and obstacles to referral. It might be that San Angelo SSLC holds more thorough living options discussions for those individuals who are more able to participate in this type of discussion as compared to those individuals who are less able to participate and directly express their preferences (i.e., Individual #308, Individual #144). For instance, even though the IDT stated that Individual #308 would not understand the purpose of site tours or the provider fair, those two activities were written down as action plans for the upcoming year.

26. Five individuals had individualized, measurable action plans to address obstacles to referral or transition, if referred. The exception was Individual #144.

27. At the annual ISP meeting for Individual #308, plans to address obstacles to referral were not done.

29. Individual #77's team did not identify significant obstacles to referral. She was referred, however, her referral was later rescinded due to a change in her health status.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.

Summary: ISPs were revised annually. This has been the case for some time at San Angelo SSLC, therefore, indicators 30 and 31 will be moved to the category of requiring less oversight. ISPs, however, were not implemented in a timely manner, and some aspects were not implemented at all (indicator 32). There was, however, improvement in the participation and attendance of the individual (indicator 33) and team members (indicator 34). Indicators 32, 33, and 34 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 316	200	153	119	144	77			
30	The ISP was revised at least annually.	100% 5/5	N/A	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.	100% 1/1	1/1	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).	83% 5/6	0/1	1/1	1/1	1/1	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.	33% 2/6	1/1	1/1	0/1	0/1	0/1	0/1			

Comments:
30-31. ISPs were revised annually. Individual #316 was recently admitted to the facility. Her ISP was developed within 30 days of her admission.

32. Documentation was not submitted that showed that all action plans were implemented within a timely basis. QIDP monthly reviews indicated that a majority of goals were either never implemented or not consistently implemented.

33. Five of six individuals attended their ISP meetings. Individual #316 did not attend her annual ISP meeting.

34. Two of the individuals had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who

participated in the planning process. Overall, attendance at annual IDT meetings was good.

- Individual #153's PCP and physical therapist did not attend his meeting. He had numerous falls and regression in his health status in the months prior to his annual ISP meeting.
- Individual #119's PCP did not attend his meeting, though he had complex medical needs that impacted his progress towards goals.
- Individual #77 had complex medical and psychiatric supports. Her PCP and psychiatrist did not participate in her ISP development meeting.
- For Individual #144, it was not clear that IDT members considered his preferences and support needs in terms of his day programming and communication supports.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: For all individuals, assessments were not always considered and/or obtained prior to the ISP meeting. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	316	200	153	119	144	77			
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.	33% 2/6	1/1	1/1	0/1	0/1	0/1	0/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting for two of six individuals.

- Individual #119's IDT did not consider assessments to address his GERD or an updated swallow study. The team also should have considered an updated polypharmacy review and pulmonology study.
- Individual #153's IDT needed to consider an updated pharmacological review to explore his medication interactions and possible impact on his current risk areas.
- Individual #144's team did not consider a situational work assessment to explore possible interest related to employment.
- Individual #77's ISP recommended a medication administration assessment and assessment for skills to ride the bus. If these assessments were completed prior to her annual ISP meeting, action plans could have been developed. Although, the IDT developed action plans to obtain these assessments, they were never completed, so action plans to support her goals had yet to be developed.

36. None of the IDTs arranged for and obtained all needed, relevant assessments prior to the IDT meeting. 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. QIDP assessment data showed the following:

- Individual #153's vocational assessment did not include recommendations for goals.
- Individual #119's dental assessment and FSA were not submitted within 10 days of his annual meeting.
- Individual #200's nursing and behavioral assessments were not timely.
- Individual #316's FSA was submitted late.
- Individual #144's FSA, audiological, and vocational assessment were not timely.
- Individual #77's nursing, medical, behavioral, psychiatry, and dental assessments were submitted late.

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

Summary: QIDP monthly reviews were being conducted and IDTs were meeting routinely. However, in order to meet criteria with these indicators, reviews must summarize progress, implementation must occur, and follow-up must occur. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 316	200	153	119	144	77			
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 met routinely when a serious incident occurred. This was good to see, however, when recommendations were made or supports were revised, IDTs rarely met again to ensure recommendations were implemented. Furthermore, reliable and valid data were often not available to guide decision-making. IDTs rarely revised goals when progress was not evident. ISPs were not fully implemented for any individual chosen for review. IDTs sometimes discontinued goals that were not being implemented, however, did not meet to revise goals or address barriers to implementation.

38. Consistent implementation and monitoring of ISP action steps remained areas of concern. ISP action plans were not regularly implemented for any of the individuals. Some QIDP monthly reviews included data for some action plans, but did not include an analysis of that data to determine what specific progress had been made towards achievement of goals. Information regarding behavioral supports, habilitation therapy, and medical supports was inserted in the monthly reviews without a summary of status, statement on the efficacy of supports, or efforts made to follow-up on outstanding issues. There was little documentation of follow-up when plans were not implemented or not effective. For example,

- Individual #144's July 2017 monthly review noted that he had nine injuries in July 2017 related to falls. The QIDP requested an interim with psychiatry on 7/25/17. There was not documentation to show that the IDT discussed this review or implemented any recommendations. He had an action plan for the SLP to revise his AAC to increase participation in activities. The QIDP noted that she had emailed the SLP regarding the status of this action plan in June 2017 and July 2017. No further information was found regarding the AAC device. It appeared that the action plan had never been completed. Direct support staff had no

knowledge of an AAC device.

- Individual #200's March 2017 QIDP monthly reviews noted, "stable – continues to follow his PBSP" for action plans related to his PBSP. His action plans to go to a movie, go on a special trip, and visit his family in March 2017 indicated that he was unable to participate due to his behaviors.
- Individual #77 had experienced significant regression in her health over the past year. Action taken by her IDT and monitoring of supports implemented was not well documented. A root cause analysis was completed regarding her health and behavioral issues in May 2017. A summary of the root cause analysis discussion included a number of recommendations for further assessment and revision of supports. The facility reported that there was no documentation of implementation or follow-up on any of those recommendations.

The Monitoring Team attended a number of meetings while onsite to review the IDT process and the facility response to incidents. At all meetings, reliable data were not available for review to facilitate decision making and ensure that supports were revised when not effective.

Going forward, the QIDPs will need to be sure that they are gathering data for the month, summarizing progress, and revising the ISP, as needed, particularly when goals are not consistently implemented.

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.

#	Indicator	Overall Score	Individuals: 119	153	363	77	144	346	344	98	370
a.	The individual's risk rating is accurate.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	50% 9/18	1/2	2/2	1/2	0/2	0/2	1/2	1/2	2/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #119 – respiratory compromise, and circulatory; Individual #153 – constipation/bowel obstruction, and seizures; Individual #363 – weight, and fractures; Individual #77 – diabetes, and urinary tract infections (UTIs); Individual #144 – falls, and skin integrity; Individual #346 – respiratory compromise, and cardiac disease; Individual #344 – constipation/bowel obstruction, and infections; Individual #98 – aspiration, and gastrointestinal (GI) problems; and Individual #370 – seizures, and GI problems].

a. For none of the individuals reviewed did the IDTs effectively identify and use supporting clinical data. Often substantial amounts of relevant data were missing from the IRRFs. This made it difficult for IDTs to effectively use the risk guidelines when determining a risk

level.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs generally 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. The following individuals did not have changes of status in the specified risk areas: Individual #119 – circulatory; Individual #153 – constipation/bowel obstruction, and seizures; Individual #363 – weight; Individual #346 – respiratory compromise; Individual #344 – constipation/bowel obstruction; Individual #98 – aspiration, and GI problems; and Individual #370 – seizures.

Psychiatry

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

Summary: This outcome requires individualized diagnosis-specific personal goals be created for each individual and that these goals reference/measure psychiatric indicators regarding problematic symptoms of the psychiatric disorder, as well as psychiatric indicators regarding positive pro-social behaviors. The Monitoring Team had the opportunity to spend a number of hours with the psychiatrists at San Angelo SSLC during the onsite week as well as with the State's newly appointed statewide discipline coordinator for psychiatry. This was one of the discussion topics. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
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 or to the absence of side effects related to psychotropic medications. 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. To reiterate:

- There need to be personal goals that target the undesirable symptoms of the psychiatric disorder and that are tied to the diagnosis, and personal goals that would indicate improvement in the individual's psychiatric status.
- The goals need to be measurable, have a criterion for success, be presented to the IDT, appear in the IHCP, and be tracked/reviewed in subsequent psychiatry documents, as well as be part of the QIDP's monthly review.

In addition, discussions with psychiatric treatment providers at the facility indicated that they were also aware of the need to review the current diagnostic assessment for many of the individuals participating in psychiatry clinic. The providers planned to undertake this task and while reviewing the diagnosis, designate specific psychiatric symptoms (psychiatric indicators) for monitoring and data collection.

Psychiatric progress notes for quarterly clinical encounters routinely documented review of available data. These data consisted of lists of numbers of events that occurred in a particular month. There was no documentation of a discussion of what these data indicated. There was documentation of the use of the BPRS noted in some examples. Unfortunately, the BPRS scores were not trended over time, and as such, could not be compared to prior scores. The use of the BPRS was good to see, but trending the results over time would make these data useable. Other than the BPRS data, all other data collected were not regarding psychiatric symptoms but rather regarding specific behavioral challenges. These data were not useable for making decisions regarding the efficacy of the individual's psychotropic medication regimens.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: CPEs existed for all individuals for this review and for the previous two reviews, too. Therefore, indicator 12 will be moved to the category of requiring less oversight. Some documentation problems with the change to the electronic record led to criteria not being met for three individuals regarding the required format for the CPEs (indicator 13). CPE content continued to be near complete, but still missing criteria for one or more components for all, but one, individual. Some attention to clerical/documentation should result in improved performance on indicators 15 and 16. Indicators 13, 14, 15, and 16 will remain in active monitoring. Of note, however, is that, for one individual, all of these indicators were at criteria.

Individuals:

#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
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	67% 6/9	0/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1

14	CPE content is comprehensive.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	0% 0/5	N/A	0/1	0/1	0/1	N/A	N/A	N/A	0/1	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	0/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1

Comments:

12. CPEs were completed for all individuals.

13. Three evaluations were not in Appendix B format. One of these, regarding Individual #322, was performed in 2013. The other two, regarding Individual #316 and Individual #227, were completed in IRIS. Both of these evaluations included a large volume of information, and it was apparent that the facility psychiatry staff had made an effort to include as much information as possible.

14. The Monitoring Team looks for 14 components in the CPE. One of the evaluations, regarding Individual #200, addressed all of the required elements. The other eight evaluations were missing anywhere from one to five elements. The most common deficiency was the bio-psycho-social formulation.

15. For the five individuals admitted since 1/1/14, four had a CPE completed within the first 30 days of admission. Individual #299 was admitted to the facility on 1/13/14, but the CPE was not completed until 2/5/15. While the remaining four individuals had a CPE completed within 30 days of admission, the IPN from nursing and primary care was not located for review in the records of Individual #119 and Individual #358. Individual #316's record included an annual medical assessment performed on the date of admission, but there was no IPN from nursing located. The document request for records regarding Individual #72 did not include the IPN documents.

16. There were two individuals whose documentation revealed inconsistent diagnoses, Individual #322 and Individual #227.

Outcome 5 – Individuals' status and treatment are reviewed annually.											
Summary: Performance remained about the same as last time for these four indicators and they will remain in active monitoring. It was good to see that psychiatrists were continuing to attend most annual ISP meetings (indicator 20). Improvements were needed in the content of the annual psychiatric evaluation, timely submission to the IDT, and psychiatry information in the final ISP document.			Individuals:								
#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72

17	Status and treatment document was updated within past 12 months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.								
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/8	0/1	N/A	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.	56% 5/9	1/1	1/1	0/1	0/1	0/1	1/1	1/1	0/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	78% 7/9	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

18. The Monitoring Team scores 16 aspects of the annual evaluation document. None of the evaluations met full criteria. The most common deficiencies in the annual evaluations were regarding the demographic information and derivation of target symptoms. Data were being collected regarding behavioral challenges, but it was not possible to attribute these to a specific diagnosis. Another common area of deficiency noted in six examples was the symptoms of diagnosis. While the assessments included a listing of the diagnostic criteria for a particular diagnosis, the symptoms that the individual was experiencing indicating they met the diagnostic criteria was not clearly stated.

20. The psychiatric clinician attended the ISP meeting in seven of the cases. This was good to see.

21. Review of the ISP documents indicated that there was a need for improvement with regard to the consistent 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: None of the individuals selected for review by the Monitoring Team had a PSP, therefore, two other individuals were chosen. Criteria were not met for either individual due, in large part, to lack of clarity in the determination and definition of psychiatric indicators/symptoms. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
22. None of the individuals in the review group had a PSP. Therefore, the Monitoring Team selected the PSPs for two other individuals (of the 16 individuals at San Angelo SSLC who had a PSP) for review for this indicator (Individual #409, Individual #203). Not all of the sub-indicators for this indicator were met.

- For Individual #409, based upon what was in the PSP, it was not clear what this individual's diagnosis was. The initial diagnosis was major depression with psychosis or Schizophrenia, but later in the document, there is a discussion of PTSD. It would be difficult to determine what symptoms to monitor given a diagnostic conundrum. There was no specific purpose of the PSP noted.
- For Individual #203, there were multiple diagnoses, some medical that might have also affected her behavioral presentation. In other words, it was not clear if the psychiatric symptoms were aspects of the psychiatric disorder, or if they were manifestations of pain and the individual's medical illnesses, such as tensing and contracting her muscles, stretching, agitation, moaning, and yelling.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
Summary: Some information was not included in the consent documentation provided to the individual and/or the LAR. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	67% 6/9	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1
30	A risk versus benefit discussion is in the consent documentation.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
31	Written documentation contains reference to alternate and/or 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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
29. The facility consent forms generally contained adequate medication side effect information. There were three examples where serious medication side effects were not included in the consent form. For example, the consent forms for Lamictal did not include the risk of life threatening rash and the consent forms for Clozaril did not include the risk of life threatening anemia.

30. The risk versus benefit discussion was not included in the consent forms.

31. For non-pharmacological alternatives, the consent forms did not include individualized alternatives and in numerous examples

indicated that there were no alternatives.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: Both indicators showed good progress since the last review. Indicator 5 is pivotal for the determination of many other indicators in behavioral health services. It was very good to see that criteria for this indicator were met for more than half of the individuals (compared with zero individuals at the last review). These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
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.										
3	The psychological/behavioral goals/objectives are measurable.										
4	The goals/objectives were based upon the individual's assessments.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	67% 6/9	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1	0/1
Comments: 5. Individual #299 did not have interobserver agreement (IOA) assessed in the last six months. Individual #358's most recent IOA, and Individual #72's most recent data collection timeliness assessments were below 80%. 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%.											

Outcome 3 - All individuals have current and complete behavioral and functional assessments.	
Summary: Functional assessments were current. This had been the case for all individuals for this review and for the previous two reviews, too, with one exception in March 2016. Therefore, indicator 11 will be moved to the category of requiring less oversight. The completeness of the functional assessments (indicator 12)	Individuals:

#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
	showed continued improvement. This indicator and indicator 10 will remain in active monitoring.										
10	The individual has a current, and complete annual behavioral health update.	86% 6/7	1/1	N/A	1/1	1/1	0/1	1/1	N/A	1/1	1/1
11	The functional assessment is current (within the past 12 months).	100% 7/7	1/1	N/A	1/1	1/1	0/1	1/1	N/A	1/1	1/1
12	The functional assessment is complete.	86% 6/7	1/1	N/A	1/1	1/1	0/1	1/1	N/A	1/1	1/1

Comments:
Criteria for indicators 1-9 were met for Individual #153 and Individual #316. Therefore, the remainder of the indicators in psychology/behavioral health were not rated for them.

10. Individual #200 did not have an adaptive assessment in his behavioral health update.

12. The direct assessment and indirect component of Individual #200's functional assessment did not include dates, or any specific information (e.g., observations of target behaviors, specific antecedents and consequences observed, reports by caregivers).

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

Summary: PBSPs were current. This had been the case for all individuals for this review and for the previous two reviews, too, with one exception in March 2016. Therefore, indicator 14 will be moved to the category of requiring less oversight. The other two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	71% 5/7	1/1	N/A	0/1	1/1	1/1	1/1	N/A	0/1	1/1
14	The PBSP was current (within the past 12 months).	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	N/A	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	71% 5/7	0/1	N/A	1/1	1/1	1/1	1/1	N/A	1/1	0/1

Comments:
13. Individual #119 and Individual #299'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 seven

PBSPs reviewed contained all of those components. The replacement behavior for Individual #322's aggression, and Individual #72's target behaviors were not functional, or had an explanation of why functional replacement behaviors were not practical or functional.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
Summary:			Individuals:								
#	Indicator	Overall Score									
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.										
Comments:											

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Based on the Monitoring Team's review of annual medical assessments for other indicators, the Center regressed with regard to the completion of timely annual medical assessments. As a result, Indicator b will move back to active oversight. The IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. Moreover, the Center did not provide any interim reviews for any of the individuals reviewed. This is of significant concern. The Center should correct this longstanding issue immediately. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
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.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
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.	Given that in numerous instances, PCPs did not complete timely annual medical assessments, Indicator b will move back to active oversight.									
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: b. Four individuals (i.e., Individual #77, Individual #346, Individual #344 – last one completed in April 2016, and Individual #98) did not have timely annual medical assessments, because they were not completed within 356 days of the previous one.											

c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." Interval reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interval reviews will need to occur more frequently. The IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. Moreover, the Center did not provide any interim reviews for any of the individuals reviewed. This is of significant concern. The Center should correct this longstanding issue immediately.

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Center staff should improve the quality of the medical assessments. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
a.	Individual receives quality AMA.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. Problems varied across the medical assessments the Monitoring Team reviewed. Individual #344's was dated 4/12/16, and given that it was at least four months overdue, was scored as not meeting the requirements for a quality AMA. It was positive that as applicable to the individuals reviewed, all of the remaining annual medical assessments addressed social/smoking histories, past medical histories, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information.

Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, pre-natal histories, family history, childhood illnesses, updated active problem lists, and plans of care for each active medical problem, when appropriate. All of these areas needed significant work. When family members are available, PCPs need to make and document efforts to obtain histories on the individuals, as well as pertinent information about family medical history. Often, plans of care were generic, and did not set forth the PCP's plan for the specific individual. For example, for an active medical problem such as osteoporosis, the PCP outlined the general care of osteoporosis, including calcium and Vitamin D supplementation, lab ordering, DEXA requirements, and medical treatment. This was simply an abbreviated version of a clinical guideline that did not state if any of these interventions were completed or would be implemented for the individual. Overall, the AMAs reviewed did not include individualized plans of care consistent with current practice guidelines. This is an area on which the Medical Department should focus.

c. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #119 – cardiac disease, and osteoporosis; Individual #153 – constipation/bowel obstruction, and seizures; Individual #363 – osteoporosis, and seizures; Individual #77 – other: advanced kidney disease, and other: pulmonary embolism and deep vein thrombosis; Individual #144

– seizures, and other: hypothyroidism; Individual #346 – diabetes, and other: hypertension, and hyperlipidemia; Individual #344 – other: colon cancer, and cardiac disease; Individual #98 – cardiac disease, and gastrointestinal (GI) problems; and Individual #370 – infections, and other: Hepatitis C].

As noted above, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

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	119	153	363	77	144	346	344	98	370
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	11% 2/18	0/2	1/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #119 – cardiac disease, and osteoporosis; Individual #153 – constipation/bowel obstruction, and seizures; Individual #363 – osteoporosis, and seizures; Individual #77 – other: advanced kidney disease, and other: pulmonary embolism and deep vein thrombosis; Individual #144 – seizures, and other: hypothyroidism; Individual #346 – diabetes, and other: hypertension, and hyperlipidemia; Individual #344 – other: colon cancer, and cardiac disease; Individual #98 – cardiac disease, and GI problems; and Individual #370 – infections, and other: Hepatitis C).

The IHCPs for Individual #153 –seizures, and Individual #363 – osteoporosis included action steps/interventions describing medical care the individual needed that were consistent with related guidelines/standards of practice.

b. As noted above, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: The Center should focus on completing timely annual dental exams, as well as improving the quality of dental exams and summaries.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
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.	0% 0/8	0/1	0/1	0/1	0/1	0/1	N/R	0/1	0/1	0/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
b.	Individual receives a comprehensive dental examination.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	0% 0/8	0/1	0/1	0/1	0/1	0/1	N/R	0/1	0/1	0/1

Comments: The Monitoring Team conducted a limited review for Individual #346.

b. It was good to see that all of the dental exams reviewed included the following, as applicable:

- A description of the individual's cooperation;
- An oral cancer screening;
- An oral hygiene rating completed prior to treatment;
- Periodontal charting;
- A description of periodontal condition;
- Caries risk;
- Periodontal risk;
- Specific treatment provided; and
- The recall frequency.

Most, but not all included:

- Sedation use;
- Information regarding last x-ray(s) and type of x-ray, including the date; and
- A treatment plan.

Moving forward, the Center should focus on ensuring dental exams include, as applicable:

- An odontogram; and
- A summary of the number of teeth present/missing.

c. On a positive note, all of the dental summaries included the following, as applicable:

- Recommendations related to the need for desensitization or other plan;
- Effectiveness of pre-treatment sedation;
- Recommendations for the risk level for the IRRF; and
- Dental care recommendations.

Most included:

- 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;
- Provision of written oral hygiene instructions; and
- Treatment plan, including the recall frequency.

Moving forward the Center should focus on ensuring dental summaries include the following, as applicable:

- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health; and
- A description of the treatment provided.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.

Summary: Due to issues with IRIS as well as concerns related to adherence to basic nursing standards, full nursing physical assessments were not documented for any of the individuals reviewed (e.g., missing weight graphs, fall assessments, and assessments of reproductive systems; lack of follow-up and/or analysis of abnormal findings; and incomplete mental status descriptions). The remaining indicators also require continued focus to ensure nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice. All of these indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
	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.	0% 0/10	0/1	N/A	0/1	0/2	0/2	0/1	0/1	0/1	0/1

Comments: a. Problems were noted for all nine individuals with regard to completion of thorough physical assessments, including weight graphs, fall assessments, and assessments of reproductive systems. Often, descriptions of individuals' mental status were incomplete (e.g., "oriented x3 without providing descriptions as to what they were oriented). In addition, abnormal findings (e.g., vital signs, pain) often did not result in further analysis, narrative, or follow-up.

This largely appeared to be due to issues with IRIS, although some basic requirements for standard nursing assessment were not met. The nurses on the Monitoring Team have discussed the issues with IRIS with the State Office Nursing Discipline Lead, and actions are being taken to address them. The nursing member of the Monitoring Team also discussed these issues in detail with the Chief Nurse Executive, the Nurse Educators, as well as RN Case Managers while on site.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #119 – respiratory compromise, and circulatory; Individual #153 – constipation/bowel obstruction, and seizures; Individual #363 – weight, and fractures; Individual #77 – diabetes, and UTIs; Individual #144 – falls, and skin integrity; Individual #346 – respiratory compromise, and cardiac disease; Individual #344 – constipation/bowel obstruction, and infections; Individual #98 – aspiration, and GI problems; and Individual #370 – seizures, and GI problems).

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. The following provide a few of examples of concerns related to nursing assessments in accordance with nursing protocols or current standards of practice in relation to individuals' changes of status:

- On 2/8/17, Individual #119 was seen in the clinic, and diagnosed with an upper respiratory infection (URI). A corroborating

nursing IPN was found describing the nurse's completion of an assessment and placement of the individual on the sick-call list. However, no acute care plan was found to define the frequency of assessment to address the URI that required the prescription of an antibiotic. Documentation of regular nursing assessments was not found. On 2/9/17 at 8:41 a.m., a medical progress note read in part: "call received regarding status of [Individual #119]. He has had about a 48 hr time of being unsteady… with complaints [of] headache last night. He also is reported to have an episode of twitching and not responsive… possibly a seizure. He does not have hx [history] of seizures. He does have hx of excess thirst and low sodium. PERRL [Pupils that are Equal, Round and Reactive to Light], he is able to say he wants to go to the hospital." On 2/9/17, Individual #119 was sent to ED, and admitted to the hospital. On 2/17/17, he returned to the Center with diagnoses of bibasilar pneumonia, large left pleural effusion/hemothorax, hyponatremia, and dysphagia.

- Individual #77's Quarterly Nursing Assessment, dated 3/14/17, reported: "On 1/5/17, HBA1c [Hemoglobin A1C] was 8.5, and her glucoses have fluctuated greatly in the past nine months." However, although IView entries sometimes documented elevated blood glucose levels, corresponding nursing IPNs were not found to document nursing assessments of potential symptoms.
- On 6/4/17 at 10:54 a.m., a nursing IPN denoted that Individual #144 "fell and landed on forehead and hands in room." Staff notified the physician, who ordered mild neuro checks. Nursing staff did not follow the Nursing Protocol for Mild Head Injury in terms of frequency of assessments, and an acute care plan was not provided.
- On 2/3/17, Individual #144 was the victim of an incident of peer-to-peer aggression, and sustained a human bite. Nursing staff initiated vital signs and documented a description of the wound, and assessed pain in accordance with the related nursing protocol, which was good to see. However, the nursing IPN, dated 2/3/17 at 2:06 p.m., and the personal injury report, dated 2/3/17 1:32 p.m., did not include a statement of whether or not his immunization history was reviewed for current Tetanus. Although the nursing entry indicated the individual's skin was broken and there was bleeding, no additional information was included as to whether this was reported to the Infection Preventionist to ensure adherence to the Center's protocols for human bites and blood borne pathogens. Moreover, the next nursing IPN was dated 3/6/17, which showed a lack of ongoing nursing assessment of this serious injury.

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 four 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: 119	153	363	77	144	346	344	98	370
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. through f. Much work was needed to improve the IHCPs for the individuals reviewed.											

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: Some improvement was noted with regard to the quality of PNMT assessments. In addition to continuing its efforts to improve assessment quality, the Center should focus on the timely referral of individuals to the PNMT, timely completion of the PNMT initial review, completion of PNMT comprehensive assessments for individuals needing them, and involvement of the necessary disciplines in the review/assessment. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	38% 3/8	0/1	N/A	1/2	0/1	0/1	N/A	0/1	1/1	1/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	50% 4/8	0/1		1/2	0/1	0/1		1/1	1/1	1/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/4	0/1		0/1	N/A	N/A		0/1	0/1	N/A
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	50% 4/8	0/1		1/2	0/1	0/1		1/1	1/1	1/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review	67%	1/1		1/2	0/1	N/A		1/1	1/1	N/A

	is completed, and the PNMT discusses the results.	4/6									
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	38% 3/8	0/1		1/2	0/1	0/1		0/1	1/1	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 for a full assessment plan.	0% 0/6	0/1		0/1	0/1	0/1		0/1	N/A	0/1
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	50% 2/4	0/1		0/1	N/A	N/A		1/1	1/1	N/A

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

- On 2/9/17, Individual #119 was sent to the ED, and admitted to the hospital. On 2/17/17, he returned to the Center with diagnoses of bibasilar pneumonia, large left pleural effusion/hemothorax, hyponatremia, and dysphagia. This was a significant hospitalization, but the Center did not submit documentation of an ISPA meeting. It also did not appear that the PNMT conducted a review, although the PNMT nurse completed a post-hospitalization assessment and was involved with the completion of a Head-of-Bed Elevation evaluation (HOBE). The PNMT PT also wrote a brief note that indicated Individual #119 was "unsteady, but OK." This note did not discuss the falls that Individual #119 had experienced since the previous ISP meeting and since the hospitalization. At a minimum, the PNMT should have documented a team review, and summarized the activity and supports added surrounding his change in status. In July 2017, the Pneumonia Committee determined that the pneumonia Individual #119 had in February was aspiration pneumonia, but still the IDT did not make a referral, and the PNMT did not conduct a review or assessment. Moreover, in August 2017, he had another episode of aspiration pneumonia, but the PNMT did not conduct a review or assessment.
- On 3/22/17, the PNMT made a self–referral of Individual #363 due to a long-bone fracture that occurred on 3/16/17. It was good to see that the PNMT identified the need for a review of this event. However, the PNMT did not complete its assessment until 8/9/17. The PNMT assessment indicated that the Hospital Liaison conducted a post-hospital review for the PNMT RN, but no evidence of this was submitted for the Monitoring Team's review.

  In addition, the information the Center provided regarding a pneumonia event was contradictory. Tier I documentation indicated that on 5/10/17, Individual #363 experienced aspiration pneumonia. However, PNMT and other IPN references in Tier II documents identified this event as pneumonia (klebsiella per sputum culture). The PNMT minutes included discussion of Individual #363, but no formal IPN documentation was found of team review. At a minimum, the PNMT should have conducted a review due to complications related to bronchiectasis, the need for reflux precautions, the need for a safe eating

plan, the previous swallow study that identified trace aspiration with large liquid boluses, her high-risk rating for aspiration/respiratory concerns, and significant weight loss. At the time of this pneumonia diagnosis, Individual #363 was on the PNMT's caseload for the femur fracture, and a review of the pneumonia would have been appropriate. However, the PNMT did not provide clinical justification for not completing an assessment related to the pneumonia and weight loss.

- During Individual #77's hospitalization for bilateral urethra re-implantation, a small bowel obstruction was identified. However, no evidence was found that the PNMT conducted a review. The RN post-hospitalization review, dated 2/22/17, did not address the bowel obstruction.
- The frequency and duration of Individual #144's falls warranted PNMT review. During the previous year, he had 20 falls, and in the seven months this year, he had fallen 16 times. Individual #144's IDT had not referred him to the PNMT.
- Individual #344's weight had fallen below the previously established referral threshold, and his IDT did not make a referral back to the PNMT in a timely manner. More specifically, in March 2016, Individual #344 met the threshold of 118 pounds, and at time of evaluation on 12/22/16, due to aspiration pneumonia, his weight was 103 pounds, and he had a Stage 1 pressure injury. On 5/5/17, the PNMT completed its assessment.
- The PNMT assessed Individual #98 due to a diagnosis of aspiration pneumonia. On 12/9/16, the PNMT initiated the assessment, but did not complete it until 7/24/17.
- For Individual #370, the PNMT tracked the incidence of vomiting, which had stopped. They conducted a review to determine which interventions were effective. The PNMT's review did not recommend relevant and measurable goals related to emesis and weight reduction, including, for example, exercise.

h. As noted above, one individual who should have had comprehensive PNMT assessments did not (i.e., Individual #119). It was positive that Individual #344 and Individual #98's PNMT assessments were thorough, and included the information, assessments, and analysis necessary to address the individuals' needs. The following summarizes some of the concerns noted with Individual #363's PNMT assessment:

- The medical history listed was extensive, but was not presented in a concise, cohesive, and meaningful way, including identifying for the reader the most relevant portions. The PNMT did not provide a rationale as to why the last entries, including the analysis and outlined goals and recommendations, were dated 8/9/17 for an assessment initiated on 3/22/17. The discussion of existing supports did not address the progress with direct PT (this would be expected as the evaluation had continued well into the provision of this service). The PNMT did not recommend a clinically relevant, measurable goal(s), but rather only included a goal that she would have a healed femur fracture with supports in place, including ambulation, use of a rolling walker, and active therapy towards independent walking. The PNMT did not offer other goals for other issues identified that might have contributed to the fracture (i.e., to address potential etiologies).

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: No improvement was seen with regard to these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370

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	0/2	0/2	1/2	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	0/1	0/1	1/1	0/1	N/A
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in 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
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% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	22% 4/18	1/2	1/2	0/2	0/2	2/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: falls, and aspiration for Individual #119; choking, and falls for Individual #153; fractures, and respiratory compromise for Individual #363; choking, and constipation/bowel obstruction for Individual #77; choking, and falls for Individual #144; choking, and respiratory compromise for Individual #346; weight, and aspiration for Individual #344; fractures, and aspiration for Individual #98; and GI problems, and weight for Individual #370.

a. and b. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP, and/or include preventative physical and nutritional management interventions to minimize the individuals' risks.

c. Individual #153, and Individual #370 did not have PNMPs and/or Dining Plans. The PNMP for Individual #344 included all of the necessary components to meet the individual's needs.

Working with the IDT, Habilitation Therapies staff had not developed a PNMP for Individual #363. Rather, six "temporary PNMP change forms" were submitted. Given she did not have a PNMP, it was unclear to what the changes referred. She also had a Dining Plan.

Problems varied across the remaining PNMPs and/or Dining Plans. For example, some did not include a full list of risks (e.g., Individual #119's and Individual #144's PNMPs did not include their fall risks). In other cases, PNMPs did not include complete precautions for fragile bones, and/or descriptions of the individuals' communication (i.e., Individual #346's PNMP did not identify how he communicated his wants and needs, in other words that he used verbal communication).

d. through f. None of the IHCPs reviewed identified the action steps necessary to meet the objective, the necessary clinical indicators, or the triggers and actions to take should they occur. g. Most of the IHCPs reviewed did not include the frequency of PNMP monitoring. The exceptions were for aspiration for Individual #119, choking for Individual #153, and choking, and falls for Individual #144.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
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% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	0/1	0/1	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/2							0/1	0/1	
Comments: a. and b. The Monitoring Team found no evidence of the IDT revising Individual #344's IRRF or IHCP in response to his change of status requiring placement of an enteral tube. For Individual #98, an ISPA meeting, held on 4/19/17, included only the QIDP, RN Case Manager, and BHS staff. This was not a properly constituted IDT to make the determination that there was medical necessity for the continuation of the enteral tube, and that the individual was not a candidate for a plan to move along the continuum to oral intake.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: Over the past four reviews, 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 regressed. The quality of OT/PT assessments continues to be an area on which Center staff should focus as well. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	119	153	363	77	144	346	344	98	370

		Score									
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									
	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.	57% 4/7	0/1	0/1	1/1	N/R	1/1	N/R	1/1	1/1	0/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	43% 3/7	0/1	0/1	0/1		1/1		1/1	1/1	0/1
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: ▪ 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.	0% 0/1	N/A	0/1	N/A		N/A		N/A	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/3	0/1	0/1	0/1		N/A		N/A	N/A	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/4	N/A	N/A	N/A		0/1		0/1	0/1	0/1

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

- In February and August 2017, Individual #119 had significant changes of status. The OT and PT completed post-hospitalization assessments, but did not provide rationales for not completing a new comprehensive assessment, even though his change of status resulted in falls, an unsteady gait, and swallowing deficits. These changes required the addition of a PNMP and Dining Plan, when he had not had one previously, and thus justified completion of a new comprehensive assessment.
- Individual #153 had a screening for his ISP. However, between December 2016 and the Monitoring Team's review, he had numerous falls, which appeared to be a change of status. The OT/PT did not conduct a review or assessment.
- On 3/20/17 and 5/19/17, the OT/PT completed consults related to Individual #363's femur fracture (i.e., that occurred on 3/16/17), and post-hospitalization for pneumonia, respectively. These did not provide thorough assessments, descriptions of the accident, and/or baseline functional status. The OT/PT should have conducted at least an update or a comprehensive assessment. On 6/20/17, the OT/PT completed a comprehensive assessment for the ISP meeting on 7/13/17.
- For Individual #370, the OT/PT did not complete an update for her ISP on 4/20/17. One was necessary to provide a summary/justification for discontinuing services.

d. As discussed above, two individuals who should have had comprehensive assessments did not (i.e., Individual #119, and Individual #153). Individual #363's comprehensive assessment contained insufficient information about the course of treatment for her femur fracture.

e. As noted above, the OT/PT did not complete an update for Individual #370, but should have. The following summarizes some examples of concerns noted with regard to the required components of the OT/PT assessments the Monitoring Team reviewed:

- 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 the two applicable individuals, the assessments did not clearly describe their wheelchairs, fit, or condition;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: For two individuals, the assessments did not address the effectiveness of programs;
- 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: Because individuals often did not have goals/objectives that were clinically relevant and measurable, the updates did not include evidence regarding progress, maintenance, or regression. For one individual, justification was not provided for not developing OT/PT supports to address identified needs; 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: Without clear analyses of current supports, and/or clinical justification regarding current or potential supports, it was unclear whether or not assessments included all relevant recommendations.

On a positive note, as applicable, all of the updates reviewed provided:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services;

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- 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: Improvements are needed with regard to integration of OT/PT supports and services into individuals' ISPs. The Monitoring Team will continue to review these indicators.

#	Indicator	Overall Score	Individuals: 119	153	363	77	144	346	344	98	370
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	14% 1/7	0/1	0/1	0/1	N/R	1/1	N/R	0/1	0/1	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.	17% 1/6	0/1	0/1	0/1		0/1		1/1	0/1	N/A
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	20% 1/5	N/A	0/1	0/1		0/1		1/1	N/A	0/1
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.	50% 1/2	N/A	N/A	0/1		1/1		N/A	N/A	N/A

Comments: b. Individual #153 did not have a PNMP, but given his falls, the IDT should have considered the need for one, and documented the results of their discussion. For other individuals, simply including a stock statement such as "Team reviewed and approved PNMP" did not provide evidence of what the IDT reviewed, revised, and/or approved.

c. and d. Examples of concerns noted included:

- For Individual #363, it did not appear that PT interventions post-fracture were ever integrated into her ISP through an ISPA.
- Although it appeared that Individual #144 had a sensory toolbox and activities, they were not integrated into the ISP.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: It was good to see continued improvement with regard to the timeliness of communication screenings and assessments, as well as the provision of the correct type of assessment (i.e., a screening, comprehensive assessment, or update). If the Center maintains this progress, then at the time of the next review, Indicators a and b might move to the category of less oversight. Improvements are needed with regard to the quality of communication assessments and updates. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
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					
	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.	100% 8/8	1/1	1/1	1/1		1/1	1/1	1/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	100% 8/8	1/1	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;	0% 0/4	0/1	0/1	N/A		N/A	0/1	N/A	N/A	0/1

	▪ 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.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/2	N/A	N/A	0/1		0/1	N/A	N/A	N/A	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	50% 1/2	N/A	N/A	N/A		N/A	N/A	1/1	0/1	N/A

Comments: Individual #77 did not have a need for formal communication supports or services, and was part of the outcome group, so these indicators were not reviewed for her.

a. and b. It was positive that individuals reviewed had timely communication screenings or assessments.

c. None of the screenings reviewed discussed the impact of medications on the individuals' communication.

d. The following describes some of the concerns with the two comprehensive assessments reviewed:

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services: Although Individual #363's assessment listed her medications and the general side effects, it lacked discussion of whether such side effects had been noted as having an impact on her communication;
- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills: Individual #363's assessment provided limited discussion of functional skills and possibilities for expansion of skills;
- A comparative analysis of current communication function with previous assessments: For Individual #363, no comparative analysis from previous assessments was noted;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated: For Individual #363, there was no evidence of collaboration or communication, and for Individual #144, the BHS staff made a recommendation related to the use of sign language, but the Speech Language Pathologist (SLP) did not reconcile that with her recommendation for mid- and low-tech AAC devices; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Given that thorough assessments were not completed of individuals' communication needs, it was unclear whether or not the assessments included a full set of recommendations to address individuals' needs (e.g., individuals' behavioral needs in relation to their communication needs, measurable outcomes, supports to address hearing deficits, etc.).

On a positive note, both assessments provided:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- The individuals' preferences and strengths were discussed and, as appropriate, used in the development of communication supports and services;
- The effectiveness of current supports, including monitoring findings; and
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services.

e. It was positive that Individual #344's update included all of the necessary components to address his communication strengths and needs, and incorporated his preferences. Individual #98's update did not address her diagnosis of Alzheimer's Disease/dementia, including assessing whether or not AAC or EC would help to address her changing needs, and/or to make other recommendations related to her communication needs.

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: These indicators will remain in active oversight.

#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
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.	38% 3/8	1/1	0/1	0/1	N/R	0/1	0/1	0/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/3	N/A	N/A	N/A		0/1	N/A	0/1	0/1	N/A
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	0% 0/3	N/A	N/A	0/1		0/1	N/A	N/A	0/1	N/A
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: a. Individual #98's ISP provided a particularly good description of her communication skills and abilities, and how staff should communicate with her. For individuals' ISPs that did not meet the criterion, problems were noted with, for example, contradictions between what the ISP said and what the communication assessment said, incomplete descriptions of how the individual communicated, lack of identification of how staff should communicate with the individual, failure to identify AAC devices identified in the communication assessment, etc.

b. Simply including a stock statement such as "Team reviewed and approved communication strategies" did not provide evidence of what the IDT reviewed, revised, and/or approved. Individual #144's IDT did not document discussion and/or reconcile the different recommendations that the SLP and BHS staff made regarding the best way for him to communicate (i.e., sign language or AAC).

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: About half of the individuals at San Angelo SSLC had zero skill acquisition plans. This was surprising given that each individual had many areas of his or her life for which skill development would improve independence, satisfaction, and quality of life. The other individuals had some SAPs, but very few, also given their many needs. This was also the case at the last review, too. For the small number of SAPs, they were all written in measurable terms, but many were not based on assessments and/or were not practical, functional, and meaningful for the individual. Further, useful reliable data were not collected or determined. This set of indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
1	The individual has skill acquisition plans.	56% 5/9	1/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1	0/1
2	The SAPs are measurable.	100% 9/9	3/3	2/2	1/1	None	2/2	None	1/1	None	None
3	The individual's SAPs were based on assessment results.	78% 7/9	2/3	2/2	1/1	None	2/2	None	0/1	None	None
4	SAPs are practical, functional, and meaningful.	44% 4/9	1/3	2/2	1/1	None	0/2	None	0/1	None	None
5	Reliable and valid data are available that report/summarize the individual's status and progress.	11% 1/9	0/3	0/2	0/1	None	0/2	None	1/1	None	None
Comments: 1. Individual #72, Individual #119, Individual #358, and Individual #227 did not have any skill acquisition plans (SAPs). The Monitoring Team chooses three current SAPs for each individual for review. There was one SAP available to review for Individual #299 and Individual #153, and two SAPs available for Individual #200 and Individual #316 for a total of nine SAPs for this review. This was substantially lower than the 27 SAPs usually reviewed at a center, and was lower than the number of SAPs available at the last review. Ensuring that every individual has meaningful SAPs needs to be a priority for San Angelo SSLC.											

3. Many of the SAPs were based on assessment results. Individual #322's prepare a meal SAP and Individual #153's safe cooking SAP were inconsistent with their functional skills assessments (FSAs), which indicated they could complete the tasks independently.

4. Four SAPs were practical and functional (e.g., Individual #316's count her change, and state her medical information SAPs, Individual #322's calculate the money he needs SAP, and Individual #299's state her medical information). 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 #322's state the name of his medication SAP), or assessment data indicated the individual already possessed the skill (e.g., Individual #322's prepare a meal SAP). Other SAPs were impractical because they required individuals to merely verbally describe skills that they ultimately needed to perform to be meaningful rather than engage in the actual skill (e.g., Individual #153's safe cooking SAP which required Individual #153 to answer questions concerning safe cooking, rather than having him demonstrate safe cooking).

5. Individual #153's safe cooking SAP had interobserver agreement (IOA) demonstrating that the data were reliable. 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: Performance deteriorated for indicators 10 and 12 and stayed the same (low) for indicator 11. Attention to these assessments can help set the stage for, and may account somewhat for the absence of, a good set of SAPs (as noted in indicator 1). These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 322	316	299	358	200	227	153	119	72
10	The individual has a current FSA, PSI, and vocational assessment.	78% 7/9	1/1	0/1	0/1	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	0/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1	1/1
12	These assessments included recommendations for skill acquisition.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
10. Individual #316 had an FSA summary, but no FSA. Individual #299 did not have an FSA.

11. Individual #358, Individual #153, and Individual #72's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to their ISP. Some individuals FSAs were late (e.g., Individual #119); others' vocational assessments were late (e.g., Individual #299).

12. None of the individuals had recommendations for SAPs in both their vocational and functional skills assessments.

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. At the last review, 19 of these indicators were moved to the category of requiring less oversight. For this review, five other indicators were added to this category, in psychiatry, behavioral health, and dental. Two indicators in restraints and behavioral health, however, were moved back into active monitoring.

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.

<u>Goals/Objectives and Review of Progress</u>
Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress with regard to individuals' physical and/or dental health. In addition, integrated progress reports, including data and analysis of the data, were not available to IDTs. 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.

With the recent hiring of full-time psychiatry providers, the psychiatry department was now more stable than it had been in a long time. As a result, a number of psychiatry-related activities that were not occurring at criteria were more likely to show improvement in the future. These activities included: quarterly reviews not being held/completed in a timely manner for some individuals, delays in the review of the medication side effect assessments by the prescribing practitioner, and follow-up to emergency/interim clinics.

There was not an on-campus neurology clinic. Individuals go off-campus for these consultations. Due to this, it is difficult to create collaborative treatment for individuals who are prescribed medications for a dual purpose.

Polypharmacy-related activities and protections remained at about the same level of performance as during the last two reviews. Some guidance might be helpful from state office regarding the operation of the polypharmacy committee. Many individuals had frequent medication changes. A number of individuals were on multiple antipsychotic medications.

Graphic presentations of behavioral health services data were useful for making decisions. San Angelo SSLC behavioral health services programming included adequate data collection systems for PBSPs. On the other hand, the Center did not achieve any of their targets for assessing data collection and treatment integrity. San Angelo SSLC did not maintain long-standing good performance with regards to peer review.

Acute Illnesses/Occurrences

In psychiatry, without measurable goals, progress could not be determined. Even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. The content and quality of the psychiatric clinics observed directly by the Monitoring Team met the various criteria. This was good to see.

Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected.

Areas in need of focused attention include ensuring that PCPs conduct assessments of acute illnesses, and conduct follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of the acute illness. Significant improvement also is needed with regard to IDTs conducting post-hospitalization reviews to identify action steps to address follow-up medical and healthcare supports to reduce risks and promote early recognition of potential problems. On a positive note, when the individuals reviewed were transferred to the hospital the PCP or nurse communicated necessary clinical information with hospital staff.

For the one dental emergency reviewed, dental services were not available at the Center to address the individual's needs, and it appeared that a back-up system was not in place to provide coverage during a two-week absence of the Dental Director.

Implementation of Plans

Regarding the use of crisis intervention restraint more than three times in any rolling 30-day period, three individuals in the review group had this occur. Overall, the various criteria in this set of indicators continued to be met. One area for focus is in the crisis intervention plans regarding the quality and specificity of the descriptions of the conditions under which crisis intervention restraint should be implemented.

In behavioral health, San Angelo SSLC had good reliable data for six of the individuals. This was good to see and three of them were making progress. Moreover, given that two of these six individuals met criteria for all indicators for outcomes 1 and 2 in psychology/behavioral health, a deeper review will not be conducted for them.

Attention, however, is needed to address/update the individual's PBSP when objectives are met and when objectives are not met (i.e., progress is not occurring). San Angelo SSLC continued to not meet criteria for staff training. This should be a priority.

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 should 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. Such treatments, interventions, and strategies also need to be included in IHCPs, and PCPs need to implement them timely and thoroughly.

For the consultations reviewed, the PCPs with few exceptions reviewed them and indicated agreement or disagreement, did so in a timely manner, and wrote corresponding IPNs that met the requirements of State Office policy. PCPs wrote orders for agreed-upon recommendations. The Center needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

The Center should 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.

It was positive that for the individuals reviewed, the Dental Department generally provided prophylactic care, treatment for periodontal disease, and restorative work in a timely manner. For this review and the last two, they also generally provided individuals and/or their staff with tooth brushing instruction, so this indicator will move to the category of less oversight. For the individuals reviewed with missing teeth, the Dental Department often did not provide recommendations regarding dentures. This is an area that needs attention.

Center staff need to include measurable action steps in the ISPs/IHCPs of individuals who require suction tooth brushing, ensure the action steps are implemented, monitor the quality of the technique staff use to provide it, and review relevant data monthly. It was concerning that these basic steps had not occurred for individuals reviewed.

Since the last review, good improvement was noted with regard to the timeliness of the completion of QDRRs. However, for most QDRRs reviewed, the Clinical Pharmacist had not conducted a thorough review of labs, and/or made recommendations to address concerns related to lab monitoring. Although some improvement was noted since the last review with regard to prescribers' timely review of QDRRs, more work was needed. Additional work also was needed to ensure prescribers order agreed-upon recommendations.

Over the past three reviews, the Center regressed with regard to the referral of individuals to the PNMT, when needed (i.e., Round 10 – 100%, Round 11 – 75%, and Round 12 – 44%). The Center should determine what has caused this change, and take action to correct it.

Proper fit of adaptive equipment was sometimes still an issue.

Based on observations, there were still numerous instances (55% of 38 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.

Summary: The IDT met as required and with sustained high performance, this indicator (18) might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring. The content of the crisis intervention plans, however, did not maintain at criteria as detailed in the comments below and, therefore, indicator 27 will be returned to active monitoring.

Individuals:

#	Indicator	Overall Score	316	358	200						
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	100% 3/3	1/1	1/1	1/1						
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. Indicator 27, however, decreased in performance and will be returned to active monitoring.									
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.										

#	Item	
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.	
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?	
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.	
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	
26	The PBSP was complete.	
27	The crisis intervention plan was complete.	
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	
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.	

Comments:
27. None of the CIPs clearly specified the designated approved restraint situation. They simply stated the occurrence of the target behaviors, without specifying the intensity, exhaustion of less restrictive interventions, potential injury to the individual or others, etc., as being necessary prior to restraint.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
Summary: Individuals not receiving psychiatric services had a screening conducted. This was the case for this review and for reviews in rounds 11 and 9 (no individuals were monitored in round 10). Therefore, indicator 1 will be moved to the category of requiring less oversight. The other two indicators will remain in active monitoring for review at the next onsite visit.			Individuals:								
#	Indicator	Overall Score	98								
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. Individual #98 was assessed utilizing the Reiss screen. Based on the results of the screen, no further evaluation was necessary.											

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	322	316	299	358	200	227	153	119	72
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%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

		9/9									

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. This was the case for all individuals in the review group.

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

Summary: Performance regarding the cross-referencing of information between these two disciplines improved to 67% from near 0% scores at the last two reviews. This progress was good to see. Psychiatrist participation in an important aspect of this coordination, that is, the development of the PBSP, however, remained at 0% for the third consecutive review. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 322	316	299	358	200	227	153	119	72
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 behaviors.	67% 6/9	0/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1
24	The psychiatrist participated in the development of the PBSP.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
23. The psychiatric documentation referenced specific behaviors that were being tracked by behavioral health. The psychiatrist attempted to correlate the behavioral health target behaviors to the diagnosis. In addition, the functional assessment generally included information regarding the individual's psychiatric diagnosis and included the effects of said diagnosis on the target behaviors.

24. There was no documentation of the psychiatrist's review of the PBSP in the psychiatric clinical documentation.

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: These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 322	316	299	358	200	227	153	119	72
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1

26	Frequency was at least annual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1

Comments:
25 and 27. These indicators applied to one individual, Individual #72. Individual #72 has a diagnosis of seizure disorder and was prescribed an antiepileptic medication as a result. He was seen in neurology clinic twice in the last year, with the most recent neurology consultation dated 4/4/17. At the time of the last neurology consultation, it was noted that he had been seizure-free for a period of time, but that the neurologist wanted to continue the medication and follow-up with this individual in clinic in six months. On 5/12/17, the psychiatrist documented the determination that psychiatry would assume responsibility for the management of the antiepileptic medication. There was no documentation of a consultation between neurology and psychiatry prior to this decision. It should be noted that this change in designation was performed by a psychiatry provider who was relatively new to the facility and might have been unfamiliar with the need for interdisciplinary consultation.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.

Summary: With the hiring of full-time psychiatrists, conduct and documentation of quarterly reviews is likely to improve. That being said, the content and quality of the psychiatric reviews observed directly by the Monitoring Team met the various criteria (indicator 35). This was good to see. These three indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
33	Quarterly reviews were completed quarterly.	78% 7/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1
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.	100% 2/2	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	1/1

Comments:
33. Quarterly reviews were not completed in a timely manner for two individuals. The last quarterly evaluation regarding Individual #200 was completed 5/2/17. There should have been a quarterly performed in August 2017. An annual evaluation regarding Individual #119 was completed in November 2016. The next quarterly evaluation was dated in April 2017. There should have been a quarterly evaluation performed in February 2017.

34. The Monitoring Team looks for nine components of the quarterly review. In general, reviews were missing three to eight components; most commonly, basic information such as height and weight and vital signs, results of the most recent MOSES and AIMS, a review of the implementation of non-pharmacological interventions recommended by the psychiatrist and approved by the IDT, and the

attendance sign in sheet. While the MOSES/DISCUS scores were generally included, the date of the assessment was not designated, so it was not possible to determine what assessment was utilized. In four examples, regarding Individual #322, Individual #299, Individual #200, and Individual #153, the most recent quarterly documentation utilized for scoring was in the form of a brief IPN, which did not address the required elements.

35. Psychiatry clinic was observed for two individuals in the review group. Overall, the psychiatric treatment providers did a good job of leading the clinical discussion and reviewing available information. In both examples, the behavioral health data were up to date, graphed, and explained by behavioral health staff. In both examples, the data focused on challenging behaviors and not on psychiatric symptom experience.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: As noted in outcome 10 above, the hiring of full-time psychiatrists should set the occasion for this indicator to meet the timeline requirements for this indicator. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1

Comments:
36. There were delays in the review of the assessments by the prescribing practitioner in eight cases. The record regarding Individual #153 contained assessments that were reviewed by the prescriber within the required timeframe. Assessments were not performed in a timely manner for Individual #322, Individual #316, Individual #200, Individual #227, and Individual #119.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary: Performance on these two indicators has been steadily declining over this and the past two reviews. Again, with the hiring of full-time psychiatrists, it is likely that the follow-up activities and resultant documentation can meet criteria. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
37	Emergency/urgent and follow-up/interim clinics were available if needed.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	44% 4/9	0/1	1/1	0/1	0/1	0/1	1/1	0/1	1/1	1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	22% 2/9	1/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
38. Emergency/interim clinics were available to individuals and there was documentation of emergency/interim clinics occurring for all individuals. There were examples where the provider requested a follow-up clinic, but there was no documentation that the clinic occurred. This was noted in the records for Individual #322, Individual #299, Individual #358, Individual #200, and Individual #153. 39. There were some examples of inadequate documentation for emergency/urgent or follow-up/interim clinics. For example, the records for Individual #72, Individual #119, Individual #153, Individual #227, Individual #200, Individual #358, and Individual #316 indicated medication adjustments in the absence of a clinical assessment.

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: These indicators maintained at 100%. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
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: Polypharmacy-related activities and protections remained at about the same level of performance as during the last two reviews. Again, with the hiring of full time psychiatry staff, San Angelo SSLC should be able to meet these criteria. Some guidance, however, might be helpful from state office regarding the operation of the polypharmacy committee. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	13% 1/8	0/1	0/1	1/1	0/1	0/1	0/1	N/A	0/1	0/1

#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
45	There is a tapering plan, or rationale for why not.	50% 4/8	0/1	1/1	1/1	1/1	0/1	1/1	N/A	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% 0/7	N/A	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1

Comments:
44. These indicators applied to eight individuals. Polypharmacy justification was appropriately documented for one individual.

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

46. When reviewing the polypharmacy committee meeting minutes, there was no documentation of committee review for the individuals meeting criteria for polypharmacy. Polypharmacy meeting was observed during the onsite visit. This meeting, while well intended, was not a facility level review of the polypharmacy regimens, but rather a case review attended by the individual's IDT members in addition to the facility medical director and pharmacist. The responsibility for the meeting had transitioned to pharmacy, which was a step in the right direction.

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: San Angelo SSLC had good reliable data for six of the individuals. This was good to see and three of them were making progress. Moreover, given that two of these six individuals met criteria for all indicators for outcomes 1 and 2 in psychology/ behavioral health, a deeper review will not be conducted for them (i.e., none of the remaining indicators in psychology/behavioral health are scored in this report for Individual #316 and Individual #153). Attention, however, is needed to address the individual's plan when objectives are met (indicator 7) and when objectives are not met (i.e., progress is not occurring, indicator 8). In those cases where lack of progress was addressed (two cases), those actions were implemented. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
6	The individual is making expected progress	33% 3/9	0/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A

#	Indicator	Overall Score									
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	40% 2/5	0/1	N/A	N/A	1/1	1/1	0/1	N/A	N/A	0/1
9	Activity and/or revisions to treatment were implemented.	100% 2/2	N/A	N/A	N/A	1/1	1/1	N/A	N/A	N/A	N/A

Comments:
6. Individual #153, Individual #316, and Individual #119's PBSP target behaviors were trending downward. Individual #322, Individual #358, Individual #200, Individual #227, and Individual #72 were not making progress. Individual #299 appeared to be progressing, however, this indicator was scored as 0 because her data were not demonstrated to be reliable (see indicator #5).

7. Individual #119's physical aggression objective was achieved in February 2017 and again in May 2017, however, the objective was not updated.

8. Individual #358 and Individual #200 were not making progress, however, their progress notes included actions to address the absence of progress. Individual #72, Individual #227, and Individual #322 were also not making expected progress, however, their progress notes 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: San Angelo SSLC continued to not meet criteria for staff training. This should be a priority. The other two indicators showed good improvement, both moving to 100%. All three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 322	316	299	358	200	227	153	119	72
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.	29% 2/7	0/1	N/A	1/1	0/1	0/1	0/1	N/A	0/1	1/1
17	There was a PBSP summary for float staff.	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	N/A	1/1	1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	N/A	1/1	1/1

Comments:
16. Individual #299 and Individual #72 had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) working in their residence were trained on their PBSPs. The others did not.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.

Summary: Graphic presentations of data were useful for making decisions, as had been the case for all individuals for this review and the past two reviews, too, with

Individuals:

one exception in March 2016. Therefore, indicator 20 will be moved to the category of requiring less oversight. Performance improved for indicator 21, which will remain in active monitoring. San Angelo SSLC did not maintain long-standing good performance with regards to peer review and, therefore, indicator 23 will be returned to active monitoring.											
#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
19	The individual's progress note comments on the progress of the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
20	The graphs are useful for making data based treatment decisions.	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	N/A	1/1	1/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 2/2	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	1/1
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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. However, performance on indicator 23 did not maintain and, therefore, this indicator will be returned to active monitoring.									
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.										

Comments:
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 #153 and Individual #72's psychiatric clinic meetings. In both meetings, current PBSP data were presented and graphed, which encouraged data based decisions by the IDT.

23. San Angelo SSLC had documentation that external peer review meetings consistently occurred, however, internal peer review occurred twice in February 2017 and May of 2017. In order to be scored as complete, internal peer review must occur at least three weeks each month in each last six months, and external peer review must occur at least five times in the last six months.

Outcome 8 – Data are collected correctly and reliably.	
Summary: San Angelo SSLC behavioral health services programming included adequate data collection systems for PBSPs as evidenced by 100% scores for indicators 26 and 27. With sustained high performance, indicator 26 might be moved to the category of requiring less oversight after the next review. The Center	Individuals:

has, however, established and maintained acceptable measures related to data collection and treatment integrity for this review and the last two reviews, too. Therefore, indicators 28 and 29 will be moved to the category of requiring less oversight. On the other hand, the Center did not achieve any of these goals for assessing data collection and treatment integrity. Indicators 26, 27, and 30 will remain in active monitoring.											
#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	N/A	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.	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	N/A	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% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	N/A	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% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	N/A	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/7	0/1	N/A	0/1	0/1	0/1	0/1	N/A	0/1	0/1

Comments:

26-27. At the time of the onsite review, the data collection system for target and replacement 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.

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 did not achieve their established goal frequencies and levels of data collection timeliness, IOA, and treatment integrity for any individuals. Several individuals did not have IOA or treatment integrity at the established frequency (e.g., Individual #200). Others had IOA, treatment integrity, or data collection timeliness measures below the established level (e.g., Individual #358, Individual #72).

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 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	119	153	363	77	144	346	344	98	370
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	6% 1/18	0/2	1/2	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.	6% 1/18	0/2	1/2	0/2	0/2	0/2	0/2	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% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #119 – cardiac disease, and osteoporosis; Individual #153 – constipation/bowel obstruction, and seizures; Individual #363 – osteoporosis, and seizures; Individual #77 – other: advanced kidney disease, and other: pulmonary embolism and deep vein thrombosis; Individual #144 – seizures, and other: hypothyroidism; Individual #346 – diabetes, and other: hypertension, and hyperlipidemia; Individual #344 – other: colon cancer, and cardiac disease; Individual #98 – cardiac disease, and GI problems; and Individual #370 – infections, and other: Hepatitis C). The goal/objective that was clinically relevant and measurable was for Individual #153 – seizures. c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports on these goals, including data and analysis of the data, were not available to IDTs. 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: The Monitoring Team could not confirm the provision of necessary preventative care for any of the nine individuals reviewed. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to	Individuals:

review these indicators until the Center improves its compliance with them, and 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 Center 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.

#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
a.	Individual receives timely preventative care:										
	i. Immunizations	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
	ii. Colorectal cancer screening	33% 1/3	1/1	N/A	N/A	N/A	N/A	N/A	0/1	0/1	N/A
	iii. Breast cancer screening	50% 1/2	N/A	N/A	N/A	0/1	N/A	N/A	N/A	1/1	N/A
	iv. Vision screen	78% 7/9	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
	v. Hearing screen	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	25% 2/8	0/1	0/1	1/1	0/1	0/1	0/1	1/1	0/1	N/A
	vii. Cervical cancer screening	67% 2/3	N/A	N/A	1/1	0/1	N/A	N/A	N/A	N/A	1/1
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.	11% 1/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1

Comments: a. The following provide examples of problems noted:

- State Office staff reported that in reconciling documentation in IRIS with other immunization data, State Office determined that the IRIS immunization record was inaccurate. As a result, the Monitoring Team could not rely on the information provided from IRIS.
- Individual #119's IDT had assigned a medium risk for osteoporosis, but he had not had a DEXA scan.
- Individual #153 had not had an eye examination. In addition, he had several risk factors for osteoporosis, but had not had a DEXA scan.
- Individual #77's AMA was blank regarding her mammogram status. In addition, she was at risk for metabolic bone disease due

to renal disease and prescribed medications, but she had not had a DEXA scan.

- For Individual #144, the Center did not provide formal hearing test results (i.e., an informal test was completed in 2015). Although he was on medications requiring regular vision testing, the Center did not submit a vision consultation. Even though he had used long-term anti-epileptic drugs, he had not had a DEXA scan.
- Individual #346 has a diagnosis of osteoporosis, and for several years, he had been treated with Fosamax. On 1/6/17, the endocrinology consultant made a recommendation to discontinue the medication (drug holiday) due to long-term use. It should be noted that the consultant indicated the last DEXA was performed in 2008. The records documented that a DEXA was completed on 2/3/15, and showed worsening of the bone mineral density in the left hip. This information might have impacted the clinical decision-making of the consultant.
- As discussed in more detail below, Individual #344's 2015 AMA stated under the preventive care section that in 2010, GI declined to perform a colonoscopy due to the need for sedation. There was no documentation that this was discussed with the IDT or guardian. There also was no documentation that an alternative opinion was sought regarding other methods of screening for colon cancer. In September 2016, the individual had a colonoscopy and was diagnosed with colon cancer. Since the diagnosis was made after the completion of the April 2016 AMA and the PCP did not conduct an annual medical assessment in 2017 or complete any interim medical reviews, it could not be determined (from PCP documentation) why the colonoscopy was eventually completed.
- It appears that Individual #98 never had a colonoscopy, and now that she is 81, the PCP documented she did not meet inclusion criteria. She had a DEXA scan in 2003 with a diagnosis of osteoporosis for which she still was prescribed Alendronate. However, the DEXA was never repeated.

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. For the individuals reviewed, only Individual #346's PCP included a full discussion of the risks. Other PCPs had cut and pasted from the QDRRs without further analysis and discussion, did not address the risks at all, and/or only addressed a partial list of the risks that were applicable to the individual.

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: The Monitoring Team will continue to review this indicator.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
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% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A
Comments: None											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Areas in need of focused attention include ensuring that PCPs conduct assessments of acute illnesses, and conduct follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of the acute illness. Significant improvement also is needed with regard to IDTs conducting post-hospitalization reviews to identify action steps to address follow-up medical and healthcare supports to reduce risks and promote early recognition. On a positive note, when the individuals reviewed were transferred to the hospital the PCP or nurse communicated necessary clinical information with hospital staff. The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
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.	50% 4/8	0/1	1/1	1/1	N/A	0/2	N/A	0/1	2/2	N/A
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	38% 3/8	0/1	1/1	1/1		0/2		0/1	1/2	
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, <u>or</u> if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	100% 9/9	2/2	N/A	2/2	2/2	N/A	1/1	1/1	N/A	1/1
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	40% 2/5	0/1		1/2	1/2		N/A	N/A		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.	89% 8/9	1/2		2/2	2/2		1/1	1/1		1/1
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 9/9	2/2		2/2	2/2		1/1	1/1		1/1

g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	25% 2/8	1/2		0/2	0/2		N/A	0/1		1/1
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	22% 2/9	1/2		0/2	0/2		0/1	1/1		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 Center, including the following with dates of occurrence: Individual #119 (chest pain on 4/12/17), Individual #153 (left toe injury on 4/26/17), Individual #363 (foot pain on 2/6/17), Individual #144 (fall with skin tear and facial contusions on 4/25/17, and seizures on 6/28/17), Individual #344 (seizure on 3/20/17), and Individual #98 (persistent cough on 4/12/17, and probable aspiration on 7/14/17).

The acute illnesses for which documentation was present to show that medical providers assessed the individuals according to accepted clinical practice were for Individual #153 (left toe injury on 4/26/17), Individual #363 (foot pain on 2/6/17), and Individual #98 (persistent cough on 4/12/17, and probable aspiration on 7/14/17).

For the following acute illnesses/occurrences for which follow-up was needed, 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: Individual #153 (left toe injury on 4/26/17), Individual #363 (foot pain on 2/6/17), and Individual #98 (persistent cough on 4/12/17,).

The following provide some examples of problems noted:

- On 4/12/17, Individual #119 complained of pain in the left chest area. The PCP assessment was chest wall pain and the plan was to check an electrocardiogram (EKG), continue Tylenol, and follow-up as needed. The PCP documented that the EKG was normal. The PCP did not follow-up to determine if the reproducible chest wall pain had resolved. This individual had a history of chest wall trauma significant enough to result in large pleural effusions. It appeared that follow-up of chest discomfort was warranted.

  Moreover, on 7/19/17, nursing staff documented that "per recommendation CT [computed tomography] chest scan was ordered due to previous chest x-ray showed bilateral small pleural effusions." In addition, on 7/30/17, nursing staff documented that a gastrointestinal (GI) consult for gastroesophageal reflux disease (GERD) and silent aspiration was requested. Additionally, a CT scan was scheduled for 8/4/17. The PCP did not provide any documentation related to the indication for these diagnostics.
- On 4/25/17, nursing staff documented that Individual #144 "Rolled out of bed and went [head] first into the floor causing a skin tear on his nose and a bruise on his forehead." The PCP was notified and ordered that nursing staff perform neurological checks. According to nursing documentation, the areas were cleaned and left open to air. There was no physician assessment related to this injury and the implementation of neurological checks. The first PCP note was on 5/24/17. It stated: "The lesion

to [Individual #144's] nose is healing well. Still has a scab."

- According to Individual #144's December 2016 AMA, the individual had full seizure control. On 6/28/17, 7/2/17, and 7/3/17, the individual experienced seizures. On 7/3/17, the PCP documented the first evaluation. Given the history of previous full seizure control, this PCP assessment appeared somewhat delayed. The PCP's assessment noted that three seizures had occurred. Per the PCP, this appeared to occur with a reduction of a maintenance dose of a benzodiazepine. The individual also was prescribed Vimpat, Keppra, and Topiramate. Although the PCP note did not make reference to the addition of a medication, it also appeared that on around 6/28/17, Luvox was added to the individual's medication regimen. The plan was to continue anti-epileptic drugs (AEDs), check labs, increase the Ativan dose, and schedule a neurology clinic appointment as soon as possible. At the time of record submission on 8/16/17, there was no documentation of a neurology consult in the records. There was also no documentation of a PCP follow-up assessment inclusive of the abnormal lab values from 7/3/17, such as a sodium of 145, chloride (cl) of 112, white blood cell (WBC) count of 11 thousand, and blood urea nitrogen (BUN) of 23.
- On 3/20/17, the PCP documented that on 3/19/17, Individual #344 had a witnessed two-minute seizure after a long period of full seizure control on Vimpat monotherapy. The plan was to check labs and monitor for further seizure activity. There was no follow-up or documentation of the labs that were ordered. On 4/2/17, the next PCP assessment occurred to address fever and respiratory issues.
- On 7/14/17, the PCP documented that Individual #98 had a self-cleared coughing episode consistent with probable aspiration. The physical exam was pertinent for rhonchi and mild wheezing with adequate air movement. The plan was to continue scheduled nebulizer treatments for three days, provide as-needed oxygen, and order labs and chest x-ray (or ER transfer), if indicated. The next PCP entry was dated 7/17/17, at which time the PCP noted that wheezing was resolved. It was not clear if any labs or a chest x-ray had been completed. It was suspected that discontinuation of the proton pump inhibitor (PPI) in preparation for the pH study may have contributed to reflux and wheezing. Follow-up should have occurred on 7/15/17, for this elderly female with wheezing and rhonchi.

c. For six of the nine individuals reviewed, the Monitoring Team reviewed nine acute illnesses requiring hospital admission, or ED visit, including the following with dates of occurrence: Individual #119 (pneumonia on 2/8/17, and nasal fracture on 4/29/17), Individual #363 (hip fracture on 3/16/17, and pneumonia on 5/8/17), Individual #77 [pneumonia and sepsis on 2/24/17, and acute kidney injury, and urinary tract infection (UTI) on 7/12/17], Individual #346 (urinary retention on 3/2/17), Individual #344 (pneumonia on 4/2/17), and Individual #370 (abdominal pain on 3/12/17).

e. For the acute illnesses reviewed, it was positive the individuals reviewed generally received timely treatment at the SSLC. The exception was for Individual #119 (pneumonia on 2/8/17). There was no documentation a physician examined him.

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

g. Significant improvement is needed with regard to IDTs conducting post-hospitalization reviews to identify action steps to address follow-up medical and healthcare supports to reduce risks and promote early recognition.

h. Similarly, an area in need of focused attention is ensuring that PCPs conduct 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.

The following provide examples of problems noted:

- On 2/8/17, nursing staff documented that Individual #119 complained of a runny nose, feeling hot, and not feeling well. Tylenol was given. Per nursing staff, the individual was seen in clinic at 2:10 p.m., and the nurse documented: "at this time md stated will put on ABX [antibiotics], duration and type of ABX md not sure." The PCP/provider did not document this assessment.

  On 2/9/17, the PCP wrote that the individual had 48 hours of unsteadiness and was seen in clinic the previous day and started on Omnicef. The PCP did not document a physical exam. The individual was transferred to the ED for an evaluation of mental status changes and a possible first-time seizure. Individual #119 was admitted with pneumonia, left pleural effusion, and hyponatremia. On 2/17/17, he returned to the Center and the PCP saw him. On 2/18/17, the PCP saw him again. This was a significant hospitalization, but the Center did not submit documentation of an ISPA meeting.
- On 5/8/17, the PCP noted that Individual #363 was reported not to be at baseline. She had not been eating and was so jittery that she needed to be fed. She was transferred to the ED for evaluation. On 5/12/17, Individual #363 returned to the Center. The PCP saw her and wrote a three-line hospital note: "Pt [patient] returned from hospital. She is doing well. Lungs are clear. We will return her to her home. Levaquin has been ordered and she will resume her previous meds. She has been walking in the hospital. We will make sure that she has Fu [follow-up] on ambulating and physical therapy on Monday." This note did not provide a discharge diagnosis, summary of hospital treatment, or a plan of care. There was no follow-up. The next PCP note was on 6/7/17, and it was an IPN entry related to an orthopedic consult.
- On 2/13/17, Individual #77 underwent elective urethral re-implantation due to chronic hydronephrosis. She had post-operative complications of shortness of breath, hypoxia, and sepsis, which required transfer to the Intensive Care Unit (ICU). On 2/22/17, she returned to the Center and the PCP saw her. On 2/23/17, the PCP saw her again.

  On 2/24/17, Individual #77 developed abdominal pain and diarrhea along with tachycardia. The PCP documented that the tachycardia was worrisome and the acute diarrhea was consistent with C-diff infection. Chemistries and a CBC were ordered along with a urinalysis (UA). The PCP ordered Loperamide for the diarrhea, but there was no testing for C-Diff. At around 3:00 p.m., the PCP documented that the individual had a fever, rigors malaise, and abnormal labs. A WBC count of 17 thousand was documented. The individual was sent back to the hospital due to possible urosepsis. At 3:41 p.m., nursing staff documented that the individual "is crashing," but a decision was made to send her to the ED in a state vehicle, which was a 30 to 40-minute drive. It was unclear why emergency medical services (EMS) were not available. Per hospital records, the individual was admitted with pneumonia, pyelonephritis, and sepsis.

  On 3/2/17, Individual #77 was transferred to a skilled nursing facility, and on 3/28/17, she returned to the Center. The IPNs reviewed did not provide any documentation of PCP post-hospital assessments upon Individual #77's return to the Center.
- On 7/12/17, the PCP noted Individual #77 was being sent to the ED due to a blood pressure of 82/50 and complaints of kidney pain. On 7/14/17, she returned to the Center. Per the PCP: "She was admitted due to low b/p and not feeling well." The actual diagnosis was not stated in this very brief post-hospital note. The physical exam only noted that the individual's

lungs were clear. The hospital discharge report documented the diagnoses as acute kidney injury, hypercalcemia, anemia and UTI.

- On 4/2/17 at 12:17 p.m., the PCP documented that Individual #344 was seen because the nurse noted fever and abnormal lung sounds. The assessment was lower respiratory infection (LRI) (acute bronchitis versus pneumonia). The plan was to check labs and a chest x-ray the following day (Saturday), prescription of Levaquin, use of nebulizers, and follow-up in the morning. The individual had a history of being allergic to Levaquin. According to the PCP, Individual #344 was referred to an allergy and immunology specialist and tested negative for a Levaquin allergy. It was not clear why there was a decision to delay obtaining diagnostics for this elderly individual with a recent history of aspiration pneumonia.

  At 9:51 p.m., the PCP was notified that the individual had swollen lips, was hypoxic, and had a temperature of 102.5. EMS transferred him to the ED, and he was admitted to the hospital with "sepsis presumably secondary to pneumonia" and urticaria due to Levaquin. On 4/6/17, Individual #344 returned to the Center, and the PCP saw him. The PCP conducted follow-up on 4/7/17, 4/9/17, and 4/10/17.

  No ISPA was submitted for this hospitalization, on which the IDT should have met. On 4/10/17, the PCP documented that the hospitalization was due to an aspiration event. A IPN entry, dated 4/26/17, described the PNMT meeting and documented that the PCP was in favor of a PEG-tube, but the IDT refused consent for PEG-tube placement. On 6/9/17, the PCP noted that during breakfast on 6/8/17, the individual had another major aspiration trigger. The PCP attended the IDT meeting and strongly recommended PEG placement for nutrition and hydration. The IDT agreed pending guardian approval.
- On 2/7/17, Individual #370 complained of abdominal pain. She was given Tylenol for the discomfort. On 3/1/17, she vomited and nursing staff initiated the emesis protocol. Nursing staff continued to document intermittent abdominal pain. On 3/11/17, Individual #370 was given a calcium carbonate tablet for complaints of abdominal pain. On 3/12/17, she was scheduled for clinic on Monday due to nausea and back pain. She also was reported to have witnessed vomiting and the PCP was contacted and ordered Zofran. On 3/13/17, she was transferred to the ED due to reported fainting.

  On 3/14/17, the PCP saw her, and documented the diagnosis of psychogenic chronic recurrent abdominal pain, splenic lesion, and constipation diagnosed from a scan completed during the ED evaluation. The plan was to check a splenic ultrasound.

  The next PCP entry regarding this issue was dated 3/28/17, noting the ultrasound showed a splenic cyst. The PCP did not conduct the appropriate follow-up. On 4/18/17, the PCP documented lab results including a normal lipase level. This was to address concerns from neurology consult done on 3/3/17.

  Of note, on 3/3/17, the neurologist saw Individual #370, and documented: "I suspect that Depakote is at least partly responsible for her complaints. I would recommend that her psychiatrist taper her off of Depakote to see if the nausea and the weight gain resolve. The concern about Depakote is not only nausea but also pancreatitis or pancreatic pseudocyst which would be difficult to detect by clinical monitoring." On 3/21/17, the PCP reviewed the neurology consult. The PCP agreed with the Depakote taper, but did not refer the discontinuation of this mood stabilizer to the IDT for review. Moreover, it did not appear that the recommendation was addressed by psychiatry until 4/14/17.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: The Center had improved its performance on a number of these indicators. More specifically, for the consultations reviewed, the PCPs with few exceptions reviewed consultations and indicated agreement or disagreement, did so in a timely manner, and wrote corresponding IPNs that met the requirements of State Office policy. PCPs wrote orders for agreed-upon recommendations. The Center needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs. All of these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	87% 13/15	2/2	N/A	1/2	1/2	1/1	2/2	2/2	2/2	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	93% 14/15	2/2		2/2	1/2	1/1	2/2	2/2	2/2	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	87% 13/15	2/2		1/2	1/2	1/1	2/2	2/2	2/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	100% 13/13	2/2		1/1	1/1	1/1	2/2	2/2	2/2	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	20% 1/5	N/A		N/A	0/1	0/1	N/A	1/1	0/1	0/1

Comments: For eight of the nine individuals reviewed, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed included those for Individual #119 for ear, nose, and throat (ENT) on 5/4/17, and pulmonary on 7/13/17; Individual #363 for ophthalmology on 6/23/17, and orthopedics on 5/31/17; Individual #77 for ophthalmology on 6/23/17, and urology on 6/6/17; Individual #144 for neurology on 2/3/17; Individual #346 for ophthalmology on 5/2/17, and endocrinology on 6/2/17; Individual #344 for allergy on 6/20/17, and cardiology on 7/18/17; Individual #98 for gastroenterology (GI) on 6/22/17, and GI on 7/18/17; and Individual #370 for neurology on 3/3/17, and gynecology on 5/16/17.

a. It was positive that PCPs generally reviewed the consultation reports the Monitoring Team reviewed, and indicated agreement or disagreement with the recommendations. The exceptions were the consultations for Individual #363 for ophthalmology on 6/23/17, and Individual #77 for ophthalmology on 6/23/17.

b. Only one of these reviews did not occur timely (i.e., the one for Individual #77 for ophthalmology on 6/23/17).

c. It was positive that most of the PCP IPNs related to the consultations reviewed included all of the components State Office policy requires. The exceptions were for Individual #363 for ophthalmology on 6/23/17, which was incomplete, and Individual #77 for ophthalmology on 6/23/17, for which there was no IPN note.

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

e. The following provide examples of problems noted:

- It appeared that the urologist discontinued Individual #77's follow-up. A renal evaluation was planned. The PCP should have referred this to the IDT, as a second opinion might have been warranted.
- Per Individual #144's neurologist: "it seems obvious from his clinical course during the last half of the year that he needs to stay on his Ativan." It was noted that there was full seizure control until changes were made in Ativan dose. The PCP agreed with the recommendations to continue current therapy. However, then, per the PCP IPN dated 7/3/17: "recurrent seizures in context of maintenance benzodiazepine dose reduction." This was not referred for IDT review but should have been.
- According to Individual #98's GI consultant: "Intermittent episodes of n/v [nausea and vomiting] with elevation of AST [aminotransferase] / ALT [Alanine transaminase]/ Alk Phos [Alkaline phosphatase] & bili. Concern for possible retained stone. Abd [abdominal] sono [sonogram]. Not a candidate for MRP-ERCP [Magnetic resonance pancreatography-endoscopic retrograde cholangiopancreatography]. If we want to further investigate this she would need to be sent for higher level of care for endoscopic ultrasound." The consultant did not state that this required no further investigation; however, the PCP appeared to determine that no further investigation would be done. The IPN entry did not convey the actual recommendations, and the PCP did not refer this to the IDT for review, but should have.
- Individual #370's neurologist recommended tapering her off of Depakote. The PCP did not refer this recommendation to the IDT, but should have, as the Depakote was prescribed as a mood stabilizer.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
Summary: Significant work is needed to ensure that individuals receive applicable medical assessment, tests, and evaluations consistent with current standards of care to address their chronic or at-risk conditions, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
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.	22% 4/18	0/2	1/2	0/2	0/2	1/2	0/2	1/2	1/2	0/2
	Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #119 – cardiac disease, and osteoporosis; Individual #153 – constipation/bowel obstruction, and seizures; Individual #363 – osteoporosis, and										

seizures; Individual #77 – other: advanced kidney disease, and other: pulmonary embolism and deep vein thrombosis; Individual #144 – seizures, and other: hypothyroidism; Individual #346 – diabetes, and other: hypertension, and hyperlipidemia; Individual #344 – other: colon cancer, and cardiac disease; Individual #98 – cardiac disease, and GI problems; and Individual #370 – infections, and other: Hepatitis C).

a. It was positive that for the following individuals' chronic or at-risk conditions, 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: Individual #153 – seizures, Individual #144 – other: hypothyroidism, Individual #344 –cardiac disease, and Individual #98 – cardiac disease. The following provide examples of concerns noted:

- Individual #119 was prescribed two medications daily for bowel management, and according to the IRRF had a KUB (abdominal x-ray) done quarterly due to a history of bowel obstruction. His IDT rated him at medium risk for bowel issues, but the AMA did not document constipation as an active medical problem. Therefore, there was no medical plan to address bowel management. There was no documentation that non-pharmacologic interventions were implemented.
- Individual #363 was at increased risk for development of osteoporosis based on a long history of AED and psychotropic medication use. She also had a history of an unusual pelvic fracture in 2010. However, the IDT assigned a low risk rating in 2016. In April 2017, following a right hip fracture, the PNMT nurse requested that a DEXA scan be performed due to an assessment of increased risk. The scan was diagnostic for osteoporosis. The current risk rating was high and the individual was now being treated.
- Individual #363's AMA, dated 6/21/17, did not reflect any of the most recent neurology consults. In fact, it documented the last consult as 1/15/16, when consults had occurred on 11/18/16 and 1/20/17. It noted a diagnosis of seizure disorder, while all of the neurology consults specified the seizure disorder as refractory. According to the 1/20/17 consult, Individual #363's seizures were occurring almost daily. The assessment was refractory temporal lobe epilepsy and the plan was to start Briviact with follow-up in six weeks. On 3/3/17 and 7/21/17, follow-up occurred. The 7/21/17 note stated that the individual was "glum and withdrawn mood today and minimally cooperative." Seizures were reported as controlled during the previous two months.
- The urologist documented that Individual #77 had medical renal disease. The AMA plan did not discuss the medical management for Stage 4 chronic kidney disease (CKD). The individual manifested several aspects of advanced kidney disease including acidosis, anemia, and metabolic bone disease. However, the AMA discussion of medical problems did not address these issues. Moreover, the only discussion related to the eventual need for renal replacement therapy was found in a note the hospital liaison nurse wrote. The PCP must ensure that there is maximal medical management in order to slow the progression of renal disease and delay the need for renal replacement therapy. The IDT should have discussed the strategies for implementation of maximal medical management, given the fact that compliance with dietary and medication requirements is important. There was no documentation of IDT discussion related to these matters.
- Similarly, for Individual #77, there was no plan regarding the management of her history of bilateral pulmonary emboli and deep vein thrombosis, for this individual who required continued anticoagulation therapy.
- Per Individual #144's AMA, dated 12/19/16, "seizures are fully controlled per neurology." According to the neurology consult, dated 2/3/17, there was an attempt to taper Ativan that resulted in two seizures in July 2016. An additional attempt to taper Ativan in November 2016 resulted in two seizures. Therefore, the seizure disorder was not fully controlled, and the neurologist noted: "it seems obvious from his clinical course during the last half of the year that he needs to stay on his Ativan."

The recommendation was "continuing present therapy," which included an Ativan dose of 1 milligram (mg) four times a day (QID).

The PCP did not document the seizure frequency in the assessment component of the AMA, and did not complete any interim medical reviews. Therefore, it is not possible to determine if the PCP who completed the AMA was even aware of the seizures that occurred in July and November 2016, and their association with the Ativan taper.

Following three seizures in June/July 2017, another PCP made an IPN entry at 2:04 p.m., stating Ativan would be increased to 1.5 mg QID. An IPN addendum at 2:07 p.m. noted that the Ativan would be increased to 2 mg four times a day (QID), stating this was the recommendation from the 2/3/17 consult, which it was not. However, some change in medication was warranted due to multiple seizures. The management of this individual's seizure disorder underscores the need to improve the continuity of care that is provided and for the PCPs to review the seizure data when making medical management decisions.

Additional concerns were found with seizure management, particularly the manner in which medication monitoring was implemented. The use of topiramate requires monitoring for the development of kidney stones, metabolic acidosis, and increase in intraocular eye pressure. All of these cautions are included in the package insert. The Center submitted document #TX SG 1709-II.F.c (page 247) that included a list of medication audit criteria and guidelines that stated they were for use with psychiatric treatment and not medical treatment. Most of the precautions and monitoring found in the package insert were included in the topiramate guidelines (page 259).

However, for Individual #144, the recommended diagnostic monitoring was not implemented. Specifically, there was no eye exam (intraocular eye pressure). Additionally, the PCP did not document significant abnormal lab results obtained on 7/3/17.

- The Assessment/Plan section of Individual #346’s AMA cited a list of general guidelines. It did not individualize these guidelines for this individual. For example, for the active problem of uncontrolled Type I Diabetes Mellitus, the recommendations section noted that a urine micro albumin and renal profile should be done, but it did not state this data for this individual. The assessment and plan component of the AMA should provide a reasonable status of the condition, including a comment on the presence or absence of micro albumin for this individual, or if there was evidence of target organ damage, such as compromised renal function for this individual. The only indicator of disease documented was the A1c, which was 7.2 on 2/6/17. The goal was <7. Based on the guidelines in the plan, the A1c should have been repeated in three months. There was no documentation of urinary albumin or the eye exam that should have been performed for an individual with diabetes mellitus. Labs showed elevated urine albumin.

  The caveat of management for this individual was the documented episodes of hypoglycemia and the PCP did not acknowledge those in the assessment/plan section of the AMA. Per American Diabetes Association (ADA) guidelines, a HbA1c target should not be set until severe or recurrent hypoglycemia is resolved.
- Individual #344’s 2015 AMA stated under the preventive care section that in 2010, GI declined to perform a colonoscopy due to the need for sedation. There was no documentation that this was discussed with the IDT or guardian. There also was no documentation that an alternative opinion was sought regarding other methods of screening for colon cancer. In September 2016, the individual had a colonoscopy and was diagnosed with colon cancer. Since the diagnosis was made after the

completion of the April 2016 AMA and the PCP did not conduct an annual medical assessment in 2017 or complete any interim medical reviews, it could not be determined (from PCP documentation) why the colonoscopy was eventually completed. According to the IRRF, the individual required multiple suppositories prior to a hospitalization on 9/16/16, and also was noted to have blood in his stool. He underwent a colonoscopy and was subsequently surgically staged with N3 T0 adenocarcinoma of the colon. The 5/17/16 IRRF documented that Individual #344 had several stools with blood, but was unable to have a colonoscopy due to the inability "to consume during prep."

- As discussed above, according to Individual #98's GI consultant: "Intermittent episodes of n/v [nausea and vomiting] with elevation of AST [aminotransferase] / ALT [Alanine transaminase]/ Alk Phos [Alkaline phosphatase] & bili. Concern for possible retained stone. Abd [abdominal] sono [sonogram]. Not a candidate for MRP-ERCP [Magnetic resonance pancreatography-endoscopic retrograde cholangiopancreatography]. If we want to further investigate this she would need to be sent for higher level of care for endoscopic ultrasound." The consultant did not state that this required no further investigation; however, the PCP did not provide discussion of this, and it appeared no further investigation would be done. Individual #98 was at risk for aspiration associated with episodes of significant emesis. There was no documentation that the option of endoscopic ultrasound was discussed with the IDT, and the PCP did not clearly document why this was not considered.
- Individual #370's AMA documented the diagnosis of Hepatitis C carrier. The Assessment/Plan component of the AMA did not list the diagnosis; therefore, there was no plan to address this chronic infection. The training section of the AMA noted that the individual would be taught about Hepatitis C and the need to monitor liver enzymes. The AMA did not provide any evidence that this individual was assessed by GI/hepatology to determine if she was a candidate for Hepatitis C treatment, or that the appropriate surveillance was implemented.

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. However, documentation was inconsistently found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs/ISPs. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.

#	Indicator	Overall Score	Individuals: 119	153	363	77	144	346	344	98	370
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	1/2	1/2	0/2	1/2	2/2	1/2	2/2	0/2

Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed were implemented inconsistently.

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	119	153	363	77	144	346	344	98	370
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: Since the last review, good improvement was noted with regard to the timeliness of the completion of QDRRs. However, for most QDRRs reviewed, the Clinical Pharmacist had not conducted a thorough review of labs, and/or made recommendations to address concerns related to lab monitoring. Although some improvement was noted since the last review with regard to prescribers' timely review of QDRRs, more work was needed. Additional work also was needed to ensure prescribers order agreed-upon recommendations. All of these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
a.	QDRRs are completed quarterly by the pharmacist.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	22% 4/18	0/2	2/2	0/2	0/2	0/2	0/2	0/2	0/2	2/2

	ii. Benzodiazepine use;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iii. Medication polypharmacy;	89% 16/18	2/2	2/2	2/2	2/2	2/2	2/2	0/2	2/2	2/2
	iv. New generation antipsychotic use; and	100% 10/10	2/2	2/2	2/2	2/2	N/A	2/2	N/A	N/A	N/A
	v. Anticholinergic burden.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	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.	78% 14/18	2/2	2/2	2/2	2/2	2/2	1/2	1/2	2/2	0/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	64% 9/14	1/2	2/2	2/2	1/2	2/2	1/2	N/A	N/A	0/2
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	69% 9/13	1/2	1/2	1/2	2/2	1/2	2/2	N/A	1/1	N/A
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: b. For most QDRRs reviewed, the Clinical Pharmacist had not conducted a thorough review of labs, and/or made recommendations to address concerns related to lab monitoring. The following provide a few of many examples:

- For Individual #119, the Clinical Pharmacist listed a series of labs noting high or low values with no discussion of the clinical significance or relation to the prescribed medications.
- Individual #363 was started on alendronate after being diagnosed with osteoporosis. No comments were found on DEXA scores or a recommendation for monitoring while she was receiving medical treatment. In addition, the exact indication for metformin was not noted in the drug profile and there was no discussion of the effectiveness. Other documents noted a diagnosis of prediabetes and there should have been a comment on the effectiveness of this treatment based on lab monitoring.
- Individual #77 had a prolactin level of 92. While psychotropic medications can significantly increase prolactin, levels approaching 100 should receive greater scrutiny. This individual was not treated with risperidone and most drugs (other than risperidone) do not cause an elevation over 100. In addition, this QDRR included vague comments about an "EKG 9/21/16: 368/424." The pharmacist should have indicated what was being reported here. There was no mention of eye exam for Seroquel monitoring.
- Individual #144 was prescribed topiramate. The State executive formulary provides cautions regarding metabolic acidosis, renal stones, etc. The Clinical Pharmacist provided no discussion of monitoring for these drug-related problems.

c. Although some improvement was noted since the last review with regard to prescribers' timely review of QDRRs, more work was needed.

For Individual #346, the pharmacist made a recommendation to obtain an A1c since the last value in February 2017 was 7.2. The PCP disagreed stating that the endocrinologist makes the recommendations for labs. It should be noted that that ADA recommends that an A1c be done every three months for individuals with uncontrolled diabetes mellitus, so this was an appropriate recommendation. Furthermore, it appeared that the PCP was not aware that the endocrine consult in July 2017 documented that the A1c was 9.9 in June 2017. This was indicative of a worsening status of this condition.

d. When prescribers agreed to recommendations for the individuals reviewed, documentation sometimes was not present to show they implemented them. For example:

- Individual #119's PCP agreed to stop supplemental Vitamin D and repeat the level. The last documented Vitamin D level was 51 on 11/21/16.
- For Individual #153, the QDRR noted the EKG was overdue, and last was done in April 2016. The recommendation was to obtain an updated one, but the one the Center submitted to the Monitoring Team was dated April 2016.
- For Individual #363, the Clinical Pharmacist made a recommendation to use a short acting beta agonist (SABA) PRN. The management of asthma is guided by the classification of asthma severity. This was not found in the records, so the rational for this recommendation was not clear. A PRN SABA is the treatment of choice for step 1 National Heart, Lung, and Blood Institute (NHLBI) guidelines. The current regimen was Step 3 for intermittent asthma. The PCP should clarify the classification and effectiveness of treatment.
- For Individual #144, the Clinical Pharmacist recommended an eye exam due to the use of topiramate. The Center did not submit an eye exam, and no order was found.

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	119	153	363	77	144	346	344	98	370
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/5	N/A	0/1	0/1	0/1	0/1	N/A	0/1	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/5		0/1	0/1	0/1	0/1		0/1		
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/5		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% 0/5		0/1	0/1	0/1	0/1		0/1		
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/5		0/1	0/1	0/1	0/1		0/1		

Comments: a. and b. Individual #119, Individual #98 (edentulous), and Individual #370 were at low risk for dental, but were part of the core group, so full reviews were conducted. Individual #346 was at low risk for dental and was part of the outcome group. As a result, a limited review was conducted. Although Individual #363, and Individual #77's IDTs rated them at low risk, they had dental issues that should have resulted in at least medium risk ratings (e.g., use of TIVA for dental work, fair oral hygiene, anticipated need for dental work due to dental conditions placing them at risk). None of the individuals reviewed 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. As noted above, the Monitoring Team conducted a limited review for Individual #363. For the remaining eight individuals, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: These are new indicators, which the Monitoring Team will continue to review.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
a.	Individuals have no diagnosed or untreated dental caries.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	N/A	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% 6/6	N/A	1/1	1/1	1/1	1/1	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.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	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 #344, and Individual #98 were edentulous, so these indicators were not applicable to them.

b. Two individuals reviewed were edentulous, and the remaining six individuals had gingivitis or a more severe form of periodontal disease. Although periodontal disease had not worsened for these individuals, during many individuals' exams, Dental Department staff documented heavy calculus/plaque, food, and/or chewing tobacco on their teeth (e.g., Individual #119, Individual #153, Individual #77,

Individual #346, and Individual #370).

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.

Outcome 5 – Individuals receive necessary dental treatment.

Summary: Given that over the last two review periods and during this review, the Dental Department generally provided tooth brushing instruction for the individuals reviewed (Round 10 – 100%, Round 11 – 89%, and Round 12 – 100%), Indicator b will move to the category requiring less oversight. It was positive that for the individuals reviewed, the Dental Department generally provided prophylactic care, treatment for periodontal disease, and restorative work in a timely manner. At the time of the next review, if the Center maintains its performance with Indicators a, and e, they might move to the category requiring less oversight.

Individuals:

#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
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.	86% 6/7	1/1	1/1	1/1	1/1	0/1	1/1	N/A	N/A	1/1
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1			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.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	N/A									
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	86% 6/7	1/1	1/1	1/1	1/1	0/1	1/1			1/1
f.	If the individual has need for restorative work, it is completed in a timely manner.	100% 4/4	1/1	N/A	1/1	1/1	N/A	1/1			N/A
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A									

Comments: a. through f. Individual #344, and Individual #98 were edentulous, so these indicators were not applicable to them. a. and e. Individual #144 required general anesthesia for the completion of prophylactic care, as well as other dental care. His IDT had not discussed and documented the risk/benefit considerations of the repeated use of general anesthesia versus the completion of preventative dental care. It also did not appear that the IDT had implemented strategies to assist Individual #144 to cooperate with regular dental care without the need for general anesthesia.

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: For the one dental emergency reviewed, dental services were not available at the Center to address the individual's needs, and it appeared that a back-up system was not in place to provide coverage during the two-week absence of the Dental Director.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	0% 0/1				0/1					
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	0% 0/1				0/1					
Comments: a. through c. Per nursing documentation on 5/9/17, Individual #77 stated: "my cavity fell out while I was sleeping… Call was placed to dental clinic and was notified that [Dental Director] would be out of the office until May 22, 2017 and that there currently is no coverage. Was also notified that individual could come to dental clinic at 1300pm today so that the staff there could look at tooth, and clean it to see what was going on." Based on the documentation provided, the PCP did not see the individual to evaluate the individual for additional management needs, such as pain control or antibiotics. Furthermore, this note indicated that the Center potentially did not provide required dental coverage for at least two weeks.											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: The Monitoring Team will continue to review all of these indicators.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
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% 0/2	N/A	N/A	N/A	N/A	N/A	N/R	0/1	0/1	N/A

b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	50% 1/2							1/1	0/1	
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/2							0/1	0/1	
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% 0/2							0/1	0/1	

Comments: The Monitoring Team conducted a limited review for Individual #346.

a. through d. Center staff need to include measurable action steps in the ISPs/IHCPs of individuals who require suction tooth brushing, ensure the action steps are implemented, monitor the quality of the technique staff use to provide it, and review relevant data monthly. It is concerning that these basic steps had not occurred for individuals reviewed.

Outcome 9 – Individuals who need them have dentures.

Summary: Improvements were needed with regard to the dentist's assessment of the need for dentures for individuals with missing teeth.

#	Indicator	Overall Score	Individuals: 119	153	363	77	144	346	344	98	370
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	33% 3/9	0/1	0/1	0/1	1/1	0/1	0/1	1/1	1/1	0/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									

Comments: a. For the individuals reviewed with missing teeth, the Dental Department often did not provide recommendations regarding dentures.

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: Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected. These indicators will remain in active oversight.	Individuals:

#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0%									
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.	0%									
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0%									
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%									
e.	The individual has an acute care plan that meets his/her needs.	0%									
f.	The individual's acute care plan is implemented.	0%									

Comments: a. through f. Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. At least in part, the conversion to the IRIS system complicated entry of acute care plans into the system. However, this is a substantial deviation from standard practice and needs to be corrected.

The Monitoring Team discussed this issue with State Office. Given that Center staff acknowledged that acute care plans have not been consistently developed and entered into the system, it was decided that the Monitoring Team would not search for needed acute care plans that might not exist. However, as a result of this systems issue, these indicators do not meet criteria. Center staff should work with State Office to correct this issue.

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.

Individuals:

#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	6% 1/18	0/2	1/2	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	28%	1/2	1/2	1/2	0/2	0/2	0/2	0/2	0/2	2/2

	measure the efficacy of interventions.	5/18									
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #119 – respiratory compromise, and circulatory; Individual #153 – constipation/bowel obstruction, and seizures; Individual #363 – weight, and fractures; Individual #77 – diabetes, and UTIs; Individual #144 – falls, and skin integrity; Individual #346 – respiratory compromise, and cardiac disease; Individual #344 – constipation/bowel obstruction, and infections; Individual #98 – aspiration, and GI problems; and Individual #370 – seizures, and GI problems).

Individual #153's goal/objective for seizures was clinically relevant and measurable. 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 #119 – circulatory, Individual #363 – weight, and Individual #370 – seizures, and GI problems.

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports, including data and analysis of the data, were not available to IDTs. 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: Given that over the last four 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.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
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.	11% 1/9	0/1	N/A	0/1	0/1	0/2	0/1	0/1	1/1	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).	6% 1/18	0/2	0/2	0/2	1/2	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. and c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs 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, or that nursing interventions were implemented thoroughly. For some of the IHCPs reviewed, some of the actions steps were implemented, but not others. In many instances, tracking sheets contained numerous blanks. The one exception was for Individual #77's action step to monitor daily Accucheck readings.

b. The following provide some examples of problems noted:

- On 2/9/17, Individual #119 was sent to the ED, and admitted to the hospital. On 2/17/17, he returned to the Center with diagnoses of bibasilar pneumonia, large left pleural effusion/hemothorax, hyponatremia, and dysphagia. The IDT did not hold a post-hospitalization ISPA meeting.
- Despite his numerous health concerns, the IDT for Individual #346 had not held meetings to approach them in an interdisciplinary manner, identify underlying causes, and develop plans to address them. For example, the QDRR, dated 7/18/17, stated: "[Individual #346] meets all the criteria for metabolic syndrome," and requested: "PCP please review!" In fact, he already had a diabetes diagnosis. His February 2017 A1c reading was 7.2, and his finger stick blood glucose varied daily and was consistently high. Individual #346 had hypertension, asthma, dyslipidemia, GERD, insulin-dependent diabetes, and a history of chest wall pain. Individual #346 also was prescribed eight medications with anticholinergic effects, and a daily benzodiazepine. On 3/2/17, he went to the ED with the chief complaint of chest pain, for which it did not appear medical or nursing staff at the Center followed up, as well as urinary retention. These circumstances should have resulted in the IDT meeting to understand his overall health conditions and the associated risk, and to develop plans of care with measurable action steps that supported his overall health. Documentation was not submitted to show this had occurred.
- Although Individual #144's IDT met to discuss skin integrity issues (i.e., 1/4/17, 4/4/17, and 6/9/17), the IDT did not appear to develop action steps that were specific to his human bite injuries from peers. For two of the three human bites, the same peer bit him. In addition, a recommendation was made to encourage Individual #144 not to pick at scabs, but it was not clear what action steps were implemented, if any, to address this issue
- On 2/24/17, Individual #77 was hospitalized with a diagnosis of urosepsis. The urine culture was positive for Klebsiella Pneumoniae Pyelonephritis. Given her surgical intervention of bilateral re-implantation of her ureters, and urosepsis/UTI, the IDT should have met to revisit her IRRF and IHCP, and to develop interventions to ameliorate her UTIs to the extent possible. The IDT should have developed measurable goals/objectives and preventive interventions for her high-risk conditions, but they did not.
- On 3/16/17, the IDT met to discuss Individual #363's intertrochanteric hip fracture. Staff reported the individual was being aggressive with them, transferred independently out of her bed, and tripped on her throw rug, which caused her to fall on her right side. An ISPA, dated 3/16/17, documented discussion of the critical incident. The IDT agreed upon the following action steps: removing Individual #363's rug from the floor and hanging it on a wall, monitoring the new medication changes that were put in place to decrease her physically aggressive behaviors, and an OT/PT assessment for home modifications, such as a

	shower chair and or different bed. The IDT did not hold a post-hospitalization ISPA, and did not document review of her IRRF or IHCP. Her fall risk was identified as being low, but no evidence was found in the documents provided to show that the IDT reviewed the risk rating or made changes.

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
Summary: For the three previous reviews, as well as this review, the Center did well with the indicators related to: 1) nurses administering medications according to the nine rights; and 2) nurses adhering to infection control procedures while administering medications. However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review these indicators 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. It was good to see that during this review, the Center did well with the indicators related to nurses following PNMPs during medication administration, and assessing lung sounds, as necessary. All of these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R		N/A							
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% 8/8	1/1		1/1	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/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A
	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	100% 1/1	N/A		N/A	N/A	N/A	N/A	N/A	1/1	N/A

	symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an 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.	100% 4/4	N/A		1/1	N/A	1/1	N/A	1/1	1/1	N/A
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 8/8	1/1		1/1	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 eight individuals, including Individual #119, Individual #363, Individual #77, Individual #144, Individual #346, Individual #344, Individual #98, and Individual #370.

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

d. It also was positive that Individual #98's ISP included an action step for medication nurses to assess lung sounds prior to and after medication administration. During the Monitoring Team member's observation, the nurse correctly competed these assessments.

f. For the applicable individuals, nurses followed their PNMPs in relation to medication administration. 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: Over the past three reviews, the Center regressed with regard to the referral of individuals to the PNMT, when needed (i.e., Round 10 – 100%, Round 11 – 75%, and Round 12 – 44%). The Center should determine what has caused this change, and take action to correct it. In addition, 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	119	153	363	77	144	346	344	98	370
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% 0/10	0/1	0/2	N/A	0/1	0/1	0/2	N/A	0/1	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	60% 6/10	1/1	1/2		0/1	1/1	1/2		0/1	2/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/10	0/1	0/2		0/1	0/1	0/2		0/1	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/10	0/1	0/2		0/1	0/1	0/2		0/1	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/10	0/1	0/2		0/1	0/1	0/2		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;	44% 4/9	0/1	N/A	1/2	0/1	0/1	N/A	1/2	1/1	1/1
	ii. Individual has a specific goal/objective that is clinically	0%	0/1		0/2	0/1	0/1		0/2	0/1	N/A

		relevant and achievable to measure the efficacy of interventions;	0/8									
	iii.	Individual has a measurable goal/objective, including timeframes for completion;	0% 0/8	0/1		0/2	0/1	0/1		0/2	0/1	
	iv.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/8	0/1		0/2	0/1	0/1		0/2	0/1	
	v.	Individual has made progress on his/her goal/objective; and	0% 0/8	0/1		0/2	0/1	0/1		0/2	0/1	
	vi.	When there is a lack of progress, the IDT takes necessary action.	0% 0/8	0/1		0/2	0/1	0/1		0/2	0/1	

Comments: The Monitoring Team reviewed 10 goals/objectives related to PNM issues that seven individuals' IDTs were responsible for developing. These included goals/objectives related to: falls for Individual #119; choking, and falls for Individual #153; choking for Individual #77; choking for Individual #144; choking, and respiratory compromise for Individual #346; fractures for Individual #98; and GI problems, and weight for Individual #370.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: falls for Individual #119; falls for Individual #153; choking for Individual #144; choking for Individual #346; and GI problems, and weight for Individual #370.

b.i. The Monitoring Team reviewed eight areas of need for six 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: aspiration for Individual #119; fractures, and respiratory compromise for Individual #363; constipation/bowel obstruction for Individual #77; falls for Individual #144; weight, and aspiration for Individual #344; and aspiration for Individual #98.

These individuals should have been referred or referred sooner to the PNMT:

- On 2/9/17, Individual #119 was sent to the ED, and admitted to the hospital. On 2/17/17, he returned to the Center with diagnoses of bibasilar pneumonia, large left pleural effusion/hemothorax, hyponatremia, and dysphagia. This was a significant hospitalization, but the Center did not submit documentation of an ISPA meeting. It also did not appear that the PNMT conducted a review, although the PNMT nurse completed a post-hospitalization assessment and was involved with the completion of a Head-of-Bed Elevation evaluation (HOBE). The PNMT PT also wrote a brief note that indicated Individual #119 was "unsteady, but OK." This note did not discuss the falls that Individual #119 had experienced since the previous ISP meeting and since the hospitalization. At a minimum, the PNMT should have documented a team review, and summarized the activity and supports added surrounding his change in status. In July 2017, the Pneumonia Committee determined that the pneumonia Individual #119 had in February was aspiration pneumonia, but still the IDT did not make a referral, and the PNMT did not conduct a review or assessment.
- On 3/22/17, the PNMT made a self–referral of Individual #363 due to a long-bone fracture that occurred on 3/16/17. It was

good to see that the PNMT identified the need for a review of this event. However, the information the Center provided regarding a pneumonia event was contradictory. Tier I documentation indicated that on 5/10/17, Individual #363 experienced aspiration pneumonia. However, PNMT and other IPN references in Tier II documents identified this event as pneumonia (klebsiella per sputum culture). The PNMT minutes included discussion of Individual #363, but no formal IPN documentation was found of team review. At a minimum, the PNMT should have conducted a review due to complications related to bronchiectasis, the need for reflux precautions, the need for a safe eating plan, the previous swallow study that identified trace aspiration with large liquid boluses, her high-risk rating for aspiration/respiratory concerns, and significant weight loss. At the time of this pneumonia diagnosis, Individual #363 was on the PNMT's caseload for the femur fracture, and a review of the pneumonia would have been appropriate.

In addition, from April 2017 through June 2017, Individual #363 lost about six pounds. The PNMT indicated that it was thought the weight loss was due to problems with her thyroid and medication regulation, as her thyroid stimulating hormone (TSH) level was low. The medications were adjusted, and she gained weight back up to 110 pounds in July. Because she had met her goals for fracture by 7/12/17, the PNMT discharged her, reported the weight gain, and said nursing would monitor labs and her weight. In August, weight records from nursing staff indicated that she was back down to 103 pounds. Given all of the other factors, the PNMT should have done more in-depth evaluation/review of her weight loss and continued to follow her at the very least to ensure that weight issue was resolved, but they did not.

- During Individual #77's hospitalization for bilateral urethra re-implantation, a small bowel obstruction was identified. However, no evidence was found that the PNMT conducted a review.
- The frequency and duration of Individual #144's falls warranted PNMT review. During the previous ISP year, he had 20 falls, and in the seven months in this ISP year, he had fallen 16 times. Individual #144's IDT had not referred him to the PNMT.
- Individual #344's weight had fallen below the previously established referral threshold, and his IDT did not make a referral back to the PNMT in a timely manner. More specifically, in March 2016, Individual #344 met the threshold of 118 pounds, and at time of evaluation on 12/22/16, due to aspiration pneumonia, his weight was 103 pounds, and he had a Stage 1 pressure injury.

For Individual #370, the PNMT tracked the incidence of vomiting, which had stopped. They conducted a review of determine which interventions were effective.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT did not develop clinically relevant, achievable, and measurable goals/objectives for these individuals.

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of measurable goals/objectives, integrated progress reports with data and analysis of the data were generally not available to IDTs. 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	119	153	363	77	144	346	344	98	370
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.	8% 1/12	0/2	0/1	0/2	0/1	0/1	0/1	0/2	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% 0/1	N/A	N/A	0/1	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. For those action steps that were included, documentation generally was not found to show their implementation.

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

- Individual #119's IDT did not address the frequency of his falls, including the suspected etiology related to hyponatremia and polydipsia. In addition, his team did not address his diagnosis of dysphagia, and did not address the hospital discharge recommendations related to food texture.
- The Monitoring Team found no evidence of the IDT revising Individual #344's IHCP in response to his change of status requiring placement of an enteral tube.

c. The Center did not submit an ISPA for Individual #363's discharge from the PNMT.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: During numerous observations, staff failed to implement individuals' PNMPs as written. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them. These indicators will remain in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	45%	

		17/38	
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.	50% 6/12	

Comments: a. The Monitoring Team conducted 38 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during zero out of two observations (0%). Staff followed individuals' dining plans during 16 out of 34 mealtime observations (47%). Staff completed one out of two (50%) transfers correctly.

b. It was particularly concerning that some observations and interviews with Mealtime Coordinators revealed a lack of knowledge and/or adherence to PNMPs/Dining Plans. For example:

- The Mealtime Coordinator for Individual #202 did not provide the food in the proper adaptive equipment, and stated that food was sometimes served on a plate with a spoon in spite of the fact that the Dining Plan said it should be offered in cups.
- The same Mealtime Coordinator did not provide a small glass for Individual #7's liquefied pureed foods. Rather, the Mealtime Coordinator gave her a larger glass, and stated that they only had one small one, although they used to have more small ones. It appeared staff had not requested replacements.
- Individual #126 began coughing during mealtime. The direct support professional was new and unsure of what to do. Again, the same Mealtime Coordinator had to be prompted to provide coaching and instruction.

Also of concern, in Home 508, individuals were brought into the dining room at approximately 11:30 a.m. for lunch that reportedly was to begin at 12:00 noon. Food was delivered late at 12:30 p.m. Although staff offered the individuals beverages, they did not offer activities. A couple of the women were becoming irritated and restless.

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: This indicator will remain in active oversight. Individuals:

#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A							N/A	N/A	

Comments: a. 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 the 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	119	153	363	77	144	346	344	98	370
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/5	0/1	0/1	0/1	N/A	0/1	N/A	0/1	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/5	0/1	0/1	0/1		0/1		0/1		
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/5	0/1	0/1	0/1		0/1		0/1		
d.	Individual has made progress on his/her OT/PT goal.	0% 0/5	0/1	0/1	0/1		0/1		0/1		
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/5	0/1	0/1	0/1		0/1		0/1		

Comments: a. and b. Individual #363 had a number of direct therapy goals/objectives related to her recovery after her femur fracture. However, based on the documents provided, the IDT never incorporated them into the ISP through an ISPA. Similarly, Individual #344 has a walking program that the OT/PT assessment indicated should continue, but there was no clear evidence that the IDT reviewed this program and determined whether or not it was effective. It also was described as transitioned to a maintenance program on 2/2/17, but the assessment offered no rationale for this decision. In addition, the Center did not submit a corresponding SAP.

Individual #77 was independent with activities of daily living, and did not require formal OT/PT supports and services. Individual #346 had functional motor skills, and did not require OT/PT services. They were part of the outcome group, so limited reviews were conducted for them. Individual #98 had functional skills, given her age and disability. Individual #370's cover sheet indicated that OT/PT supports were discontinued in January 2017. They were part of the outcome group, so full reviews were conducted for them.

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, integrated progress reports with data and analysis of the data were generally not available to IDTs. 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.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: These indicators will remain inactive oversight.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/3	N/A	N/A	0/1	N/R	0/1	N/R	0/1	N/A	N/A

#	Indicator	Overall Score									
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/2	N/A	N/A	0/1		0/1		N/A	N/A	N/A
	Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that supports were implemented.										

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: Some concerns were noted with regard to the proper fit of individuals' adaptive equipment. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, 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 this indicator, scores continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	7	38	202	126	25	146	40	328	344
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	75% 15/20	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1
		Individuals:									
#	Indicator		150	315	98	273	383	409	203	189	24
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	0/1	1/1	0/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		268	26							
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1							
	Comments: c. The Monitoring Team conducted observations of 20 pieces of adaptive equipment. Based on observation of Individual #7, Individual #25, Individual #344, Individual #273, and Individual #409 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, dental, and communication. At the last review, one indicator was moved to the category of requiring less oversight. At this review, no other indicators will be moved to this category.

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.

For personal goals in the ISP, without implementation and without reliable data collected, it was impossible to determine if goals were met or progressing. Implementation of ISP goals and action plans remained a long-standing problem at San Angelo SSLC

It was good to see that staff were generally knowledgeable about individuals' risks and ISPs.

Individuals were not making progress on their SAPs and data were not available to make a reliable determination of progress. Attention needs to be paid to the quality of each component of the SAP, especially regarding instructions for teaching and use of reinforcement. Two SAPs observed by the Monitoring Team were implemented as written (though problems with the written content of SAPs was prevalent).

All nine individuals were directly observed multiple times in various settings on campus during the onsite week and most were not consistently engaged. That being said, fewer individuals were observed wandering around campus than during previous onsite weeks. This may be due, at least in part, to recent efforts to improve attendance in the various day and work programs. The Center had a variety of activities going on all over campus and had also recently initiated a new engagement monitoring system.

San Angelo SSLC continued to have a positive working relationship with the local public school district. School-related IEP items were integrated with the ISP.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.	
Summary: Without implementation and without reliable data collected, it was impossible to determine if goals were met or progressing. Implementation of ISP goals and action plans remained a long-standing problem at San Angelo SSLC. Much	Individuals:

work is conducted to develop the ISP (e.g., ISP preparation meetings, PSIs, clinical assessments, annual meeting, various support plans), but all that is for naught if implementation does not occur and/or if there are no data or records made that allow for some determination of how the individual is performing or responding. These indicators will remain in active monitoring.												
#	Indicator	Overall Score	316	200	153	119	144	77				
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 with indicators 1 and 2, there was no evidence that action plans to support those goals were consistently implemented because reliable and valid data were not available (i.e., indicator 3).

This was noted to be a problem during the last monitoring visit and had not improved prior to this review.

Outcome 8 – ISPs are implemented correctly and as often as required.												
Summary: It was good to see that staff were generally knowledgeable about individuals' risks and ISPs. An ongoing need was to ensure that the goals and action plans were implemented. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	316	200	153	119	144	77				
39	Staff exhibited a level of competence to ensure implementation of the ISP.	83% 5/6	1/1	1/1	1/1	1/1	0/1	1/1				
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				

Comments:

39. Overall, direct support staff were generally able to describe individual's health and behavioral risks. Most staff were knowledgeable regarding individuals' ISPs based on observations and interviews. This was very good to see. Individual #144's staff was not aware that he had an AAC device to augment communication. ISPs rarely included detailed instructions to guide staff when implementing the ISP.

40. Action steps were not regularly and correctly implemented for all goals and/or action plans, as noted throughout this report. IDTs need to monitor the implementation of all action plans and address barriers to implementation.

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: Individuals were not making progress on their SAPs and data were not available to make a reliable determination of progress. Actions were taken for a few individuals if the IDT determined that progress was not occurring. This set of indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
6	The individual is progressing on his/her SAPS	0% 0/9	0/3	0/2	0/1	None	0/2	None	0/1	None	None
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A	N/A	N/A	N/A	None	N/A	None	N/A	None	None
8	If the individual was not making progress, actions were taken.	14% 1/7	1/2	0/2	N/A	None	0/2	None	0/1	None	None
9	Decisions to continue, discontinue, or modify SAPs were data based.	25% 2/8	1/2	0/2	1/1	None	0/2	None	0/1	None	None

Comments:
6. The majority of SAPs were not progressing (e.g., Individual #316's count change SAP). Individual #299's state her medication information SAP appeared to be progressing, however, was scored as a zero because the data were not demonstrated to be reliable (see indicator 5). Similarly, Individual #322's calculate the money he needs SAP had insufficient data to assess progress, but was rated as zero because the data were not demonstrated to be reliable.

8-9. In one of the seven SAPs that were judged to not be progressing (i.e., Individual #322's prepare a meal SAP) there were actions to address the lack of progress (i.e., retrain staff). Overall, there were data based decisions to continue, discontinue, or modify SAPs in 25% of the SAPs. San Angelo SSLC should ensure that SAP progress is closely monitored and that data based decisions to continue, discontinue, or modify SAPs are consistently applied.

Outcome 4- All individuals have SAPs that contain the required components.											
Summary: San Angelo SSLC was using the new statewide SAP template format. This helped somewhat, but as noted in the comments below, attention needs to be paid to the quality of each component, especially regarding instructions for teaching and use of reinforcement. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
13	The individual's SAPs are complete.	0% 0/9	0/3	0/2	0/1	None	0/2	None	0/1	None	None

Comments:
13. San Angelo SSLC recently began using a new SAP format. Six of the nine SAPs were in the new format.

In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. None of the SAPs were judged to be complete, however, some SAPs contained the majority of these components (e.g., Individual #322's state the name of his medication SAP, Individual #200's state the name of his vitamin).

The most common missing component was specific instructions to teach the skill. Several of the new SAP format training sheets were unclear as to the number of steps required (e.g., Individual #322's prepare a meal SAP, Individual #316's counting change SAP).

Additionally, all of the SAPs lacked the use of specific reinforcement following a correct response. Most SAPs stated that correct responses should be followed by telling the individual "good job." Verbal praise may be very reinforcing for some individuals, however, other individuals require additional motivation to complete the task (e.g., access to preferred activities, etc.). Ensuring that individuals are motivated is a critical component of a successful skill acquisition plan.

Outcome 5- SAPs are implemented with integrity.											
Summary: It was good to see that two SAPs observed by the Monitoring Team were implemented as written (though problems with the written content of SAPs was prevalent as noted in indicator 13). There was, however, no organized plan was implemented over the past nine months to assess integrity of SAP implementation, but a plan was put in place at the time of the onsite review. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
14	SAPs are implemented as written.	100% 2/2	N/A	1/1	N/A	None	N/A	None	1/1	None	None
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	11% 1/9	0/3	0/2	0/1	None	0/2	None	1/1	None	None

	achieved.										

Comments:
14. The Monitoring Team observed the implementation of two SAPs (Individual #316's count her change SAP, and Individual #153's safe cooking SAP). Both were judged to be implemented and documented as written. The Monitoring Team attempted to observe additional SAPs however, some individuals refused to participate (e.g., Individual #200), or were unavailable to participate in their SAPs.

15. One SAP integrity assessment was documented (Individual #153's safe cooking SAP). San Angelo SSLC established a schedule of SAP integrity that would ensure that each SAP was observed immediately after it was developed, and once every six months thereafter.

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

Summary: Both indicators showed good improvement from the time of the last review. Both will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 322	316	299	358	200	227	153	119	72
16	There is evidence that SAPs are reviewed monthly.	78% 7/9	3/3	2/2	1/1	None	0/2	None	1/1	None	None
17	SAP outcomes are graphed.	100% 9/9	3/3	2/2	1/1	None	2/2	None	1/1	None	None

Comments:
16. Individual #200's state the risks of poor dental hygiene and state his vitamin SAPs were not included in his monthly review.

17. It was encouraging to see that all SAP outcomes were graphed.

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

Summary: These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 322	316	299	358	200	227	153	119	72
18	The individual is meaningfully engaged in residential and treatment sites.	22% 2/9	0/1	0/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	56% 5/9	1/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1	0/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	40% 2/5	1/1	0/1	N/A	N/A	0/1	0/1	1/1	N/A	N/A

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 Individual #299 and Individual #358 consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

19-21. San Angelo SSLC recently initiated a new engagement monitoring system. At the time of the onsite review, not all treatment sites were monitored monthly. The Center had established an engagement goal of 100% for all individuals and treatment sites. That, however, is likely to be an unrealistic and unachievable objective. The Monitoring Team suggest that San Angelo SSLC attempt to individualize the engagement goals based on realistic improvements over baseline levels across each treatment site.

The Center had a variety of activities going on all over campus. These included classes and programs (e.g., Building Imaginations, Gymnasium, Suzy Crawford Center), group sessions regarding sexual offending management, various classes on self-improvement (e.g., Boundaries, Anger Management, Building Character), and on campus employment (e.g., workshop, greenhouse, apprenticeship [though this only had one participant]). Throughout the week, the Monitoring Team found individuals to be present at each of these programs as scheduled. This was not always the case during past onsite review weeks. In particular, the weekly house meetings were occurring and house managers were actively facilitating these meetings. The capturing of accurate engagement data, attendance data, and individuals' data may help ensure that all individuals are taking advantage of these opportunities and for those who are not, that IDTs are thoughtful in creating the conditions to set the occasion for their participation.

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

Summary: Community outings, for recreation and/or for training, should be (and often are) an important part of the treatment program for individuals at San Angelo SSLC. Higher scores should be occurring by now for these indicators at San Angelo SSLC. They will remain in active monitoring.

#	Indicator	Overall Score	322	316	299	358	200	227	153	119	72
22	For the individual, goal frequencies of community recreational activities are established and achieved.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	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 #72 was the only individual to achieve 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 community outing and SAP community training goals are achieved.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
Summary: San Angelo SSLC has a long history of a positive working relationship with the local public school district. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	316								
25	The student receives educational services that are integrated with the ISP.	100% 1/1	1/1								
Comments: 25. Individual #358 was under 22 years of age and attended public school. There was evidence that Individual #358's educational services were integrated into in a 6/5/17 ISPA.											

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: N/A			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A									
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									
Comments: a. through e. Based on the documentation the Center provided, none of the individuals reviewed had refused dental services.											

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: Overall, IDTs did not have a way to measure communication outcomes for individuals. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/6	N/A	0/1	0/1	N/A	0/1	0/1	N/A	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/6		0/1	0/1		0/1	0/1		0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/6		0/1	0/1		0/1	0/1		0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/6		0/1	0/1		0/1	0/1		0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/6		0/1	0/1		0/1	0/1		0/1	0/1

Comments: a. and b. Individual #119 had functional communication skills. Individual #77's and Individual #344's screenings did not identify a need for further assessment or formal communication services and supports. The remaining individuals did not have clinically relevant, measurable goals/objectives to address their communication needs, and/or had behavioral issues that were linked to communication issues without clear coordination between the SLP and BHS staff on the development of goals/objectives.

c. through e. As noted above, Individual #119, Individual #77, and Individual #344 did not have needs for formal communication supports or services. Individual #77 was part of the outcome group, so further review was not conducted for her related to communication. Individual #119 and Individual #344 were part of the core group, so full reviews were conducted for them. For the remaining six individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	119	153	363	77	144	346	344	98	370
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	N/A				N/R					

b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									
	Comments: None.										

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
Summary: The Center should focus on ensuring that staff prompt individuals to use AAC devices in a functional manner. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	211	144	40	118	27				
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	33% 1/3	1/1	0/1	0/1	N/A	N/A				
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% 3/3									
	Comments: a. and b. It was concerning that often when opportunities for using the AAC devices presented themselves, staff did not prompt individuals to use them.										

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.

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.

San Angelo SSLC's transition department was comprised of a stable group of professionals. They facilitated 15 transitions since the last review, double the number in the previous nine-month period. This is transitioning about two individuals every month. There was again improvement in returns from the community, that is, there were none during this review period. This was a problem for many years that has now more than 18 months of stability.

There was continued improvement in the measurability of the pre- and post move supports. There was improvement in the comprehensiveness of the list of pre- and post-move supports. There was improvement in the supports written for community provider training and competency. Content and training modalities were described. The assurance of competency, though, requires improvement to ensure that provider staff know all they need to know before the individual transitions to their care and supervision. The list of supports contained many of the supports that they should have. Even so, a number of supports that should have been included were identified by the Monitoring Team.

The Monitoring Team also suggests that IDTs take guidance from the transition staff, especially in those situations when the transition staff suggest that a support be included that the IDT thinks is not necessary. San Angelo SSLC transition staff know the most about community providers, their strengths and weaknesses, what happens after someone moves, and how to best ensure good continued support. They have experience with the minutiae of failed placements, PDCTs, and so forth. With good rationale, its unlikely that any transition department suggestion will not be in the best interest of the individual's successful transition.

Post move monitoring was conducted as required in terms of timeliness, locations, and report format. For some supports, the post move monitor (PMM) did not provide comments that addressed the full scope of the support's requirements or provide sufficient detail to demonstrate supports were in place. There were some good examples of work by the PMM to ensure needed follow-up took place when there was a problem. Improvements to the follow-up processes were still needed, as evidenced by examples regarding pursuing employment, some medical testing, and one individual's self-reported dissatisfaction with the day habilitation program. The Monitoring Team attended and observed the conduct of a post move monitoring a six-month review for one of the individuals. The transition specialist was filling in for the PMM. She was diligent in monitoring for every support,

one by one, pretty much going in the order they were listed in the CLDP. She looked for all evidence that was listed in the CLDP specifically, as well as asking for additional information, too. Progress was seen, with four indicators showing improvement since the last review in scoring.

Transitions occurred in a timely manner.

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: San Angelo SSLC's transition department was comprised of a stable group of professionals. There was continued improvement in the measurability of the pre- and post move supports. There was improvement in the comprehensiveness of the list of pre- and post-move supports. There was improvement in the supports written for community provider training and competency. Content and training modalities were described. The assurance of competency, though, requires some improvement. The list of supports contained many of the supports that they should have. Even so, a number of supports that should have been included were identified by the Monitoring Team. These two indicators will remain in active monitoring. The Monitoring Team also suggests that IDTs take guidance from the transition staff, especially in those situations when the transition staff suggest that a support be included that the IDT thinks is not necessary. San Angelo SSLC transition staff know the most about community providers, their strengths and weaknesses, what happens after someone moves, and how to best ensure good continued support. They have experience with the minutiae of failed placements, PDCTs, and so forth. With good rationale, its unlikely that any transition department suggestion will not be in the best interest of the individual's successful transition.			Individuals:									
#	Indicator	Overall Score	317	362								
1	The individual's CLDP contains supports that are measurable.	0/2 0%	0/1	0/1								
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0/2 0%	0/1	0/1								
Comments: Fifteen individuals transitioned from the facility to the community since the last monitoring review. Two were included in this review (Individual #317 and Individual #362). Both individuals transitioned to a group home that was part of the State's Home and Community-based Services (HCS) program. The Monitoring Team reviewed these two transitions and discussed them in detail with the												

San Angelo SSLC Admissions and Placement staff while onsite.

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how needs and preferences must be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. These two CLDPs demonstrated improvements since the previous monitoring period, but the defined supports did not yet always provide the Post Move Monitor (PMM) with measurable criteria or indicators that could be used to ensure supports were being provided as needed. Examples of supports that met criterion and those that did not meet criterion are provided below.

- The IDT developed nine pre-move supports for Individual #317 and six for Individual #362. Some of these supports were measurable, such as those describing the need for an all-male or all-female home and the need for reliable transportations.
    - Both individuals had three pre-move supports for staff competency training. To meet criterion, pre-move training supports should address both the content of training provider staff would need as well as describe how staff competence to provide the supports would be assessed. The Center must also describe how it will verify that provider staff have the knowledge and competence to provide each individual's unique set of needed supports prior to relinquishing day-to-day responsibility for his or her health and safety. The Center had made improvements in constructing these pre-move training supports for measurability. To that end, transition staff noted that they had been holding pre-CLDPs to discuss training needs and how they would be addressed, including encouraging IDTs to consider a variety of training methodologies and using layperson's terms to promote comprehension. This had yielded some positive results.
        - For example, both CLDPs included pre-move training supports that provided a summary of topics to be covered in pre-move training and specified the staff to be trained.
        - For Individual #317, it was good to see that the CLDP described role-playing requirements for demonstration of competency.
        - Both CLDPs also stated provider staff needed to achieve an 80 to 90% score to be considered competent and it was positive that IDTs made an effort to define a competency threshold.

      The IDTs did not, however, indicate if there were any priorities for knowledge or competence that were essential for health and safety. This was of concern because many written competency tests were brief and did not cover all the trained material. In some cases, competency tests did not include many of the trained requirements, so a score of 80% would not validly indicate that provider staff had knowledge of 80% of the trained material. This compromised the support's validity as a measure of staff actual knowledge and competence. For example:
        - For Individual #317, a support for pre-move training for medical and nursing needs indicated the following topics would be covered: GI/GERD/constipation; cardiac; skin integrity/ infection; prescribed medication, including purpose and side effects; medical diagnosis; and monthly weights. The competency quiz consisted of five questions. None of the questions tested staff knowledge of constipation, prescribed medications or side effects, monthly weights or medical diagnoses.
        - The support for pre-move training for medical and nursing needs for Individual #362 indicated the following topics would be covered: medications, including side effects and purposes; medical risks, including gastro-

intestinal, edema, weight, metabolic syndrome, skin integrity, neurologic; active medical diagnosis; drug allergies labs; monthly weights; diet; vision and dental; immunizations, and purpose for head of bed risers. The competency test was comprised of 10 questions, none of which addressed medication purpose and side effects, monitoring for edema, weight monitoring or diet, or dental needs.

    - The IDT also needed to evaluate whether the format of competency tests or the wording of the questions would yield valid results. For example, the test posed the following question, to be answered as true or false: "If Individual #362 says to you 'I stuck something in my arm' it's no big deal." This question was the only one to address Individual #362's skin integrity issues which, per the IRRF, included very sensitive skin due to a diagnosis of psoriasiform spongiotic disorder and supports for using mild soap for bathing, applying a cream all over as soon as she got out of the bath and to being encouraged to take special care to dry under skin folds. Another true/false question asked if she was diabetic. The correct answer was, technically, false, but this did not confirm staff understood she had considerable risk for diabetes due to her diagnosis of metabolic disorder. Similarly, one true/false question for Individual #317 asked whether his risk for cardiac disease was high. Again, the correct answer was, technically, false, but did not test staff knowledge about his actual medium risk and the need for monthly monitoring of vital signs as a result.

- The respective IDTs developed 28 post-move supports for Individual #317 and 40 post-move supports for Individual #362. Both CLDPs included many measurable supports that met criterion, especially related to arranging for medical appointments, consultations, and laboratory testing requirements within specific timelines.
    - Overall, Individual #317's post-move supports met criterion for measurability, which was positive. The IDT should be cautious, though, about developing supports that are very broad and/or do not focus on the achievement of a desired outcome. For example, one of Individual #317's post-move supports called for provider staff to assist him with initiating contact with the Texas Workforce Commission within three months after transition. This support, while technically measurable, did not require the provider to continue to assist Individual #317 to achieve paid employment, which was one of his most important desired outcomes. Transition staff indicated they were working with IDTs on this issue.
    - For Individual #362, the IDT also developed many measurable post-move supports, but this was not yet consistent. For example, the CLDP included a post-move support for staff to check her cell phone once a week per her guardian's request due to her history if using it to send inappropriate photos. The support did not indicate what would be considered "inappropriate" photos or provide direction for staff action if such material was found.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place for this indicator to be scored as meeting criterion. These two CLDPs did not comprehensively address support needs and did not meet all of the criteria. In addition to those identified above under Indicator 1, other examples included:

a. Past history, and recent and current behavioral and psychiatric problems: Supports in this area demonstrated improvement from the previous monitoring visit, but did not yet sufficiently reflect past history, and recent and current behavioral and psychiatric problems in a consistent manner. Examples included:
    - The CLDP did not fully address the need for staff knowledge regarding Individual #317's behavioral history. For

example, the CLDP narrative and pre-move and post-move supports focused attention on Individual #317's history of sexual exploitation of children, which was appropriate. But, neither the narrative nor the supports provided staff with a clear picture of his proclivity for inappropriate sexual activity toward other vulnerable individuals. The CLDP focused on two specific incidents in 1997, and repeatedly emphasized no inappropriate sexual activity had occurred within the last year. It was unknown what level of inappropriate sexual activity, or the nature of that activity, may have occurred between 1997 and 2016. This was of concern because Individual #317 would be in regular, daily contact with other vulnerable individuals at the day habilitation program. The CLDP narrative noted he could not be left alone with vulnerable individuals, but did not define vulnerability, nor did it include this as a specific support.

- Individual #317's Social/QIDP assessment recommended a support for increased supervision, calling for staff and a group of peers to accompany Individual #317 on community outings and when off the home due to his diagnoses and history. Per the CLDP discussion narrative, the provider stated Individual #317 would not be dropped off alone for community activities per the provider's policy and standards and, therefore, requested the recommendation be removed. The IDT agreed and did not include this support. The IDT should not exclude needed supports based solely on a provider's statement that their policy and/or practice will cover it. The CLDP narrative also referenced the need for provider staff to check restrooms for the presence of children and to monitor to ensure children did not enter while Individual #317 was making use of those facilities, but the IDT did not include this specific support. In this instance, the IDT would have been prudent to develop a comprehensive supervision support that specified all of Individual #317's requirements for supervision in all settings.
- Individual #362 had a history of self-injurious behavior, but no supports required staff knowledge of this issue, including either the nature of the behavior or whether the behavior had been in evidence in the recent past. The behavioral health assessment did not provide any information about either of these criteria and pre-move training topics did not include this, but the medical assessment did document Individual #362 had been to the emergency room in January of 2015 after inserting four plastic graphite pencil ends into her right leg. The CLDP and assessments included insufficient information to determine whether this was the sole issue related to self-injurious behavior.
- The CLDP did not include a specific support related to staff knowledge of Individual #362's history of sexual abuse and exploitation. CLDP assessments indicated there may have been some history of Individual #362 sexually abusing a child in the home of her aunt and uncle, which merited some attention.
- Individual #362 received individual counseling related to her diagnosis of PTSD while at the Center and this was discussed during the CLDP, but the IDT did not develop any supports for counseling after transition or provide a justification for why that support would no longer be needed.
- Individual #362's CLDP included a pre-move training support for staff to learn her PBSP and procedures for behavioral data collection, but there was no post-move support for either PBSP implementation or related data collection.

b. Safety, medical, healthcare, therapeutic, risk, and supervision needs: Overall, the Center evidenced progress in developing supports that addressed safety, medical, healthcare, therapeutic, risk, and supervision needs. As noted in indicator 1, the respective IDTs developed many supports to ensure medical/healthcare treatments and consultations were provided as needed and in a timely manner, which was positive. Both CLDPs also included pre-move training supports that specified direct support staff needed to be trained for medical, healthcare, therapeutic, and risk needs. Overall, however, the respective IDTs did not develop comprehensive supports for some of the significant needs in these areas. Examples included:

- Individual #317 was a generally healthy individual, but he did have some health risks that were rated medium and that required staff knowledge and ongoing monitoring. For example, his risk for constipation was rated medium due to his history in this area and his IHCP called for daily medication for this diagnosis, a need to increase fluid intake, and to engage in sufficient walking. In addition, the nurse was to be notified if he did not have a bowel movement in more than two days. The CLDP include a pre-move support for provider staff about his medical risks, including constipation, but did not include post-move supports for staff knowledge of the needs for increased fluids, walking, or monitoring/reporting bowel movement frequency. He also had a medium cardiac risk, for which he required monthly vital signs monitoring, per the IHCP. Post-move supports did not address this need.
- The CLDP did not include comprehensive supports regarding Individual #317's required level of supervision while in the community, as discussed above.
- The CLDP for Individual #362 did not include comprehensive supports regarding her required level of supervision. The narrative included a statement that she did not require 24-hour awake staff, but would require staff to accompany her on any outings due to her risk of exploitation and history of sexual abuse. The latter requirement was captured in a formal support for staff knowledge and action, which was positive. The narrative also described the guardian's requirements for approval of any visitors and any visits/overnight stays with her family. A pre-move support called for training staff about these requirements, but the CLDP did not include a post-move support for ensuring these requirements were implemented.
- Individual #362 was morbidly obese with related risk factors for cardiac disease and diabetes. Her weight reduction strategies had been ineffective. Her IHCP required she be weighed weekly and have her waist measurement taken monthly as a means of monitoring her weight. The IDT developed a support for her to be weighed within 72 hours and then monthly thereafter in the community. It did not provide any rationale for reducing the monitoring of this critical data.

c. What was important to the individual: Neither of the CLDPs met criterion. The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI) and the CLDP for the section that lists the outcomes important to the individual.
   - For Individual #317, the PSI had not been updated since 3/8/16, but it indicated some of the things important to him were spending time with his girlfriend, playing basketball, working, and earning money. It also indicated he wanted to learn to make hamburgers and improve his reading skills. He hoped to have the opportunity to go to church and shopping more frequently, to have more work hours and earn more money, and have more control over how he spent his time. The CLDP narrative indicated his important outcomes and related personal goals were that he enjoyed cooking and wanted to continue learning recipes and that he wanted to continue participating in Special Olympics events. Overall, the IDT addressed these various preferences and hoped-for outcomes in a minimal manner.
     - The CLDP should include supports that formalize the expectation that transition will offer enhanced opportunities for an individual to partake in community life as well as the normal rhythms of day-to-day home life. Individual #317's CLDP included one post-move support to attend church services once a quarter and two broadly worded post-move supports for him to attend at least one leisure activity per week in the community and at least one at home.
     - For outcomes that are important to an individual, the IDT should also develop specific and measurable

expectations. The latter two supports listed examples of activities, which included visiting friends and family and learning to cook, among others. The wording of these two supports did not state an expectation that either visits with family and friends or learning to cook would occur, however, they were simply part of a list of possibilities. The CLDP did not address Special Olympics participation or maintaining his relationship with his girlfriend. It also did it assertively address his desire for employment and opportunities to earn money, as described in more detail below.

- Individual #362's CLDP also included a section describing her important outcomes, which were identified as locating part-time employment and to exercise to lose weight. Her ISP and PSI affirmed these as important outcomes as well. As described in the following subsection of this indicator, the IDT did not assertively address employment. The CLDP did include a support to join a gym, but again this was not formulated as a measurable outcome to exercise on a regular basis.

d. Need/desire for employment, and/or other meaningful day activities in integrated community settings: Transition staff noted in interview that obtaining community employment for individuals had been very challenging. The Monitoring Team encouraged them to engage the State Office about the nature of these challenges and to obtain information about any systemic resources specific to employment for individuals with intellectual and developmental disabilities, such as the efforts of the Employment First initiative.

- Individual #317 had expressed strong preferences for employment and earned income, as documented in his vocational assessment, ISP, and PSI, but these were minimally addressed with CLDP supports. The vocational assessment described his employment options as working at a cabinet or carpentry shop; collecting trash; and jobs that were similar to those he performed at the Center, such as assembling meal kits, folding blankets, and shredding paper. It further described Individual #317 as a good worker who dedicated himself to doing a job well to completion, a fast learner capable of working with different types of machinery, and a good candidate for most entry level jobs that do not involve working around or near children. He was reported to follow all safety rules and guidelines at work and needed minimal prompting to recognize potential hazards. Despite these strong preferences and skills, the only employment-related support was for the provider to assist him to initiate contact with the Texas Workforce Commission within three months. As described above, the CLDP did not include supports that focused on the outcome of having employment. The Monitoring Team was concerned that the IDT agreed to exclude a recommendation for the provider to transport Individual #317 to apply for jobs based on the provider's opinion this would be difficult without a current Texas identification card.
- Individual #362 had similarly strong preferences for employment and earned income that were not assertively addressed with CLDP supports. The only employment-related support was also for the provider to assist her to initiate contact with the Texas Workforce Commission within three months.
- Neither CLDP focused on other meaningful day activities in integrated community settings. Individual #317's CLDP did not include any support for attending day habilitation, even though the expectation he would do so was readily inferred from the narrative and supports for training day habilitation staff. Otherwise, the CLDP included only one support for the expectation he would engage in at least one leisure activity a week in the community. Individual #362 did have supports for attending day habilitation, but these did not specify any meaningful day activities in integrated community settings.

e. Positive reinforcement, incentives, and/or other motivating components to an individual's success:
   - The CLDP for Individual #317 did include some supports that specified strategies for positive reinforcement, incentives, and/or other motivating components to his success. These were largely included in his behavioral supports as describe above. The lack of assertive supports for meaningful and appropriate relationships, productive full-time work, and interesting ways to fill his non-work time created an environment that was not reinforcing of or motivating to his successful adjustment to community living.
   - Individual #362's CLDP did include post-move supports related to specific motivating activities, including joining a gym, exploring and choosing a church for membership, and participation in choir. The CLDP also included post-move supports for learning to cook healthy meals because she loved to help in the kitchen and obtaining a library card because she wanted to continue to work on her reading skills. This CLDP met criterion for this sub-indicator.

f. Teaching, maintenance, participation, and acquisition of specific skills: Neither CLDP included specific supports for skill acquisition and maintenance.
   - Individual #317 had several learning needs that would have been particularly relevant for community living, but the IDT did not assertively address them. For example, he had expressed an interest learning additional cooking skills. The Functional Skills Assessment (FSA) included a recommendation for an ISP goal that he prepare his own supper, including learning how to pick a recipe from the cookbook, making a list of ingredients, and shopping for the ingredients. Learning to cook was only included in a list of possible leisure activities in the CLDP, without a specific expectation this would occur. It was positive that transition staff reported observing Individual #317 preparing a meal during a PMM visit, however. The FSA also noted Individual #317 was independent in many money management skills, but did not have his own account and needed assistance in learning how to balance a checkbook. This was not addressed, nor was his interest in improving his reading skills. The Social/QIDP assessment included a recommendation for math skills training, but the CLDP narrative indicated the provider stated math skills would be covered at the day habilitation program Individual #317 would be attending. The IDT agreed to remove the recommendation rather than incorporating the recommendation into a support for day habilitation to include this skill building activity.
   - Individual #362 had post-move supports for preparing a grocery shopping list and learning to make a healthy meal. While this CLDP did minimally meet criterion, the IDT should also consider other opportunities for learning and skill maintenance needed to support community living. For example, per the FSA, Individual #362 also needed some assistance with reading, arithmetic, and money management.

g. All recommendations from assessments are included, or if not, there is a rationale provided: The Center had a process for reviewing CLDP assessments, documenting discussion and making final recommendations. The documentation of the discussion typically provided an understanding of the IDT's rationale when it chose to modify or exclude a recommendation, which was helpful. Concerns included:
   - For Individual #317, some of the discussion related to modification and/or excluding a recommendation did not provide a clear justification. One such example was the decision to remove a recommendation for math skills training because the provider indicated this would be something covered in the day habilitation program. Recommendations

for individuals' specific needs and preferences should be reflected in required supports whether the provider indicates this is something they do as a matter of course. In another instance, the IDT agreed to remove a recommendation related to assisting Individual #317 to sell his craft items at a craft fair. The discussion indicated the provider said there really wasn't a venue for such an activity and didn't know if Individual #317 would be able to afford to reserve a booth. The CLDP narrative went on to state that the team and provider agreed to remove this recommendation because a modification could not be agreed upon. This did not address whether the support was important to/for Individual #317, but rather addressed the IDT's lack of agreement concerning how to approach it and, therefore, was not a sufficient justification for exclusion. The IDT also agreed to remove a recommendation for a support that called for the provider to provide transportation for Individual #317 to apply for jobs at least twice per month without a clear rationale or alternative.

- For Individual #362, the psychiatric assessment recommended a MOSES to be completed every six months and an AIMS to be completed every three months. The final support included the AIMs, but did not mention the MOSES or provide any discussion as to why the IDT left that recommendation out.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.

Summary: Post move monitoring was occurring timely and with documentation. Progress was seen, with four indicators showing improvement since the last review in scoring. For some of the supports, more thorough exploration of the support's provision was required both in action by the PMM and in documentation in the report. Ensuring follow-up to any supports that were not being provided and/or any other problems observed by the PMM also needed some attention. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	317	362							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	2/2 100%	1/1	1/1							
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0/2 0%	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.	0/2 0%	0/1	0/1							
6	The PMM's assessment is correct based on the evidence.	1/2 50%	0/1	1/1							
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	0/2 0%	0/1	0/1							

8	Every problem was followed through to resolution.	0/2 0%	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	100% 1/1	1/1	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	100% 1/1	1/1	N/A							

Comments:

3. Post-move monitoring had been completed for the seven, 45, and 90-day post move monitoring periods for Individual #317 and each was completed on a timely basis. For Individual #362, the PMM also made both the seven and 45-day visits on a timely basis. The PMM completed each of these post-move monitoring visits in the proper format. For both individuals, the PMM typically provided comments regarding the provision of supports. These CLDPs both met criterion for timeliness. Still, some improvements were needed to this documentation process, as described below and throughout this outcome.

4. The PMM Checklists provided reliable and valid data that reported/summarized the status regarding receipt of supports in some instances, but there were issues that compromised reliability and validity. IDTs should carefully consider how the PMM can best assess whether a support is being met as required, reviewing which of the "three prongs" of evidence should be included. These prongs, are interviews, observation, and documentation, and should not be considered mutually exclusive, because reliability and validity are enhanced when more than one source of data can be cross-checked. Concerns regarding reliable and valid data available for these two CLDPs included:

- For some supports, the CLDP did not specify how the PMM could reliably measure the presence of the support. This was true for many of the staff training and knowledge supports for both individuals.
- For some supports, the PMM did not provide comments that addressed the full scope of the requirements or provide sufficient detail to demonstrate supports were in place. Examples included the following, as well as other examples described further below:
  - For Individual #317's post-move support for 24-hour awake staff due to history of seizures, bilateral hearing loss and use of hearing aids, and history of inappropriate sexual behavior, the evidence required included PMM observations and interviews. The PMM indicated at the time of the seven-day PMM visit only that the support was complete. At the time of the 45-day PMM visit, the PMM stated staff were interviewed as to the presence of 24-hour staff, but provided no comments as to whether staff were knowledgeable of why this level of support was required or the needs to be addressed.
  - Individual #317 had a post-move support to attend at least one leisure activity in the community at least one time weekly. The support included a list of activities that he preferred as examples. The PMM comment indicated at the time of the 45-day and 90-day PMM visits that interview with Individual #317 and documentation indicated he was participating in leisure activities, but provided no detail as to the frequency or type of activities. The accuracy of this finding, at least for the 45-day PMM visit, was also called into question by documentation related to the support calling for staff to take action if Individual #317 were to stare at children when on outings. This documentation indicated Individual #317 had been on two van rides since his move to the community by the time of the 45-day PMM visit.
  - For Individual #362's post-move support for staff to monitor shortness of breath or swelling of extremities and report any incidents of either to the nurse, the comments for the seven-day PMM visit indicated the PMM observed the Special

Needs Sheet the staff used to document shortness of breath or swelling of extremities. The 45-day PMM documentation indicated staff were interviewed and the Special Need Sheets were reviewed. Neither indicated whether staff documented any incidents of either symptom or whether these were reported to the nurse.
    - Individual #362 had gained 13 pounds by the time of the 45-day PMM visit. Per the support, a weight gain of five pounds in one month should have resulted in a report to the PCP for possible referral to a dietitian. The PMM commented that Individual #362 had seen the PCP on 7/17/17 with no changes being made. The PMM did not comment on the timeframe for the weight gain or whether it was reported to the PCP for a possible referral.

5. Based on information the Post Move Monitor collected, neither individual had consistently received supports as needed. While many supports were provided, neither individual had consistently received all supports as listed and/or described in the CLDP. For example:

- For Individual #317, examples of supports that had not been received as needed included:
    - At the time of the seven-day PMM visit, Individual #317 had not attended his SOTP group as required, due to a staff misunderstanding of the schedule.
    - At the time of the seven-day PMM visit, the provider had not obtained an initial weight as required.
    - At the time of the 45-day PMM visit, Individual #317 had not been given the opportunity to attend church.
    - At the time of the 45-day PMM visit, care had not been established with an optometrist/ophthalmologist, dentist, or an audiologist as required. He had also not seen his PCP by the required date.
    - At the time of the 90-day PMM visit, Individual #317 had not seen the dentist as required, nor had he had his EKG.
    - At the time of the 90-day PMM visit, for a support calling for the provider to assist Individual #317 to initiate contact with the Texas Workforce Commission by 5/23/17, the PMM documented that a resume had been completed on 6/12/17. It was not clear whether this reflected contact had been initiated with the Texas Workforce Commission.
- For Individual #362, the evidence the PMM provided did not substantiate that she was receiving some supports as needed. For example:
    - Individual #362 reported at both the seven-day and 45-day PMM visits that she was dissatisfied with the day habilitation program and that she would rather be working. While, technically, she was receiving day habilitation supports as prescribed, it was clear this was not meeting her needs.
    - As described above, the evidence provided by the PMM did not substantiate that Individual #362 had received needed attention related to her weight gain.

6. Based on the supports defined in the CLDP, the Monitoring Team could not verify that the PMM's scoring was consistently correct for these two CLDPs. For example:

- For Individual #317, the PMM documented at three separate times that the privacy fence, as required in a pre-move support, allowed for Individual #317 to see in the backyard of the neighbor's home. Given the purpose of the support was related to his Child Avoidance Plan, this should not have merited an affirmative score as being in place. The PMM should have brought this to the attention of the IDT for review.
- The evidence provided by the PMM related to Individual #362's weight gain and possible need for referral to a dietitian did not substantiate the affirmative score that this support was in place.

7-8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed

and that every problem is followed up through to resolution. The Monitoring Team noted some good examples of follow-up to ensure needed follow-up took place. It was positive the PMM met with Individual #317's IDT to address unmet supports as well as additional concerns related to inappropriate sexual behaviors. It was also positive the IDT provided additional provider staff training, including role play and modeling, following this latter event. Improvements to the follow-up processes were still needed, however. Examples included:

- It was not clear the provider had assisted Individual #317 to contact the Texas Workforce Commission. The 180-day PMM visit had just been completed, but transition staff were not able to confirm if this support was yet in place.
- No resolution had yet been documented regarding Individual #317's pending EKG.
- Individual #362 had reported on two occasions that she was dissatisfied with the day habilitation program and wanted to be working. The PMM documented reporting this to the IDT's QIDP, but no action had been taken.

9. The Monitoring Team accompanied the PMM during the conduct of the six-month post move monitoring for Individual #317. The transition specialist conducted the post move monitoring because the previous PMM had recently left the Center and the Center's other PMM was conducting post move monitoring in another part of the state. Even though she was not the regular PMM, the transition conducted post move monitoring thoroughly and completely. She looked for all of the evidence that was specified in the CLDP and also asked for additional evidence for some of the supports. In addition, she took the opportunity to interview the individual when he was away from direct support staff, and she took the opportunity to interview the direct support staff when not right with the individual (the individual did not require any type of line of sight supervision when in the home). For some supports, the PMM utilized whatever information was available. The Monitoring Team spoke with her about the usefulness of provider checklists for many of the supports typically included in CLDPs that are not part of providers' typical data systems.

10. The report accurately portrayed what was observed by the Monitoring Team.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.												
Summary: One individual had no negative events occur. The other individual experienced a PDCT shortly after his transition. A review of the incident, 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	317	362								
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.	1/2 50%	0/1	1/1								

Comments:
11. Individual #317 had experienced a PDCT event within the first 90 days after transition. On 04/1/17, approximately one week after transition, Individual #317 was reported to be masturbating with the window open while there were children outside playing. A neighbor called the police. Per the provider, police talked with him about it, but no charges were filed. The IDT met to review the PDCT and determined the issue had been anticipated and addressed in planning for the move with supports put in place, such as transportation to attend the Sexual Offender Therapy Program (SOTP) group sessions at the SSLC campus on Tuesdays and Thursdays; a Replacement Behaviors Skills Program of Conflict Resolution; and a home with a privacy fenced back yard and where no elementary schools, day care programs, playgrounds, school bus stops or places children may congregate could be located within 1000 feet. The ISPA also indicated the CLDP included supports for provider staff and a group of peers to accompany Individual #317 on community outings; for staff to check public restrooms for presence of children/minors and to ensure no children/minors entered; and, for provider staff not leave Individual #317 unsupervised with vulnerable individuals, children, or anyone under the age of 18. The IDT further concluded that nothing could have been done differently. It was positive to see that the Center acted after the event to offer additional provider staff training in this area as a remedial strategy. While identification of remedial actions is one valuable purpose of the PDCT process, another important component is to critically analyze the Center's actions during and after transition and use this information for process improvement in future transitions. The IDT did not perform this analysis with the needed critical attention. Concerns included:

- It was not clear that the IDT had adequately assessed the environment of the home prior to transition. For example:
  - The CLDP called for frosted windows in his bedroom, but did not provide any indication the IDT had considered whether Individual #317 could readily open the window.
  - It was unclear why there were children playing outside within view of his window, given the support that called for the home not to be within 1000 feet of any place that children might congregate. It called into question whether the IDT had assessed the neighborhood correctly prior to the transition.
- It was not clear that the IDT had been diligent in ensuring all necessary supports related to his history of pedophilia were identified and in place. For example:
  - As described in indicator 2 above, the CLDP did not include some of the supports the IDT referenced as evidence nothing else could have been done to prevent the PDCT event. For example, the CLDP narrative referenced the need for provider staff to check restrooms for the presence of children and to monitor to ensure children did not enter while Individual #317 was making use of those facilities and that he could not be left alone with vulnerable individuals. The IDT did not include either of these as formal supports in the CLDP.
  - The CLDP called for a privacy fence in the back yard of the home due to his history of pedophilia, but the PMM identified during the Pre-Move Site Review and at each of three completed PMM visits that the geography of the home would allow Individual #317 to see into the neighbor's back yard. No follow-up action was taken.
- As described under indicator 2, the IDT failed to develop a comprehensive set of assertive supports for Individual #317 that included meaningful and appropriate relationships, productive full-time work and interesting ways to fill his non-work time. These strategies for developing a "Good Life" that is full and meaningful to the individual are critical to the prevention of relapse for sexual offenders. It was positive that the IDT developed supports for strategies to prevent inappropriate sexual behaviors, but by themselves these are not enough.

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. The transition 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	317	362							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0/2 0%	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.	2/2 100%	1/1	1/1							
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.	0/2 0%	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.	0/2 0%	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0/2 0%	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.	0/2 0%	0/1	0/1							
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the	2/2 100%	1/1	1/1							

	transition and following the transition.										
19	Pre-move supports were in place in the community settings on the day of the move.	0/2 0%	0/1	0/1							

Comments:

12. Assessments did not yet consistently meet criterion for this indicator. The Monitoring Team considers four sub-indicators when evaluating compliance.

- Assessments updated with 45 Days of transition:
  - For Individual #317, most assessments were updated within 45 days of transition, but this was not yet consistent. The audiology assessment had not been updated because the Center's audiologist was on extended leave, but this was a significant need for Individual #317 due to his bilateral hearing loss and use of a hearing aid. The Center also did not provide a communication assessment for review or reference it in the review of assessments.
  - For Individual #362, several assessments were completed prior to the 45-day timeframe, including the medical, psychiatric, and dental assessments. This appeared to be due to the need to re-schedule the CLDP date to meet the guardian's needs and did not appear to have impacted the reliability of the information contained in those assessments. In the future, if similar circumstances occur, the affected disciplines should review their assessments to and add a brief addendum affirming the currency of the findings and recommendations. The Center did not provide communication, OT/PT, or vision assessments for review.
  - The Center did not review or update the Integrated Risk Rating Form (IRRF) for these 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.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Assessments did not consistently meet criterion. Examples included:
  - For Individual #317, the behavioral health assessment did not provide a clear history of the frequency or intensity of his inappropriate sexual behaviors. It referenced two specific events in 1997 and then indicated there had been no instances of those behaviors in the past year. It did not indicate whether there had been any instances in the intervening period.
  - For Individual #362, the behavioral health assessment was very detailed in many respects, but did not provide any description of the nature of her self-injurious behavior or how recently it had occurred. This would be important for provider staff to know to be alert to any recurrence.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: The Monitoring Team noted the Social/QIDP assessments for these two individuals contained a set of recommendations that was much more comprehensive than has been the norm. Per interview, transition staff reported they had been working with the QIDPs to focus on the ISP as a whole in developing supports both for the transition period and following it. This was a positive step and good to see. Assessments did not consistently meet criterion for this indicator, however. Missing assessments factored into this determination, but even assessments that had been updated did not consistently provide recommendations to support transition.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not consistently address/focus on the new community home and day/work settings. Assessment recommendations varied considerably in

comprehensiveness and individualization. The best example for both individuals was the aforementioned Social/QIDP assessment. Assessments that did not meet criterion for recommendations for Individual #317 included his vocational and dental assessments as well as the nursing assessment described above. Individual #362's vocational assessment also did not provide such recommendations.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator, including the following: 1) There was documentation to show IDT members actively participated in the transition planning process; 2) the CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed; 3) 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. Both CLDPs met criterion for this indicator.

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: The Monitoring Team requested and reviewed the training documentation, including the training and testing materials. As described above in indicator 1, the Center still needed to improve upon its training practices to ensure that staff have all needed knowledge and competencies prior to transition. Neither of the CLDPs met criterion for this indicator, but the Monitoring Team did find notable improvement in one area, as described below.

- Per the CLDP for Individual #317, inservices were completed for both home staff and the workshop during his pre-placement visit and again on 3/16/17. The Monitoring Team reviewed the training and competency testing materials for Individual #317's behavioral needs and found these to show considerable improvement in content. It was positive to seek that the training methodology included having provider staff practice the deep breathing relaxation exercise they would need to have Individual #317 undertake per the post-move supports. One portion of the competency exam related to thought stopping also required provider staff to provide written answers; this more clearly demonstrated they had learned the necessary information than true/false questions.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The IDT should include in the CLDP a specific statement as whether any collaboration was needed, and if any completed, summarize findings and outcomes. Neither CLDP provided such a specific statement regarding this need.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. Neither CLDP included a specific statement regarding this need.

17. The CLDP should include a specific statement of the IDT considerations of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results. 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. Neither CLDP included a specific statement regarding this consideration.

18. LIDDA participation: These two CLDPs met criterion. It was positive to see the participation of the LIDDA in both pre-and post-transition activities in some instances. For Individual #317, for example, a LIDDA representative and the HCS service coordinator

participated in the CLDP. The LIDDA also participated in some post move ISPAs, including the PDCT meeting. The receiving LIDDA also participated in Individual #362's CLDP.

19. The Pre-Move Site Reviews (PMSRs) for both individuals were completed prior to the transition date, but otherwise did not meet criterion.

- For Individual #317:
  - The PMSR on 3/14/17 documented that not all supports were in place. These included the pre-move training for health care needs, behavioral needs, and QIDP training. The PMM indicated these were being scheduled for 3/16/17 and that evidence was due to the PMM by 3/21/17, two days before the transition was scheduled to take place. The Center did not provide any additional pre-move documentation that these critical trainings had been completed, although the PMM noted the documentation confirming the training had been received as required at the time of the seven-day PMM visit on 3/29/17. To meet criterion, the Center should clearly document that all pre-move supports are in place before the transition takes place.
  - Due to this lack of pre-move documentation for Individual #317, the PMSR failed to document that provider staff had required knowledge of important health and safety needs that should have been clearly in place at the time of transition.
  - Another pre-move support for Individual #317 called for 24-hour awake staff to be in place due to his history of seizures, bilateral hearing loss and use of hearing aids, and history of inappropriate sexual behavior with vulnerable individuals. The PMM marked this support as in place, but the evidence only referred to an interview with staff that indicated the home was an all-male residence. This did not address the presence of 24-hour awake staff or staff knowledge of the reasons for the required level of supervision.
  - Individual #317's CLDP called for a privacy fence in the back yard due to pedophilia, the requirements of his child avoidance plan, and his history of inappropriate sexual behavior. The PMM marked this support as in place, although the comment provided indicated the privacy fence allowed for some visibility into the neighbor's back yard. It was not confirmed whether children might be present in the neighbor's yard at any time and the pre-move requirement for supervision did not indicate whether Individual #317 could be unsupervised while in his own back yard in any event.
- For Individual #362, the PMSR provided no evidentiary documentation to confirm pre-move supports were in place. Each requirement was checked off as in place, but did not describe how that was determined. For example, four of the six pre-move supports required PMM interviews as evidence to be obtained, but the PMSR included no evidence (other than a checked box) to show the interviews occurred as well as demonstrated the presence of the respective support.

Outcome 5 – Individuals have timely transition planning and implementation.											
Summary: Both individuals transitioned in a timely manner and lots of transition-related activities were occurring during the months from referral to transition. This was an improvement compared with the last review and was exceptionally noteworthy given that the number of transitions had doubled compared with the last review. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall	317	362							

		Score									
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	2/2 100%	1/1	1/1							

Comments:
20. Both CLDPs met criterion for this indicator.

- Individual #317 was referred on 10/25/16 and transitioned on 3/23/17, which was within 180 days.
- Individual #362 was referred on 12/1/16 and transitioned on 6/21/17, just over 180 days. The transition proceeded on a timely basis and was only briefly delayed when Individual #362 changed her mind about the city she wanted to live in, requiring a new search for potential providers.

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 <u>or</u> 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