United States v. State of Texas

Monitoring Team Report

San Angelo State Supported Living Center

Dates of Onsite Review: March 18-21, 2019

Date of Report: May 31, 2019

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

Table of Contents

Background 3
Methodology 4
Organization of Report 5
Executive Summary 5

Status of Compliance with Settlement Agreement
- Domain 1 8
- Domain 2 30
- Domain 3 89
- Domain 4 139
- Domain 5 151

Appendices
- A. Interviews and Documents Reviewed 167
- B. List of Acronyms 175

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.

Even so, many problems were noted with the documents submitted (e.g., missing documents, documents misfiled or out of order). Although the Monitors and Monitoring Team members worked to identify these issues, and ask for corrections, it is likely that these document issues negatively impacted the findings.

Two serious problematic aspects of service provision were evident during the onsite week:

1. Direct care staffing vacancies:
   The Center told the Lead Onsite Monitor that about half of the direct support professional staff positions were vacant. The Center was struggling to address what had become a crisis. They were attempting to fill positions, but were unable to do so. The Monitoring Team heard about (from individuals and from staff at all levels), and directly observed, the effects of the staffing shortages during the onsite week. Based on this, the Monitors submitted to the parties, on 4/4/19, a list of three dozen things the Monitoring Team observed, heard, or was told. Examples included individuals not being supervised, staff present who did not know the individuals, insufficient minimum staffing ratios, staff being held over (i.e., unable to go home), clinical and management staff working multiple direct care shifts, individuals being fearful, and various on- and off-campus activities being cancelled (e.g., on-campus gym, community outings).

2. Peer to peer aggression:
   There was a high number of peer to peer aggressive violent incidents at San Angelo SSLC. The Center's own count was approximately 200 occurrences per month. Resultant minor and serious injuries were not uncommon. Discussions of incidents of peer to peer aggression had become routine parts of morning medical, unit morning, and IMRT meetings. The Center completed a quarterly report called the Quarterly Aggression Report. The report included data, which was good to see being presented, but provided very little in the way of recommendations or actions. In other words, the Monitoring Teams' observations onsite and their review of documentation showed a weak response and weak approach to dealing with this issue in any systemic Center-wide manner.

   A reasonable comparison is with the Mexia SSLC. At Mexia SSLC, a Center-wide approach was initiated more than a year ago. It involved a monthly report, a weekly discussion at IMRT, a deeper review and assessment of the data, and a set of actions directed towards (a) specific individuals and their plans, and (b) the Center as a whole. Mexia SSLC, which had a similar, though not identical, population and a higher census (about 225 individuals versus about 200 individuals at San Angelo SSLC), reported about 50

occurrences each month. Although more improvement was needed, Mexia SSLC was moving in a positive direction. San Angelo SSLC needs to take a more organized and intensive approach to this problem.

This might benefit from State Office oversight, partnering with Mexia SSLC, and a special work group. One consideration is to involve the Center's self-advocacy committee and its primary facilitator, the Rights Protection Officer. It was a vibrant part of the Center, held a monthly meeting attended by about 80 individuals, and had a history of engaging in Center-improvement activities from time to time. Indeed, at the meeting held during the onsite review week, a number of individuals spoke out about the need for there to be no more fighting, less drama, and no more making false accusations.

The Monitors spoke with the parties about these two topics. State Office reported being aware of the problems and was putting some actions into place. These included developing a Center action plan (similar to what they had done for other Centers over the past years, such as at El Paso, Corpus Christi, and Richmond SSLCs). This plan was to address/include at least four target areas: staffing vacancies, peer to peer aggression, engagement in activities, and IMRT. The State agreed to send a weekly update to the Monitors on the development, implementation, and outcomes of this action plan.

Lastly, during the onsite week, the Monitoring Teams identified the following individual-specific issues that required follow-up by the Center:

- Individual #331: Consideration and specialized treatment approaches for her diagnosed tobacco use disorder.
- Individual #241: First, explore more extensive collaboration between psychiatry and neurology because he received multiple anti-seizure medications and one psychiatric medication. The medications were not considered to be for "dual usage." Second, Individual #241 went on frequent home visits. His team might benefit from more involvement from the Center's transition department.
- Individual #270: There were conflicting reports about whether or not she was eating at mealtimes. Different reports were made on the same day at morning medical and morning unit meetings. This should be reconciled/resolved.

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, 27 of these indicators were moved to, or already in, the category of requiring less oversight. During this review, two other indicators had sustained high performance scores and will be moved to the category of requiring less oversight. These were in the areas of restraint and ANE/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.

Note: Two areas affected individuals' protection from harm: direct support professional staffing vacancies, and peer to peer aggression. See discussion above in the executive summary of this report. About half of the direct support professional positions were vacant. There were approximately 200 instances of peer to peer aggression each month.

Restraint

Overall usage of crisis intervention restraint at San Angelo SSLC continued to decrease, though there was some ascension to the trend line over the past few months. Average duration of a crisis intervention physical restraint was also slightly higher than at the last review.

Problems around crisis intervention chemical restraint and Center-made medical restraint devices that were observed at the last review were not found during this review.

There were almost no issues with the restraint documentation. A thorough review of all crisis intervention restraints was conducted. If recommendations were made for revision of services and supports, recommendations were implemented.

For about one-third of the restraint occurrences, the restraint monitor did not arrive within the required timeframe. This may be an area impacted by the staffing shortage at the Center.

Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: for individuals with protective mechanical restraint for self-injurious behavior (PMR-SIB), defining needed nursing assessments and other requirements in Integrated Health Care Plans (IHCPs), and documenting their completion; monitoring individuals for potential side effects of chemical restraints and providing follow-up for abnormalities; and providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline.

Regarding psychiatry's involvement with crisis intervention chemical restraints, performance remained low (though slightly higher than at the last review). Similar to many other outcomes and indicators regarding psychiatry, clerical support might be helpful in setting the occasion for these activities to occur.

Abuse, Neglect, and Incident Management

Most incidents were reported timely and correctly. Investigation content (including development of fact patterns and drawing conclusions) was good. At the last review, San Angelo SSLC did not have a properly operating review authority. This was corrected at the time of this review.

The serious injury audit process was exemplary. The department conducted frequent audits and the auditor identified any issues, no matter how seemingly small, that needed attention. Trend reports, analysis, and corrective action planning were much improved from what was noted in the last review, and returned to the higher quality seen in prior years.

About 20% of the investigations involved some aspect of late reporting and/or late completion of the investigation. Two investigations did not show completion of disciplinary actions and two investigations did not show completion of programmatic actions. This was noted in the last report, too. The Center needs to ensure that recommendations are implemented to completion.

The system regarding non-serious injury investigations needed to be corrected. This is regarding determining if a NSI investigation is needed and then completing all of the required content.

In the ISPs, ANE/injury data were not presented in a manner that LARs/guardians and individuals would find useful. There was very little summary data noting, for example, witnessed versus discovered injuries, body parts/causation, investigation outcomes, and so forth. In most cases, the data numbers were presented, but not summarized in a useful, easy to understand, manner.

Other
For pretreatment sedation, none of the activities of the IDT were documented (or occurred) regarding review, possible strategies to reduce future need, or implementation.

As the Monitoring Team has indicated in a number of previous reports, the Center needs to complete Drug Utilization Evaluations (DUEs) that are clinically significant, and identify, implement, and document follow-up action, as needed.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.											
Summary: Overall usage of crisis intervention restraint at San Angelo SSLC continued to decrease, though there was some ascension to the trend line over the past few months. Average duration of a crisis intervention physical restraint was also slightly higher than at the last review. These indicators remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	83% 10/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	80% 8/10	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1

Comments:
1. Twelve sets of monthly data provided by the facility for the past nine months (May 2018 through January 2019) were reviewed. Overall, across the nine-month period, this was the lowest census-adjusted rate in the six nine-month periods in the Monitors' reports. That being said, a slightly ascending trend was noted across the second half of the nine-month period and is worthy of continued focus by the Center. The well-discussed problems with filling direct support professional positions may also be a factor in this ascending trend. Further, the Center had the third highest frequency of crisis intervention restraints in the state, when adjusted for census (though not for acuity of individuals' behavior and psychiatric disorders).

Most crisis intervention restraints were crisis intervention physical restraints. Therefore, the trend almost paralleled the overall usage of crisis intervention restraint at the Center. The average duration of a crisis intervention physical restraint was about four minutes, about half a minute longer than at the last review. This average duration was the fourth highest in the state. The trend was also slightly ascending in the second part of the nine-month period.

The usage of crisis intervention chemical restraints showed a clear ascending trend, to about 10 per month over the past three months. There were no usages of crisis intervention mechanical restraint. There was one injury (deemed non-serious) during restraint application during the review period.

The number of individuals who had one or more crisis intervention restraints each month showed an ascending trend, too. The number of individuals with protective mechanical restraint for self-injurious behavior was low, at one. For medical and dental procedures, non-chemical restraint was rarely used (twice during the review period), pretreatment sedation was showing a descending trend, and TIVA was used when available (i.e., variable from month to month).

Thus, facility data showed low/zero usage and/or decreases in 10 of these 12 facility-wide measures (overall usage of crisis intervention restraint, use of crisis intervention physical and 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).

Note: Crisis intervention restraint should be used when there are imminently dangerous circumstances for which the staff need to intervene with crisis intervention restraint to protect the individual and others from immediate and serious risk of harm. Although the Monitoring Team looks for decreasing trends in the usage of crisis intervention restraint, appropriate usage of crisis restraint does not prevent the Center from moving forward towards substantial compliance with the protection from harm restraint aspects of the Settlement Agreement.

2. Five of the individuals reviewed by the Monitoring Team were subject to restraint. In addition, the Monitoring Team reviewed the PMR-SIB used for an additional individual (Individual #346). Four individuals received crisis intervention physical restraints (Individual #335, Individual #331, Individual #297, Individual #233), three received crisis intervention chemical restraint (Individual #335, Individual #331, Individual #402), and one received PMR-SIB (Individual #346). Data from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for four (Individual #402, Individual #297, Individual #233, Individual #346 for PMR-SIB). The other four 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: Not all supports were in place to reduce the likelihood of a crisis intervention being needed. Problems around crisis intervention chemical restraint and Center-made medical restraint devices that were observed at the last review were not found during this review. Indicator 9 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	335	331	402	297	233	346			
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 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% 0/3	0/2	0/1							
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, these indicators were moved to the category of requiring less oversight.									
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.										

Comments:
The Monitoring Team chose to review nine restraint incidents that occurred for six different individuals (Individual #335, Individual #331, Individual #402, Individual #297, Individual #233, Individual #346). Of these, five were crisis intervention physical restraints, two were crisis intervention chemical restraints, and one was PMR-SIB. 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. For Individual #335 and for Individual #331, there were not enough data or other information to indicate that ISP supports and PBSPs were consistently implemented. Individual #331 was rarely engaged in activity, thus, setting the occasion for frequent incidents around cigarette smoking.

11. More detail regarding IDT true consideration of contra-indications for restraint should be included in the ISP/discussed by the IDT, especially those related to the individual's risk ratings and diagnoses. This could be documented via a special form, an ISPA, reference to the AMA, or any other documentation developed by the Center.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
Summary: One direct support professional was unable to identify/describe prone restraint as a prohibited type of restraint.			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: For some restraint occurrences, the restraint monitor did not arrive within the required timeframe. This may be another area impacted by the staffing shortage at the Center. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	331	402	297	233	346			
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	63% 5/8	3/3	1/2	0/1	0/1	1/1				
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
13. For three restraints, the restraint monitor did not arrive within the required timeframe (Individual #331 12/27/18, Individual #402 1/22/19, Individual #297 1/2/19).

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: for individuals with PMR-SIB, defining needed nursing assessments and other requirements in IHCPs, and documenting their completion; monitoring individuals for potential side effects of chemical restraints and providing follow-up for abnormalities; and providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	331	402	297	233	346			
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	33% 3/9	1/3	1/2	0/1	0/1	1/1	0/1			
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	56% 5/9	1/3	1/2	1/1	0/1	1/1	1/1			
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	50% 4/8	0/2	1/2	1/1	0/1	1/1	1/1			

Comments: The restraints reviewed included those for: Individual #335 on 11/8/18 at 12:13 p.m., 1/28/19 at 4:26 a.m. (chemical), and 1/28/19 at 4:34 a.m.; Individual #331 on 12/27/18 at 6:19 p.m., and 12/24/18 at 1:30 p.m. (chemical); Individual #402 on 1/22/19 at

5:50 p.m. (chemical); Individual #297 on 1/2/19 at 4:45 p.m.; Individual #233 on 12/26/18 at 2:13 p.m.; and Individual #346 from 2/4/19 to 2/10/19 [protective mechanical restraint for self-injurious behavior (PMR-SIB)].

a. through c. For Individual #335 on 11/8/18 at 12:13 p.m., Individual #331 on 12/27/18 at 6:19 p.m., and Individual #233 on 12/26/18 at 2:13 p.m., the nurses performed physical assessments, documented whether there were any restraint-related injuries or other negative health effects, and took action, as needed, to meet the needs of the individuals.

The following provide examples of problems noted:

- On 1/28/19, Individual #335 received a chemical restraint of Thorazine intramuscular (IM), for which a horizontal physical hold was needed in order for the nurse to administer it. Although in an IPN, the nurse wrote: "Nurse to assess q [every] 15 x2 hours, q 30 min x1 hour, and q 2 x4 hours then q 4 hours for a minimum of 24 hours, after released until deemed stable by the nurse," no documentation was found in IView or the IPNs to show that nurses implemented the plan. Based on the documentation submitted, the nurse also did not instruct the individual and/or the staff on the possible side effects of the Thorazine injection. It was concerning that nurses did not monitor the individual for side effects, such as orthostatic hypotension. Although the nurses documented that the individual initially refused vital signs three times, monitoring respirations does not require the cooperation of the individual. The nurse also did not document a skin assessment to check for injuries related to the horizontal physical hold. With regard to mental status, the only note indicated the individual was "alert."
- On 12/24/18, at 1:30 p.m., Individual #331 received a chemical restraint of Thorazine IM. At 1:30 p.m., the initial vital sign assessment showed a high pulse (127), and low blood pressure (85/50). At 1:45 p.m., a second set of vital signs showed a pulse of 125, and continued low blood pressure (75/50). At 2:01 p.m., the vital signs were still abnormal, with a pulse of 120, and a blood pressure of 71/57. Given the potential side effect for Thorazine of hypotension, the nurse should have notified the PCP, but did not. Of significant concern, after the vital signs documented at 2:01 p.m., based on documentation submitted, nurses did not check the individual's vital signs again, which was not consistent with the nursing guidelines for the administration of a chemical restraint.
- For Individual #402's chemical restraint on 1/22/19, the nurse documented his refusals to allow vital sign assessments, but did document his respirations, which was good to see. In this case, the nurse followed the nursing guidelines for continued monitoring of (or attempts to monitor) the individual's vital signs and status. The problem, though, related to the nurse's documentation related to the individual's mental status. The nurse generally did not provide specifics about the individual's behavior.
- For Individual #297, the restraint occurred at 4:45 p.m. The nurse documented notification at 6:00 p.m. The nurse entered an IPN indicating that the individual was "running around on campus is not in the building." Although the Debriefing form stated that a nurse checked the individual's mental status, and vital signs, and assessed the individual for injury, Center staff provided no supporting documentation to show the nurse conducted assessments. The IPN referenced IView, but no IView entries were found for this restraint.
- For Individual #346's PMR-SIB, which consisted of the bilateral use of Kevlar gloves/mittens:
    - Paragraph IV.D.2.b of the State Office policy on restraint, effective 10/1/18, requires an IDT to develop an IHCP that describes the need for PMR-SIB. Although not outlined in the policy, the IHCP should include action steps for all needed physical assessments, monitoring activities, and needed assistance with care.
        - Based on the documentation submitted, Individual #346's IDT did not have a current IHCP in place to address

the use of the PMR-SIB.
- In Paragraph IV.E.3, State Office policy indicates that: "The protective mechanical restraint plan describes the level of monitoring to be used when the mechanical restraints are in place and when the mechanical restraints are removed."
  - Based on the documents submitted, Individual #346 did have a Protective Mechanical Restraint Plan for Self-Injurious Behavior, which described the monitoring that direct support professional was to complete.
- State Office policy in Paragraph IV.D.4, also requires that: "A nursing staff completes a check of the device once per shift and documents the individual's medical status. The restraint monitor and nursing staff document their information in IRIS."
  - In terms of nursing assessments that did occur, for each nursing IPN, a corresponding flowsheet was found with vital signs and a skin integrity assessment, which included removing the gloves, a circulation check (i.e., capillary refill), as well as a description of the nurses' response to any of the individual's symptoms or complaints.
  - The individual communicated verbally, and responded to the nurse's verbal prompts or questions. For example, he told the nurse: "bite on my arm hurts," and reported to staff that he thought his blood sugar was low. He also told the nurse: "you may need to send me in I swallowed the staple."
  - Based on the documentation submitted, nurses completed vital signs as required.
  - However, most entries, with regard to mental status only said "alert," or "no change from baseline."

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.											
Summary: This indicator will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	335	331	402	297	233	346			
15	Restraint was documented in compliance with Appendix A.	100% 9/9	3/3	2/2	1/1	1/1	1/1	1/1			
Comments:											

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
Summary: With sustained high performance, both indicators might be moved to the category of requiring less oversight after the next review. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	331	402	297	233	346			
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 8/8	3/3	2/2	1/1	1/1	1/1				
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 6/6	2/2	2/2	1/1	1/1					
Comments:											

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: Performance remained low, however, scores were higher than at the last review. Similar to many other outcomes and indicators regarding psychiatry, clerical support might be helpful in setting the occasion for various activities to occur and to have the minimum required content. These three indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	335	331	402							
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	67% 2/3	1/1	0/1	1/1							
48	Multiple medications were not used during chemical restraint.	67% 2/3	1/1	1/1	0/1							
49	Psychiatry follow-up occurred following chemical restraint.	33% 1/3	0/1	1/1	0/1							

Comments:
47. The above indicators applied to crisis intervention chemical restraints for Individual #335, Individual #402, and Individual #331. The Administration of Chemical Restraint: Consult and Review form was completed within the required time period for Individual #335 and Individual #402. The psychiatrist did not complete the review form for the restraint regarding Individual #331.

48. The chemical restraint for Individual #402 involved a combination of medications, specifically Haldol and Benadryl.

49. The medical record indicated psychiatry follow-up regarding the administration of chemical restraints for Individual #331.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.												
Summary: Half of the direct support professional positions were vacant. There were approximately 200 instances of peer to peer aggression each month. Staff background checks were done for all staff and false allegation protocols were followed (except for one aspect noted below). For two incidents, PBSP supports were not in place or implemented as required. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	335	245	337	331	402	297	272	233	241	45

1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	85% 11/13	1/2	1/1	1/1	1/2	1/1	2/2	1/1	1/1	1/1	1/1

Comments:
The Monitoring Team reviewed 13 investigations that occurred for 10 individuals. A 14th investigation was not completed at the time of this review (regarding the death [UIR 12316] and allegation of neglect [UIR number unknown] of Individual #320). Of these 13 investigations, eight were HHSC PI investigations of abuse-neglect allegations (two confirmed, three unconfirmed, two inconclusive, one administrative referral). The other five were for facility investigations of serious injuries (fractures), unauthorized departure, suicidal ideation, law enforcement contact, and a sexual incident. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #335, UIR 11888, HHSC PI 474-57591, inconclusive neglect allegation, 9/30/18
- Individual #335, UIR 11787, unauthorized departure, suicidal actions, law enforcement contact, date unknown
- Individual #245, UIR 12174, HHSC PI 475-69613, administrative referral of verbal emotional abuse, 12/24/18
- Individual #337, UIR 11737, HHSC PI 473-74447, unconfirmed sexual abuse allegation, 8/3/18
- Individual #331, UIR 11778, HHSC PI 473-98406, confirmed neglect allegation, 8/18/18
- Individual #331, UIR 12062, serious injury, discovered, orbital bone fracture, 11/21/19
- Individual #402 and two other individuals, UIR 12047, HHSC PI 475-24802, inconclusive and unconfirmed physical abuse and neglect allegation, 11/17/18
- Individual #297, UIR 12198, HHSC PI 475-74390, unconfirmed physical and verbal abuse allegation, 12/31/18
- Individual #297, UIR 12212, sexual incident, date unknown
- Individual #272, UIR 11873, HHSC PI 474-46757, confirmed sexual abuse allegation, 9/23/18
- Individual #233, UIR 12278, HHSC PI 476-00716, unconfirmed verbal emotional abuse, 1/21/19
- Individual #241, UIR 12241, serious injury, discovered, laceration eyebrow, date unknown
- Individual #45, UIR 12186, serious injury, discovered, pelvis fracture, 12/26/18

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.

For all 13 investigations, related background checks and duty to report forms were done correctly. For 10 of the 13, the investigation was regarding allegations of staff misconduct or of an incident for which there was no relevant history. Thus, for each of these, there were no relevant individual-related trends to be reviewed. For the other three, one met criteria for review of prior trends/history and the development, implementation, and review of plans (Individual #241 UIR 12241). Thus, sub-indicators b, c, and d were met. For Individual #335 UIR 11787, the prior history section in the UIR was listed as pending and his PBSP did not address any of the behaviors

related to this incident (sub-indicators b and c). For Individual #331 UIR 12062, the PBSP addressed the related behavior, but it was ineffective and needed revision (sub-indicator d).

Three individuals at San Angelo SSLC were deemed for streamlined investigations by HHSC PI for certain types of allegations based on their histories of frequent reporting of unfounded allegations. Two were selected for more in depth review (Individual #300, Individual #37). Two sets of protocols were relevant. One was HHSC PI's regarding assignment and maintenance of one's name on their list. This was being followed; documentation for the most recent two quarterly reviews were provided (December 2018 and March 2019). Most recently one individual was removed from the list and one was added. The other was the SSLC protocols for there to be a plan in place, and for it to be reviewed. A plan to address this behavior was part of both individuals' PBSPs.

Eighteen individuals were deemed chronic callers by San Angelo SSLC (San Angelo SSLC and Mexia SSLC are the only two Centers with this additional list). This was less than the 32 names on the list at the time of the last review. The Monitoring Team is aware that both Centers have implemented various procedures and protocols over the years in order to manage the high number of unfounded allegations. Their Center-specific policies were almost identical. State Office might consider having a single identical policy for these two Centers (in addition, San Angelo SSLC's was written in 2015 and referred to out of date items, such as Avatar). Two individuals were selected for a more in depth review (Individual #270, Individual #247). For both, the frequent false accusation behavior was addressed in the PBSP, the Center showed it had reviewed its list with APS, and documented that the alleged perpetrator was under special monitoring until cleared, but was unable to show documentation that supervision of the alleged perpetrator actually occurred.

Peer to peer aggression: The Center reported approximately 200 instances of peer to peer physical aggression each month. This was higher than at the last review. The Center did not have a strong plan (e.g., review process, actions for individuals, actions for the Center as a whole). At the last review, the Monitor recommended State Office involvement/oversight and also potentially partnering with Mexia SSLC. Neither of these actions occurred. The seriousness of the frequency and intensity of these incidents now warrants special action more so than ever before. Please see the comments in the Executive Summary in the first part of this report.

Direct support professional staffing vacancies: The Center reported that approximately 50% of the direct support professional positions were vacant. This has resulted in limitations on activities, absence of some supports for some individuals, increased likelihood of abuse/neglect, and less supervision of individuals. Direct support professional staff, managers, clinicians, and individuals all told the Monitoring Team about this problem and its impacts. Although the Center was taking some actions, more assistance and direction, perhaps from State Office, is required to try to stem this problem and address this crisis. Please also see the comments in the Executive Summary in the first part of this report.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.												
Summary: Most incidents were reported timely and correctly. Three were not rated as meeting criteria for reporting; one was the result of a critical incident review meeting, and the other two were one to three hours later than the one-hour requirement. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall	335	245	337	331	402	297	272	233	241	45

		Score										
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	77% 10/13	2/2	1/1	1/1	1/2	0/1	2/2	1/1	1/1	0/1	1/1

Comments:
2. The Monitoring Team rated 10 of the investigations as being reported correctly. The other three 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 #331 UIR 11778, the UIR noted that it was not reported within one hour (after the critical incident meeting was held). It may have been that discussion during the critical incident meeting led to a determination that filing an allegation was appropriate, but there was nothing in the UIR explaining this delay, other than that it occurred.
- For Individual #402 UIR 12047, the HHSC PI report showed that the incident occurred at 5:55 pm and was reported at 8:00 pm. DFPS Intake reported it to the Center at 8:43 pm. The Center director/designee was notified at 9:03 pm. When reported to DFPS Intake, it should also have been reported to the director/designee. There was nothing in the UIR that explored whether the reporter might have been staff or an individual, that is, it did not address any of the reporting circumstances.
- For Individual #241 UIR 12241, the UIR noted that the injury was coded at 12:14 am, but not reported to EDO until 4:10 am. There was no explanation of any circumstances around this reporting timeframe.

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: Regarding indicator 4, the ISPs included minimal information and met criteria, however, they did not reflect summarized data that would actually be useful to an individual and/or LAR/guardian. For example, better would be a short paragraph regarding witnessed versus discovered injuries, serious versus non-serious, investigation outcomes, and trends. Information should be presented in summary form that is understandable and helpful to the individual and/or LAR/guardian in understanding the prior year's protection from harm events. This indicator will remain in the category of requiring less oversight, however, the Monitor recommends that the Center improve upon this aspect of the ISP/IDT process.

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.									

#	Indicator	
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:			Individuals:								
#	Indicator	Overall Score									
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
	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: Given sustained high performance across this and the previous two reviews (i.e., only one exception, during the last review), indicator 8 will be moved to the category of requiring less oversight. Indicators 9 and 10 will remain in the category of requiring less oversight, however, a comment is provided below for one of the 13 investigations that did not meet criteria with these two indicators.			Individuals:									
#	Indicator	Overall Score	335	245	337	331	402	297	272	233	241	45
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 13/13	2/2	1/1	1/1	2/2	1/1	2/2	1/1	1/1	1/1	1/1

#	Indicator	
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:
9-10. For Individual #335 UIR 11888, the UIR noted that he was on one-to-one staffing throughout the day. Neither the HHSC PI nor the UIR reports identified and interviewed all staff who were assigned to the individual for the 18-24 hours prior to the incident (because this could have potentially identified relevant information). Also, there was conflicting evidence reported that was not reconciled. The UIR review committee noted that he had alcohol in his system, but in the subsequent paragraph it said that there was no factual evidence that he consumed alcohol. Further, the UIR noted that tests from the hospital emergency department showed negative for alcohol and that the behaviors observed might have been a result of recent medications changes (for which a statement or input from a psychiatrist or psychologist could have provided additional support). After receiving the draft version of this report, HHSC PI wrote that they agreed that additional relevant evidence could have been collected and that they would work with district staff regarding ensuring all relevant is collected and appropriately reviewed. The Monitor appreciated HHSC PI's attention to this going forward.

Outcome 7– Investigations are conducted and reviewed as required.

Summary: All investigations were completed, but two were completed a few days beyond the required timelines without approved extensions. The review of investigations process identified problems with some investigations, but for three investigations, late completion of the investigation or contradictory information was not identified. It was good to see that both indicators scored higher than at the last review; both will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	335	245	337	331	402	297	272	233	241	45
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	2/2	0/1	1/1	2/2	1/1	2/2	1/1	1/1	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 accurate, complete, and coherent.	77% 10/13	1/2	0/1	1/1	2/2	1/1	2/2	1/1	1/1	1/1	0/1

Comments:

12. Two investigations were not completed within the required timeline and/or did not have extension requests.

- For Individual #245 UIR 12174, the incident occurred on 12/24/18. The investigator review was dated 1/10/19 and the manager review 1/11/19. There were no extension requests.
- For Individual #45 UIR 12186, the incident occurred on 12/26/18 and the investigation was completed on 1/8/19. There were no extension requests.

13. At the last review, San Angelo SSLC did not have a properly operating review authority. This was corrected at the time of this review.

Three reviews, however, did not meet criteria with this indicator. Two of these were absence of identification of late completion of the investigation (Individual #245 UIR 12174, Individual #45 UIR 12186). The third was the absence of identification of the contradictory information regarding alcohol consumption and staff interviews (Individual #335 UIR 11888).

On the other hand, the review did identify late reporting for Individual #331 UIR 11778.

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: The Center had an excellent system of audits for significant injuries. It did not, however, have a system to correctly determine when a non-serious injury investigation was warranted or to complete those investigations correctly. The four positive scores were for individuals for whom a non-serious injury investigation was not required during the review period. Indicator 15 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	335	245	337	331	402	297	272	233	241	45
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.	40% 4/10	0/1	1/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1

Comments:

#	Indicator	Overall Score	Individuals:								
Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
Summary: Two investigations did not show completion of disciplinary actions and two investigations did not show completion of programmatic actions. This was noted in the last report, too. The Center needs to ensure that recommendations are implemented to completion in order for indicators 16 and 17 to remain in the category of requiring less oversight after the next review.											
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.										
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.										

Comments:
17. Recommended staff-related actions were not completed for Individual #335 UIR 11888 and Individual #272 UIR 11873.

In three investigations, there was confirmed allegations of physical abuse category 2. In all cases, the employment of the confirmed employee was terminated.

18. Recommended programmatic actions were not completed for Individual #335 UIR 11888 and UIR 11787.

#	Indicator	Overall Score	Individuals:								
Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
Summary: This outcome consists of facility indicators.											
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: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									
Comments: a. Since August 2018, the Center has not conducted a total intravenous anesthesia (TIVA) clinic. Furthermore, the Center does not have a collaborative arrangement with a local oral surgeon or a dentist who can perform hospital dentistry. Individuals who require TIVA, oral surgery, or hospital dentistry are not receiving services. For the one instance of the use of TIVA, the individual (i.e., Individual #185) did not meet criteria for its use. The Center had also not ensured the medical clearance form was fully completed. As discussed in the last report, the Center did not have a policy that clearly outlined preoperative assessment and perioperative management. Otherwise, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, an operative note defined procedures and assessment completed, and post-operative vital sign flow sheets were completed as required. b. Based on the documentation provided, during the six months prior to the review, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation for dental procedures.											

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
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	0/1	N/A	N/A	N/A	N/A	N/A

Comments: a. According to Tier I documentation (i.e., TX-SG-1903-III.12.t), Individual #185 was administered oral pre-treatment sedation for a computed tomography scan of the chest. The Monitoring Team's Tier II document request #49 asks for: "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." Center staff provided no documentation in response to this request.

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: For the individual chosen for review, none of the criteria were met for this outcome. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	405	335	245	337	331	402	297	241	272	233
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	0% 0/1	0/1									
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.	0% 0/1	0/1									
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										
4	Action plans were implemented.	N/A										
5	If implemented, progress was monitored.	N/A										
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A										
Comments: None of the individuals in the review group had PTS, so Individual #405 was reviewed to score this indicator. 1. Available documentation did not reflect a discussion of Individual #405's need for PTS or supports needed for the procedure, treatment, or assessment. 2-6. No treatments or strategies to minimize the need for PTS were documented.												

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: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	71	344	38	7	320	66	146		
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.	43% 3/7	1/1	1/1	1/1	0/1	0/1	0/1	0/1		
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1	0/1		
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1	0/1		
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1	0/1		
e.	Recommendations are followed through to closure.	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1	0/1		
Comments: a. through e. Since the last review, seven individuals died. The Center did not provide the Monitoring Team with a complete set of documents requested with regard to these deaths. Apparently, due to a change in policy and the wording of the titles of the revised mortality review documents, it was not clear to Center staff which of the mortality documents they could provide copies to the Monitoring Team. Given that the Settlement Agreement requires Center staff to provide relevant documents to the Monitoring Team, the reason remains unclear to the Monitoring Team why Center staff did not provide these documents for review at the Center on the first day of the onsite visit, which potentially would have allowed the Monitoring Team time to review hard copies on site. On Thursday of the onsite review week, Center staff provided some, but not all of the requested documents. While the Monitoring Team attempted to review documents on site, Center staff sometimes added documents to folders the Monitoring Team already had reviewed. Since the review, the Lead Monitor worked with State Office staff to resolve this misunderstanding to prevent similar problems at other Centers. However, due to the lack of documents San Angelo SSLC staff provided as well as problems with the quality of the reviews that the Center did submit, the Center's scores for this section are poor.											

Based on the limited information to which the Monitoring Team had access, the following provides information about the individuals who died:

- On 10/6/18, Individual #71 died at the age of 77 with causes of death listed as acute respiratory failure, pneumonia, and infra-cervical upper motor neuron disease.
- On 11/11/18, Individual #344 died at the age of 78 with cause of death listed as acute on chronic respiratory failure with hypoxia.
- On 11/23/18, Individual #38 died at the age of 62 with cause of death listed as advanced diastolic heart failure.
- On 1/7/19, Individual #7 died at the age of 75 with cause of death listed as cancer of the esophagus.
- On 2/1/19, Individual #320 died at the age of 18 with cause of death listed as epilepsy due to chronic encephalitis.
- On 2/10/19, Individual #66 died at the age of 46 with causes of death pending.
- On 2/12/19, Individual #146 died at the age of 84 with causes of death pending.

Evidence was not submitted to show the Center conducted thorough reviews of the health care provided to individuals who died, nor was evidence found that the mortality review process resulted in an analysis of medical/nursing reviews to determine additional steps that should be incorporated in the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews reviewed. The following provide some examples of problems:

- The administrative death review (ADR) for Individual #71 indicated that the group agreed with the recommendations in the clinical death review (CDR). However, due to the formatting of the information submitted (i.e., hundreds of pages of emails mixed with committee minutes and recommendations), it was not clear which recommendations came from the CDR.

  The CDR noted that there was inadequate PCP documentation by a "provisional PCP who had pervasive documentation deficits" and was no longer on staff, but it was not clear if the group agreed upon recommendations for Medical Department implementation.
- All medical and nursing recommendations from the death reviews were not carried over to the ADR or CDR without explanation.
- For Individual #344, it was unclear to what the following recommendation referred: “Staff will need to be trained on revised policy and given resources."
- For Individual #320, who died at the age of 18, Center staff did not submit an ADR. The CDR underscored problems with the implementation of cardiopulmonary resuscitation (CPR). Based on discussion with the Medical Director, this was not an isolated event.

  There were also problems with the neurological consultation. Individual #320 was admitted on 11/15/18. She was prescribed three antiepileptic drugs (AEDs) and had a vagus nerve stimulator (VNS). Upon her admission, the "external controller" could not be located. Based on the records submitted, there was no documentation that it was ever found. Since the VNS was never interrogated, it was not clear if it was functioning properly. Center staff instructed her guardian to go to the NIX hospital, obtain records, and send them to the Center. Center staff had a responsibility to request and obtain these records in a timely manner themselves. On 1/25/19, she had an electroencephalogram (EEG) that was read as normal. The neurologist indicated that a normal EEG did not exclude epilepsy, and also stated: "EEG findings do suggest that the patient's diagnosis of epilepsy

needs critical re-evaluation." She was scheduled to see the neurologist the day she died. For an individual who was treated with three AEDs and had a VNS, neurology consultation should have occurred in a prompt manner.

At the time of the onsite review, the final report from the Adult Protective Services investigation was pending. However, the Center's investigation identified a number of significant concerns. For example:

- The investigation noted that she had seizure disorder, and she refused medications all day prior to her death. No evidence was found that the nurse notified the MD/PCP, but the investigator did not identify this as a concern;
  - State Office asked about medication refusals, and the investigator listed 12 days on which refusals occurred. It appeared that the only team response was on 12/12/18, when they approved use of applesauce because she complained the pills were too big.
- Based on video review, she had an unwitnessed three-minute seizure in the living room, while staff were in the office for shift change;
- Staff delayed initiating CPR, but from the investigation, it was unclear for how long, and the probable version of events did not help to define the delay. However, it seemed that staff waited some period of time for the Licensed Vocational Nurse (LVN) to arrive;
- The investigator confirmed that staff training/drills on CPR were not up-to-date "for an extended period of time;"
- The investigation showed that Behavioral Health Services staff had not developed a positive behavior support plan (PBSP) for this individual who had lived at the Center for four months;
- On the night/day of her death, staff did not complete "well-being" checks accurately. They were supposed to do them every 30 minutes: Staff were not observed doing checks on the video;
- Overnight staff documented that she "slept all night," when she was up all night; and
- Per Emergency Medical Staff (EMS), the day before, during an altercation with peer, Individual #320 sustained a hit to the throat.

As noted above, it was difficult to identify and follow the recommendations that the mortality review committee agreed upon. In addition, the documentation submitted to show the completion of recommendations was not well organized. Some examples of problems included:

- For Individual #344's death, the Center did not provide a status report for the eight nursing recommendations, the two medical recommendations, or the one recommendation for Habilitation Therapy.
- Similarly, Center staff did not provide a status report for the recommendations related to Individual #38's death.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
a.	ADRs are reported immediately.	N/A									

b.	Clinical follow-up action is completed, as necessary, with the individual.	N/A									
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A									
d.	Reportable ADRs are sent to MedWatch.	N/A									
Comments: a. through d. Center staff had not identified and/or reported adverse drug reactions for any of the individuals reviewed.											

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: As the Monitoring Team has indicated in a number of previous reports, the Center needs to complete DUEs that are clinically significant, and take and document follow-up action as needed. 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.	0% 0/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/2

Comments: a. and b. Center staff submitted documents in response to the Monitoring Team's request for DUEs. These included documents that the Center identified as DUEs for:

- Management of clozapine-induced sialorrhea, which was dated November 2018. The document submitted provided some good information on clozapine-induced sialorrhea, including the pathophysiology, risk factors, and treatment. The document did not provide any information on the specific use of clozapine at the Center. This was general information on sialorrhea, but did not include the information necessary for a DUE; and
- Keppra and behavioral changes, which was dated February 2019. The goal of the DUE was to evaluate the incidence of behavioral changes in individuals receiving Keppra. There were 19 individuals residing at the Center that were treated with Keppra. The report discussed only four individuals. No data were presented regarding the other 15 individuals. The evaluation did not summarize findings or make any recommendations.

State Office has issued a template for the completion of DUEs. The San Angelo SSLC Pharmacy Director, Medical Director and Clinical Pharmacist were not familiar with this template. Neither of the documents submitted included any data on the Center's use of the medication, summary of findings/conclusions, or recommendations. Moreover, the Center did not submit any minutes to document that the Pharmacy and Therapeutics Committee discussed the DUEs.

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, 17 of these indicators were already in, or were moved to, the category of requiring less oversight. For this review, three other indicators were moved to this category, in ISPs and behavioral health. Two indicators, however, were returned to active monitoring; these were in the area of communication.

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.

The Monitoring Team attended annual ISP meetings, ISP preparation meetings, ISPA meetings, and a variety of other meetings during which individuals' services and supports were discussed. All individuals were visited at their homes and in their day programs.

There were a number of positive observations. Many individuals were aware of their rights and reported that they often looked to, and received support from, the Rights Protection Officer. Most individuals were dressed appropriately for age and season.

In one home (510), individuals were engaged in Richard Simmons Jazzercise. Most individuals were actively participating and seemed to be enjoying themselves. There were several job postings and opportunities for engagement displayed at the coffeehouse. People who were working were being paid minimum wage and seemed to value the positions they held. Working at the greenhouse and the woodshop appeared to be preferred employment for some individuals, and a great opportunity to develop organizational and interpersonal skills.

Common areas of the home did not feel homelike. Furniture, which was industrial and plain, was arranged around the perimeters of the rooms, which were large. Chairs and sofas were sometimes too far apart to encourage interaction. Home 504 was particularly chaotic. Several of the women expressed fear of their peers due to past incidents of aggression. Some stated that they did not want to live at the Center because they felt unsafe and/or unsupported.

<u>Assessments</u>
San Angelo SSLC determined what assessments were needed (an improvement from the last review), but did not then arrange for obtaining those needed assessments for the individuals.

For the individuals' risks reviewed, IDTs continued to struggle to effectively use supporting clinical data, and complete needed analysis of the data, including comparisons from year to year. As a result, for the great majority of the risk ratings reviewed, it was not clear that the risk ratings were accurate. In addition, when individuals experience changes in status, IDTs need to timely review related risk ratings, and make changes, as appropriate.

Many ISP action steps were pending assessments, which should have been completed prior to the ISP in order to incorporate assessment results into the development of the goals. Most action steps were written as service objectives, which required little to no response on the part of the individual.

Psychiatric CPEs were formatted correctly. CPE content needed attention to ensure that all required components were included. Perhaps clerical support can assist with this.

In psychiatry, all annual evaluations were completed. The contained most of the required components, but all were missing from one to four components. There was some confusion regarding completion of annual psychiatric assessment/evaluations. For the individuals in the review group, these were conducted by the consulting psychiatrist, not by the treating psychiatrist.

Behavioral health assessments consistently continued to be timely and complete. One individual did not have a functional assessment, the first occurrence observed by the Monitoring Team since 2015. For the functional assessments for all of the other individuals, all criteria for content were met.

In addition to improving timeliness, focused efforts are needed on the part of Center staff to improve the quality of the medical assessments. Moving forward, the Medical Department should focus on ensuring medical assessments include family history, childhood illnesses, and plans of care for each active medical problem, when appropriate.

For most individuals reviewed, the annual dental exam occurred more than 90 days prior to the ISP meeting; as a result, the annual dental summaries sent to the IDTs did not provide current dental exam information for the purposes of decision-making, risk analysis, and goal setting. The Center should focus on improving the quality of the dental exams, and particularly, the annual dental summaries.

For all nine individuals reviewed, nurses completed timely annual nursing reviews and physical assessments. With regard to nurses' timely completion of quarterly nursing record reviews and/or physical assessments, improvements are needed.

Work is needed to ensure that nurses complete annual and quarterly physical assessments that address the necessary components. Work is also needed to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to individuals' at-risk conditions. 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. It was

good to see that in some instances, when individuals experienced changes of status, nurses completed assessments in accordance with current standards of practice, but this is also an area in which improvements are still needed.

It was positive that as needed, a Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and the Physical and Nutritional Management Team (PNMT) discussed the results. Since the last review, the scores showed some improvement with regard to timely referral of individuals to the PNMT, but this is an area that requires continued focus. The Center should also focus on improving the completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT reviews and comprehensive assessments.

The Center should focus on improving the timeliness of Occupational and Physical Therapy (OT/PT) consults/assessments when individuals experience changes in status. Overall, the comprehensive OT/PT assessments reviewed were lacking with regard to most of the criteria for a quality assessment.

Significant work continued to be needed to improve the quality of communication assessments and updates in order to ensure that Speech Language Pathologists (SLPs) provide IDTs with clear understandings of individuals' functional communication status; alternative and augmentative communication (AAC) options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports is objectively evaluated.

Of note, as part of the onsite review week, the Monitoring Team appreciated the Habilitation Therapy Director's willingness to conduct an objective review of one individual's OT/PT and communication assessments, review the findings with the Center therapists, and then discuss her findings openly with the members of the Monitoring Team and State Office staff. This effort showed Center staff's ability to identify strengths, as well as weaknesses in the assessments, as well as to identify potential solutions to the significant improvements that are needed with regard to the assessments. The Monitoring Team is hopeful that the Habilitation Therapy Director's ongoing auditing of assessments with feedback provided to therapists will assist in improving the quality of the assessments.

Regarding skill acquisition, most, but not all, individuals had FSA, PSI, and vocational assessments completed. However, for all individuals, these assessments did not include recommendations for skill acquisition.

<u>Individualized Support Plans</u>
The number of personal goals that were individualized and meaningful was slightly lower than at the last review (indicator 1). Moreover, there was a range across individuals from one to five goals that met these criteria. Thus, the Center demonstrated that it can create a set of goals for some individuals (with the exception of the health/wellness/IHCP area).

- Of note was an ISP meeting observed by the Monitoring Team for Individual #337. During this meeting, the ISP facilitator challenged the IDT's goals because they were not adequately personalized, aspirational or long-term. This led to good discussion at the meeting.

Additional work needs to be done to take those goals that address important topics for the individual (i.e., indicator 1) and then write them in measurable terminology.

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, physical and nutritional, and OT/PT supports and interventions.

The ISP was implemented in a timely manner for just one-third of individuals. Action plans were generally not implemented, and barriers to implementation were not addressed.

As has been the case for some time, reliable data are needed in order to ultimately determine progress and if there is a need to make changes to implementation.

QIDP monthly reviews were being conducted and IDTs were meeting routinely. However, reviews did not, but must, summarize progress, develop actions if needed, and document follow-up.

In psychiatry, there was some stability in the staffing, which was good to see. The department had made only small steps forward towards the development of psychiatric indicators and psychiatry-related goals. On the positive, individuals had psychiatric indicators for reduction that were (for most individuals) related to their diagnoses. Most, however, were not written in observable measurable terminology and data were not available for any indicators that were not identical to PBSP target behaviors. Regarding indicators for increase, these indicators were not identified for any of the individuals. Regarding psychiatric goals, they were not written for every individual and they were not present in the ISP documentation (and if they were, there were differences across documents).

The psychiatrist attended the ISP meeting for six of the individuals in the review group. Criteria were met for psychiatric support plans (PSPs) for the first time.

In behavioral health, overall, performance was maintained from the last review. This was a positive. In particular, it was good to see that the Center maintained a relatively high performance on indicator 5, regarding data being reliable for PBSPs.

PBSPs were implemented when approved, and PBSPs contained relevant content for most, but not all individuals. One individual still had an initial admissions PBSP, but it was now six months since she was admitted.

Counseling and psychotherapy were occurring on campus as they had been for many years. Attendance remained low (see comments in Skill Acquisition and Engagement indicator 18).

All individuals had at least one SAP. About half of the individuals, however, merely had a single SAP when they had numerous skill deficits that might have benefited if skill acquisition planning was done. About half were based on assessments, and were practical/functional/meaningful for the individual. All but three had data that were shown to be reliable.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: The number of goals that met criteria for indicator 1 was slightly lower than at the last review. Moreover, there was a range across individuals from one to five goals that met criteria. Thus, the Center has shown that it can create a set of goals for some individuals (with the exception of the health/wellness/IHCP area). Additional work needs to be done to take those goals that address important topics for the individual (i.e., indicator 1) and then write them in measurable terminology. And, as has been the case for some time, reliable data are needed in order to ultimately determine progress and if there is a need to make changes to implementation. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	331	241	297	245	270	185			
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	1/6	2/6	4/6	3/6	5/6	1/6			
2	The personal goals are measurable.	0% 0/6	0/6	0/6	2/6	0/6	0/6	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	1/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed the ISP process for six individuals at the facility: Individual #241, Individual #331, Individual #297, Individual #245, Individual #270 and Individual #185. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff, including DSPs, QIDPs, House Managers, and clinicians, and directly observed each of the individuals in a variety of natural 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.

The San Angelo SSLC's IDTs continued to work toward developing personal, measurable goals. For this review period, none of the six ISPs contained individualized goals in all areas; therefore, none had a comprehensive set of goals that met criterion. Still, San Angelo SSLC continued to make progress in this area, as described below.

1. During the last monitoring visit, the Monitoring Team found 20 goals met criterion for being individualized, reflective of the individual's preferences and strengths, and based on input from the individual on what was important to him or her. During the current site visit, 16 personal goals met criterion. The personal goals that met criterion were:

- the leisure goals for Individual #297 and Individual #270;
- the relationship goals for Individual #331, Individual #245 and Individual #270;
- the school/work goal for Individual #297, Individual #245 and Individual #270;
- the independence goals for Individual #241, Individual #297, Individual #270 and Individual #185;
- and the living options goals for Individual #241, Individual #297, Individual #245 and Individual #270.

Of the remaining personal goals, many were not aspirational and did not seem to be based on the personal preferences, strengths, or capabilities of the individual.

The IDTs did make attempts to develop personal goals to address individual preferences in all domains. The Center also made progress toward developing personal goals that addressed important <u>relationships</u> in meaningful ways. Examples included,

- Individual #331's goal to prepare a meal for her volunteer.
- Individual #245's goal to spend an overnight with her sister.
- Individual #270's goal to spend the weekend with her daughter in Oklahoma City.

While these were positive examples, the Center still needed to ensure these well-developed personal goals were implemented, and that valid and reliable data were being collected to measure progress toward goal-achievement.

There were many goals that had the potential to meet criterion for being well-developed and personal, but they were lacking aspirational outcomes. These goals required very little action on the part of the individual and were considered to be attendance or compliance goals. There was also very little movement towards attainment of these goals. For example:

- Individual #241, Individual #331, Individual #245, and Individual #185 had leisure goals to participate in various events, but they had little involvement in the coordination of these events (and most of these goals were never implemented).
- Individual #185's leisure goal was to complete three hiking trails. This plan was developed with Individual #185's preference for walking around the campus in mind, but his preference for hiking trails was never assessed. Individual #185 had limited communication skills, and was unable to participate in the planning process, but the IDT did not demonstrate effort to determine whether or not Individual #185 would enjoy a trail, or if he would be able to successfully navigate the terrain.
- Individual #331's leisure goal was to have a glamour day (manicure and pedicure) once per quarter. For Individual #331's

previous ISP year, manicures and pedicures were included in the action plans for her leisure goal. According to the QIDP monthly report, Individual #331 did not participate in manicures or pedicures, and it was stated that Individual #331 "has shown no interest in having her nails done." As written, this goal had the potential to meet the criteria for a well-developed personal goal, but it was clear that it was not a personal or preferred activity for Individual #331 and should not have been included in the current ISP.

At Individual #337's ISP, observed by the Monitoring Team, there was a very good review and revision of goals. The ISP facilitator said to the team that the existing goals were bad goals because they did not consider barriers to goal achievement or incorporate the individual's vision. The ISP facilitator told the IDT that the existing goals were instead more appropriate as action steps, and she worked to help the team to understand the distinction. No goals were finalized, and IDT members were told to consult the individual about his vision and come up with real goals that better reflected that vision and addressed barriers to goal-achievement.

2. The Monitoring Team reviewed the 16 personal goals that met criterion for Indicator 1 to evaluate whether they also met criterion for measurability. Of these 16 personal goals, two met criterion for measurability. These goals were:

- The leisure goal for Individual #297
- The work/school goal for Individual #297

In order to meet criterion for measurability, personal goals must be measurable in a stand-alone manner, that is, a review of the ISP and action plans is not needed to make this determination. The outcome of the goal must be observable and measurable, and the goal must be specific, clearly defining the conditions under which the goal would be achieved. Vague terminology, such as participation, does not describe actions on the part of the individual working toward goal-achievement.

In general, most goals used broad and vague terminology to describe goal-achievement, such as "Individual #245 will go on an overnight visit with her sister," "Individual #270 will work part-time as a greeter at Walmart," and "Individual #185 will complete three hiking trails." As written, the path toward goal-achievement was not clear. Specifically for Individual #185, it was unclear how completion of a trail would be determined and measured (i.e., would Individual #185 be expected to walk for a predetermined distance or duration?). Although the same type of vague terminology was used to describe Individual #297's leisure and school goals ("Individual #297 will earn her driver's permit" and "Individual #297 will graduate high school"), the achievement process and requirements were clear and standardized, and there was an expected timeline for completion.

3. Of the 16 personal goals that met criterion in indicator 1, one had reliable and valid data and met criterion for this indicator. This was the work/school goal for Individual #297.

- For Individual #297's goal of graduating high school, her school attendance was documented, as was her participation in extracurricular activities, which were action steps toward goal-achievement.

For the remaining goals that did not meet criterion, some had data collection systems that were either not implemented or had action steps that were not relevant to the goal. Some of these data captured the individual's attendance instead of his or her active participation or meaningful engagement in the activity leading to goal-achievement.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.												
Summary: This set of indicators speaks directly to the overall quality of the ISP for the individual's upcoming year. The Monitoring Team looks across the entire ISP when scoring each of these indicators. Performance remained about the same as at the time of the last review, that is, some indicators scored higher and some scored lower than at the last review. As detailed in the comments below, there were some bright spots in some of the IDTs in terms of meeting or working towards ISPs and IDT activities as per these indicators. That being said, scoring across these 11 indicators was low. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	331	241	297	245	270	185				
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	2/6	1/6	0/6	0/6				
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1				
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
11	ISP action plans supported the individual's overall enhanced independence.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
12	ISP action plans integrated strategies to minimize risks.	17% 1/6	0/1	1/1	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.	33% 2/6	0/1	0/1	1/1	1/1	0/1	0/1				
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	33% 2/6	0/1	0/1	1/1	1/1	0/1	0/1				
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
17	ISP action plans were developed to address any identified barriers to achieving goals.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1				

18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments: As San Angelo SSLC focuses on the design of more individualized personal goals with action plans that map out a clear path to achieving each goal, and include SAPs, SOs, and data collection systems that measure active and meaningful participation/engagement in activities, it is likely that the facility can achieve compliance with this outcome and its indicators.

8. Three of six goals had corresponding action plans to support goal-achievement. These were the leisure goal for Individual #297, the work/school goal for Individual #297, and the work/school goal for Individual #245.

- For Individual #297, the action plans outlined steps leading to achievement of Individual #297's goal to earn her driver's permit. These steps included: familiarizing herself with the Texas Drivers' Handbook, completing an ophthalmology appointment due to the need for corrective lenses, and working to save the money needed to pay for driving school.
- For Individual #297's work/school goal (graduating high school), action steps included: maintaining school attendance, maintaining passing grades, and participating in extracurricular activities.
- For Individual #245, the action plan supporting her goal to work part-time as a cosmetologist included: obtaining a job in the salon on campus, visiting Howard College to meet with the guidance counselor, and exploring grants and scholarships.

For the 33 remaining goals, the goals were either not personal (and therefore not scoreable), or they did not have supportive action plans. For example:

- Individual #270's leisure goal to crochet and sell scarves had 13 action steps. Five of the 13 action steps were relevant to and supportive of the goal. The remaining action steps included a medical assessment, a psychiatric assessment, weekly reinforcer trips based on attending her work program and following her behavior plan, dining out in the community, wearing a PFD in water over 4-feet deep, having a lifeguard on duty during swimming activities, wearing sunscreen, and wearing appropriate swimming clothes and shoes. These action steps would not lead to the goal of learning to crochet and selling scarves.

9. One of the six ISPs contained a set of action plans that integrated both preferences and opportunities for choice. Individual #297's preferences and strengths were identified in the ISP and were used to develop her action plans. It was positive to see that Individual #297 was consulted prior to the ISP and that she had informed the IDT of what she wanted to pursue.

For the five other individuals, their action plans did not integrate individual preferences and opportunities for choice. Per onsite observation and staff interview, Individual #241 and Individual #185 followed schedules that had been created for them. Their ISPs indicated that their schedules did not "allow for choice during the course of (his) day." Individual #185 and Individual #241 both had communication deficits, which posed a challenge to their active participation in supports and services. Per document review, QIDP and staff interviews, Individual #185's and Individual #241's IDTs had not considered targeting functional communication as a goal to promote active involvement and encourage choice-making.

It was positive to hear that for people whose hair required more care and maintenance, there was a hair stylist who was familiar with different textures of hair, and who was prepared to provide services to those with coarser hair textures. It was also positive to hear that the Center was in the process of ordering hair care products, specifically for those with coarse hair, who required more care and maintenance.

10. None of the ISPs had action plans that addressed strengths, needs, and barriers related to informed decision-making. None of the individuals was assessed for their abilities to make informed decisions. Individual Capacity Assessments for each individual were written in standard and rote fashion. One of six individuals, Individual #270, did not require training or support to make decisions. Individual #270 did not have a guardian/LAR. Still, Individual #270's ability to make informed decisions was not highlighted as a strength in her ISP. For each area of competency, the IDT acknowledged the individual's lack of capacity and agreed to "continue to educate and provide assistance when issues arise…" Other findings included:

- Individual #245 inquired into re-establishing her rights in order to make decisions for herself. This, however, was discouraged by her IDT. Individual #245 was told that she could write a letter to a judge, but that her behavioral challenges would "be weight-bearing" on the judge's decision. The IDT should have educated Individual #245 about what it would take to re-establish her rights and to make her own decisions. The IDT should have supported Individual #245 to follow the process for modifying her guardianship arrangement and allowed the Court to make the final determination.
- Individual #331's IDT acknowledged her lack of capacity in multiple areas, but it did not feel that Individual #331 needed to make decisions in these areas, because she had a LAR.
- Individual #185 did not have a guardian/LAR. Individual #185 had a significant communication deficit – he did not use verbal language. Individual #185 was not actively involved in his services or supports and did not make decisions on his own behalf. His ISP did not include Individual #185's communication deficit as a barrier to his decision-making, and it did not include an assessment of this communication deficit or action plans to address it.

Self-advocacy committee continued to be active, meeting each month. Attendance remained high at about 60-80 individuals per meeting. During the onsite visit, the committee tried something new, that was to hold the meeting in the gym and demonstrate/talk about Special Olympics. It was good to see them trying something new, but unfortunately, the setting had bad acoustics and was very large, which set the occasion for lower engagement from attendees and various behavior problems. Self-advocacy activities to teach and support decision-making, however, are ones that could be incorporated into individuals' ISPs, depending upon the individual. Further, self-advocacy committee might take on projects to improve the Center, as they have done in the past. Perhaps the topic of peer to peer aggression would be of interest to the members. Three attendees spoke about fighting, drama, and false allegations during the meeting during the onsite review week.

Weekly home meetings provide another opportunity for individual and group decision making. The Monitoring Team attended two of these meetings. They were well-attended and there was good participation. Topics were about getting along better, and regarding outings for the upcoming months.

11. As written, independence goals had the potential to support overall enhanced independence for all six individuals. For example:

- Individual #241's goal was to independently set up his own hair appointments in the community.
- Individual #331's goal was to independently prepare a meal once per month.
- Individual #185's goal was to independently bathe himself.

These goals were promising and could have led to the development of new and functional skills, but the corresponding action steps and follow-up did not support achievement of the goal. For example, in Individual #331's ISP, one of the action steps was for Individual

#331 to complete a microwave assessment. Another was for the IDT to review the assessment recommendations, then to develop a SAP. According to the QIDP monthly review, the assessment (completed three months after the ISP meeting) revealed that Individual #331 could already independently use the microwave. This should have resulted in a revision to the goal and/or action plan, or the development of a new goal and/or action plan because there are multiple modes for meal preparation. Moreover, this might have been better explored during the three-month interim period between the ISP preparation meeting and the annual ISP meeting, so that a more meaningful goal could have been ready for the beginning of the new ISP year. Instead, the goal/action plan was never revised, and monthly updates to the QIDP review simply read, "maint" (maintenance).

12. The IDT for one of the six individuals, Individual #241, did work assertively to address identified risk areas. Individual #241 had a seizure disorder that resulted in at least two serious falls/injuries in the past year. Although Individual #241 was not actively involved in his healthcare or health planning, his IDT worked to address the fall risk and prevent further injury. In addition to neurology consults, quarterly nursing and neurological assessments, quarterly nursing consults, medication regimen reviews, prescription of anti-seizure medication and quarterly testing of drug levels, a visit to the home revealed an automated system, developed by the IDT, to prompt Individual #241 to apply his helmet independently and wear it throughout the day. A basket was placed at the head of Individual #241's bed to store Individual #241's helmet. When Individual #241 removed his helmet from the basket, an automated voice would prompt him to put the helmet on. This was a positive example of integrated strategies to minimize risk.

For the five other individuals, risk was not assertively or consistently addressed. Examples included:

- Individual #331 was at risk for retaliatory violence and serious injury from her peers. She was also at risk for respiratory compromise due to COPD. Individual #331 had a history of osteoporosis and had fallen nine times in the past year. Individual #331's ISP did not incorporate strategies to minimize these risks. Individual #331's behavioral programming targeted her aggression toward others. There was no plan to address her victimization by peers. A smoking schedule (one cigarette every 30 minutes) was instituted, but this schedule was not designed to address the COPD or her underlying Tobacco Use Disorder diagnosis.
- Individual #245's ISP referenced drug-seeking behaviors. The only plan to address this risk was found in her behavior plan, which called for zero of these behaviors to be exhibited for 30 days before Individual #245 was able to visit an amusement park or visit her sister. There was no integrated strategy to minimize risk, and the consequence to exhibiting drug-seeking behaviors seemed excessively punitive.
- Individual #185 engaged in pica. According to the ISP and the QIDP, this behavior was "nonstop" and considered to be significant health risk because Individual #185 had a history of ingesting a variety of non-food items. Pica was also documented as, and reported to be, the greatest barrier to Individual #185's goal achievement and community referral. This was not consistent with documentation found in the IHCP and the IRRF. Per the IRRF, pica was classified with a "medium" risk rating. Individual #185's IHCP included pica as the behavioral health target, but interventions were not suggestive of a high-risk behavior. Interventions listed in the IHCP included ongoing data collection, monthly/yearly data analysis and staff training.
    - Strategies to address the behavior could be found in the PBSP and included blocking immediate access to items Individual #185 might ingest, verbal reprimands, and reinforcement for complying with said reprimands. Strategies did not include preventative/proactive measures to address the behavior. It was reported that routine pica sweeps were conducted on a regular basis, but this strategy was not documented, and data were not being collected. Multiple

visits to the home revealed cigarette butts on the ground and stairs in front of the home.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were integrated for two of the six individuals (Individual #297, Individual #245). For example:

- Individual #245's primary support need was behavioral health. Individual #245 exhibited self-injury and aggression. She was diagnosed with Borderline Personality Disorder and PTSD. She reportedly "cheeked and stored" her Benadryl, which the IDT classified as "drug/med-seeking" behavior. The IDT had integrated strategies to address these need areas. Individual #245 attended group therapy sessions; she was seen regularly by her psychiatrist; she was prescribed psychotropic medications; she attended anger-management classes; and she had a PBSP.

For the four remaining individuals, action plans did not integrate their support needs. In general, supports were insular and discrete. There was little evidence that the IDT members were working in collaboration or sharing data. Examples of this lack of integrated supports included:

- For Individual #241, the IDT had not addressed his communication deficit and language barrier. His primary language was Spanish. Individual #241 reportedly understood English, but this was not observed. When spoken to in English and Spanish, Individual #241 did not verbally respond. Per Monitoring Team observation, staff were not communicating with Individual #241 in his primary language, and there was no evidence that the team was working to enhance Individual #241's functional communication. There was also no indication that the IDT had considered the importance of Spanish-speaking staff in Individual #241's home and day program.
- Also, for Individual #241, his seizure disorder, fall risk, and complicated medication regimen warranted communication between his medical providers. Although Individual #241 was followed by a neurologist, psychiatrist, and a general practitioner, communication between these medical providers was lacking, which was another example of discrete and insular supports.

14. To meet this indicator, action plans should lead to the development of skills and activities to promote community participation and integration. Three of the six individuals had recreational/leisure goals that involved attending community events and participating in community activities, but none of these was likely to lead to integration into the community. For example:

- Individual #241's leisure goal was to attend a Tejano music concert in the community every quarter.
- Individual #245's leisure goal was to visit an amusement park during the summer.
- Individual #185's leisure goal was to complete three hiking trails in the community.

The three other individuals had leisure goals that would be achieved through on-campus activities. With regard to the former group, none of the corresponding action plans was implemented. The first action step in Individual #241's plan was to purchase a wallet. This had not been completed. Aside from not being implemented, these corresponding action plans would not have facilitated community integration or membership for these individuals. These individuals would have had access to the community, which would have been positive, but they would not have had the opportunity to develop the skills and resources to become more independent and integrated into the community.

Some individuals had action plans that included monthly or quarterly reinforcer trips into the community to restaurants, shopping

centers, parks, and movies. Again, community access was positive, but there was no indication that once in the community, the individual was actively participating in the activity or event or developing skills to become integrated into the community.

Community access was generally infrequent for most individuals at the Center. This may have been due to the apparent staffing shortage across the facility. Individuals and staff across the facility complained about the low staffing levels. Numerous individuals reported to the Monitoring Team that they were not getting the supports and services that they needed due to the shortage. Lack of engagement was identified as a problem area for most individuals who were being reviewed by the Monitoring Team. During home visits, individuals were generally found to be sleeping or idle.

15. Two of the six individuals had opportunities for day programming in the most integrated setting consistent with their preferences and support needs. Examples included:

- Individual #297 attended high school in the community during the day. This was her preference, and her goal was to graduate.
- Individual #245 worked part-time at the facility salon. Obtaining this position was her preference, and it was one action step toward her goal of becoming a cosmetologist.
- Individual #245 also worked evenings at the coffeehouse, which was her choice.

For three of the four other individuals, day and work opportunities did not appear to be consistent with their preferences. This was evidenced by the following:

- Individual #241 frequently refused to attend his Life Skills work program.
- Individual #331 secured a job at the greenhouse, but she refused to attend. Her attendance was described as inconsistent and poor. Individual #331 was transferred to the work center, but she refused to attend this program as well. The team worked to provide more support and to make the work center more appealing by providing Individual #331 access to cigarettes during the work day.
- Individual #270 attended her work program less than 15% of the month.

For Individual #185, it was unclear whether or not his day programming was consistent with his preferences and support needs. Individual #185 spent the majority of his day shredding paper at Life Skills alongside his peers. Individual #185 had a communication deficit and was unable to comment on his satisfaction with his day programming. Individual #185's schedule, which was posted and visible to the Monitoring Team, did not appear to dedicate much time to the development of skills that might lead to employment in a more integrated setting.

A positive observation was that the Center had developed a new work site at a gardening plant company where individuals were involved in assembly of gardening products.

16. None of the six ISPs had substantial opportunities for functional engagement with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Opportunities for engagement were infrequent, and skill-development did not appear to be the focus. Examples include:

- Individual #245 will go on dates with her boyfriend at least twice in the next year.
- Individual #185 will go shopping once a quarter for his favorite clothing styles and favorite soft drinks.

- Individual #270 will dine out in the community quarterly.

In general, functional engagement was lacking across the facility, not only for those individuals reviewed by the Monitoring Team, but for many individuals observed incidentally during home and day program visits who were found to be sleeping or idle. Overall, the ISPs for these six individuals provided limited opportunities for training, learning, and functional skill-development. For most of these six individuals, visits to their homes confirmed the lack of engagement described in their ISPs. For example:

- During four separate Monitoring Team visits, Individual #331 was either found to be asleep or reported to be walking the campus looking for cigarettes.
- During three separate Monitoring Team visits, Individual #270 was found to be asleep in bed or seated idly in the common area.
- During one Monitoring Team visit, Individual #297 was found to be seated alone in the common area at the entrance to the home. There were no staff or housemates in the immediate area. There was another individual seated outside of the entry door. The door was transparent and both individuals could see one another, but they did not appear to be actively engaged.

17. The ISP for one individual, Individual #270, did adequately address barriers to her goal-achievement and skill-development. Individual #270's psychiatric instability, behavioral challenges, and lack of funds were identified as barriers to achieving most goals. There was an action plan for money-management that was associated with the independence goal to learn to download music (learning to manage money in order to save for an iPod purchase). Psychiatric assessments were recommended action steps for most goals. Meeting the goals of her PBSP and using replacement behavior for cursing were action steps to address barriers to her potential employment as a greeter at Walmart and her goal to live independently in Oklahoma City.

For the five other individuals, ISPs did not adequately address barriers to achieving goals and developing skills. Examples include:

- Individual #185 exhibited pica, which was reported to be his greatest hindrance to goal-achievement. Pica was addressed in his PBSP, but only with expectations that he engage in zero instances of this behavior for 10 of 12 months. There were no plans/supports to address this barrier.
- Lack of funds was identified as a barrier to Individual #245's goal-achievements. Individual #245 had two minimum-wage jobs on campus. There was an action plan to increase her work attendance, but there was no plan to help her to budget and learn to save her money.
- Cigarette addiction/tobacco-use disorder was identified as a barrier to Individual #331's goal-achievement. Although she was placed on a schedule to manage the frequency of her smoking, the addiction was never addressed in her ISP and there were no supports put in place to address the barrier to achieving goals.

A review of ISP preparation documents and QIDP Monthly Reviews indicated that some goals either had not been implemented or were continued from year to year without progress and without addressing barriers. For example, the Monitoring Team observed Individual #245's ISP preparation meeting. Her goal to attend cosmetology school was individualized, aspirational, and based on her preferences. One of the first steps to attending classes was going to visit the school and meeting with admissions staff. After a year of implementation, this had not been completed. The IDT agreed to continue this goal without considering why it had not been implemented the previous year. No specific timelines were set, and responsibility was not assigned to specific staff to ensure completion.

None of the ISPs addressed barriers to community referral.

18. None of the action plans provided enough detailed information for implementation, data collection and review to occur. Skill-acquisition plans were either not developed or not implemented, but also lacked detail. In general, goals had corresponding action plans that were broad and vague. For many of the goals, it was not clear what data were to be collected, what constituted progress, or how staff would determine when the action plan was met. Individual #245's ISP was a prime example of this, with the following action steps included:

- Individual #245 will use sunscreen and drink plenty of water when she goes on her trip.
- Individual #245 will purchase good walking shoes prior to going to the amusement park.
- Individual #245 will use her replacement behaviors when at amusement parks.
- Individual #245 will apply at the beauty salon on campus.
- Individual #245 will apply for financial aid made available to her.
- Individual #245 will work in a minimum wage job to make the cell phone payment.
- Individual #245 will have community excursions as scheduled.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.

Summary: Performance remained about the same as at the last review. As a result, indicators 22 and 24 will be moved to the category of requiring less oversight because high performance was sustained for this review and the previous two reviews, too. More thoughtful consideration of individuals' living options and how to address barriers to referral was needed and if occurred, would likely lead to higher performance on the other indicators in this outcome. These will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 331	241	297	245	270	185			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	67% 4/6	0/1	1/1	1/1	1/1	1/1	0/1			
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.	1/1									
21	The ISP included the opinions and recommendation of the IDT's staff members.	67% 4/6	0/1	1/1	1/1	1/1	0/1	1/1			
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			

#	Indicator	Overall Score									
23	The determination was based on a thorough examination of living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	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.	100% 1/1									
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
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									
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

19. The ISPs of four individuals (Individual #241, Individual #297, Individual #245, Individual #270) included a description of their preferences for where to live and how their preferences were determined. For one of the two other ISPs (Individual #331), the IDT agreed to pursue Individual #331's transfer to a different facility. This was not Individual #331's preference. Rather, she was looking forward to community placement and had expressed excitement to her peers when she thought she was to be referred to the community. The reason for the plan to move her to an alternate facility was that she was being victimized in the current setting. Individual #331 attempted to steal cigarettes from her peers. Her attempts, which were often aggressive, were met with retaliatory violence, and resulted in significant injury to Individual #331.

Individual #185's living preference could not be determined due to his communication deficits. Although photos and other supplemental information were provided to Individual #185 in order to ascertain his preference, Individual #185 would not look at any of the materials presented and would not respond when asked questions about his preference. Given Individual #185's inability to make an informed decision and given Individual #185 had lived at San Angelo SSLC for 30 years, his IDT should know him well and be able to identify his environmental preferences. Individual #185's ISP did not document input from his staff or family regarding his known preferences with regard to living options.

20. The Monitoring Team did not observe any ISPs for the individuals in the review group. The Monitoring Team did, however, attend Individual #337's ISP meeting. His preference to remain at the San Angelo SSLC was clearly stated after a discussion of his living options.

At Individual #337's meeting, the IDT did a nice job asking for and incorporating the individual's input into the discussion. The individual was well-dressed, with matching pants, shirt, and hat. His hair was trimmed and he was clean-shaven. He acknowledged that he saw better now that he was wearing his glasses. During the meeting, there were several instances of the individual interrupting someone who was speaking about him. He wanted to share the information himself. IDT members apologized to him and allowed him to speak. He was often asked for his opinion or asked to provide an update about his progress. All of this was good to see.

21. Four of six ISPs included the opinions and recommendations of the IDTs staff members. For those that did not meet criteria, relevant assessments were not submitted prior to the ISP meeting, and could not be used to develop the ISP:

- For Individual #331, the ISP included statements from the medical and dental staff, but these statements were not included in the independent medical or dental assessments.
- For Individual #270, medical and psychiatric assessments were pending, and contingent upon the team meeting to review IDT recommendations.

22. Five of five ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the LAR. Although Individual #297's guardian (mother) did not attend the meeting, she was aware of, and agreed with, the decision for Individual #297 to remain at the San Angelo SSLC. Individual #297's grandfather attended the meeting in place of Individual #297's mother. He supported Individual #297 to participate in the meeting and helped her to make decisions. Individual #297 and her entire IDT agreed that Individual #297 should remain at the facility until she could develop appropriate self-management and coping skills to return home with her mother.

23. None of the six individuals had a thorough examination of living options based upon their preferences, needs, and strengths. None of the individuals was referred for community placement. For each individual, this determination was based on their behavioral challenges and need for intervention. Besides the standard process for someone considering community placement (e.g., meeting with LIDDA, receiving information about living options, attending site tours and the annual provider fair), the IDTs did not thoroughly discuss or consider available settings that might meet the individuals' needs.

24. All six individuals had ISPs that met criterion and identified a comprehensive list of obstacles to the individuals' referral to the community. None of the individuals was referred for community placement based on behavioral challenges, psychiatric instability, frequent need for intervention, vulnerability, lack of safety awareness, and/or need for supervision.

25. The Monitoring Team did not attend ISP meetings for any of the six individuals in the review group. For Individual #337, sexual-related behaviors were identified as an obstacle to referral.

26. None of the six individuals was referred for community placement, and none of their IDTs created individualized, measurable action plans to address any identified obstacles to referral. In most cases, action plans to address these obstacles included the standard process of providing information about living options, arranging a site tour for the individual, meeting with the LIDDA, and attending the annual provider fair.

- For Individual #185, the action plan included a money management objective, but finances and the need for support in this area were not identified as obstacles to referral.

- For Individual #297, the action plan included meeting with Individual #297's mother/guardian to determine whether or not community placement (returning to the family home) was a realistic goal. This should have been discussed with Individual #297's mother/guardian prior to the ISP meeting, so that her input and expectations could have been considered by the IDT and included in the ISP.

27. The Monitoring Team did not attend ISP meetings for any of the six individuals in the review group. For Individual #337, the team discussed his progress, and encouraged him to participate in group therapy, but there was no discussion regarding any plan to eventually move towards transition.

28. None of the six ISPs included individualized and measurable plans to educate the individual/LAR about community living options. Plans included the standard process for pursuing community referral (e.g., meeting with LIDDA, receiving information about living options, attending site tours and attending the annual provider fair). This process is the same for anyone who's goal is to live in the community.

29. For all six individuals, significant obstacles to referral were identified and no action plans were created to facilitate referral. This indicator was not applicable to these six individuals.

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

Summary: It was good to see that individuals participated in/attended their ISP meetings and that most were knowledgeable and able to talk about some of their ISP content. This has been the case for this and the previous two reviews, too, with one exception in each of the two previous reviews and no exceptions in this review. Therefore, indicator 33 will be moved to the category of requiring less oversights. On the other hand, for half of the individuals, not all relevant IDT members attended the meeting and after the meeting the ISP was implemented in a timely manner for just one-third of individuals. Indicators 32 and 34 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	331	241	297	245	270	185			
30	The ISP was revised at least annually.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.										
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	33% 2/6	0/1	0/1	0/1	1/1	1/1	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).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
34	The individual had an appropriately constituted IDT, based on the	50%	0/1	1/1	0/1	1/1	0/1	1/1			

	individual's strengths, needs, and preferences, who participated in the planning process.	3/6									

Comments:
30. All ISPs were revised annually. Individual #297 was at the facility for less than one year. This indicator was not applicable to Individual #297.

31. Individual #297 was admitted within the past year. Individual #297's ISP was developed within 30 days of her admission.

32. Two of the six individuals had ISPs that were implemented within 30 days of the meeting. For the other individuals, according to QIDP monthly reports and interviews, implementation of most action plans was pending the completion of an assessment, pending the development of a SAP or SO, or pending the acquisition of necessary learning materials. For example:

- The QIDP reported that Individual #297 had recently acquired a driver's manual to study for her driver's test. Her ISP was developed in October 2018.
- Individual #270's ISP, developed 11/29/18, indicated that a SAP would be developed for community socialization. This was not in place at the time of the review.

33. All six individuals attended their ISP meetings, which was positive. Five of the six individuals were knowledgeable of the goals, preferences, strengths and needs as articulated in their ISPs. Although Individual #185 attended his ISP meeting, his level of knowledge and comprehension was unclear. Individual #185 had a substantial communication deficit. Effort was made to provide familiar staff to explain what was being discussed and to interpret Individual #185's nonverbal communication. Supplemental materials were also provided. Individual #185 did not look at or appear to be interested in the material. He also did not appear to be interested in the discussion. Individual #185 indicated his preference to leave the meeting and left early. According to his Individual Capacity Assessment, Individual #185 was not able to provide informed consent and had significant support needs in many areas. This sub-indicator of indicator 33 was not applicable to Individual #185.

34. Three of the six individuals had appropriately constituted IDTs based on the individuals' strengths, needs and preferences, who participated in the planning process. The three other individuals had IDTs that were missing crucial members who could contribute to the plan and provide input and recommendations for condition-specific needs. Examples included:

- Individual #270 was experiencing a number of physiological challenges that began around the time of her ISP meeting. Following the ISP meeting, Individual #270's physiological condition continued to deteriorate, and a host of medical, psychiatric, and neurological assessments took place. Prior to the meeting, she had a cardiac evaluation for an elevated heart rate. She had also experienced an unexplained 15 pound weight-loss over the course of 11 months. Given these conditions, Individual #270's PCP should have attended the meeting to provide input into service and support. A nutritionist should also have been in attendance. Also prior to the meeting, Individual #270 was engaging in aggressive and self-injurious behavior. There was no behavioral health specialist in attendance to provide input regarding Individual #270's behavioral challenges and expectations.
- Individual #297's LAR was not in attendance. Individual #297's grandfather, who advocated for Individual #297 and helped her to make decisions, attended the meeting and supported Individual #297 to participate.
- Individual #331 was at risk for retaliatory violence by peers. Most incidents involved an initial aggressive act carried out by

Individual #331 toward her peers. Individual #331 also had a cigarette schedule to address the frequency of her smoking. A behavioral specialist was not in attendance to provide behavioral updates and input into Individual #331's plan.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: San Angelo SSLC determined what assessments were needed (an improvement from the last review), but did not then arrange for obtaining those needed assessments for the individuals. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	331	241	297	245	270	185			
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.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
Assessments conducted prior to the ISP are essential for ensuring that comprehensive services and supports are developed during the meeting. Without relevant assessments, it is likely that irrelevant action steps leading to the goal will be created. It is also likely that risks and barriers to goal-achievement will go unaddressed. For all six of the individuals, there were relevant and necessary assessments that were not submitted prior to the ISP meeting. For some individuals, incomplete assessments hindered progress toward goal-achievement. IDT members should work to obtain all assessments and information prior to the ISP that would allow for a thorough evaluation of the individual's strengths, preferences, needs and challenges, and enable the IDT to provide individualized and person-centered services and supports in a timely manner.

35. For all six individuals, the IDTs considered which assessments were needed and relevant to the development of an individualized ISP prior to the annual ISP meeting.

36. None of the IDTs then arranged for or obtained all needed, relevant assessments prior to the ISP meeting. Examples include:

- Individual #185's Individual Capacity Assessment was not submitted prior to the meeting.
- Individual #270's behavioral health assessment and medical assessment were not submitted prior to the ISP meeting.
- Individual #331's medical and dental assessments were not submitted prior to the ISP meeting. An assessment for scheduling appointments (using a calendar) was also requested, but not received prior to the meeting.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.	
Summary: To repeat from the last reviews: 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	Individuals:

occur, and follow-up must occur. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	331	241	297	245	270	185			
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.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			

Comments:

37. In general, IDTs met as needed to review supports, services, and serious incidents, however, they did not routinely revise goals, action plans or supports when an individual was not making progress toward goal-achievement. IDTs also did not routinely revise goals, action plans or supports to address barriers to progress. For example, Individual #185's leisure goal had multiple action steps, one of which was to participate in leisure activities in the community three times per month. Another action step was to go shopping for clothing, shoes and other items every quarter. According to the QIPD monthly report, for the months of August, October, November, and December 2018, these objectives were not implemented. Lack of progress should have resulted in a revision to the goal and/or action plan. In this case, no revisions were made.

The lack of progress and the IDTs' failures to revise goals may have been a function of the low staffing levels throughout the facility. During several home visits, the QIDP was found, or reported to be, working direct-care shifts on the home. Individuals, as well as residential and day staff complained about the staffing shortage at the facility. Numerous individuals reported to the Monitoring Team that they were not getting the supports and services that they needed due to the shortage.

The Monitoring Team also found that the implementation of a number of action steps was contingent upon completion of a particular assessment or another prerequisite step. For example: "QIDP to check on documents needed for driving school," and "IDT will inquire with SSLC music director regarding flute lessons." Many of these prerequisite steps/actions were never completed. Therefore, successive steps were not implemented, and the individual was not able to make progress toward achieving the goal. This should have led the IDT to discuss and address lack of progress, or to revise the goal if any prerequisite step/action was not achievable.

There were also a number of action plans that had been continued from the previous year without progress and without addressing barriers. For example, to repeat from comments in indicator 17 above, the Monitoring Team observed Individual #245's ISP preparation meeting. One of Individual #245's goals was to become a cosmetologist. One of the first steps of the action plan was for Individual #245 to visit the school to meet with admissions staff. After a year of implementation, this had not been completed. Neither the goal nor the action plan was ever revised. The IDT agreed to continue this goal without considering why it had not been implemented the previous year. No specific timelines were set, and responsibility was not assigned to specific staff to ensure completion.

38. For one of six individuals, the QIDP ensured the individual received required monitoring/review, as well as any necessary revision of treatments, services, and supports. Individual #297 was exhibiting adverse side effects from a Haldol injection. ISPA meetings were

facilitated by the QIDP. This resulted in a medication review by the psychiatrist who, in turn, adjusted Individual #297's medication regimen. As a result, the side effect resolved.

The remaining individuals had service and support needs that were not addressed. Examples include:

- Individual #241 and Individual #185 had communication deficits and language barriers, which were not addressed. The team did not consider increasing supports in these areas to facilitate more active involvement of these individuals in their services and supports. For these individuals, Spanish was their primary language. Per observation, there was a lack of Spanish-speaking staff available, and all communication with these individuals was in English. Although staff reported that these individuals understood and responded to English directives, it was unclear how much these individuals actually comprehended, because directives were paired with gestures and prompts.
- For Individual #270, an ISPA meeting was held (8/31/18), during which it was recommended that a SAP for community socialization be developed. According to the QIDP report, this SAP was never implemented and the barrier to implementation was never addressed.
- For Individual #245, an ISPA meeting was held (also 8/31/18), during which it was recommended that a SAP for money-management (counting back change) be developed. There was no evidence that this SAP was ever created. There was also no evidence that the IDT reviewed or followed up on the barriers to implementation.

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: 331	241	270	185	248	343	237	150	367
a.	The individual's risk rating is accurate.	0% 0/16	0/2	0/2	N/A	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.	33% 6/18	1/2	0/2	0/2	1/2	0/2	1/2	1/2	2/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #331 – gastrointestinal (GI) problems, and respiratory compromise; Individual #241 – seizures, and falls; Individual #270 – choking, and aspiration; Individual #185 – dental, and skin integrity; Individual #248 – GI problems, and respiratory compromise; Individual #343 – aspiration, and GI problems; Individual #237 – skin integrity, and constipation/bowel obstruction; Individual #150 – circulatory, and GI problems; and Individual #367 – weight, and falls].

a. For the individuals reviewed, the IDTs did not effectively use supporting clinical data, and analysis of that data to support the risk

rating on which they decided. b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #331 – GI problems, Individual #185 – dental, Individual #343 – GI problems, Individual #237 – constipation/bowel obstruction, and Individual #150 – circulatory, and GI problems. For the following individuals, IDTs met to discuss changes of status, and although they appeared to review the IRRFs, they did not include necessary updates or information: Individual #331 – respiratory compromise, and Individual #270 – choking, and aspiration.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.												
Summary: San Angelo SSLC had made only small steps forward towards meeting this set of indicators since the last review. On the positive, individuals had psychiatric indicators for reduction that were (for most individuals) related to their diagnoses. Most, however, were not written in observable measurable terminology and data were not available for any indicators that were not identical to PBSP target behaviors. Regarding indicators for increase (i.e., positive/desirable behaviors that indicate the individual's condition, or ability to manage the condition is improving), these indicators were not identified for any of the individuals. Psychiatric goals were not written for every individual and they were not present in the ISP documentation (and if they were, there were differences across documents). These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	0% 0/9	1/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
5	The individual has goals related to psychiatric status.	0% 0/9	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
6	Psychiatry goals are documented correctly.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments:												

The scoring in the above boxes has a denominator of 2, which is comprised of whether criteria were met for all sub-indicators for psychiatric indicators/goals for (1) reduction and for (2) increase. Note that there are various sub-indicators. All sub-indicators must meet criterion for the indicator to be scored positively.

4. Psychiatric indicators:
A number of years ago, the State proposed terminology to help avoid confusion between psychiatric treatment and behavioral health services treatment, although the two disciplines must work together in order for individuals to receive comprehensive and integrated clinical services, and to increase the likelihood of improvement in an individual's psychiatric condition and behavioral functioning.

In behavioral health services positive behavior support plans (PBSPs), the focus is upon what are called target behaviors and replacement behaviors. These are the observable, measurable behaviors for reduction and for increase, respectively. They are hypothesized to be, for the most part, under operant control. A functional assessment is conducted to determine the variables that set the occasion for, and maintain, target behaviors (i.e., their function). Replacement behaviors are chosen to provide a functionally equivalent, more socially appropriate alternative to the target behavior. Replacement behaviors sometimes need to be taught to the individual. Many times, however, replacement behaviors are already in the individual's repertoire, in which case the task for the Center is to set the occasion for those replacement behaviors to occur, be reinforced, and maintained.

In psychiatry, the focus is upon what have come to be called psychiatric indicators. These are the observable, measurable symptoms chosen by the psychiatrist (with input from behavioral health services and IDT members) to determine the presence, level, and severity of the individual's psychiatric disorder. They are hypothesized to be, for the most part, due to the individual's psychiatric disorder.

Psychiatric indicators can be measured via recordings of occurrences of indicators directly observed by SSLC staff. Another way is to use psychometrically sound rating scales that are designed specifically for the psychiatric disorder and normed for this population.

The Monitoring Team looks for:

a. The individual to have at least one psychiatric indicator related to the reduction of psychiatric symptoms and at least one psychiatric indicator related to the increase of positive/desirable behaviors that indicate the individual's condition (or ability to manage the condition) is improving. The indicators cannot be solely a repeat of the PBSP target behaviors.
b. The indicators need to be related to the diagnosis.
c. Each indicator needs to be defined/described in observable terminology.

San Angelo SSLC showed some progress in this area as all individuals in the review group had one or more indicators related to the reduction of psychiatric symptoms. For two of the individuals, the indicators were shown to be related to their diagnoses and the indicators were described in observable terminology (Individual #335, Individual #331). For seven of the individuals, the indicators were reasonably relevant to their diagnoses. For the other two, it was not possible to determine how the indicators related to the individual's psychiatric diagnosis or diagnoses. First, Individual #337 had a diagnosis of Schizophrenia, a psychiatric disorder characterized by psychotic symptoms (e.g., hallucinations and delusions). The documents indicated that the indicator for reduction was inappropriate sexual behavior. The relationship of this indicator to the diagnosis was not documented. There was notation in some documents of Individual #337 experiencing symptoms of psychosis such as talking to unseen stimuli. While it could be that Individual

#337's psychotic symptoms resulted in inappropriate sexual behavior, this was not indicated. In this example, an indicator of psychotic symptoms may be more appropriate. Second, Individual #272 had a diagnosis of Attention Deficit Hyperactivity Disorder. Two indicators, aggression and anxiety, were inconsistently identified. Furthermore, it was not clear how these indicators related to the diagnosis because this was not documented. In this example, well-defined indicators, such as an inability to focus or concentrate on a specific task may be more appropriate. For these seven individuals, the indicators were not described in observable terminology.

None of the individuals in the review group had psychiatric indicators for increase in positive/desirable actions identified. The Center psychiatrists will need identify psychiatric indicators for increase and document their rationale of how the positive/desirable actions relate to the diagnosis.

Thus, criteria were met for all three sub-indicators (a, b, c) for psychiatric indicators for reduction for two individuals in the review group and for none of the individuals for psychiatric indicators for increase.

5. Psychiatric goals:
The Monitoring Team looks for:

d. A goal is written for the psychiatric indicator for reduction and for increase.
e. The type of data and how/when they are to be collected are specified.

At San Angelo SSLC, there were acceptable goals written regarding psychiatric indicators for reduction for one of the individuals in the review group (Individual #335). Even though the goal was somewhat-oddly worded as "decrease incidents of suicidal statements/behavior at least once a month for three months," because there was evidence of an attempt at goal development, this was credited. Future goal development will need to include the psychiatric indicator, what change is expected, and a criterion (sub-indicator d). Because there were no indicators identified for increase, there were also no goals written regarding these psychiatric indicators.

There were notations indicating that data would be collected via direct care staff or behavioral health services and while this seemed reasonable, the indicators will need to be clearly described in observable terminology in order for them to be accurately identified. Because the purpose of the psychiatric indicator is to determine an individual's symptom experience, a mixture of individually defined indicators and/or data from direct observations by staff of psychiatric indicators with goals and the collection of data utilizing rating scales normed for this population could be considered. Currently, the facility was utilizing the BPRS (Brief Psychiatric Rating Scale). While some symptom data can be extracted from this rating scale, there is a need to trend the results of this scale over time.

Thus, both sub-indicators were met for one of the individuals for goals for reduction and for none of the individuals for goals for increase.

6. Documentation:
The Monitoring Team looks for:

f. The goal to appear in the ISP in the IHCP section.
g. Over the course of the ISP year, goals are sometimes updated/modified, discontinued, or initiated. If so, there should be some

commentary in the documentation explaining changes to goals.

At San Angelo SSLC, psychiatric indicators/goals for reduction were not regularly incorporated into the Center's overall documentation system, the IHCP. In one example, regarding Individual #331, the goal for reduction was included in the IHCP indicating that there should be no more than 10 incidents of physical aggression for 10 consecutive months. While similar to the goal in the psychiatric documents, the IHCP goal differed in the metrics of allowable occasions. In this example, the goal in the IHCP was noted as "done," although psychiatric documentation did not support this statement. A goal entered into the new year's ISP/IHCP should probably not say it was already done. If so, then one would expect a different goal. It may be that the psychiatrist wanted to keep the same goal from the previous year. That is, an individual might have met a goal for no occurrences of psychiatric indicators (for reduction). The psychiatrist might feel it appropriate to keep the same goal and target for the upcoming year (not uncommon in psychiatry practice). If so, it might be better to indicate this logic rather than inserting statement that the goal was done.

Goals for increase were not yet authored and, therefore, not incorporated into the IHCP.

7. Data:
Reliable and valid data need to be available so that the psychiatrist can use the data to make treatment decisions. Data are typically presented in graphic or tabular format for the psychiatrist. Data need to be shown to be reliable. Reliability assessments are often done by behavioral health services, residential, or psychiatry staff. In addition to using data regarding psychiatric goals/indicators, psychiatrists often utilize behavioral health services target/replacement behavior data as supplemental information when making treatment decisions.

At San Angelo SSLC, data were reported for behavioral challenges and their identified target behaviors. Data for psychiatric indicators that were not identical to target behaviors were not provided, and likely not collected at all. In many examples, the data provided at psychiatry clinic were stale in that they were reported through the end of the previous month. More useful to the psychiatrist would be data up to the previous day or so. Data graphs were not included in the psychiatric documents. In addition, for each quarterly clinic, one set of BPRS data was provided. These results were apparently not always available for the clinical encounter, but rather entered later. For example, in examples regarding Individual #272 and Individual #233, while the BPRS data were included, they were added after the clinical encounter. In the example regarding Individual #272, the quarterly clinical encounter occurred 11/14/18, but the BPRS included in the documentation was not dated until 12/12/18, almost a month later. In the case of Individual #233, the most recent quarterly psychiatry clinic was documented as occurring on 12/27/18 with the BPRS dated 1/24/19, again indicating that the data were entered after the clinic and not available for use in clinical decision making.

The collection and presentation of reliable data is an area of focus for the psychiatry department. Likely, maintaining this will require ongoing collaborative work between psychiatry, behavioral health, residential services, day/vocational services, and the Center's ADOP. This will be the case as San Angelo SSLC moves towards further individualizing psychiatric indicators for decrease and increase that may not be identical to what is already being measured by the PBSP as target behaviors/replacement behaviors.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.	
Summary: CPEs were formatted correctly and with sustained high performance,	Individuals:

this indicator (13) might be moved to the category of requiring less oversight after the next review. CPE content needed attention to ensure that all required components are included. Perhaps clerical support can assist with this. Similarly, other documentation was not completed as required. This set of indicators will remain in active monitoring.											
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
12	The individual has a CPE.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	CPE content is comprehensive.	22% 2/9	0/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
15	If admitted within two years prior to the onsite review, 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% 0/3	0/1				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.	22% 2/9	0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1

Comments:
12-13. Nine individuals required CPEs. All were completed.

14. The Monitoring Team looks for 14 components in the CPE. Two of the CPEs included all of the required components. The evaluations were missing one to six elements. One evaluation was missing one element, one evaluation was missing two elements, two evaluations were missing three elements, two evaluations were missing four elements, and one evaluation was missing six elements. The most common deficient element was the bio-psycho-social formulation. This was incomplete in six examples.

15. For Individual #335, Individual #402, and Individual #297, who were admitted in the two years prior to the onsite review, there were delays in completion of the admission assessments. For example, Individual #335 was admitted to the Center 1/27/17 with the initial CPE performed just over 30 days later on 2/28/17. For Individual #402, who was admitted 3/28/17, the initial CPE was completed a week or so after 30 days on 5/4/17. There was no admission note from the primary care provider. Individual #297 was admitted to the facility on Monday 9/17/18; the admission note from the primary care provider was completed on 9/21/18.

16. There were seven individuals whose documentation revealed inconsistent diagnoses across disciplines, Individual #335, Individual

#245, Individual #331, Individual #297, Individual #241, Individual #272, and Individual #233.

Outcome 5 – Individuals' status and treatment are reviewed annually.											
Summary: Performance on these four indicators has been about the same for five consecutive reviews. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
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	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.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	75% 6/8	1/1	1/1	0/1	1/1	1/1	0/1	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:
17. Eight individuals required annual evaluations. All were completed.

18. The Monitoring Team scores 16 aspects of the annual evaluation document. None of the annual evaluations contained all of the required elements. The annual evaluations were missing two to four of the required elements. One evaluation was missing two elements, two evaluations were missing three elements, and four evaluations were missing four elements. The most common missing elements were the risk benefit discussion and the symptoms of the diagnosis. The evaluations included the diagnostic criteria for each diagnosis, but did not indicate how a particular individual met the criteria.

19. Eight individuals requiring an annual CPE had one completed prior to the annual ISP meeting. The ISP regarding Individual #272 occurred 4/5/18, and there was a quarterly psychiatry clinic documented 90 days prior to the ISP meeting on 2/7/18. One individual, Individual #297, was a new admission to the facility. The initial CPE was dated 9/19/18 with an ISP date of 10/16/18. For one individual, Individual #233, the annual evaluation was not completed until after the ISP meeting. The ISP regarding Individual #233 occurred 3/28/18, but the psychiatric evaluation was not completed until three weeks later on 4/19/18.

20. The psychiatrist attended the ISP meeting for six of the individuals in the review group. This was good to see. If the psychiatrist does not participate in the ISP meeting, there needs to be some documentation that the psychiatrist participated in the decision to not be required to attend the ISP meeting; this can be by the psychiatrist attending the ISP preparation meeting, or by some other documentation/note that occurs prior to the annual ISP meeting. Even so, in the three-month period between the ISP preparation meeting and the annual ISP meeting, the status of the individual may have changed, as there may have been psychiatry related incidents, a change in medications, and so forth. The presence of the psychiatrist always allows for richer discussion during the ISP

with regard to the required elements.

21. In all examples, there was a need for improvement with regard to the documentation of the ISP discussion to include the rationale for determining that the proposed psychiatric treatment represented the least intrusive and most positive interventions, the integration of behavioral and psychiatric approaches, the signs and symptoms monitored to ensure that the interventions are effective and the incorporation of data into the discussion that would support the conclusions of these discussions, and a discussion of both the potential and realized side effects of the medication in addition to the benefits.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.											
Summary: Criteria were met for PSPs for the first time. None of the individuals selected for review by the Monitoring Team had a PSP, therefore, two other individuals were chosen. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	100% 2/2									
Comments: 22. PSP documents regarding Individual #203 and Individual #218 were reviewed. The PSPs were brief, but direct, and contained a description of the psychiatric symptoms for monitoring and targeted recommendations for staff regarding how to respond to and support the individual.											

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
Summary: More attention needs to be paid to the details required regarding consent for psychiatric medications. Clerical support might be helpful. Indicators 28-31 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	56% 5/9	0/1	1/1	1/1	0/1	0/1	1/1	1/1	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:
28. Current medication consent forms were provided for all medications prescribed for eight of the individuals. Individual #402 was prescribed Lithium and the consent form for this medication expired as of 3/1/19. The prescriber had updated the consents for the other psychotropic medications prescribed for Individual #402, but Lithium was not addressed. The consent form for Individual #272 regarding Abilify included the name of another individual and symptoms that, per the record review, Individual #272 did not experience.

29. The consent forms included adequate medication side effect information in five examples. Individual #335, Individual #331, Individual #402, and Individual #233 were prescribed benzodiazepines, and the consent forms were inadequate because the risks of dependency and withdrawal were not included.

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

31. The consent forms for the individuals in the review group did not include alternate, individualized, non-pharmacological interventions. This section of the consent forms was either left blank, or there was a statement 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: Performance scores remained identical to the last review. It was good to see that the Center maintained a relatively high performance on indicator 5, regarding data being reliable for PBSPs. For five of the individuals, both of the two indicators met criteria. For the other four individuals, one of the two indicators were met. This indicated that the Center has the capacity to meet criteria for all individuals. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
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.	78% 7/9	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1

Comments:
4. Individual #297 was admitted on 9/17/18, but did not have a functional assessment, therefore, her objectives were not based on current assessments. Individual #245's most recent PBSP contained a target behavior (i.e., gang activity) not included in her most recent functional assessment

5. Individual #335 did not have an interobserver agreement (IOA) assessment since April of 2018, and Individual #272's most recent data collection timeliness (DCT) assessment was below 80%. When IOA or DCT assessments are below 80%, staff should be retrained and reassessed as soon as possible.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.											
Summary: One individual did not have a functional assessment (indicator 11), the first occurrence observed by the Monitoring Team since 2015. For the functional assessments for all of the other individuals, all criteria for content were met. This was the case for the last two reviews, too (with one exception. Therefore, indicator 12 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
10	The individual has a current, and complete annual behavioral health update.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
11	The functional assessment is current (within the past 12 months).										
12	The functional assessment is complete.	100% 7/7	1/1	1/1	1/1	1/1	1/1	No FA	1/1	1/1	

Comments:
Criteria for indicators 1-9 were met for Individual #233. Therefore, the remainder of the indicators in psychology/behavioral health were not rated for her.

11-12. Individual #297 did not have functional assessment.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.	
Summary: Performance remained the same as at the last review. That is PBSPs were implemented when approved and PBSPs contained relevant content for most,	Individuals:

but not all individuals. One individual still had an initial admissions PBSP, but it was now six months since she was admitted (indicator 14). Indicators 13 and 15 will remain in active monitoring.											
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	88% 7/8	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	
14	The PBSP was current (within the past 12 months).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
15	The PBSP was complete, meeting all requirements for content and quality.	75% 6/8	1/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1	

Comments:

13. Individual #337's PBSP was implemented prior to him receiving necessary consents

15. The Monitoring Team reviews 13 components in the evaluation of an effective positive behavior support plan. Six of the eight PBSPs contained all of those components.

- Individual #241's PBSP was scored as incomplete because opportunities for reinforcement were not specified, and PBSP reinforcement (i.e., staff attention) was not identified as a preference for Individual #241.
- Individual #245's PBSP contained a target behavior, gang activity, that was not included in her functional assessment. Therefore, her PBSP was judged as to not be based on her functional assessment.

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: Medical Department staff should continue to focus on ensuring the timely completion of annual medical assessments. Center staff also should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
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, this indicator 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.	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1
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. The most recent AMA for Individual #270 was dated 11/8/17. The Center provided a "summary update," dated 2/14/19, which was not an AMA.

For Individual #150, the 2018 AMA was overdue by five months (i.e., AMAs dated 7/25/17, and 12/21/18).

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." Interim reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interim 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. In some instances, IRRFs and IHCPs indicated that annual PCP review was sufficient, despite individuals having significant medical issues (e.g., Individual #270, who experienced a 27-pound weight loss, and had tachycardia).

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Focused efforts are needed on the part of Center staff to improve the quality of the medical assessments. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367

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, this indicator 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 with the medical assessments the Monitoring Team reviewed. Individual #270 did not have an up-to-date medical assessment (i.e., her most recent assessment was dated 11/8/17, making it 16 months old at the time of the review). It was positive that as applicable to the remaining eight individuals reviewed, the annual medical assessments addressed past medical 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, pertinent laboratory information, and updated active problem lists. Most, but not all included, as applicable, pre-natal histories, social/smoking histories, and complete interval histories. Moving forward, the Medical Department should focus on ensuring medical assessments include family history, childhood illnesses, and plans of care for each active medical problem, when appropriate.

c. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions [i.e., Individual #331 – falls/osteoporosis, and seizures; Individual #241 – constipation/bowel obstruction, and other: hypothyroidism; Individual #270 – weight, and cardiac disease; Individual #185 – gastrointestinal (GI) problems, and cardiac disease; Individual #248 – other: chronic kidney disease, and cardiac disease; Individual #343 – respiratory compromise, and diabetes; Individual #237 – seizures, and other: hypothyroidism; Individual #150 – diabetes, and osteoporosis; and Individual #367 – respiratory compromise, and other: benign prostatic hyperplasia (BPH)].

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: As indicated in the last several reports, overall, much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 331	241	270	185	248	343	237	150	367
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	6% 1/18	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review,	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	based on current standards of practice, and accepted clinical pathways/guidelines.										
Comments: a. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions (i.e., Individual #331 –falls/osteoporosis, and seizures; Individual #241 – constipation/bowel obstruction, and other: hypothyroidism; Individual #270 – weight, and cardiac disease; Individual #185 – GI problems, and cardiac disease; Individual #248 – other: chronic kidney disease, and cardiac disease; Individual #343 – respiratory compromise, and diabetes; Individual #237 – seizures, and other: hypothyroidism; Individual #150 – diabetes, and osteoporosis; and Individual #367 – respiratory compromise, and other: BPH). The following IHCP included action steps to sufficiently address the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations: Individual #331 – seizures. 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. In some instances, IRRFs and IHCPs indicated that annual PCP review was sufficient, despite individuals having significant medical issues (e.g., Individual #270, who experienced a 27-pound weight loss, and had tachycardia).											

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: For most individuals reviewed, the annual dental exam occurred more than 90 days prior to the ISP meeting; as a result, the annual dental summaries provided to the IDTs did not provide current dental exam information for the purposes of decision-making, risk analysis, and goal setting. The Center should focus on improving the quality of the dental exams, and particularly, the annual dental summaries. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	364
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	N/A	N/A	N/R	N/A	N/A	N/R	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.	14% 1/7	0/1	0/1		0/1	0/1		1/1	0/1	0/1
	iii. Individual receives annual dental summary no later than	14%	0/1	0/1		0/1	0/1		1/1	0/1	0/1

	10 working days prior to the annual ISP meeting.	1/7									
b.	Individual receives a comprehensive dental examination.	22% 2/9	1/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	0% 0/7	0/1	0/1		0/1	0/1		0/1	0/1	0/1

Comments: a. The Monitoring Team conducted limited reviews for the following two individuals: Individual #343, who was edentulous, and for Individual #270, who had low dental risk.

For six of the seven individuals reviewed for this indicator, successful/completed annual dental exams and summaries did not occur in a timely manner. Only Individual #237 had a dental exam that was completed within 365 days of the last exam and no more than 90 days prior to the ISP meeting. For the other individuals, the annual dental exam was more than 90 days prior to the ISP meeting; as a result, the annual dental summaries provided to the IDTs did not provide current dental exam information for the purposes of decision-making, risk analysis and goal setting.

b. Two of the nine individuals reviewed had dental exams that included all of the required components, including Individual #331, as well as Individual #343, who was edentulous. Most, but not all, of the remaining dental exams reviewed included the following:

- A description of the individual's cooperation;
- An oral hygiene rating completed prior to treatment;
- Periodontal condition/type;
- The recall frequency;
- Caries risk;
- Periodontal risk;
- An oral cancer screening;
- Sedation use;
- A summary of the number of teeth present/missing;
- Treatment provided/completed;
- An odontogram; and;
- Periodontal charting.

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

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

c. Most, but not all, of the dental summaries reviewed included the following:

- Effectiveness of pre-treatment sedation; and,
- Recommendations for the risk level for the IRRF

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

- Recommendation of need for desensitization or another plan;
- A description of the treatment provided (i.e., treatment completed);

• The number of teeth present/missing; • Dental care recommendations; • Dental conditions that could cause systemic health issues or are caused by systemic health issues; • Treatment plan, including the recall frequency; and, • Provision of written oral hygiene instructions;

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.											
Summary: For all nine individuals reviewed, nurses completed timely annual nursing reviews and physical assessments. With regard to nurses' timely completion of quarterly nursing record reviews and/or physical assessments, improvement is needed. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	56% 5/9	0/1	0/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1
Comments: a.i. and a.ii. It was positive to see that all of the individuals reviewed had timely annual comprehensive nursing reviews and physical assessments. With regard to quarterly nursing record reviews and physical assessments, most were timely, but problems included: • For Individual #331 and Individual #241, Center staff only submitted one quarterly review. • Individual #185's annual comprehensive nursing review was completed on 7/12/18, but the first quarterly record review was not completed until 11/26/18. • On 7/11/18, a nurse completed Individual #237's annual comprehensive nursing review, and on 10/30/18, the first quarterly record review was completed. However, the second quarterly record review was not completed until 2/13/19.											

Outcome 4 – Individuals have quality nursing assessments to inform care planning.											
Summary: Work is needed to ensure that nurses complete annual and quarterly physical assessments that address the necessary components. Work is also needed to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to individuals' at-risk conditions. It was good to see that in some instances, when individuals experienced changes of status, nurses completed assessments in accordance with current standards of practice, but this is also an area in which improvements are still needed. All of these indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
a.	Individual receives a quality annual nursing record review.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual receives quality annual nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	11% 1/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1
c.	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
d.	Individual receives a quality quarterly nursing record review.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality quarterly nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs;	33% 3/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1	1/1

	vi. Pain; and vii. Follow-up for abnormal physical findings.										
f.	On a quarterly basis, nursing assessments completed to address the individual’s at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk.	0% 0/16	0/2	0/2	N/A	0/2	0/2	0/2	0/2	0/2	0/2
g.	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.	42% 5/12	1/1	1/2	0/2	0/1	1/2	1/1	1/1	N/A	0/2

Comments: a. It was positive that all of the annual nursing record reviews that the Monitoring Team reviewed included, as applicable, the following:

- Active problem and diagnoses list updated at the time of annual nursing assessment (ANA);
- Procedure history;
- List of medications with dosages at time of the ANA; and
- Consultation summary.

Most, but not all included, as applicable:

- Lab and diagnostic testing requiring review and/or intervention; and
- Tertiary care.

The components on which Center staff should focus include:

- Family history;
- Social/smoking/drug/alcohol history;
- Immunizations; and
- Allergies or severe side effects to medication.

b. For Individual #185, the nurse completed an annual physical assessment that addressed the necessary components. Problems with other assessments varied, but some examples of problems included a lack of waist circumference measurements, no fall assessment scores, missing body system assessments, and a lack of follow-up on abnormal findings.

c. and f. For nine individuals, the Monitoring Team reviewed a total of 18 specific risk areas (i.e., Individual #331 – GI problems, and respiratory compromise; Individual #241 – seizures, and falls; Individual #270 – choking, and aspiration; Individual #185 – dental, and skin integrity; Individual #248 – GI problems, and respiratory compromise; Individual #343 – aspiration, and GI problems; Individual #237 – skin integrity, and constipation/bowel obstruction; Individual #150 – circulatory, and GI problems; and Individual #367 – weight, and falls).

Overall, none of the annual comprehensive nursing or quarterly assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Nurses often had not included status updates in annual and quarterly assessments, including relevant clinical data; analyzed this information, including comparisons with the previous quarter or year; and/or made 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.

d. It was positive that all of the quarterly nursing record reviews that the Monitoring Team reviewed included the following, as applicable:

- Procedure history;
- List of medications with dosages at the time of the quarterly nursing assessment; and
- Tertiary care.

Most, but not all of the quarterly nursing record reviews the Monitoring Team reviewed included, as applicable:

- Active problem and diagnoses list updated at the time of the quarterly assessment; and
- Consultation summary.

The components on which Center staff should focus include:

- Family history;
- Social/smoking/drug/alcohol history;
- Immunizations;
- Lab and diagnostic testing requiring review and/or intervention; and
- Allergies or severe side effects to medication.

e. For Individual #185, Individual #150, and Individual #367, nurses completed quarterly physical assessments that addressed the necessary components. Problems with other assessments varied, but some examples of problems included a lack of waist circumference measurements, missing body system assessments, and a lack of follow-up on abnormal findings.

g. The following provide positive examples related to nursing assessments in accordance with nursing guidelines or current standards of practice in relation to individuals' changes of status:

- On 10/13/18, Individual #331 presented with signs and symptoms of respiratory distress (i.e., oxygen saturation of 45%, and the individual reporting that she did not feel well, and requiring oxygen). The nursing IPN, dated 10/13/18, at 12:58 p.m., and the corresponding IView entry, dated 10/13/18, at 10:20 a.m., which was the time of the compliant, showed that the nurse followed applicable nursing guidelines/standards for assessment. The nurse notified the PCP, and the individual was transferred to the ED.
- Individual #241 had an increase in seizure activity. A 2/4/19 IPN, at 10:51 p.m., and an IView entry, dated 2/4/19, at 10:00 p.m., showed that the nurse followed the seizure nursing guideline for assessment criteria.
- A nursing IPN, dated 12/25/18, at 8:59 p.m., and an IView entry, at 2:50 p.m., indicated that Individual #248 had a "wet cough noted when getting vitals @ 14:50 for vitals [sic]. 02 sat 88%." The record documented that the nurse completed lung sounds that revealed congestion and the individual was coughing. The nursing IPN indicated that the nurse re-positioned the individual, and re-assessed the individual's oxygen saturations, and notified the PCP. This showed assessments consistent with applicable standards of care. The PCP ordered respiratory treatments every four hours for 24 hours and Guaifenesin (i.e., cough/congestion medication) three times a day for 24 hours. A medical IPN, dated 12/26/18, at 7:37 a.m., indicated the PCP evaluated the individual and ordered an IM injection of an antibiotic.
- On 12/30/18, Individual #343 tripped and fell over chair, and hit his head. A nursing IPN, dated 12/20/18, at 9:19 a.m., and IView entries, dated 12/30/18, at 6:30 a.m., showed that the nurse followed the nursing guidelines for falls, including an initial

neurological assessment, and physician notification.

- According to a nursing IPN, dated 11/28/18, at 3:02 a.m., and an IView entry, dated 11/28/18, at 1:25 a.m., staff notified the nurse that Individual #237 fell (i.e., witnessed fall). The nurse followed the nursing guidelines on falls when assessing the individual, including notifying the PCP.

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

- For Individual #241, a nursing IPN, dated 12/19/18, stated: "Staff reported individual sitting on floor at end of bed with back against bed. Light bruise to right laterals side of back. DSP [direct support professional staff] report they asked individual what happened and did they fall. Individual said 'SI'." Based on the information included in the nursing IPN, dated 12/19/18, at 11:21 p.m., and the IView entry, dated 12/19/18, at 10:23 p.m., the nurse did not follow nursing guidelines for a fall/suspected fall, and/or skin integrity issues. For example, the nursing assessments did not include a neurological assessment, and did not include measurements for the "light bruise noted to right laterals side of back, area reddened at present, slight swelling noted to area." The nurse did not notify the PCP.
- On 1/24/19, Individual #270 choked on a chopped hamburger patty, and required staff to administer the abdominal thrust. For this individual, the Center did not submit any IPNs past 10/11/18. The IView entry, dated 1/24/19, at 1:54 p.m., did not include a respiratory assessment (e.g., lung sounds), and did not indicate that a nursing progress note existed. Nursing staff did not follow standards of care for this life-threatening incident.
- On 2/3/19, Individual #270 experienced excessive coughing during a meal. Again, the Center submitted no IPNs for this time period for this individual. An IView entry, dated 2/3/19, at 7:41 p.m., stated there was a progress note, and stated "choking." However, the nurse did not document any vital signs or a respiratory assessment.
- An IPN, dated 8/18/18, at 2:54 a.m., and an IView entry, dated 8/18/18, at 2:54 a.m., noted that Individual #185 had Shingles with blisters on the left posterior thigh. The nurse did not follow standards of care for assessment in that a full set of vital signs were not documented (i.e., only a respiratory rate).
- On 10/19/18, during a hospitalization, Individual #248 had a PEG tube placed. Upon her return to the Center, it was positive that the nurse assessed the new PEG tube site, and documented the size and location. However, with regard to "two vertical red friction shears to middle/upper back," the nurse did not include measurements, which was not consistent with skin impairment nursing guidelines.
- On 8/6/18, Individual #367 weighed 122.8 pounds; on 1/14/19, he weighed 116.2 pounds; on 1/18/19, he weighed 113.4 pounds, and on 1/25/19, he weighed 110.4 pounds. This represented a 10% weight loss is approximately six months, and a 5% loss in one month. In January 2019, no IPNs were found showing a nursing assessment to address his decreasing weight.
- On 12/6/18, Individual #367 fell: "was walking to class and stumbled to the ground 3 times." No IPN was found related to this fall. An IView entry, dated 12/6/18, at 2:50 p.m., did not contain an assessment consistent with nursing guidelines for falls. The cognitive assessment was incomplete (i.e., it stated: "no change from baseline"), and there was no pain assessment.

Outcome 5 – 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 several review periods, the Center's scores have	Individuals:

been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.											
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
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. In some cases, IDTs included a number of interventions in individuals' ISPs/IHCPs that were assigned to nursing staff. However, often times, these action steps referred only to the routine activities in which nurses are required to engage (e.g., administering ordered medications, completing quarterly nursing assessments, etc.), and/or the were not measurable. The plans were still missing key nursing supports. For example, RN Case Managers and IDTs generally had not individualized interventions in relevant nursing guidelines to include in IHCPs nursing assessments at the frequency necessary to address conditions that placed individuals at risk. Often, the IDTs had not included in the action steps nursing assessments/interventions to address the underlying cause or etiology of the at-risk or chronic condition (e.g., if an individual had poor oral hygiene, a nursing intervention to evaluate the quality of the individual's tooth brushing, and/or assess the individual's oral cavity after tooth brushing to check for visible food; if an individual's positioning contributed to her aspiration risk, a schedule for nursing staff to check staff's adherence to the positioning instructions/schedule; if an individual's weight loss was due to insufficient intake, mealtime monitoring to assess the effectiveness of adaptive equipment, staff adherence to the Dining Plan, environmental factors, and/or the individual's food preferences). Significant work is needed to include nursing interventions that meet individuals' needs into IHCPs.											

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: It was positive that as needed, a Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results. Since the last review, the scores during this review showed some improvement with regard to timely referral of individuals to the PNMT, but this is an area that requires continued focus. The Center should also focus on improving the completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT reviews and comprehensive assessments.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	67% 4/6	1/1	N/A	0/1	N/A	1/1	1/1	1/1	N/A	0/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	50% 3/6	0/1		1/1		1/1	1/1	0/1	N/A	0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/3	N/A		0/1		0/1	N/A	0/1	N/A	N/A
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	50% 3/6	0/1		1/1		1/1	1/1	0/1	N/A	0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 4/4	1/1		N/A		1/1	N/A	1/1	1/1	N/A
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/6	0/1		0/1		0/1	0/1	0/1	N/A	0/1
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	33% 1/3	0/1		N/A		N/A	1/1	N/A	N/A	0/1

	• Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.										
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/3	N/A		0/1		0/1	N/A	0/1	N/A	N/A

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

- On 1/27/18, 2/11/18 (2), 2/12/18, 3/2/18 (2), 3/4/18, and 3/14/18, Individual #331 fell. Each of these falls was related to a peer-to-peer aggression event, except for the fall on 3/14/18, when she was walking backwards and fell, although this fall also was described as behavior-related. On 3/19/18, her IDT held a "root cause analysis" meeting. As a result of its weekly review of the episode tracker, the PNMT made a self-referral. On 3/21/18, the PNMT conducted a review of her falls. Falls also occurred on 6/18/18, 6/25/18, 7/11/18, 7/21/18, and 7/25/18. An ISPA, dated 8/30/18, cited numerous peer-to-peer issues during the same time period. Although notes also referenced a PNMT review on 10/10/18, for falls and weight loss, Center staff did not submit any formal review documentation, nor did they submit meeting minutes for this date. There appeared to be some discussion about her hospitalization for pneumonia and chronic obstructive pulmonary disease (COPD) exacerbation with referral to the PCP for gastroesophageal reflux disease (GERD), but again, Center staff did not submit any formal review documentation.

  The PNMT note listed medications and side effects, but the PNMT did not document any discussion of the impact on the individual's functional motor performance or falls (e.g., many of the medications had dizziness listed as a side effect). The PNMT did not document a review of the individual's medical history, or diagnoses, nor did it document collaboration or actions with Behavioral Health Services staff to address the individual's falls. The PNMT offered no discussion for whether the individual had a need for protective devices, and did not mention the syncope and whether they saw any connection between it and the falls. The PNMT offered no recommendations.
- On 3/2/18, Individual #270 weighed 115 pounds. She had continued weight loss to 100.6 pounds on 9/1/18. A gradual increase followed to 107.2 pounds on 12/7/18, but her weight dropped again after the first of the year to 92 pounds on 2/5/19. On 1/23/19, the PNMT made a self-referral of Individual #270 related to weight loss, and on 1/24/19, the SLP wrote a note related to dysphagia and a choking incident. However, previous referrals were indicated for at least a review related to her weight loss (i.e., on 5/23/18, 7/25/18, and 9/1/18). Although the Registered Dietician took some actions at these times, the PNMT did not conduct a review/assessment. On 1/23/19, the PNMT initiated an assessment. Although it was not due at the time the Monitor submitted the Tier II document request, it was due prior to the Monitoring Team's onsite review. While on site, the Monitoring Team member requested a copy of the PNMT assessment, but Center staff did not submit an assessment. Based on the documentation available, the PNMT RN wrote limited notes, but the contributions from other PNMT members was not documented.
- On 9/20/18, Individual #248, was hospitalized for bacterial pneumonia. On 10/17/18, her IDT referred her to the PNMT due to a new percutaneous endoscopic gastrostomy (PEG) tube placement. On 10/23/18, the PNMT initiated an assessment. At that time, she was still hospitalized (i.e., from 10/17/18 to 11/19/18). Staff believed that the dysphagia and silent aspiration were due to chronic lithium intoxication. She was hospitalized due to a change in mental status, and was diagnosed with lithium toxicity, severe hypernatremia, acute kidney injury, failure to thrive, and seizures. She was non-responsive, and a

nasogastric tube was unsuccessful due to high residual rates and constipation, according to a KUB (i.e., abdominal x-ray). She received total patient nutrition (TPN), and then underwent gastrostomy tube (G-tube) placement. Hospital staff completed two modified barium swallow studies (MBSS) with findings of silent aspiration.

Although the PNMT assessment was "entered on" 10/23/18, the completion date was not clear. Numerous updates to the document occurred on 10/26/18, 2/19/19, 2/20/19, and 2/21/19. The latter three dates were after the Center was notified that Individual #248 was one of the individuals that the Monitoring Team selected for review (i.e., on 2/14/19).

- Between October 2018 and January 2019, Individual #343 fell 11 times (i.e., 10/16/18, 10/25/18, 11/6/18, 11/24/18 x2, 11/26/18, 12/22/18, 12/30/18, 1/13/19, 1/15/19, and 1/19/19). On 1/25/19, the PNMT conducted a review of his falls in a PNMT note. This review also addressed his weight loss/anemia. The PNMT RN documented the review, but from the documentation, it was not clear which other team members participated. The review identified issues related to anemia and the kitchen not sending proper portions. The PNMT noted that some falls were related to altercations with peers and participation in sports. The review concluded that the IDT had not implemented previous PNMT recommendations, but it was unclear what those recommendations were (i.e., other than wearing protective sports gear).
- After Individual #237's hospitalization from 4/20/18 to 4/24/18, the PNMT conducted a review for pneumonia with possible aspiration. On 4/25/18, the PNMT initiated an assessment, but then on 5/2/18, the PNMT changed from an assessment to a review. On 5/9/18, notes indicated that the PNMT members completed a review, which the OT did not sign until 6/6/18. It appeared that on 6/28/18, the PNMT completed another review. The PNMT did not provide a rationale for not completing an assessment.
- Although it appeared that at the time of the Monitoring Team's review, the PNMT continued to follow Individual #150, his referral and assessment process occurred in late 2017/early 2018, so the Monitoring Team did not score them for this review.
- On 6/4/18, Individual #367 weighed 122.8 pounds, and on 6/7/18, the records showed he weighed 148.4 pounds. Although this possibly was an error, it did not appear staff reweighed him. However, on 7/6/18, his weight dropped to 115.2 pounds. These weight variations continued. On 8/6/18, he weighed 122.8 pounds, but then, he experienced weight decline to 116.40 on 12/10/18, with a low of 110.4 pounds on 1/25/19. His weight appeared to increase again during the week of 2/7/19, to 117.4 pounds. Based on the meeting minutes submitted, the Monitoring Team found no evidence of PNMT review, nor did the Center staff submit a formal review or assessment, and the IPNs did not reflect any PNMT action.

f. As the Monitoring Team has discussed with State Office, without signature pages that include dates, it is not possible to determine which members of the PNMT participated in the PNMT reviews/assessments. Currently, PNMT documents include a list of "participants" within the document. Given that PNMT members are licensed clinicians, the Center needs to have a mechanism to verify the participation of each clinician in the PNMT assessment process. The author or person entering information could potentially populate the list of "participants" without those clinicians having any role in the process or even knowing that they are listed as "participants." Other entries in IRIS provide a "signature" of sorts, because the system identifies the author of each entry as the user that entered the system using a password. Such entries are also time-stamped. Given the ongoing challenges with IRIS related to the inability to have more than one user "sign" a document, the State should propose a mechanism to allow this verification (i.e., allowing one user to simply include the names of "team members" at the bottom of the report does not suffice).

e. It was positive that as needed, a RN Post Hospitalization Review was completed for the individuals reviewed, and the PNMT

discussed the results.

h. As noted above, the Monitoring Team requested Individual #270's assessment on site, but Center staff did not provide a copy. The PNMT did not provide a rationale for not completing a comprehensive assessment for Individual #237. The following summarizes some of the concerns noted with the one assessment that the PNMT completed:

- As noted above, it appeared that the PNMT only finalized Individual #248's PNMT assessment after the Monitoring Team notified the Center that she was part of the review group. In addition, the overall quality of the assessment was poor. It appeared that most of the content was copied from other documents without any summary or analysis. As a result, it was difficult to pick out what was pertinent to the issues that were the reason for the assessment. No evidence was found of a nutritional assessment. Recommendations were not connected to specific evidence and analysis of objective findings.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. In some cases, IDTs had included many necessary PNM interventions in individuals' ISPs/IHCPs, which was movement in the right direction. However, the plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps. In addition, many action steps were not measurable. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
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).	11% 2/18	0/2	0/2	0/2	0/2	1/2	1/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	17% 3/18	0/2	0/2	0/2	1/2	0/2	1/2	0/2	1/2	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.	33% 3/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1
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	11%	0/2	0/2	0/2	0/2	1/2	0/2	1/2	0/2	0/2

	actions to take when they occur, if applicable.	2/18									
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	28% 5/18	0/2	0/2	2/2	1/2	1/2	0/2	0/2	0/2	1/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: Individual #331 – falls, and choking; Individual #241 – falls, and GI problems; Individual #270 – choking, and weight; Individual #185 – choking, and GI problems; Individual #248 – falls, and aspiration; Individual #343 – choking, and falls; Individual #237 - falls, and aspiration; Individual #150 – falls, and aspiration; and Individual #367 – choking, and weight.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMPs. The exceptions were for: Individual #248 – falls, and Individual #343 – falls; and Individual #150 – aspiration. In some cases, IDTs included many necessary PNM interventions in individuals' ISPs/IHCPs, which was movement in the right direction. However, the plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps (e.g., if behavior was a frequent cause of falls, measurable interventions to address the behaviors should be included; or if an individual was at increased risk of choking due to a fast eating pace or improper positioning during meals, then measurable action steps are needed to address these factors). In addition, many action steps were not measurable (e.g., "encourage upright positioning during and after medication pass," "encourage use of sidewalks," etc.).

b. The IHCPs that included preventative physical and nutritional management interventions to minimize the individuals' risk were for: Individual #185 – choking, and Individual #343 – choking.

c. All individuals reviewed had PNMPs and/or Dining Plans. It was good to see that the PNMPs/Dining Plans for Individual #270, Individual #150, and Individual #367 contained the information necessary to meet their needs. Problems varied across the remaining PNMPs and/or Dining Plans reviewed.

- It was positive that all of the PNMPs were reviewed or updated within the last 12 months, and, as applicable to the individuals' needs included:
    - Photographs;
    - Descriptions of assistive/adaptive equipment;
    - Bathing instructions;
    - Toileting/personal care instructions;
    - Handling precautions or moving instructions;
    - Medication administration instructions; and
    - Communication instructions.
- As applicable to the individuals, most, but not all of the PNMPs reviewed included:
    - Positioning instructions;
    - Transfer instructions;
    - Mobility instructions;
    - Mealtime instructions; and
    - Oral hygiene instructions.

- The components of the PNMPs on which the Center should focus on making improvements include:
  - Some PNMPs/Dining Plans did not include triggers, and/or risk levels.

With minimal effort and attention to detail, the Habilitation Therapy staff could make the needed corrections to PNMPs, and by the time of the next review, the Center could make good progress on improving individuals' PNMPs.

f. The IHCPs that identified triggers and actions to take should they occur were for: Individual #248 – aspiration, and Individual #237 - aspiration.

g. Often, the IHCPs reviewed did not include monitoring expectations, including the frequency of monitoring. Those that did were for: Individual #270 – choking, and weight; Individual #185 – choking; Individual #248 –aspiration; and Individual #367 – choking.

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	331	241	270	185	248	343	237	150	367
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	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% 0/1					0/1				

Comments: a. In the Change of Status (CoS) IRRF/IHCP, dated 10/17/18, Individual #248's IDT did not describe the clinical justification for her PEG tube, which was placed in October 2018. The dysphagia evaluation, dated 10/26/18, provided a better description than what the IDT included in the ISPA/revised IRRF.

b. On 10/26/18, in the dysphagia evaluation, the speech language pathologist (SLP) included a thorough plan for the individual to move along the continuum. However, based on the documentation submitted, the IDT did not discuss or approve the plan, and/or document its decisions in an ISPA.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied. The quality of OT/PT assessments continues to be an area on which Center staff should focus. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
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.	56% 5/9	1/1	1/1	0/1	0/1	1/1	1/1	0/1	0/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	67% 6/9	1/1	1/1	0/1	0/1	1/1	1/1	0/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement;	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A

	▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	N/A									

Comments: a. and b. Five of the nine individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status. The following concerns were noted:

- Individual #270 did not receive a comprehensive OT/PT assessment following a change in status that indicated a potential need for OT/PT services. On 1/29/19, she experienced a choking event, followed by a diet downgrade and a plan to initiate swallow therapy. The ISPA also indicated direct support professional (DSP) staff reported they had begun working with her to increase her functional dining skills (e.g., slowing her eating pace and assistance due to tremors). She also experienced weight loss and refusals to participate in activities, get out of bed, and complete activities of daily living (ADLs). Overall the IDT reported changes in her oral motor skills, posture, affect, weight and sleep patterns in the ISPA, dated 2/15/19.
- Two individuals with PNMPs and/or OT/PT skill acquisition plan supports had not had a comprehensive assessment within three years as required, unless the OT/PT provides specific clinical justification. Neither Individual #185 nor Individual #237 had a comprehensive assessment since 2014.
- On 12/10/18, the OT/PT completed a comprehensive assessment for Individual #150. However, in October 2018, when he had a CVA, and in January 2019, when he had changes in mobility, the OT/PT did not complete comprehensive assessments.

  In its response to the draft report, the State sought to provide clarification to this finding, and stated: “Comprehensive assessments are not completed for change of status. This is done through a focused assessment which is completed on a HT consult form.” However, as the interpretive guidelines for the audit tool state: “If an individual experiences a significant change of health status (i.e., a change that has the potential to globally impact the individual’s functioning), then a comprehensive assessment is completed.” The changes of status Individual #150 experienced met this criterion, and the therapists should have conduced comprehensive assessments.

c. It was positive the screening for Individual #270 met her needs.

d. All nine individuals should have had a comprehensive assessment. As noted above, the Center did not submit comprehensive assessments for Individual #270, Individual #185, or Individual #237.

Overall, the comprehensive assessments reviewed were lacking with regard to most of the criteria for a quality assessment. Many, but not all met criteria, as applicable, with regard to only one of the sub-indicators: a discussion of pertinent health risks and their

associated level of severity in relation to OT/PT supports. The Center should focus on all of the remaining sub-indicators:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths were used in the development of OT/PT supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

It was positive one of the efforts underway at the Center was to conduct audits of all assessments to ensure all elements were thoroughly addressed before submission to the IDTs. The Monitoring Team is hopeful that this, in conjunction with additional training, a revised assessment format, and clear expectations for therapists will result in improved assessments. Also of note, as part of the onsite review week, the Monitoring Team appreciated the Habilitation Therapy Director's willingness to conduct an objective review of one individual's OT/PT and communication assessments, review the findings with the Center therapists, and then discuss her findings openly with the members of the Monitoring Team and State Office staff. This effort showed Center staff's ability to identify strengths, as well as weaknesses in the assessments, as well as to identify potential solutions to the significant improvements that are needed with regard to the assessments. The Monitoring Team is hopeful that the Habilitation Therapy Director's ongoing auditing of assessments with feedback provided to therapists will assist in improving the quality of the 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: Improvement is needed with regard to all of these indicators. To move forward, QIDPs and OTs/PTs should work together to make sure IDTs discuss and include information related to individuals' OT/PT supports in ISPs and ISPAs. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 331	241	270	185	248	343	237	150	367
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	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.	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	14% 1/7	N/A	0/1	N/A	1/2	0/1	0/1	0/1	0/1	N/A
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	0% 0/3	N/A	N/A	0/1	N/A	0/1	N/A	N/A	0/1	N/A

Comments: a. The ISPs reviewed did not include concise, but thorough descriptions of individuals' OT/PT functional statuses, particularly with regard to their specific functional motor skills. Therapists should work with QIDPs to make improvements.

b. None of eight ISPs referenced any specific discussion by the IDT related to the individuals' PNMPs. Simply including a stock statement such as "Team reviewed and approved the PNMP/Dining Plan" did not provide evidence of what the IDT reviewed, revised, and/or approved. Therapists should work with QIDPs to make improvements.

c. and d. Overall, OT/PT assessments often did not identify specific strategies, interventions and programs to meet individuals' needs, which hampered the IDTs' abilities to effectively address those needs. Examples of concerns included:

- Often, IDTs did not address individuals' OT/PT needs by including recommended interventions in ISP action plans, and/or include goals/objectives for direct therapy that OT/PT's recommended or implemented.
- IDTs also did not hold ISPA meetings to review and approve OT/PT assessment recommendations for the initiation of or modification to therapy services and supports. For example, both Individual #248 and Individual #150 had direct OT or PT initiated, but the respective IDTs did not hold ISPAs to review and approve.
- Individual #241 had a choking event, which potentially impacted formal OT/PT supports, but the OT/PT did not conduct an assessment, and the IDT did not modify the IHCP. More specifically, as discussed above, on 1/29/19, she experienced a choking event, followed by a diet downgrade and a plan to initiate swallow therapy. The ISPA also indicated DSP staff reported they had begun working with her to increase her functional dining skills (e.g., slowing her eating pace and assistance due to tremors). She also experienced weight loss and refusals to participate in activities, get out of bed, and complete ADLs. Overall the IDT reported changes in her oral motor skills, posture, affect, weight and sleep patterns in the ISPA, dated 2/15/19, but did not make necessary modifications to OT/PT supports.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.	
Summary: In assessing Indicators c through e, the Monitoring Team found	Individuals:

significant work is needed to improve the quality of communication assessments and updates in order to ensure that SLPs provide IDTs with clear understandings of individuals' functional communication status; AAC options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated. These indicators will remain in active oversight. In addition, as a part of its review of Indicators c through e, the Monitoring Team noted that many individuals did not receive timely ISP assessments as required by Indicator a.iii., or assessments in accordance with their needs as required in Indicator b. These indicators will return to active oversight.

#	Indicator	Overall Score	331	241	270	185	248	343	237	150	364
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									
	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.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight. In assessing Indicators d, and e., the Monitoring Team identified a significant number of individuals had not received timely ISP assessments. As a result, this indicator will return to active oversight.									
b.	Individual receives assessment in accordance with their individualized needs related to communication.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight. In assessing Indicators d, and e., the Monitoring Team identified a significant number of individuals had not received assessments in accordance with their individualized needs related to communication. As a result, this indicator will return to active oversight.									

c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/7	0/1	N/A	0/1	0/1	0/1	0/1	N/A	0/1	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments. a and b. Although Indicator a.iii. and Indicator b had moved to less oversight, in assessing indicators c through e, the Monitoring Team noticed that in many instances, individuals had not received timely communication assessments for the annual ISP, at least 10 days prior to the ISP meeting, based on change of status, and/or in accordance with their needs. As a result, these indicators will return to active oversight. For example:

- The Center did not provide needed re-evaluations following a change in status for two individuals (i.e., Individual #241 and Individual #270).
- The Center did perform a comprehensive assessment for another individual (i.e., Individual #248) following a change in status after hospitalization from 9/28/18 through 10/22/18, with dysphagia and weakness secondary to chronic lithium intoxication, but did not complete it until approximately four months later, on 2/21/19. It is important to note that the SLP completed this assessment after the Monitoring Team submitted its document request (i.e., on 2/14/19), which identified Individual #248 as one of the individuals included in the review group.
- Individual #343's ISP highlighted issues not described in the screening, which called into question whether he should have had an assessment rather than merely a screening. The ISP described degenerative brain disease and difficulty formulating thoughts and responses in conversation. He displayed frustration with communication difficulties.

d. As noted above, Individual #343 and Individual #270 should have had comprehensive assessments, but did not. None of the five comprehensive assessments reviewed met all criteria, as applicable. Overall, comprehensive assessments met very few criteria for the nine sub-indicators:

- Two of seven assessments fully addressed the following sub-indicators:
    - Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on 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; and,
    - A comparative analysis of current communication function with previous assessments.
- One of seven assessments addressed the individual's preferences and strengths are used in the development of communication supports and services.
- None of the seven assessments fully addressed the remaining sub-indicators:
    - Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
    - The effectiveness of current supports, including monitoring findings;
    - Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services;
    - Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated; 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.

e. One individual (i.e. Individual #241) had a communication update, which met criteria as applicable, with regard to:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- The effectiveness of current supports, including monitoring findings; and,
- Assessment of communication needs (including AAC, 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;

The Center should continue to focus on the following sub-indicators:

- The individual's preferences and strengths are used in the development of communication supports and services;
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills; and,
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.											
Summary: Improvement is needed with regard to all of these indicators. To move forward, QIDPs and SLPs should work together to make sure IDTs discuss and include information related to individuals' communication supports in ISPs. To further this effort, SLPs will also need to ensure they provide IDTs with foundational guidance and recommendations about needed supports in their assessments. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	364
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.	33% 3/9	0/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/6	N/A	0/1	0/1	0/1	N/A	0/1	N/A	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
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. For six of nine individuals, ISPs did not provide complete functional descriptions of their communication skills. Each of these ISPs provided only limited description of the individual's communication skills and/or how others should communicate with him or her. As an example, Individual #331's ISP described her communication skills only as verbal in English and broadly stated that she responded to verbal prompts and instruction. It did not include any specific strategies or instructions for staff to use to address her lack of intelligibility, and to increase her understanding and reduce her frustration.

b. The IDTs did not provide evidence they reviewed the Communication Dictionaries for any of six individuals for whom it was needed. For two individuals (i.e. Individual #241 and Individual #185), the ISPs provided no evidence of discussion of the Communication Dictionaries or of the recommended changes per their communication updates. For another two individuals (i.e. Individual #270 and Individual #343), the IDTs did not provide Communication Dictionaries, but had not clearly established they did not require that support. More specifically, based on these two individuals' needs (i.e., Individual #270 for whom intelligibility had become an issue

after a change of status, and Individual #343 who was experiencing frustration with communication due to a degenerative brain disease), it appeared they potentially would have benefitted from Communication Dictionaries, but their IDTs had not developed the support and/or provided justification for not developing the support. For the remaining individuals, the IDTs documented only that they had approved the Communication Dictionaries without providing any evidence of what the IDTs reviewed, revised, and/or approved, and/or whether the current Communication Dictionaries were effective at bridging the communication gap.

c. For the eight individuals with identified communication needs, the IDTs did not ensure these needs were addressed in their ISPs/ISPAs. While Individual #150's ISP indicated a voice-operated device would be added to his wheelchair, the Center did not provide any evidence it developed a skill acquisition program (SAP) to teach him how to use it or any measurable action plan to facilitate its use. It was concerning that the communication assessments for these individuals also did not offer any guidance to the IDTs through the provision of recommendations for strategies, interventions (e.g., therapy interventions), and programs (e.g., SAPs) to meet their communication needs.

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: All individuals had at least one SAP. About half of the individuals, however, merely had a single SAP when they had numerous skill deficits that might have benefited if skill acquisition planning was done. About half were based on assessments, and were practical/functional/meaningful for the individual. All but three had data that were shown to be reliable. This set of indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 335	245	337	331	402	297	241	272	233
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	100% 19/19	3/3	1/1	3/3	1/1	1/1	1/1	3/3	3/3	3/3
3	The individual's SAPs were based on assessment results.	74% 14/19	3/3	1/1	3/3	1/1	1/1	1/1	2/3	1/3	1/3
4	SAPs are practical, functional, and meaningful.	53% 10/19	3/3	1/1	3/3	0/1	0/1	1/1	1/3	0/3	1/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	84% 16/19	3/3	1/1	3/3	1/1	0/1	0/1	3/3	2/3	3/3

Comments:

1. All individuals had skill acquisition plans (SAPs). The Monitoring Team chooses three current SAPs for each individual for review.

There was only one SAP available to review for Individual #402, Individual #297, Individual #331, and Individual #245, and for a total of 19 SAPs for this review. Thus, although each individual scored 1 for having at least one SAP; each of these individuals had numerous skill deficits and could have benefited from a wide variety of skill acquisition topics.

3. The majority of the SAPs were based on assessment results. Individual #272's money management and identify community signs SAPs, Individual #233's make an omelet and write her address SAPs, and Individual #241's brush his teeth SAP were inconsistent with their functional skills assessments (FSAs) which indicated they could already complete these tasks independently.

4. Several SAPs were scored as impractical because they were not clearly related to the individual's ISP vision statement and goals (e.g., April's state her medications). Other SAPs were scored as impractical because the FSA indicated that the individual possessed the skill (Individual #233's make an omelet SAP).

San Angelo SSLC should prioritize the identification of individualized, practical, functional SAPs for each individual that are critical to the achievement their ISP goals.

5. Eighty-four percent of SAPs (e.g., Individual #402's socialization SAP) had interobserver agreement (IOA) demonstrating that the data were reliable. This represents an improvement from the last review when 40% of SAPs had IOA. Several of the SAP integrity measures, however, appeared to consist of DSP's role playing the implementation of the SAP. SAP integrity measures ideally should involve direct observations of DSPs implementing SAPs with individuals.

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 was the same as at the last review for indicator 10, higher for indicator 11, and lower for indicator 12. Attention to these assessment-related indicators sets the foundation for good behavioral programming. All three will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 335	245	337	331	402	297	241	272	233
10	The individual has a current FSA, PSI, and vocational assessment.	78% 7/9	1/1	1/1	0/1	0/1	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.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	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 #331 and Individual #337 did not have vocational assessments.

11. Individual #402's FSA was not available to the IDT at least 10 days prior to their ISP.

12. No individual 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, 28 of these indicators were already in, or were moved to, the category of requiring less oversight. For this review, seven other indicators were added to this category, in restraint, psychiatry, behavioral health, medical, and dental.

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>
In psychiatry, given the absence of appropriate indicators, goals, and data shown to be reliable for psychiatric goals/indicators, progress could not be determined for goals for reduction or for increase.

Individuals were seen for psychiatry clinic as scheduled, at least quarterly. Documentation and observation by the Monitoring, showed that some required content components were missing.

In polypharmacy, three of four individuals were not being reviewed by polypharmacy committee, but should have been. For those who were reviewed, criteria were met for some of the indicators.

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 with data and analysis of the data generally 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.

<u>Acute Illnesses/Occurrences</u>
When there were frequent restraints for an individual (i.e., more than three in a rolling 30-day period), the Center was meeting the requirements for review timeliness and content.

In psychiatry, it was apparent that in general, when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (e.g., medication adjustments) were developed and implemented.

In psychiatry, for some individuals, there were rapid and frequent medication adjustments and use of multiple medications. In two cases, the individuals were under the care of the psychiatric nurse practitioner without apparent regular involvement from the supervising psychiatrist.

With regard to acute illnesses/occurrences, in the months prior to the review, State Office provided training to all of the Centers on the development of acute nursing care plans. As a result, the Monitoring Team only reviewed a couple of acute care plans. Nursing guidelines and standards of care include the expectation that nurses will document the time that an acute event occurs or an individual experiences the onset of symptoms. For the couple of acute events reviewed, nurses did not document these times, and as a result, it was unclear whether or not they conducted assessments timely or notified PCPs timely. The quality varied of nurses' completion of assessments in accordance with relevant nursing guidelines or standards. Improvements are needed with regard to the quality of acute care plans, as well as nurses' implementation or documentation of completion of the interventions.

Of note, as part of the onsite review week, the Monitoring Team appreciated the Interim Chief Nurse Executive and the Program Compliance Nurse's willingness to conduct an objective review of one acute care plan for one of the individuals reviewed, and discuss their findings openly with the members of the Monitoring Team and State Office staff. This effort showed Center staff's ability to identify strengths, as well as weaknesses in the acute care plans and the related nursing assessments, as well as to identify potential solutions to the significant improvements that are needed. The Monitoring Team is hopeful that at the time of the next review improvements will have occurred.

It was positive that for the applicable individuals reviewed, prior to transfer to the ED or hospital, individuals received necessary treatment and interventions, and often PCPs or nurses communicated necessary clinical information with hospital staff. However, as noted in the last report, numerous problems continued to exist with regard to the Center's handling of acute issues addressed at the Center, as well as for acute issues requiring ED visits or hospitalizations.

Implementation of Plans

There was little coordination between psychiatry and behavioral health services. Psychiatry was not participating in development of the PBSP.

Additional collaboration between psychiatry and neurology was warranted. This was especially true for individuals who were receiving multiple medications for seizure control and other medications for psychiatric treatment. Even though the records stated that none of the medications were for "dual usage," more integration of these two disciplines was warranted, such as for Individual #241, who was receiving four anti-seizure medications and one psychiatric medication.

Most individuals had timely PBSP integrity measures, however, many only involved paper and pencil measures. PBSP integrity checks should include the observation of DSPs implementing the various components of PBSPs. San Angelo SSLC needs to do more training of staff on individual's PBSPs. Possibly, the direct care staffing crisis may be competing with accomplishing this.

In behavioral health, same as at the last review, San Angelo SSLC had good reliable data for seven of the individuals (indicator 5). This was good to see and, consequently, progress could be evaluated. One of them was making progress. Moreover, given that this individual met criteria for all indicators for outcomes 1 and 2 in behavioral health, a deeper review was not conducted for her (Individual #233). For the other individuals, attention is needed to address when objectives were met. When an individual was not making progress, actions were identified.

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.

For most of the individuals' chronic or at-risk conditions reviewed, medical assessment, tests, and evaluations consistent with current standards of care were not completed, and/or the PCP had not identified the necessary treatment(s), interventions, and strategies, as appropriate.

IHCPs did not include a full set of action steps to address individuals' medical needs. Even for those that did, documentation generally was not found to show implementation of action steps assigned to the PCPs.

It was positive that for the non-Facility consultations reviewed, the PCPs generally reviewed them in a timely manner, indicated agreement or disagreement, wrote Integrated Progress Notes (IPNs) explaining the consultations, and ordered/implemented agreed-upon recommendations. This resulted in two indicators moving to the category requiring less oversight. The Center needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate.

A number of problems were noted with the provision of preventative care to the individuals reviewed. In fact, none of the nine individuals reviewed received all of the preventative care they needed. In addition to making improvements with preventative care, 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.

Overall, individuals reviewed received necessary dental treatment, but the Center should focus on ensuring individuals who have a medium or high caries risk rating receive at least two topical fluoride applications per year.

Improvement was noted with regard to the quality of the Quarterly Drug Regimen Reviews (QDRRs), particularly with regard to lab values. However, since the last review, regression occurred with regard to the timeliness of QDRRs. Improvements were needed with regard to prescribers, particularly psychiatrists, reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations, as well as following up on agreed-upon recommendations.

Proper fit of adaptive equipment was sometimes still an issue.

Based on observations, staff completed transfers correctly. Significant efforts are needed to improve positioning. Continued work also is needed to reduce errors that occurred with Dining Plan implementation. Also, of note, due to issues with direct support staffing, a number of staff from different departments (e.g., therapy, behavioral health services, etc.) assisted with mealtimes, and did a good job. It is not sustainable, though, to have these staff involved in mealtimes in the long-term. Some of the direct support professional staff had been pulled from other homes, and sometimes needed reminders that they should always review the PNMPs/Dining Plans of individuals to whom they are assigned.

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: Performance returned to high levels (at the time of the last review, there was a temporary decrease in performance, but the Monitor kept the indicators in the category of requiring less oversight). In addition, indicator 27 will be returned to the category of requiring less oversight. With sustained high performance, the same might occur for indicator 18 after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	331							
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% 2/2	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.									
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.										
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.	100% 2/2	1/1	1/1							
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
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:
18-29. This outcome and its indicators applied to Individual #335 and Individual #331. There was documentation that both individuals received a thorough review of their programming, treatment, supports, and services to minimize that use of future restraint. This represents an improvement from the last review.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
Summary:			Individuals:								
#	Indicator	Overall Score									
1	If not receiving psychiatric services, a Reiss was conducted.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
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.										
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.										
Comments:											

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Once San Angelo SSLC routinely obtains reliable data for psychiatric indicators, then indicators 8 and 9 can be assessed by the Monitoring Team. Similarly, indicators 10 and 11 can then be assessed, too. Comparing the Center's psychiatry goal/indicator data with actual incidents may help ensure that the data being collected are valid, too. That being said, the Monitoring Team acknowledges the efforts of the psychiatry staff in taking action for individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 8. Given the absence of appropriate indicators, goals, and data shown to be reliable (and perhaps valid) for psychiatric goals/indicators, progress could not be determined for goals for reduction or for increase.											

9. For six individuals, no goals were written or included in the IHCP, thus, goals could not be updated. Individual #331, Individual #241, and Individual #272 had goals included in the IHCP, but these were for psychiatric indicators that were identical to the identified PBSP target behaviors that, as noted in monitoring tool indicator 2, were not relevant to their diagnoses. 10-11. It was apparent that in general, when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (e.g., medication adjustments) were developed and implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary: There was little coordination between psychiatry and behavioral health services. Psychiatry was not participating in development of the PBSP. Good collaboration would also serve to help psychiatry meet psychiatry monitoring tool indicators 1-7. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
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.	44% 4/9	0/1	1/1	1/1	0/1	1/1	1/1	0/1	0/1	0/1
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 the behavioral health target behaviors. There were issues with diagnostic concordance for Individual #241, Individual #331, Individual #272 and Individual #233. In the documentation regarding Individual #335, the role of the psychiatric disorder was not discussed other than a statement that Individual #335 was psychiatrically unstable. 24. The documentation did not reveal evidence of psychiatric participation in the development of the PBSP; and during the monitoring visit, it was confirmed that the psychiatrists had not begun to collaborate with behavioral health in any regard outside of the psychiatric clinical encounters.											

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: None of the individuals in the review group had medications prescribed for dual use and, therefore, no required collaboration between psychiatry and neurology. That being said, the Monitor points to an example of where this collaboration would have, perhaps, benefited an individual who was receiving multiple anti-seizure medications along with one psychiatric medication (Individual #241). Indicators 25 and 27 will remain in active monitoring for possible review at	Individuals:

the next monitoring visit.											
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	N/A									
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.	N/A									

Comments:
25 -27. These indicators did not apply to any of the individuals in the review group. Although Individual #331, Individual #402, and Individual #241 each had a diagnosis of seizure disorder, it was noted that the medications prescribed for seizures were not being utilized for a dual purpose.

Even so, the untoward effects of the lack of collaborative treatment for seizures and psychiatric diagnoses were unfortunately apparent in the example regarding Individual #241. This individual had experienced multiple psychotropic medication adjustments in the absence of neurology consultation. After psychiatry ordered the taper and discontinuation of Ativan, a medication utilized to decrease seizure activity and seizure threshold, Individual #241 experienced an exacerbation of seizure activity. While the exacerbation of seizures may have been multifactorial, the timeline of events makes the discontinuation of Ativan a strong possible etiology. Per document review and staff interview, the consulting neurologist is reputed to perform a comprehensive consultation, and this is a potential missed opportunity for coordination of care.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: Individuals were seen for psychiatry clinic as scheduled, at least quarterly. This has been the case for each of the past reviews, too, with some exceptions. Given this sustained high performance, indicator 33 will be moved to the category of requiring less oversight. Documentation of these clinics, however, were missing some of the required content, and observation of five clinics also showed some missing components. Indicators 34 and 35 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
33	Quarterly reviews were completed quarterly.	100% 8/8	1/1	1/1	1/1	1/1	1/1		1/1	1/1	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	0%				0/1					

	components.	0/5									

Comments:
33. Quarterly reviews were completed in a timely manner for eight individuals requiring them. Individual #297 was newly admitted to the facility in September 2018. Thus, there was not adequate time to determine a pattern of quarterly review.

34. The Monitoring Team looks for nine components of the quarterly review. None of the examples included all the necessary components, with examples missing three to seven components.

35. During the monitoring visit, the psychiatric clinic was observed for one individual in the review group. In addition, psychiatry clinic was observed for four individuals not included in the review group. There was a need for improvement with regard to the use of data in psychiatric decision-making. In the psychiatry clinic regarding Individual #331, data were reportedly not entered into the system and were not available for review during the clinical encounter. Medication decisions were made with anecdotal information. There was a need for psychiatry to identify indicators or symptoms for monitoring in order to allow for the use of data to determine improvement, or lack thereof, with regard to psychiatric symptomatology.

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

Summary: The assessments were not done as often as required and when done, the prescriber's review was delayed. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
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	1/1	0/1	0/1	0/1

Comments:
36. There were issues with both the timely completion and prescriber review of MOSES and AIMS assessments. For example, regarding Individual #241, the AIMS dated 11/13/18 was not reviewed by the prescriber until 12/11/18. The previous AIMS was performed 7/30/18, so there should have been a review in October 2018. The MOSES dated 9/6/18 was not reviewed by the prescriber until 12/11/18. In another example, regarding Individual #272, the AIMS dated 9/4/18 was not reviewed by the prescriber until 10/10/18. The AIMS and MOSES dated 6/9/18 were not reviewed by the prescriber until 7/14/18. The AIMS dated 3/5/18 was not reviewed by the prescriber.

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

Summary: With sustained high performance, both indicators might be moved to the category of requiring less oversight after the next review. They will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
37	Emergency/urgent and follow-up/interim clinics were available if	Due to the Center's sustained performance, this indicator was moved to the									

	needed.	category of requiring less oversight.								
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 7/7	1/1	1/1	1/1	1/1	1/1		1/1		1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 7/7	1/1	1/1	1/1	1/1	1/1		1/1		1/1

Comments:
38-39. There was documentation of emergency/interim clinics regarding seven of the individuals in the review group (the other two did not require interim clinics). The documentation from these emergency/interim clinics was generally brief, but overall appropriate.

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

Summary: These indicators remain in active monitoring.

#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
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									

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: Criteria were met for one or more individuals for each of the indicators, showing that San Angelo SSLC had the capability to meet criteria. But for each indicator, criteria were not met for one or more individuals, too. These indicators will remain in active monitoring.

#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	75% 3/4				1/1	1/1		0/1		1/1
45	There is a tapering plan, or rationale for why not.	50%				0/1	1/1		0/1		1/1

		2/4									
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.	25% 1/4				1/1	0/1		0/1		0/1

Comments:
Comments:
44. These indicators applied to four individuals. Polypharmacy justification was briefly, but appropriately, documented in three examples. For Individual #241, there were multiple changes to his regimen. The justification for polypharmacy and the alterations to the regimen were not clearly documented.

45. There was documentation for individuals who met criteria for polypharmacy showing a plan to taper various psychotropic medications or documentation as to why this was not being considered in two examples.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for one of the individuals meeting polypharmacy criteria. Polypharmacy meeting minutes for the last year were requested and received. There was a polypharmacy meeting documented on 3/21/19, 11/29/18, 10/18/18, 9/20/18, 8/8/18, and 6/7/18. There was a notation that polypharmacy meetings did not occur in March, April, May, July and December of 2018.

A review of the meeting minutes did not reveal documentation of a polypharmacy review for Individual #233, Individual #241, or Individual #402.

The polypharmacy committee meeting was observed during the monitoring visit. During this meeting, the regimens of four individuals were reviewed. The committee meeting was attended by multiple disciplines, including primary care, nursing, pharmacy, and behavioral health. There were appropriate challenges to the polypharmacy regimens by nursing and primary care staff. This was very good to see.

Overall, there was a need for improvement with regard to the review and justification of the regimens. This meeting should be a brisk discussion of the regimens with the psychiatrist presenting the justification of polypharmacy for critique. There was improvement in that the minutes of the meeting included a review of specific regimens. Individuals should be scheduled for review annually, or quarterly if medication adjustments are made or if there is an active medication taper in progress.

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: Same as at the last review, San Angelo SSLC had good reliable data for seven of the individuals (indicator 5). This was good to see and, consequently, progress could be evaluated. One of them was making progress. Moreover, given	Individuals:

that this individual met criteria for all indicators for outcomes 1 and 2 in psychology/ behavioral health, a deeper review will not be conducted for her (i.e., none of the remaining indicators in psychology/behavioral health are scored in this report for Individual #233). For the others, attention is needed to address the individual's plan when objectives are <u>met</u> (indicator 7). When an individual was not making progress, actions were identified (indicator 8). With sustained high performance, this indicator might be moved to the category of less oversight after the next review. Indicators 6, 7, and 8 will remain in active monitoring.

#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
6	The individual is making expected progress	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/1		0/1							
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	100% 5/5	1/1		1/1	1/1	1/1		1/1		
9	Activity and/or revisions to treatment were implemented.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

6. Individual #233's PBSP target behaviors were trending downward, therefore she was judged to be improving. Individual #335, Individual #337, Individual #331, Individual #241, and Individual #402 were not making progress. Individual #272 appeared to be progressing, however, this indicator was scored as 0 because her data were not demonstrated to be reliable (see indicator #5). Individual #297 and Individual #245 were progressing however ,they were scored as 0 because their objectives were not based on their assessments (see indicator #4).

7. Individual #245's physical and verbal aggression objective was achieved in October 2018, however, it was not updated.

8. All five of the individuals who were not making progress had clear actions, documented in their progress notes, of action to address the lack of progress (and there was evidence that these actions were implemented, i.e., indicator 9).

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.	
Summary: San Angelo SSLC needs to do more training of staff on individual's PBSPs. Possibly, the direct care staffing crisis may be competing with accomplishing this. Nevertheless, with staff not trained, individuals are not getting proper supports. Indicator 16 will remain in active monitoring. The Center, however, continued to meet criteria for all individuals for having a	Individuals:

written summary for float staff and for having plans written by behavioral health services staff who met the required minimum criteria. This has been the case for 100% of the individuals for this and the last two reviews, too. Therefore, indicators 17 and 18 will be moved to the category of requiring less oversight.											
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
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.	13% 1/8	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	
17	There was a PBSP summary for float staff.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
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% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	

Comments:
16. Individual #241 had documentation that at least 80% of direct support professionals (DSPs) working in his residence were trained on his PBSP. This was not the case for any of the other individuals.

San Angelo SSLC needs to prioritize ensuring that DSPs working in individuals' residences have training on their PBSPs.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
Summary:			Individuals:								
#	Indicator	Overall Score									
19	The individual's progress note comments on the progress of the individual.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	The graphs are useful for making data based treatment decisions.										
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.										
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.										
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:

Outcome 8 – Data are collected correctly and reliably.											
Summary: Performance regarding achieving data and treatment integrity was not yet at criteria. Indicator 30 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.										
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.										
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).										
30	If the individual has a PBSP, goal frequencies and levels are achieved.	75% 6/8	0/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	
Comments: 30. Individual #272's most recent DCT measure was below 80%, and Individual #335 did not have documentation of an assessment of IOA in nine months.											

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 clinically relevant outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/2

d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/1	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 #331 – falls/osteoporosis, and seizures; Individual #241 – constipation/bowel obstruction, and other: hypothyroidism; Individual #270 – weight, and cardiac disease; Individual #185 – GI problems, and cardiac disease; Individual #248 – other: chronic kidney disease, and cardiac disease; Individual #343 – respiratory compromise, and diabetes; Individual #237 – seizures, and other: hypothyroidism; Individual #150 – diabetes, and osteoporosis; and Individual #367 – respiratory compromise, and other: BPH).

Some medical conditions require action plans, but do not require a goal/objective in which the individual or direct support professionals need to engage to improve the individual's health. This included: Individual #237 – 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 with data and analysis of the data often 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 medical supports and services to these nine individuals.

Outcome 4 – Individuals receive preventative care.

Summary: None of the nine individuals reviewed received the preventative care they needed. Center staff need to take steps to make improvements. 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	Individuals: 331	241	270	185	248	343	237	150	367
a.	Individual receives timely preventative care:										
	i. Immunizations	67% 6/9	1/1	0/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1
	ii. Colorectal cancer screening	60% 3/5	N/A	N/A	N/A	1/1	0/1	1/1	N/A	1/1	0/1
	iii. Breast cancer screening	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	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	11% 1/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
	vi. Osteoporosis	0% 0/6	0/1	N/A	0/1	N/A	0/1	N/A	0/1	0/1	0/1
	vii. Cervical cancer screening	67% 2/3	1/1	N/A	1/1	N/A	0/1	N/A	N/A	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	33% 3/9	1/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1	0/1

Comments: a. The following problems were noted:

- For Individual #331, a hearing evaluation, dated 12/31/15, indicated that her hearing was "essentially normal," but there was a question about a perforated tympanic membrane. A more up-to-date hearing evaluation was not found.
- For Individual #241:
  - No documentation was found of his varicella status.
  - His vision screening, dated 10/28/16, recommended he return in two years. Based on documentation submitted, this did not occur.
  - His last hearing evaluation occurred in 2015.
- For Individual #270:
  - The immunization record did not document the individual's Hepatitis B or varicella status.
  - The Center's response to the document request indicated that she did not require a DEXA. However, she had a significant Vitamin D deficiency, with a level of 15 documented in the 11/20/18 QDRR. She also had had significant hyperprolactinemia, and received medroxyprogesterone, which increases the risk for loss of bone mineral density (BMD).
- On 8/20/15, the audiologist last assessed Individual #185's hearing as "normal" without formal testing. No timeframe was provided for retesting.
- For Individual #248:
  - She had a history of colon polyps. A gastroenterology (GI) consult, dated 9/16/10, documented the difficultly in completing a colonoscopy and recommended either fecal immunochemical testing (FIT) or a barium enema which he believed would be difficult. He documented in the 2010 consult that the three stool Hemoccults were negative. The Center did not submit any evidence that the yearly FIT testing was completed as required.
  - Her last vision exam was in 2017, with no explanation related to further attempts.
  - A hearing evaluation, dated 9/24/15, indicated: "clinical impression is that she probably has essentially normal hearing." However, there was no plan, recommendation, or documentation of follow-up hearing screenings.
  - In 2016, she refused a DEXA scan, but again, there was no strategy to complete one.
  - The PCP indicated that a pap smear was not required, but there was no documentation to show that adequate screening was done when it was required in order to be compliant with the United States Preventive Services Task Force (USPSTF) guidelines.

- Individual #343's last hearing evaluation was dated 9/10/15.
- In 2014, Individual #237 had his last hearing evaluation. It did not provide a recommendation for the timing of follow-up. In addition, in the Center's response to the document request, it noted that a DEXA scan was not needed. However, he was treated with Primidone, an older antiepileptic drug, commonly associated with decreasing BMD by inducing the cytochrome P450 enzyme system.
- For Individual #150:
  - According to the immunization records, in March 2018, the Shingrix vaccine was administered, and the second dose was due two to six months after the first dose. The immunization records did not include documentation of administration of the second dose. The AMA noted that the second dose was administered in December 2018.
  - A hearing evaluation, dated 3/3/16, involved limited formal testing, but concluded that he had: "essentially normal hearing." No follow-up had occurred since then.
  - He had a diagnosis of and was treated for osteoporosis. His last DEXA scan was in 2015.
- For Individual #367:
  - On 12/15/10, GI completed a consultation documenting that the individual would be a good candidate for a colonoscopy. There was no report submitted. The preventive care section of the AMA noted that the sedation risk was too great. However, there was no discussion of risk for this ambulatory individual who smoked one package of cigarettes per day.
  - A hearing evaluation, dated 10/18/16, involved limited formal testing, but concluded that he had: "essentially normal hearing." No follow-up had occurred since then.
  - He had a history of osteopenia. On 1/23/17, a DEXA scan was attempted unsuccessfully, but there was no plan/strategy found to complete one.

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. In other words, the PCP should review the QDRR, provide an interpretation of the results, and discuss what changes can be made to medications based on this information, or state if the individual is clinically stable and changes are not indicated. This occurred for three individuals, but not the other six individuals.

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.

Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
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.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A

Comments: a. A GI consult, dated 5/30/17, stated that staff were trying different food textures with Individual #150. The consultation indicated that an enteral feeding tube was a last resort, "but not ready for that."

On 6/23/17, the Medical Director noted that during a PT assessment the prior day, the individual coughed six times.

On 7/14/17, the Medical Director noted in an IPN that the gastroenterologist stated: "PEG is indicated… because the individual continues to have aspiration trigger." The sister refused to consent for PEG placement. The Medical Director documented: "I requested OOH [out-of-hospital]-DNR status if PEG is not placed." The note indicated that this case would be presented at the next Ethics Committee meeting. There was no documentation submitted of an Ethics Committee discussion.

On 8/3/17, the Legally Authorized Representative signed the DNR. It is unclear how dysphagia is considered a qualifying diagnosis for implementation of a DNR Order.

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: It was positive that for the applicable individuals reviewed, prior to transfer to the ED or hospital, individuals received necessary treatment and interventions, and often PCPs or nurses communicated necessary clinical information with hospital staff. However, as noted in the last report, numerous problems continued to exist with regard to the Center's handling of acute issues addressed at the Center, as well as for acute issues requiring ED visits or hospitalizations. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
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.	45% 5/11	1/2	0/1	0/1	0/1	N/A	2/2	0/1	2/2	0/1
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	18% 2/11	0/2	0/1	0/1	1/1		0/2	0/1	1/2	0/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, <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.	60% 6/10	1/2	2/2	1/1	N/A	0/2	N/A	1/1	1/1	0/1
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary	25%	0/1	N/A	N/A		0/2		N/A	1/1	N/A

	admission, the individual has a quality assessment documented in the IPN.	1/4									
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.	80% 8/10	2/2	2/2	1/1		0/2		1/1	1/1	1/1
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	80% 8/10	2/2	2/2	1/1		0/2		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.	50% 3/6	1/2	N/A	N/A		0/2		1/1	1/1	N/A
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	30% 3/10	1/2	0/2	0/1		0/2		1/1	1/1	0/1

Comments: a. For eight of the nine individuals reviewed, the Monitoring Team reviewed 11 acute illnesses addressed at the Center, including: Individual #331 (human bite on 8/18/18, and left middle finger wound on 11/15/18), Individual #241 (lethargy on 2/5/19), Individual #270 (tachycardia on 10/2/18), Individual #185 (herpes zoster on 8/18/18), Individual #343 (furuncle on 10/13/18, and facial trauma/contusion on 11/6/18), Individual #237 (contusion on 11/28/18), Individual #150 (acute rhinitis on 10/25/18, and left hand swelling on 10/26/18), and Individual #367 (pneumonia/rib fracture on 10/3/18).

PCPs assessed the following acute issues according to accepted clinical practice: Individual #331 (left middle finger wound on 11/15/18), Individual #343 (furuncle on 10/13/18, and facial trauma/contusion on 11/6/18), and Individual #150 (acute rhinitis on 10/25/18, and left hand swelling on 10/26/18).

b. For Individual #185 (herpes zoster on 8/18/18), and Individual #150 (acute rhinitis on 10/25/18), the PCPs 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.

The following provide examples of concerns noted:

- On 8/18/18, the PCP documented that Individual #331 was bitten on the left jaw "last night or early this A.M." The exam was pertinent for a superficial wound over the angle of the left jaw. The PCP prescribed clindamycin for seven days and nursing staff were to monitor for signs of infection. Clinic follow-up was planned for Monday, 8/20/18.

  The PCP documented that the individual had an open wound; therefore, the potential to transmit infectious diseases through a human bite should have been discussed, as well as the vaccination status and serology for both individuals. The PCP also should have documented the need for further serology and/or post-exposure prophylaxis, if appropriate. There was no documentation of follow-up on 8/20/18.
- On 11/15/18, the PCP documented that Individual #331 was involved in an altercation over the weekend and re-injured her

finger and opened a wound. The PCP also documented that the direct support professional stated that "this swelling and wound has been there even on the day [Individual #331] was discharged from the hospital."

The PCP's exam revealed localized swelling in the left middle finger proximal interphalangeal (PIP) joint with "faint bluish bruising and 3 areas of reddish bruising in the palmar aspect." The plan was to obtain radiographs and provide routine wound care. Clinic follow-up was noted to be PRN.

On 11/19/18, the PCP documented that the individual refused the x-ray. There was no re-assessment of the wound or swollen and contused joint.

- On 2/5/19, the PCP documented that nursing staff reported that Individual #241 was lethargic. In the IPN entry, the PCP commented that the individual appeared lethargic and sleepy, but awakened easily, followed commands, and had a normal blood glucose. The plan was to check the ammonia and medication levels, and complete a comprehensive metabolic panel (CMP) the next day. He would also have his 24-hour electroencephalogram (EEG) removed. The PCP ordered increased monitoring and neuro checks for the night. Up until the time of the Monitoring Team's document request on 2/14/19, the PCP did not document any follow-up of the labs.
- On 10/2/18, the PCP documented that he was asked to evaluate Individual #270 due to an elevated pulse of 160. The individual was off campus. The PCP noted that based on review of IRIS, on 9/24/18, the individual's heart rate was 80 to 130, and blood pressure was 131/84. The plan was for another PCP to evaluate the individual later that day. Three days later, on 10/5/18, the PCP documented that the individual's heart rate was 110, and she was being referred to cardiology for evaluation. It was not clear why there was a delay in the PCP evaluation for an individual who was reported to have a heart rate of 160.
- On 11/6/18, Individual #343 experienced a fall while at the gym. On 11/7/18, the PCP evaluated him due to facial trauma. The exam was pertinent for a left orbit that was swollen and contused, but without tenderness or deformity. The plan was to x-ray the left orbit and plan follow-up after the x-ray and on 11/13/18. On 11/9/18, the PCP documented that the x-ray was negative, but did not document a follow-up exam for this individual who had frontal-zygomatic "swelling and purpura." There was no documentation of follow-up on 11/13/18.
- On 11/28/18, the PCP documented that Individual #237 had a swollen left buttock presumably due to a fall. The PCP planned to evaluate the individual in the clinic. In a separate note, the PCP described the right lateral buttock as ecchymotic, firm, tender, enlarged and encroached over the anus. A bruise was also noted to the left buttock. The plan was to obtain a radiograph, and prescribe Norco and constipation medications. On 11/30/18, the PCP documented that x-rays were negative. However, there was no follow-up exam for this individual who had a very abnormal initial examination.
- On 10/27/18, the PCP documented that Individual #150 was evaluated on 10/26/18, due to an increase in left hand swelling. He had a history of chronic regional pain syndrome and staff reported that he appeared to have pain. The assessment was left hand swelling, acute on chronic, consider dependent edema in an individual with left upper extremity weakness. The plan was to elevate the left hand, continue Neurontin for pain, and add Vicodin. Habilitation Therapy staff were consulted to consider changing the splint.

  On 10/29/18, the PCP documented discussing the individual with the nurse, but "no formal sick call visit" today. On 10/30/18, the PCP documented an email discussion from a new Occupational Therapist (OT) who through chart review found that in 2017, rheumatology diagnosed the individual with complex regional pain syndrome (CRPS) in his left lower extremity (LLE).

The concern was that this had spread to the left upper extremity (LUE). The PCP did not reevaluate the individual, but added CRPS of LUE to the active problem list.

- On 10/2/18, while out on pass, Individual #367 was involved in a motor vehicle crash. Per nursing documentation, "staff stated a car was turning and ran right in to them." Nursing staff documented an assessment and noted no change from baseline. There was no documentation that the individual was evaluated in the ED.

  On 10/3/18, the social worker notified the individual's guardian by email that the individual was involved in a vehicle accident on the previous day. The guardian was informed that after returning to the Center, the individual "was assessed by the doctor for injuries," and none were observed. On 10/3/18, the PCP documented that there was a report of a minor traffic accident and a Center RN assessment was ordered.

  On 10/3/18, staff noted minimal bruising to the right eye. On 10/3/18, at around 4:16 p.m., the PCP documented that on 10/1/18, a chest x-ray was ordered and was completed on 10/3/18. A left rib fracture was noted in addition to a possible left lung pneumonia. The PCP prescribed Tylenol and antibiotics, but did not discuss the need for incentive spirometry.

  There was no plan for follow-up, and the PCP did not document a follow-up exam. On 10/6/18, nursing staff documented that the individual was coughing. On 10/10/18, nursing staff documented that the individual did not feel well. He was encouraged to drink fluids. The PCP did not see him. On 10/12/18, a white blood cell (WBC) count of 19.9 thousand was reported to the PCP. At that time, the PCP assessed him. The physical exam was pertinent for scattered lung crackles. He was given Rocephin, the Augmentin was continued, and Levaquin was started. Oxygen saturation was not documented. On 10/15/18, the PCP documented that the chest x-ray showed no pneumonia.

  On 10/16/18, the PCP documented "usual inspiration." No complaints. It was unclear if the lungs were auscultated.

  On 10/17/18, the PCP documented that the individual refused examination. Antibiotics would continue and the individual would be re-evaluated the next week. On 10/22/18, the pneumonia was documented as resolved.

  This individual was involved in a motor vehicle crash that was described as a fender bender. Even though this was reported as a minor accident, a physician should have examined the individual upon his return to the Center. Elderly persons (i.e., this individual was 64 years old) are more likely to sustain injuries even in minor crashes compared to other groups.

c. For seven of the nine individuals reviewed, the Monitoring Team reviewed 10 acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #331 (respiratory distress on 10/1/18, and orbital fracture on 11/21/18), Individual #241 (laceration on 12/11/18, and laceration on 1/11/19), Individual #270 (arrhythmia on 12/13/18), Individual #248 (metabolic encephalopathy, bacterial pneumonia, viral meningitis, and seizures on 9/4/18, and lithium toxicity on 9/28/18), Individual #237 (hand contusion on 10/13/18), Individual #150 [cerebral vascular accident (CVA) on 10/15/18], and Individual #367 (facial trauma due to a fall on 12/30/18).

c. through e., g., and h. The following provide examples of the findings for these acute events:

- It was positive to see that the following individuals displaying signs/symptoms of acute illness received timely acute medical care, and follow-up care: Individual #237 (hand contusion on 10/13/18), and Individual #150 (CVA on 10/15/18).
- On 10/1/18, Individual #331 was hospitalized with a diagnosis of acute hypoxemic respiratory failure, and chronic obstructive pulmonary disease with acute exacerbation. On 10/18/18, she returned to the Center. The hospital discharge summary noted "this lady should not be able to smoke. She is not capable of making informed decisions about her health and I feel that this is extremely detrimental to her overall well-being and will eventually result in her death." While the PCP acknowledged that the individual should not smoke, there was little documentation regarding the specific efforts and assistance that the PCP and IDT offered to her. On 10/25/18, the IDT held an ISPA meeting. Based on the documentation, the Monitoring Team could not determine who attended. However, the IDT focused on the allocation of cigarettes (i.e., one every hour with e-cigarettes in between). The IDT did not discuss assessing her for smoking cessation and attempting a multi-disciplinary approach to cessation.
- On 11/21/18, nursing staff documented that Individual #331 was referred to the ED for evaluation after being involved in an altercation that resulted in facial trauma. This transfer occurred during normal business hours, but there was no PCP assessment or note.

  The first PCP assessment in the records submitted was entered on 11/27/18. The PCP noted: "I could not find any hospital reports at that time and do not know if a head to toe assessment was completed. We know that she has a left orbital fracture, but I don't know if any other x-rays were obtained."

  In a separate note that included an addendum, the PCP documented the individual was seen in the ED on 11/21/18, and was diagnosed with an orbital fracture. The PCP's exam revealed facial bruising and bruising of the right ribs. The plan was to obtain additional x-rays. Based on the IPNs reviewed, the PCP did not conduct follow-up.

  The CT report in the IPN stated: "There is a left orbital floor fracture with considerable depression of the bone fragment and extension of the inferior rectus muscle through the defect suggesting possible entrapment." This individual had no medical follow-up assessments at the Center over a period of six days for serious injuries, including an orbital fracture, eye trauma, and significant contusions. The PCP's notes did not document the plan of care for the orbital fracture. The next PCP documentation discussed a pneumonia vaccination and provided no follow-up assessment or information related to the orbital fracture and possible muscle entrapment.
- On 12/11/18, Individual #241 was referred to the ED for evaluation and treatment of facial lacerations sustained during a fall. On 12/12/18, the PCP conducted a follow-up assessment. The PCP noted that wounds were repaired, but did not provide any further details about the wounds or a plan for wound care. The plan was to monitor the wounds for infection and films were to be reviewed. The PCP did not specify when follow-up or suture removal would occur. The cause of the fall was classified as unknown.

  On 12/17/18, the PCP documented that the wound had not healed adequately for suture removal. The plan was to allow it to heal. The PCP did not discuss or document review of the films. The PCP also did not comment further on assessment of the etiology of the fall. On 12/20/18, the PCP documented that the neurologist would see the individual the next day due to an increase in falls. There was no comment on the chin laceration.

- On 1/11/19, Individual #241 sustained a laceration to his left eyelid and eyebrow during an apparent seizure. He was transferred to the ED for evaluation and treatment. On 1/11/19, the PCP conducted follow-up. According to the PCP, the individual got up from bed and did not put on his helmet. He fell, but reportedly, he was not post ictal after the fall. The PCP documented swelling and bruising over the superior orbit, as well as a repaired laceration. The assessment was blunt head trauma/facial trauma and repaired laceration. The CT scan was negative for acute findings. The plan was to implement neurological checks, provide wound care, and suture removal in five to seven days. The PCP did not document wound re-assessment, healing, or suture removal.
- On 12/14/18, the PCP documented that after 8:00 p.m., on 12/13/18, Individual #270 was sent to the ED due to a pulse of 160 and an electrocardiogram (EKG) that read: "consider possible infarct." The individual reportedly also had an altered mental status, slurred speech, and drooling for several days. The individual was discharged from the ED with the recommendation to start Metoprolol XL 25 milligrams (mg). The PCP made an IPN entry related to the ED transfer and discharge. However, there was no post-hospital evaluation. On 12/14/18, the PCP noted that the ED chest x-ray was negative and follow-up spine films were planned. On 12/17/18, the PCP noted that the individual was walking around, was "still not understandable," and had appointments scheduled with neurology and cardiology. There was no physical assessment documented for this individual.
- Even after the Lead Monitor's multiple requests for corrected IPNs, the Center did not submit IPNs that were in chronological order for Individual #248. As a result, the Monitoring Team could not use the 921 pages of IPNs to assess the significant hospitalization that occurred on 9/4/18. This was a 10-day hospitalization for metabolic encephalopathy, bacterial pneumonia, viral meningitis, and seizures.
- Similarly, the Monitoring Team could not assess Individual #248's hospitalization for lithium toxicity on 9/28/18.
- On 12/30/18, Individual #367 was transferred to the ED for evaluation of facial trauma sustained during a fall. The ED records noted that the CT scan of the head showed fluid in the left mastoid air cells that could be mild mastoiditis or benign effusion. There was no documentation in the records that a medical provider conducted an assessment upon his return to the Center. The findings of the CT were not addressed in the IPNs.

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

Summary: Given that over the last two review periods and during this review, for the consultations reviewed, the PCPs generally reviewed consultations timely (Round 12 – 93%, Round 13 – 100%, and Round 14 – 88%), and ordered/implemented agreed-upon recommendations (Round 12 – 100%, Round 13 – 100%, and Round 14 – 100%), Indicators b, and d will move to the category requiring less oversight. It was good to see improvement with regard to PCPs writing IPNs explaining the consultations, and indicating agreement, or providing justifications for disagreements. The Center needs to focus on ensuring that PCPs refer consultation recommendations to IDTs, when appropriate, and that IDTs review the recommendations and document their decisions and plans in ISPAs.

Individuals:

#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367

a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	100% 17/17	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	1/1
b.	PCP completes review within five business days, or sooner if clinically indicated.	88% 15/17	2/2	1/2	1/2	2/2	2/2	2/2	2/2	2/2	1/1
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.	100% 17/17	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	1/1
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	100% 17/17	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	1/1
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	25% 1/4	N/A	0/1	1/2	N/A	0/1	N/A	N/A	N/A	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 17 consultations. The consultations reviewed included those for Individual #331 for hematology/oncology on 12/13/18, and neurology on 1/18/19; Individual #241 for neurology on 9/7/18, and neurology on 12/21/18; Individual #270 for cardiology on 10/16/18, and neurology on 1/18/19; Individual #185 for urology on 10/3/18, and neurology on 8/3/18; Individual #248 for neurology on 11/2/18, and neurology on 1/18/19; Individual #343 for GI on 11/6/18, and cardiology on 8/6/18; Individual #237 for pulmonary on 8/6/18, and neurology on 10/5/18; Individual #150 for cardiology on 9/28/18, and Ear, Nose, and Throat (ENT) on 10/24/18; and Individual #367 for podiatry on 9/28/18.

a. For all of the consultation reports reviewed, PCPs indicated agreement or disagreement with the recommendations, and provided rationales for disagreements. This was good to see.

b. Only two of these reviews did not occur timely (i.e., those for Individual #331 for neurology on 1/18/19, and Individual #241 for neurology on 12/21/18).

c. The PCP IPNs related to the consultations reviewed included all of the components State Office policy requires.

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

e. In the following instances, the PCP should have made a referral to the IDT, but did not:

- On 12/21/18, the neurologist recommended that Individual #241 undergo a 24-hour ambulatory EEG. The PCP should have referred this to the IDT to ensure proper supports were in place.
- On 10/16/18, Individual #270's cardiologist recommended a 14-day cardiac monitor. Given the individual's behavioral issues, the PCP should have referred this to the IDT.
- Similarly, on 11/2/18, the neurologist recommended that Individual #248 undergo a 24-hour ambulatory EEG, which the PCP should have referred to the IDT so that they could discuss proper supports.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
Summary: For most of the individuals' chronic or at-risk conditions reviewed, medical assessment, tests, and evaluations consistent with current standards of care were not completed, and/or the PCP had not identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
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.	11% 2/18	1/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #331 – falls/osteoporosis, and seizures; Individual #241 – constipation/bowel obstruction, and other: hypothyroidism; Individual #270 – weight, and cardiac disease; Individual #185 – GI problems, and cardiac disease; Individual #248 – other: chronic kidney disease, and cardiac disease; Individual #343 – respiratory compromise, and diabetes; Individual #237 – seizures, and other: hypothyroidism; Individual #150 – diabetes, and osteoporosis; and Individual #367 – respiratory compromise, and other: BPH).

a. For the following individuals' chronic or at-risk conditions, PCPs conducted medical assessment, tests, and evaluations consistent with current standards of care, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #331 – seizures, and Individual #248 –cardiac disease. The following provide examples of concerns noted:

- Per the AMA, Individual #331 was treated with vitamin D3 supplementation. In 2013, she had a normal BMD. She was treated with medroxyprogesterone, which is associated with loss of BMD. The PCP did not address the risk for osteoporosis in the plan for vitamin D deficiency.
- Per the AMA, Individual #241 had a diagnosis of constipation and had no bowel management issues in the past 12 months. The plan was to continue MiraLax. The AMA did not address non-pharmacologic treatment of constipation.
- Individual #241's AMA included one line related to hypothyroidism: "Monitor serum thyroid tests annually or as necessary." The PCP provided no discussion of the individual's current clinical or biochemical status.
- For Individual #270, the PCP had not completed an updated AMA, and no interval medical reviews were submitted. The IPNs included multiple entries from the Registered Dietician (RD) related to weight loss. On 10/3/18, the RDH noted the individual had a 12.5% weight loss in six months. At this time, no medical provider documented weight loss. Multiple PCPs made very brief notes regarding tachycardia, but none addressed the documented weight loss. PCPs also documented dysarthria, drooling, and coughing with meals with the only plan being to refer the individual to neurology and complete a dysphagia gram.

  On 12/11/18, the PCP documented that the individual was being evaluated for sick sinus syndrome, and was reported to have eyelid drooping and slurring of speech. Cardiology and endocrinology consults were pending, and she was due for a neurology consultation. The PCP ordered a CT of the abdomen and pelvis due to pelvic pain. On 12/12/18, the PCP documented that a chest x-ray was attempted due to weight loss. On 12/13/18, the individual was sent to the ED due to tachycardia. On

12/17/18, the PCP noted that the individual was walking around, was "still not understandable," and had appointments scheduled with neurology and cardiology. The PCP did not document a physical assessment. On 1/18/19, the PCP noted the CT of the abdomen and pelvis was abnormal. On 1/25/19, the neurology consult was documented, and on 2/5/19, the PCP documented that the dysphagia gram showed moderate to severe dysphagia with silent aspiration.

For this individual, there was no continuity of care. Multiple primary providers wrote brief notes related to various problems. As noted above, the PCP did not complete an AMA or interval medical reviews. The PCP, in coordination with the IDT, did not complete a comprehensive assessment of Individual #270's weight loss that outlined potentially contributing factors and a plan of care.

On 2/14/19 (i.e., the day on which the Center was notified of the Monitoring Team's selection of individuals for review), the Medical Director wrote a four-page IPN, which was not an AMA. It included discussion of several medical problems, including weight loss. In this note, the Medical Director documented a 27.4-pound weight loss since admission. It also included a discussion of dysphagia. The Medical Director indicated that the psychiatric medications prescribed to the individual were possibly contributing to dysphagia, weight loss, as well as the progressive dysarthria and slurring of speech. She was referred to neurology for further evaluation. Prior to this comprehensive note, there was little documentation from the PCPs regarding the issue of weight loss and there appeared to be a delay in addressing this issue.

- According to the AMA, Individual #185 did not have a diagnosis of constipation. However, his PCP had ordered docusate 100 mg twice a day (BID). Pro re nata (PRN, or "as needed") constipation medications were not utilized. Docusate is a stool softener intended to prevent dry hard stools or for relief of occasional constipation. If the individual required daily BID dosing of it, then the PCP should reassess its use and consider that the individual might have a constipation diagnosis. If the individual has a diagnosis of constipation, the medical plan should also address non-pharmacologic interventions.

  A separate gastrointestinal (GI) issue was the gastric polyp, which was discovered in 2011. This should be documented along with the pathology of the polyp and any need for follow-up.
- Per the AMA, Individual #185 had a history of a mild cardiomyopathy. The PCP provided no further discussion of the diagnosis, etiology of the cardiomyopathy, or the description of any symptoms. The individual received a daily statin for treatment of hyperlipidemia, but there was no plan to address this diagnosis.
- With regard to Individual #248's chronic kidney disease (CKD), according to the AMA, the individual's renal function was declining with a glomerular filtration rate (GFR) of 46. The AMA noted that: "Reasons given for this are either a long history of hypertension or possibly her lithium therapy." Per the PCP, the psychiatrist attempted to lower the lithium and the individual did not respond well to the lower dose. Although reportedly, a nephrologist followed her, the Center did not submit any renal consults. The PCP did not discuss important management issues, such as the need for a renal diet, management of anemia due to the CKD, dosing of medications for an individual with a reduced GFR, and avoidance of nephrotoxic agents.
- Although Individual #343's AMA listed nicotine dependence as an active problem, the PCP did not include a plan to address it.
- Individual #343's AMA listed an active diagnosis of diabetes, but the PCP did not specify the type of diabetes. The PCP documented that the individual's hyperglycemia was worse, and in January 2018, it crossed into the diabetes range with an A1c of 6.8. The PCP increased the metformin and started glyburide. The PCP ordered eye and podiatry appointments. The AMA listed the diet as a ground regular diet.

The plan outlined in the AMA was not comprehensive. The medical plan of care should document the needed lifestyle modifications, as well as the pharmacologic interventions. The plan should align with the current recommendations of the American Diabetes Association, as well as State Office/Center clinical guidelines.

- In the AMA, the PCP did not discuss the clinical or biochemical status of Individual #237 relative to the diagnosis of hypothyroidism. The plan was to continue Synthroid and obtain a thyroid stimulating hormone (TSH) level every six months.
- The PCP included the diagnosis of seizure disorder in the recommendation section of Individual #237's AMA. The PCP commented on dysarthria, but provided no summary of the status of the individual's seizure disorder or the management plan. The individual was followed closely by neurology.
- In the AMA, Individual #150's PCP documented a history of prediabetes. At the time of the assessment, the A1c was 5.5. Therefore, the PCP rated the individual at low risk for diabetes. However, the individual was at increased risk for diabetes due to treatment with a second-generation antipsychotic (SGA), a diagnosis of hyperlipidemia, and a sedentary lifestyle. Additionally, the A1c was 5.5, which is at the higher limits of normal. The low risk rating that the IDT assigned did not appear correct.
- Individual #150's PCP documented in the AMA that the individual had a diagnosis of osteoporosis, based on the 2015 DEXA scan, and was treated with alendronate and vitamin D. The PCP documented the vitamin D level, but not the calcium level. The plan was to continue supplements and monitor levels, continue Habilitation Therapy supports, and attempt a DEXA scan. The PCP did not discuss under this section why the DEXA scan had not been completed since 2015.
- Per the AMA, Individual #367 was a long-time smoker. The PCP noted: "It would be good to be able to substitute with possibly a nicotrol cigarette or e-cigarette to prevent damage to his lungs." The plan was to have a chest x-ray in order to monitor for possible complications of smoking.

  There was no documentation of a discussion with the IDT about assessing for and encouraging the implementation of a smoking cessation program. Clinician involvement increases the likelihood that the patient will stop smoking. Therefore, clinicians must be familiar with the various treatment frameworks. Additionally, most studies demonstrate that quit rates increase with increasing behavioral support and counselling.

  The AMA did not specify the number of packs per day or years of smoking. However, the individual was reported to smoke about a pack per day. National guidelines, such as the United States Preventive Services Task Force (USPSTF), do not recommend performing a chest x-ray to screen for lung cancer. The USPSTF recommends annual screening with a low dose CT of the chest for individuals who meet criteria for lung cancer screening.
- According to the AMA, Individual #367 had BPH, and this was an active diagnosis. He received daily medication to treat it, but the PCP had not included an assessment and plan in the recommendations.

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. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.	Individuals:

#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	25% 2/8	1/1	N/A	0/2	N/A	0/1	1/2	N/A	N/A	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, the action steps assigned to the PCPs were implemented for the following: Individual #331 – seizures, and Individual #343 - diabetes.											

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: Not rated (N/R).			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
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: a. and b. 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: Improvement was noted with regard to the quality of the QDRRs, particularly with regard to lab values. However, since the last review, regression occurred with regard to the timeliness of QDRRs. Improvements were needed with regard to prescribers, particularly psychiatrists, reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations, as well as following up on agreed-upon recommendations. At this time, these indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367

a.	QDRRs are completed quarterly by the pharmacist.	72% 13/18	1/2	2/2	2/2	2/2	1/2	1/2	1/2	1/2	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;	83% 15/18	2/2	1/2	2/2	2/2	0/2	2/2	2/2	2/2	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;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iv. New generation antipsychotic use; and	100% 14/14	2/2	2/2	2/2	N/A	N/A	2/2	2/2	2/2	2/2
	v. Anticholinergic burden.	94% 17/18	2/2	2/2	2/2	2/2	2/2	1/2	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.	83% 15/18	0/2	2/2	2/2	2/2	2/2	2/2	2/2	1/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	60% 9/15	0/2	1/2	1/2	N/A	0/1	2/2	2/2	1/2	2/2
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	69% 11/16	0/2	1/2	1/2	1/1	0/1	2/2	2/2	2/2	2/2
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	N/R									

Comments: a. Since the last review, regression occurred with regard to the timeliness of QDRRs.

b. Overall, with a few exceptions, the quality of the QDRRs met criteria. Problems noted included:

- In the October 2018 QDRR, the labs indicated the Individual #241 had hypoglycemia, but the Pharmacist did not make a formal recommendation. In the next QDRR, the Clinical Pharmacist did make a recommendation related to this issue.
- For Individual #248, the Clinical Pharmacist did not comment on her deteriorating renal function.
- For Individual #343, the Clinical Pharmacist did not adequately comment on the individual's lipid status (targets), despite the fact that the individual had diabetes and had Simvastatin listed as an active medication.

c. Improvements were needed with regard to prescribers, particularly psychiatrists, reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations.

d. When prescribers agreed to recommendations for the individuals reviewed, documentation was presented to show they implemented them, except for the following:

- In August 2018, Individual #331's PCP agreed to repeat the lab test for micro albumin/creatinine in Oct 2018, but did not repeat it. In addition, the October 2018 recommendation to repeat an electrocardiogram (EKG), last done on 4/29/16, was not done until 12/21/18. The PCP also agreed with the recommendation for a repeat EKG back in May 2018. The QDRR, dated 5/15/18, also commented on low protein, but it was unclear what was done.
- For Individual #241, the Clinical Pharmacist recommended review of hypoglycemia with a blood glucose level of 58 and 60. The PCP responded "N/A."
- For Individual #270, the QDRR, dated 11/20/18, noted that the MOSES was due every six months, and it was last done on 5/8/18. Also, the AIMS screening was due every three months, and it was last done on 8/14/18. The psychiatrist did not review the QDRR, and there was no response to these two recommendations.
- For Individual #248, the Clinical Pharmacist commented on the lithium level that on 9/27/18, was 1.62, and requested a review of the dose. On 9/28/18, the individual was admitted to the hospital with lithium toxicity. The Clinical Pharmacist also noted the individual's fasting blood glucose level was elevated and thyroid function tests (TFTs) were not done appropriately.

e. As noted with regard to Outcome #1, 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 and the Monitoring Team is able to identify the full scope of new medications requiring interventions, this indicator is not being rated.

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	331	241	270	185	248	343	237	150	367
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	0/1	0/1	N/A	0/1	0/1	N/A	0/1	0/1	N/A
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.	Monthly 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 dental goal(s)/objective(s); and	0% 0/6	0/1	0/1		0/1	0/1		0/1	0/1	
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/1	0/1		0/1	0/1		0/1	0/1	

Comments: a. and b. Individual #367 and Individual #343 were edentulous, and Individual #270's IDT rated her as at low risk for dental health. The Monitoring Team reviewed the other six individuals who had medium or high dental risk ratings and found none had a clinically relevant, achievable, and measurable goal/objective related to dental.

The Monitoring Team will be working with State Office on this issue so that State Office can provide more guidance to the Centers. A good way to think about it, though, is: "what would the dentist tell the individual he/she or staff should work on between now and the next visit?" For different individuals, the causes of their dental problems are different, and so the solution or goal should be tailored to the problem. For example, should an individual reduce the amounts of sugary snacks he/she consumes, should an individual brush his/her teeth twice a day for two minutes instead of once a day, should a goal revolve around the individual tolerating tooth brushing for 30 seconds leading up to an eventual two minutes? These are the type of questions IDTs should be asking themselves when deciding upon a goal.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, integrated progress reports on existing goals with data and analysis of the data generally 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.

The Monitoring Team conducted full reviews of the processes related to the provision of dental supports and services for seven individuals, including Individual #367, who was edentulous, but was part of the core group. The Monitoring Team conducted limited reviews for Individual #343, who was edentulous and part of the outcome group, and for Individual #270, who had low dental risk.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	Not Rated (N/R)									

Comments: a. 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 and implemented a process to ensure inter-rater reliability with the Centers.

Outcome 5 – Individuals receive necessary dental treatment.

Summary: Overall, individuals reviewed received necessary dental treatment, but the Center should focus on ensuring individuals who have a medium or high caries risk rating receive at least two topical fluoride applications per year. Given that over two previous review periods and during this review, individuals reviewed had extractions only when restorative options were exhausted (i.e. Round 10 – 100%, Round 11 – N/A, Round 12 – N/A, Round 13 – 100%, and Round 14 – 100%), Indicator f will move to the category requiring less oversight.

#	Indicator	Overall Score	Individuals: 331	241	270	185	248	343	237	150	367
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	0/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	N/A
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	86% 6/7	0/1	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.	50% 1/2	N/A	1/1	N/A	N/A	N/A		N/A	0/1	
e.	If the individual has need for restorative work, it is completed in a timely manner.	N/A									
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 1/1	N/A	N/A	N/A	N/A	1/1		N/A	N/A	

Comments: In its request for documents, the Monitoring Team asks Center staff to submit: "For **past year**, dental progress notes and IPNs related to dental care." The Monitoring Team uses these documents to assess a number of the dental indicators, and particularly, these indicators related to the provision of dental care. It did not appear that Center staff complied with the request for dental IPNs for a full year for a number of the individuals reviewed. Findings might have been negatively impacted as a result.

a. and b. Individual #343 and Individual #364 were edentulous. Most individuals who had teeth received prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified. Similarly, most individuals and/or their staff also received tooth brushing instruction from Dental Department staff twice each year. The exception for both of these indicators was for Individual #331, for whom the Center did not provide evidence either had occurred.

d. One of the two individuals who were identified with medium or high caries risk received at least two topical fluoride applications per year. Individual #241 did receive the needed fluoride applications, but Individual #150 did not.

f. Only Individual #248 required an extraction, and the documentation indicated it was completed only when restorative options were exhausted. Informed consent was also obtained as required.

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: For two of the four dental emergencies reviewed, documentation from a dentist was not available to show that an assessment occurred and necessary treatment was provided. Pain assessment and management, and documentation of it are areas on which the Center should focus.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	50% 2/4	0/2	N/A	1/1	N/A	N/A	1/1	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	33% 1/3	0/2		N/A			1/1			
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	0% 0/3	0/2		0/1			N/A			

Comments: a through c. Three individuals experienced one or more dental emergencies.

- Individual #331 experienced two dental emergencies, on 11/20/18 and 1/16/19, respectively. In both instances, a peer struck her and she then complained of tooth pain. For the November incident, no dentist or PCP saw the individual. For the January incident, the dentist did not write a note.
- On 10/19/18, Individual #270's PCP referred her to the ED for evaluation of facial trauma due to self-injurious behavior. ED personnel completed an exam and noted a tender nodule in her mouth upon palpation. They took x-rays, which proved negative, and recommended an ice pack for the swelling, which the individual refused. The documentation did not reflect any discussion of pain management for the tenderness upon palpation.
- A dentist saw Individual #343 within 24 hours his dental emergency. He received prompt treatment as required, and did not require pain management.

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	0% 0/1	N/A	N/A	N/R	N/A	N/A	N/R	0/1	N/A	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/1							0/1		

#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 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% 0/1							0/1		

Comments: a. through d. The Monitoring Team conducted limited reviews for the following two individuals: Individual #343, who was edentulous, and for Individual #270, who had low dental risk.

The IDT for Individual #237 did not include suction tooth brushing strategies/plans in his ISP/IHCP, but should have. On 4/30/18, the dentist saw Individual #237 and documented poor oral hygiene, with thick plaque covering his teeth. The dentist recommended suction tooth brushing, but the Center provided no evidence the IDT had addressed this in his ISP/IHCP, or did not provide any other documentation (e.g., ISP monthly reviews) to show that it had ever been implemented.

Going forward, IDTs should ensure that action plans are developed to implement recommendations for suction tooth brushing. IHCPs will need define the frequency of monitoring and ensure it is implemented according to the schedule. In addition, QIDP ISP monthly reviews will need to include specific suction tooth brushing data to summarize the frequency of sessions completed in comparison with the number anticipated (e.g., 60 out of 62 sessions). Additionally, a second data subset will be needed on the number of such events during which the individual completed the expected duration of suction tooth brushing (e.g., of the 60 completed sessions, in 12 sessions the individual completed two minutes of suction tooth brushing).

Outcome 9 – Individuals who need them have dentures.

Summary: These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 331	241	270	185	248	343	237	150	367
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	83% 5/6	N/A	N/A	1/1	1/1	1/1	N/A	1/1	0/1	1/1
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 usually provided clinical justification for not recommending dentures. The exception was for Individual #150. Per his annual dental summary, dated 2/27/18, he had twelve teeth, but neither the summary nor his annual examination, dated 1/10/19, assessed for the appropriateness of 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: Nursing guidelines and standards of care include the expectation that nurses will document the time that an acute event occurs or an individual experiences the onset of symptoms. For the couple acute events reviewed, nurses did not document these times, and as a result, it was unclear whether or not they conducted assessments timely or notified PCPs timely. The quality varied of nurses' completion of assessments in accordance with relevant nursing guidelines or standards. Improvements are needed with regard to the quality of acute care plans, as well as nurses' implementation or documentation of completion of the interventions. These indicators will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0% 0/2	0/1	0/1							
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% 0/2	0/1	0/1							
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	N/A	N/A	N/A							
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0% 0/2	0/1	0/1							
e.	The individual has an acute care plan that meets his/her needs.	0% 0/2	0/1	0/1							
f.	The individual's acute care plan is implemented.	0% 0/2	0/1	0/1							

Comments: Given that State Office recently provided training and the Centers are at the beginning stages of developing and implementing acute care plans that reflect the training, the Monitoring Team reviewed a small number of acute care plans. Specifically, the Monitoring Team reviewed two acute illnesses and/or acute occurrences for two individuals, including those for Individual #331 – on 11/21/18, fracture of the lateral wall orbit – left eye, subconjunctival hemorrhage/afferent pupillary defect acute; and Individual #241 – on 1/11/19, a fall/seizure with blunt trauma to eye area, including a laceration with five sutures.

a. For the acute illnesses/occurrences reviewed, nursing staff documented some initial nursing assessments (physical assessments), but did not include the time of the incidents in the IPNs, so the timeliness of the nursing assessments could not be determined. For both

individuals, more information is discussed below about the quality of the initial assessments.

b. For both of the acute illnesses/occurrence reviewed, licensed nursing staff informed the practitioner/physician of signs/symptoms in accordance with the SSLC nursing protocol entitled: "When contacting the PCP," but because nurses did not document the time of the incidents, the timeliness of notification could not be determined.

e. Common problems with the acute care plans reviewed included a lack of: instructions regarding follow-up nursing assessments that were consistent with the individuals' needs; alignment with nursing protocols; specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; clinical indicators nursing would measure; and the frequency with which monitoring should occur.

The following provide some examples of findings related to this outcome:

- On 11/21/18, at 3:17 p.m., a nurse documented in an IPN a call from the direct support professional stating that Individual #331 needed a nurse, because "she was beat up and was bleeding in the lobby." Based on the initial signs and symptoms as stated in the nursing IPN: "dried blood coming from her left nostril and abrasion around her left eye and blood in the sclera of her left eye… Her left pupil was fixed and dilated," the nurse conducted some of the necessary assessments. However, based on the IView assessment, dated 11/21/18 at 1:50 p.m., the individual had an increased pulse (103), which the nurse did not reassess; the nurse did not document the location of pain (e.g., which eye and where on her head); although the nurse noted visual changes with double vision, it was not clear how the nurse assessed this; and the nurse documented that the individual's left pupil was not reactive, but did not indicate if that was her norm or an abnormal finding. The nurse contacted the PCP, who documented: "a presumed altercation when she received severe facial trauma resulting in enlarged unreactive pupil and decreased vision." The individual was sent to the ED.

  Based on review of the acute care plan, it did not include action steps related to antibiotic therapy (i.e., for her prescribed topical eye ointment that the physician ordered in the ED), or for the assessment for pain/pain medication. Given that the individual had a potential head injury, nursing assessments were not in alignment with applicable nursing guidelines. Of note, this individual's IPNs were out-of-date order, making it difficult to confirm what assessments nurses performed. Often, the documented assessments indicated that the individual was "oriented x4," but did not describe to what she was oriented.
- On 1/11/19, 12:19 a.m., a nursing IPN indicated: "Staff asked for assessment after individual had a fall and noted bleeding from his head. Staff states that individual appeared to be having a seizure. Staff stated that they heard resident when he fell. Noticed resident on floor in hallway with helmet device in hand. Lacerations left eyelid and eyebrow." The nurse notified the PCP. Based on the IPNs and IView documentation, nursing staff appropriately completed ongoing neurological checks prior to the individual's transfer to the ED.

  With regard to the acute care plan, some of the problems included: it was not individualized; it did not include specific action steps regarding what nurses were to clean daily (e.g., the suture line or the other skin integrity issues/areas); it only included pain assessments on two of the three shifts; the assessment was based on reporting from direct support professional staff; and, it did not include a plan for assessing the wound for subtle signs and symptoms of infection (e.g., temperature, skin assessment, etc.).

Of note, this individual's IPNs were out-of-date order, making it difficult to confirm what assessments nurses performed. However, based on the documentation, it did not appear that nurses conducted necessary assessments. For example, it did not appear that nurses conducted twice daily assessments of the suture line as required in the acute care plan.

Of note, as part of the onsite review week, the Monitoring Team appreciated the Interim Chief Nurse Executive and the Program Compliance Nurse's willingness to conduct an objective review of one acute care plan for one of the individuals reviewed, and discuss their findings openly with the members of the Monitoring Team and State Office staff. This effort showed Center staff's ability to identify strengths, as well as weaknesses in the acute care plans and the related nursing assessments, as well as to identify potential solutions to the significant improvements that are needed. The Monitoring Team is hopeful that at the time of the next review improvements will have occurred.

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 clinically relevant outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 331	241	270	185	248	343	237	150	367
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	22% 4/18	0/2	1/2	0/2	0/2	0/2	0/2	1/2	1/2	1/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT 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: For nine individuals, the Monitoring Team reviewed a total of 18 specific risk areas, and the related IHCPs, as available (i.e., Individual #331 – GI problems, and respiratory compromise; Individual #241 – seizures, and falls; Individual #270 – choking, and aspiration; Individual #185 – dental, and skin integrity; Individual #248 – GI problems, and respiratory compromise; Individual #343 – aspiration, and GI problems; Individual #237 – skin integrity, and constipation/bowel obstruction; Individual #150 – circulatory, and GI problems; and Individual #367 – weight, and falls).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #241 – seizures, Individual #237 – constipation/bowel obstruction,

Individual #150 – circulatory, and Individual #367 – weight.

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports with data and analysis of the data often 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 6 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.

Summary: Nurses often did not include interventions in IHCPs to address individuals' at-risk conditions, and even for those included in the IHCPs, documentation often was not present to show nurses implemented them. In addition, IDTs often did not collect and analyze information, and develop and implement plans to address the underlying etiology(ies) of individuals' risks. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 331	241	270	185	248	343	237	150	367
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/9	0/1	0/2	0/2	0/1	0/1	N/A	N/A	N/A	0/2
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).	33% 6/18	0/2	2/2	0/2	2/2	0/2	1/2	0/2	0/2	1/2

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, or that nursing interventions were implemented thoroughly. The IHCPs for which documentation was found to show implementation of the nursing components were for: Individual #241 – seizures, and falls; Individual #185 – dental, and skin integrity; Individual #343 – aspiration; and Individual #367 - weight.

b. As illustrated below, a pervasive problem at the Center was the lack of urgency with which IDTs addressed individuals' changes of status through the completion of comprehensive reviews and analyses to identify and address underlying causes or etiologies of

conditions that placed individuals at risk. The following provide some examples of IDTs' responses to the need to address individuals' risks:

- On 10/15/18, Individual #331's IDT held a COS ISPA meeting, and changed her risk rating with regard to respiratory compromise from low to high, based on her new diagnosis of COPD. The IRRF noted the date of the hospitalization, but the IDT did not include/discuss any additional information regarding her aftercare for her new diagnosis of COPD and hospitalization for pneumonia. Her current supports did not include any mention of the impact that her smoking had on her COPD. Moreover, available nursing assessments did not assist the IDT in the analysis of the related data, or include recommendations to assist the IDT in planning. For example, the nursing assessments did not review the extent of her smoking, her use of the Nicotine patch, and/or results of respiratory assessments. At times, the individual refused medications/respiratory treatments, but the nursing assessments did not provide specific data on the frequency of her unaccepted doses. The nursing assessments did not offer recommendations to address the chronic problem of COPD coupled with tobacco-use disorder (smoking). Given the complexities of overcoming a tobacco-use disorder, the IDT needed to use an integrated approach to developing supports that would assist this individual to develop healthier habits, but they did not.
- Individual #241 had one seizure in November 2018, he had 2 in December 2019, one in January 2019, and one in February 2019. Between December 2018 and January 2019, he fell five times. He also had ED visits due to falls with lacerations, including on 12/11/18, for a laceration requiring chin repair, and on 1/11/19, for a laceration requiring repair of his left eyebrow. On 12/12/18, and 1/11/19, his IDT held ISPA meetings for these critical incidents/serious injuries. On 12/12/18, the discussion related to the use of his helmet with prompting, and the Registered Nurse Case Manager (RNCM) discussed his referral to neurology in January due to the increase in seizures. On 1/11/19, the IDT documented: "Social worker will contact family regarding helmet use at home." The meaning of this was not clear. During neither of these meetings did the IDT review an acute care plan, his IRRF, or the related IHCPs to determine whether or not the individual needed modified or additional supports.
- On 1/24/19, Individual #270 choked on a chopped hamburger patty, and required staff to administer the abdominal thrust. On 1/28/19, her IDT held a COS ISPA meeting. Although the IDT discussed the need for a ground textured diet instead of chopped, the use of pudding/applesauce during medication administration, the need for a swallowing study, and the need for the OT to conduct an eating assessment, the IDT did not modify the IHCPs to include preventative interventions. For example, the only two intervention for nursing staff were: 1) "Nursing -Medication admin per PNMP, doc. in notes;" and 2) instruction sheet for choking for DSP by 2/11/19.

  On 2/3/19, staff reported the individual experienced an aspiration trigger of excess coughing, and on 2/5/19, she reportedly was feeding herself too fast. On 2/15/19, the IDT held an ISPA meeting, and made recommendations, including: 1) head-of-bed-elevation (HOBE) with three-inch blocks for reflux precautions; and 2) increase choking risk from low to high. However, the recommendations, such as the HOBE, did not make it into the COS IRRF, or the COS IHCP. As a result, these recommendations that the IDT designed to reduce her risk were not followed through for tracking on the IHCP. Moreover, no physician or pharmacist was present to assist the IDT in reviewing medications, and based on the ISPA documentation, the IDT did not consider their potential impact on her swallowing difficulties. She was prescribed five medications with anticholinergic effect, which put her at increased risk of side effects, such as a dry mouth, which can interfere with swallowing.
- On 9/12/18, Individual #367's IDT held his ISP meeting. Between 9/15/18, and 1/26/19, he fell 11 times with three or more falls occurring within a 30-day period. Based on the documentation submitted, the IDT did not hold an ISPA meeting to discuss

	his falls. • On 8/6/18, Individual #367 weighed 122.8 pounds; on 1/14/19, he weighed 116.2 pounds; on 1/18/19, he weighed 113.4 pounds, and on 1/25/19, he weighed 110.4 pounds. This represented a 10% weight loss is approximately six months, and a 5% loss in one month. Based on the documentation submitted, the IDT did not hold an ISPA meeting to discuss his weight. Moreover, his ANA and quarterly nursing assessments for weight consisted of documented weights and his BMI. The RNCM had not completed an analysis to provide the IDT with information about whether or not he was maintaining his caloric intake, or whether his propensities to smoke rather than eat had increased or decreased. The RNCM offered no recommendations.

Outcome 7 – Individuals receive medications prescribed in a safe manner.											
Summary: For at least the two 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 following individuals' PNMPs while administering medications. However, given the importance of these indicators to individuals' health and safety, these indicators will continue in active oversight 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. Improvements are needed with regard to the inclusion in IHCPs and the implementation of respiratory assessments for individuals at high risk for respiratory issues and/or aspiration pneumonia.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R			N/R						
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 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.	50% 2/4	0/1	N/A	N/A	N/A	1/1	N/A	0/1	1/1	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 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.	43% 3/7	0/2	N/A	N/A	N/A	2/2	N/A	0/2	1/1	N/A
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% 8/8	1/1	1/1		1/1	1/1	1/1	1/1	1/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	88% 7/8	1/1	1/1		1/1	0/1	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 #331, Individual #241, Individual #185, Individual #248, Individual #343, Individual #237, Individual #150, and Individual #367. The Monitoring Team member made three attempts to observe a medication pass for Individual #270, but each time, the individual refused to come to the nurse's station.

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. With regard to the completion of respiratory assessments during medication administration, the following concerns were noted:

- On 10/13/18, Individual #331 was hospitalized for COPD with acute exacerbation, hypoxia, and pneumonia. Her IHCP, dated 1/4/19, did not define nursing interventions for lung sound/respiratory assessments. It stated: "XXX N-Q assess lung sounds???"
- On 4/2/18, Individual #237 was hospitalized for acute hypoxemic respiratory failure and pneumonia. His IHCP included: 1) quarterly assessments, including lung sounds; and 2) lung sound assessments before and after nebulizer treatments. Based on the Medication Administration Record (MAR) provided and a look back at previous orders, the individual did not have Care Management orders for any inhalation therapy. He does use intra-nasal inhalers. Based on review of a sample of records from 12/1/18 to 12/15/18, nurses had not completed and/or documented lung sound/respiratory assessments in IView, nor was there documentation of attempts or refusals. This was the case as well for records from 10/1/18 to 10/12/18, except for a notation on 10/9/18, of a lung assessment prior to, but not after the medication intratropium nasal - two sprays.

f. During the observations, the medication nurses followed applicable instructions on the individuals' PNMPs, including checking the position of the individuals prior to medication administration.

g. For the individuals observed, nursing staff generally followed infection control practices, which was good to see. The exception was that when the nurse was administering medications to Individual #248, the tip of the Mickey button's connecting tube, which was not capped, touched the towel on the individual's lap. In addition, the nurse dropped the stethoscope on the floor and proceeded to pick it up and move toward the individual. A member of Monitoring Team asked about this, at which point, the nurse stopped, sanitized the stethoscope, and proceeded with her assessment.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: It was good to see some improvement with regard to individuals being referred to the PNMT, when needed. Overall, though, IDTs and/or the PNMT did not have a way to measure clinically relevant outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
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	0%	0/1	0/2	0/1	0/2	0/1	0/1	0/1	0/1	0/1

		relevant and achievable to measure the efficacy of interventions;	0/11									
	ii.	Individual has a measurable goal/objective, including timeframes for completion;	0% 0/11	0/1	0/2	0/1	0/2	0/1	0/1	0/1	0/1	0/1
	iii.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/11	0/1	0/2	0/1	0/2	0/1	0/1	0/1	0/1	0/1
	iv.	Individual has made progress on his/her goal/objective; and	0% 0/11	0/1	0/2	0/1	0/2	0/1	0/1	0/1	0/1	0/1
	v.	When there is a lack of progress, the IDT takes necessary action.	0% 0/11	0/1	0/2	0/1	0/2	0/1	0/1	0/1	0/1	0/1
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;	83% 5/6	1/1	N/A	1/1	N/A	1/1	1/1	1/1	N/A	0/1
	ii.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7	0/1		0/1		0/1	0/1	0/1	0/1	0/1
	iii.	Individual has a measurable goal/objective, including timeframes for completion;	29% 2/7	0/1		1/1		0/1	0/1	0/1	0/1	1/1
	iv.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/7	0/1		0/1		0/1	0/1	0/1	0/1	0/1
	v.	Individual has made progress on his/her goal/objective; and	0% 0/7	0/1		0/1		0/1	0/1	0/1	0/1	0/1
	vi.	When there is a lack of progress, the IDT takes necessary action.	0% 0/7	0/1		0/1		0/1	0/1	0/1	0/1	0/1

Comments: The Monitoring Team reviewed 11 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: Individual #331 – choking; Individual #241 – falls, and GI problems; Individual #270 - choking; Individual #185 – choking, and GI problems; Individual #248 – falls; Individual #343 – choking; Individual #237 - falls; Individual #150 - falls; and Individual #367 - choking.

a.i. and a.ii. The IHCPs reviewed did not include clinically relevant, achievable, and/or measurable goals/objectives.

b.i. The Monitoring Team reviewed seven areas of need for seven individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goals/objectives were included. These areas of need included those for: Individual #331 – falls, Individual #270 – weight, Individual #248 - aspiration,

Individual #343 – falls, Individual #237 – aspiration, Individual #150 – aspiration, and Individual #367 - weight.

On 6/4/18, Individual #367 weighed 122.8 pounds, and on 6/7/18, the records showed he weighed 148.4 pounds. Although this possibly was an error, it did not appear staff reweighed him. However, on 7/6/18, his weight dropped to 115.2 pounds. These weight variations continued. On 8/6/18, he weighed 122.8 pounds, but then, he experienced weight decline to 116.40 on 12/10/18, with a low of 110.4 pounds on 1/25/19. His weight appeared to increase again during the week of 2/7/19, to 117.4 pounds. Based on the meeting minutes submitted, the Monitoring Team found no evidence of PNMT review, nor did the Center staff submit a formal review or assessment, and the IPNs did not reflect any PNMT action.

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

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #270 – weight, and Individual #367 - weight.

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of clinically relevant and measurable goals/objectives, integrated progress reports with data and analysis of the data generally were 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: None of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Many of the PNM action steps that were included were not measurable, making it difficult to collect specific data. Substantially more work is needed to document that individuals receive the PNM supports they require. In addition, in numerous instances, IDTs did not take immediate action, when individuals' PNM risk increased or they experienced changes of status. At this time, these indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 331	241	270	185	248	343	237	150	367
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.	18% 2/11	0/1	1/1	1/2	N/A	0/2	0/1	0/2	0/2	0/1

c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	0/1	0/1	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, overall, data were not available to show implementation of those action steps that IDTs had included in the IHCPs reviewed.

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

- Appropriately, Individual #241's IDT met to develop a plan in response to a serious injury he sustained on 1/11/19, when he was not wearing his helmet. The IDT developed action steps to request a referral to the neurologist, train direct support professional staff, and implement a device to remind the individual to wear his helmet.
- Individual #331 experienced numerous falls (e.g., on 1/27/18, 2/11/18 x2, 2/12/18, 3/2/18 x2, 3/4/18, and 3/14/18, 6/18/18, 6/25/18, 7/11/18, 7/21/18, and 7/25/18). Her IDT did not develop an IHCP to address her fall risk. Although in March 2018, her IDT and the PNMT identified behavioral issues and peer-to-peer aggression as contributing factors to her falls, they did not employ an interdisciplinary process to identify and address the etiology(ies) of her falls to prevent, to the extent possible, behavior-related falls.
- It was not until January 2019 that Individual #270's IDT made a referral to the PNMT related to weight loss. An ISPA, dated 8/16/18, indicated that she was refusing medications and foods, and she stated that she was going to starve herself. The IDT did not develop and/or implement clear strategies to address this concern. On 9/5/18, the IDT held an ISPA meeting to discuss her diet and meal options. At this time, she reportedly was within her desired weight range. On 10/8/18, the IDT held an ISPA meeting to discuss the individual's challenging behaviors, medication refusals and some meal refusals. The IDT discussed a referral to psychiatry, arrangements to go out to eat, reminders to take her medications, and a private bedroom due to screaming. On 1/25/19, the IDT reviewed a choking episode. No evidence was found of previous investigation of signs of dysphagia related to refusals prior to this choking event.
- Between October 2018 and January 2019, Individual #248 fell at least 11 times. No evidence was found to show that her IDT reviewed and revised her IHCP, which was not effective at preventing falls.
- Between October 2018 and January 2019, Individual #343 fell numerous times (i.e., 10/16/18, 10/25/18, 11/6/18, 11/24/18 x2, 11/26/18, 12/22/18, 12/30/18, 1/13/19, 1/15/19, and 1/19/19). No evidence was found to show the IDT reviewed the falls, and/or modified, as needed, the supports included in the IHCP. In January 2019, the PNMT conducted a review, and determined that the IDT had not implemented the PNMT's previous recommendations.
- For Individual #237, no evidence was found to show that the IDT met to discuss falls that occurred on 10/30/18, 11/18/18, 11/21/18, 11/27/18, and 11/28/18.
- In October 2018, Individual #150 experienced a CVA, but based on the documentation submitted, his IDT did not conduct a thorough review to determine its potential impact of his fall risk and aspiration risk, and/or to develop/modify related plans. Moreover, in September 2018, he fell at least three times, but his IDT did not hold and/or document an ISPA meeting to address these falls.
- On 6/4/18, Individual #367 weighed 122.8 pounds, and on 6/7/18, the records showed he weighed 148.4 pounds. Although this possibly was an error, it did not appear staff reweighed him. However, on 7/6/18, his weight dropped to 115.2 pounds. These weight variations continued. On 8/6/18, he weighed 122.8 pounds, but then, he experienced weight decline to 116.40 on 12/10/18, with a low of 110.4 pounds on 1/25/19. His weight appeared to increase again during the week of 2/7/19, to 117.4

pounds. Based on the documentation submitted, his IDT did not hold ISPA meetings to address his weight loss/variations.

c. Center staff did not submit evidence to show that the PNMT met with Individual #237's IDT to discuss its findings and recommendations.

Although it appeared that at the time of the Monitoring Team's review, the PNMT continued to follow Individual #150, in the Tier I document request, staff did not include him on the list of the PNMT's current caseload.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: Based on observations, staff completed transfers correctly. Significant efforts are needed to improve positioning. Continued work also is needed to reduce errors that occurred with Dining Plan implementation. Also, of note, due to issues with direct support staffing, a number of staff from different departments (e.g., therapy, behavioral health services, etc.) assisted with mealtimes, and did a good job. It is not sustainable, though, to have these staff involved in mealtimes in the long-term. Some of the direct support professional staff had been pulled from other homes, and sometimes needed reminders that they should always review the PNMPs/Dining Plans of individuals to whom they are assigned. These indicators will continue in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	70% 28/40	
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.	67% 4/6	

Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during none out of seven observations (0%). Staff followed individuals' dining plans during 26 out of 31 mealtime observations (84%). Staff completed transfers correctly during two out of two observations (100%).

The following provides more specifics about the problems noted:

- With regard to Dining Plan implementation, the errors often related to staff not using correct techniques (e.g., cues for slowing, presentation of food and drink, prompting, etc.), and in one instance each, adaptive equipment was incorrect, and the individual was not positioned correctly. Texture/consistency was generally correct.

  On a positive note, the dining rooms were all much more organized, calmer, and quieter. Habilitation Therapy staff who

accompanied the Monitoring Team member on mealtime observations noted the same issues as the Monitoring Team member, and articulated plans to address the issues.

Of note, due to issues with direct support staffing, a number of staff from different departments (e.g., therapy, behavioral health services, etc.) assisted with mealtimes, and did a good job. Although it is not sustainable to have these staff involved in mealtimes in the long-term, there are many benefits to their immersion in the home and day program environments.

That being said, some of the direct support professional staff had been pulled from other homes, and sometimes needed reminders that they should always review the PNMPs/Dining Plans of individuals to whom they are assigned.

- With regard to positioning, problems varied, but the most common problems were that staff had not used equipment correctly, and individuals were not positioned correctly. With one exception, necessary adaptive equipment/supports were present.

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	331	241	270	185	248	343	237	150	367
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.	0% 0/1					0/1				
Comments: a. For Individual #248, the measurable goals were related only to aspiration triggers. According to the PNMT meeting minutes, she did not meet this goal, because she experienced triggers. However, the IDT did not make revisions to the plans/goal. The plan did not include goals to measure her success with "pleasure feedings" of ice chips per the Frazier Water Protocol.											

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: Individuals reviewed did not have clinically relevant, and measurable goals/objectives to address their needs for formal OT/PT services. In addition, QIDP interim reviews often did not include data related to existing goals/objectives. As a result, IDTs did not have information in an integrated format related to individuals' progress or lack thereof. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367

a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/7	N/A	0/1	N/A	0/2	0/1	0/1	0/1	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/7		0/1		0/2	0/1	0/1	0/1	0/1	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/7		0/1		0/2	0/1	0/1	0/1	0/1	
d.	Individual has made progress on his/her OT/PT goal.	0% 0/7		0/1		0/2	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% 0/7		0/1		0/2	0/1	0/1	0/1	0/1	

Comments: a. and b. Based on documentation reviewed, Individual #331 and Individual #367 did not have an indicated need for formal OT/PT intervention. Also, at the time of the ISP meeting, the Center had completed a screening for Individual #270, which did not indicate a need for OT/PT services. None of the six remaining individuals had clinically relevant or measurable goals to address their OT/PT needs. The following provide some examples:

- Individual #185 had two goals: 1) to identify the stop safety sign; and 2) using a dining platform, to accept items which he is not using into his personal space for 15 minutes before removing them. The IDT did not include the first goal in his ISP. The goal for using the dining platform was reflected in the ISP and should have been implemented in August 2018, but the available evidence indicated the IDT had only implemented it shortly before the monitoring site visit. As of the December 2018 QIDP monthly progress report, dated 1/28/19, the IDT had not assessed the goal's implementation or progress. Further, the goals did not accurately reflect the desired outcome related to encouraging him not to push his plate and cup away during his meal, but rather the goals related to his use of the platform to accept items that he was not using into his personal space for 15 minutes. There were actions to assess him for the dining platform and complete a trial using the dining platform. None of the goals were measurable as written, because they did not include frequencies.
- Individual #150 had a goal to reduce edema by 50% in four weeks, but it was not included in the ISP or ISPA. The goal was not clinically relevant; it did not define a baseline by which the reduction could be measured.
- Individual #241's assessment identified that he had experienced a "decline in function overall," yet it did not identify specific needs or supports to address this issue.
- For Individual #248, a consult related to a change in status, dated 9/17/18, indicated she required interventions related to increasing muscle performance, activity tolerance and dynamic balance, as well as gait training. The IDT did not develop measurable goals/objectives for these recommendations. A comprehensive evaluation, dated 10/31/18, also was completed in response to a change in status. It recommended PT intervention, but identified no measurable goals.
- Individual #343 had been recommended for direct PT in 2017, which appeared to have been related to his left shoulder as well as degenerative joint disease, back pain, and falls. He was referred for pain management, and then from 11/13/17 through 11/29/17, the PT saw him. He was then discharged due to pain. The assessments since provided no further recommendations to address his pain in order to further pursue the direct PT as indicated.

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult

to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For the two individuals who had goals, the Monitoring Team found no evidence to show the PT worked with the QIDP to analyze the data and include it in the monthly integrated reviews for the IDTs' consideration.

The Monitoring Team conducted full reviews for all nine individuals. Individual #331 and Individual #367 did not need goals, but were included in the core sample. Per the screening completed, Individual #270 did not have a need for OT/PT services at the time of her ISP meeting, but experienced a choking event on 1/25/19 that resulted in a need for further assessment and consideration for OT/PT intervention. A full review was completed for her as well.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.

Summary: For the individuals reviewed, evidence was not found in ISP integrated reviews to show that OT/PT supports were implemented. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 331	241	270	185	248	343	237	150	367
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/4	N/A	N/A	N/A	0/2	0/1	N/A	N/A	0/1	N/A
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% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A

Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that supports were implemented. OTs and PTs should work with QIDPs to ensure data are included and analyzed in ISP integrated reviews. Improvements were needed with regard to entries in Integrated Progress Notes (IPNs) for each OT/PT goal and outcome. Such IPNs should include a presentation of the data, as well as analysis of the effectiveness of the intervention. QIDP monthly summaries also needed to include this summary information.
Examples of concerns included:

- As discussed above for Individual #185, the ISP did not include one of his goals (i.e., identify stop sign), and the IDT provided no evidence of implementation of the other (i.e., use a dining platform) through 12/31/18.
- For Individual #248, the PT had written IPNs related to direct therapy intervention, but sessions were inconsistent and the QIDP did not document them in the monthly reviews.
- For Individual #150, the Center provided no evidence that direct OT was completed as prescribed. Initially, the treatment plan required the OT to provide treatment three times per week. However, based on documentation provided, the OT did not see him at this frequency. On 12/14/18, the frequency increased to five times per week, but there was no documentation related to this until 1/24/19, and still, the documentation did not show that the OT saw him five times per week. During the onsite review, the Monitoring Team member observed the clinician during a mealtime, and the OT stated that she was providing treatment to the individual. However, based on the documentation provided, the OT had not documented statements of

progress on the goals and nothing was found in an ISPA related to goals for OT treatment. In addition, the QIDP did not report on direct OT supports in the monthly summaries.

b. The Center did not consistently ensure that proposed terminations of OT/PT services or supports were discussed and approved by the individuals' IDTs. For example, for Individual #248, the Center did not provide evidence of an ISPA to show the IDT approved the discontinuation of therapy, though therapy notes continued only through 11/13/18.

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

Summary: Proper fit of adaptive equipment was still an issue for some individuals observed. Indicator c will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators.

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

Individuals:

#	Indicator	Overall Score	384	150	23	118	31	328	295	189	40
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance, these indicators 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.	63% 10/16	1/1	0/1	1/1	0/1	1/1	0/1	0/1	1/1	1/1

Individuals:

#	Indicator		98	202	126	294	268	382	273		
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	0/1	1/1	1/1	1/1	1/1	1/1		

Comments: c. Based on observations of the following individuals in their wheelchairs, the outcomes were that they were not positioned correctly or supported adequately: Individual #150, Individual #118, Individual #328, Individual #295, Individual #98, and Individual #202. 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. At the last review, one indicator was already in, or was moved to, the category of requiring less oversight. At this review, twp other indicator will be moved to this category, in the area engagement.

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.

It was good to see, that even given the staffing crisis, there were some staff who knew about some of the individuals for whom they were providing support.

One ISP goal had reliable data and was showing progress.

Individuals were not making progress on their SAPs, with a handful of exceptions. When there was no progress, actions were not taken.

Although none of the SAPs were scored as complete, most contained the majority of the components. Most frequently missing were clear instructions for staff, and potent reinforcers for individuals.

The majority of SAPs had integrity and reliable data. Some of those measures, however, were based on DSPs role-playing the implementation of SAPs. To be most useful, SAP integrity measures should consist of observations of DSPs implementing SAPs. There was no evidence that actions were taken to address the lack of SAP progress.

The Monitoring Team attempted to observe eight SAPs, but only saw one. Some individuals refused to participate during multiple attempts, or were unavailable to participate in their SAPs (e.g., asleep, couldn't be found). One individual's DSP could not find the SAP materials necessary to conduct the SAP. These examples indicated that it was likely that SAPs were not implemented regularly. Ensuring that SAPs are consistently implemented should be a priority for San Angelo SSLC.

Most individuals were not actively engaged throughout the day. Attendance at group counseling sessions was low. There were, however, some positive activities occurring, such as an exercise class and various job activities.

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

The Center should continue to focus on ensuring individuals have their alternative and augmentative communication (AAC) devices with them and that they are in functioning condition. Most importantly, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.												
Summary: One goal had reliable data and was showing progress. The four indicators of this outcome will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	331	241	297	245	270	185				
4	The individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	1/6	0/6	0/6	0/6				
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/5	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	0/5	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: As the San Angelo SSLC works to develop individualized and personal goals, it should focus on action plans that clearly support the achievement of those goals, thus, achieving compliance with this outcome and its indicators.

A personal goal that meets criteria for indicators 1 through 3 is a pre-requisite for evaluating whether progress has been made. For this review period, one goal met these prerequisite criteria, and there were valid data demonstrating progress toward goal-achievement.

Focusing on the design of action plans that map out a clear path to achieving each goal, and include SAPs, SOs, and data collection systems that measure active and meaningful participation/engagement in activities will likely result in the SSLC achieving compliance with this outcome and its indicators.

4. One individual, Individual #297, was making progress toward achieving her work/school goals. For Individual #297, the goal was to graduate high school. While she was not making progress in all of her personal goal areas, her work/school goal was a good example of personalized and meaningful skill-development opportunities to promote independence, with action plans and data collection systems that supported the goal.

5. No individual had a comprehensive set of goals that met criterion because the pre-requisite personal goal criteria described above were not met. For the two goals for which there was progress made, neither goal was met. Thus, this indicator was not applicable to

these two goals.

6. Overall, no individual had a comprehensive set of personal goals that could be evaluated for progress. For the one goal with valid and reliable data, activities and/or revisions to the goal were not necessary because there was progress being made toward achievement of this goal. This indicator was, therefore, not applicable to this one goal.

7. No individual had a full set of goals that met criterion for this indicator because the pre-requisites described above were not met. Monthly QIDP reports consistently showed little to no progress made toward goal achievement, but no revisions to supports to promote progress.

For example, for Individual #245, there was minimal progress made toward enrolling in cosmetology school (work/school/day goal). This goal was carried over from the previous ISP year. The action steps included exploring grants and scholarships, visiting Howard College, and applying for financial aid. According to the QIDP monthly reports, none of these steps was attempted.

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

Summary: It was good to see, that even given the staffing crisis, there were some staff who knew about some of the individuals for whom they were providing support. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 331	241	297	245	270	185			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	50% 3/6	0/1	1/1	1/1	0/1	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. For three of six individuals, staff exhibited a level of competence to ensure implementation of the ISP. That is, staff were generally familiar with the individuals' risks and behavioral challenges, but they remained unfamiliar with the individuals' goals and action plans. For Individual #331, a DSP interviewed onsite was unable to recall any of Individual #331's goals. Another staff was familiar with Individual #331's behavioral programming and could explain Individual #331's cigarette schedule. However, this staff person was witnessed by the Monitoring Team providing a cigarette to Individual #331 20 minutes earlier than scheduled. This was immediately following the staff person's explanation to the Monitoring Team that Individual #331 received cigarettes every 30 minutes.

40. None of the six individuals had action plans that were implemented consistently. As reported for previous indicators, there was a consistent and pervasive lack of implementation of goals and action plans for all individuals. The Monitoring Team was not able to observe the implementation of SAPs and SOs for a variety of reasons. In most cases, SAPs and SOs had not been developed or implemented. In some cases, the individual was asleep or unavailable during the home visit.

In other cases, the staff were unprepared to demonstrate SAP teaching. In response to the Monitoring Team's pre-arrival document

request, a coversheet was submitted indicating there had been no SAPs developed for Individual #297. Upon arrival, the Monitoring Team was told that Individual #297 had a SAP for familiarizing herself with the Texas Drivers' Handbook. Upon visiting the home, the materials necessary to complete the SAP could not be located.

Similarly, SOs requiring action on the part of the IDT had not been completed. Many of these SOs were prerequisite steps to the implementation of successive action steps, which meant the staff working with the individual had no opportunity to facilitate teaching and the individual had no opportunity to learn, develop skills or make progress toward achieving their goals.

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, with a handful of exceptions. When there was no progress, actions were not taken. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
6	The individual is progressing on his/her SAPs.	6% 1/17	0/3	Insuff. data	0/3	0/1	0/1	0/1	1/3	0/3	0/2
7	If the goal/objective was met, a new or updated goal/objective was introduced.	100% 3/3			1/1				1/1	1/1	
8	If the individual was not making progress, actions were taken.	0% 0/12	0/3		0/3		0/1		0/2	0/2	0/1
9	(No longer scored)										

Comments:
6. Individual #241's call his family SAP was progressing. The majority of SAPs were not progressing (e.g., Individual #402's identify her medications SAP). Individual #272 was progressing on her identify her medication SAP, however it was scored as 0 because her data were not demonstrated to be reliable (indicator 5). Individual #331's state her personal boundaries SAP was also progressing, however, it was scored as 0 because it was not judged to be practical (indicator 4).

Individual #245's fill out an application and Individual #233's combine coins SAPs had insufficient data to assess progress and were not scored. Individual #233's write her address also had insufficient data, however, was scored as 0 because it was judged as impractical. Similarly, Individual #297's practice her driver's test SAP had insufficient data, but was scored as 0 because it did not have data demonstrated to be reliable.

7. There was evidence that Individual #272's identify her medication, Individual #241's call his family, and Individual #337's read a prayer SAPs were updated (i.e., moved to the next step) when they achieved the objective.

8. There was no evidence that actions were taken to address the lack of progress (i.e., retrain staff and modify the SAP) of any SAPs. San Angelo SSLC should prioritize ensuring that when SAPs are not progressing, actions to address the lack of progress are consistently conducted.

Outcome 4- All individuals have SAPs that contain the required components.											
Summary: One SAP had all of the required components. All SAPs had six of the required components. Most frequently missing were clear instructions for staff, and potent reinforcers for individuals. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
13	The individual's SAPs are complete.	5% 1/19	0/3 26/30	0/1 6/10	1/3 25/29	0/1 8/10	0/1 9/10	0/1 7/10	0/3 26/30	0/3 27/30	0/3 24/29

Comments:
13. In order to be scored as complete, a skill acquisition plan (SAP) must contain 10 components necessary for optimal learning. Individual #337's preheat the oven SAP was judged as complete.

Because all 10 components are required for the SAP to be judged to be complete, the Monitor has provided a second calculation in the individual boxes above that shows the total number of components that were present for all of the SAPs chosen/available for review.

Although only Individual #337's preheat the oven SAP was judged to be complete, many of the SAPs contained the majority of the components. For example, 100% of the SAPs had a plan that included:

- behavioral objectives
- operational definitions of target behaviors
- relevant discriminative stimuli
- teaching schedule
- specific consequences for incorrect responses
- documentation methodology.

One common missing component from the majority of SAPs was clear documentation of instructions. For example, Individual #337's reading The Our Father SAP indicated that all previous steps should be completed, however, it was not clear if untrained steps should also be reviewed. Many of the SAPs would benefit from more instructional detail, including specific teaching instructions clearly specifying how staff should address the training and non-training steps. Additionally, if a SAP indicates that a previously mastered step is to be reviewed (e.g., Individual #337's reading The Our Father SAP), instructions of how staff should respond/record if the individual cannot complete the previously trained step at the goal prompt level should be included. Finally, the instructions of some SAPs did not clearly identify the training step (e.g., Individual #272's identify her medication).

Ensuring that individuals are motivated to complete SAPs is a critical training component and, therefore, it is important that efforts are made to ensure that potent reinforcers are provided following the successful completion of all SAPs. This individualization of

reinforcement for correct SAP completion was apparent in some SAPs (e.g., Individual #335's make banana bread SAP where correct responses were to be followed by praise and the opportunity to eat the bread), however, many SAPs merely included saying "good job," which was not documented to a preference (e.g., Individual #331's state personal boundaries SAP).

All SAPs had generalization plans, however, some SAPs (e.g., Individual #245's fill out an application SAP) did not have a complete generalization plan that specified how San Angelo SSLC would ensure that the individual maintains the skill (e.g., require that individual continue to independently complete the SAP) once it is mastered.

Outcome 5- SAPs are implemented with integrity.											
Summary: The Center showed that it was checking on the integrity of almost all of the SAPs. Yet, one that was observed was done incorrectly and the others could not be implemented due to individuals' refusing to participation, being asleep, or not being found. For one, the materials could not be located. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
14	SAPs are implemented as written.	0% 0/1	Not located	Refused	0/1	Asleep		Refused	Asleep	No materials	Refused
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	84% 16/19	3/3	1/1	3/3	1/1	0/1	0/1	3/3	2/3	3/3

Comments:
14. The Monitoring Team observed the implementation of Individual #337's read Our Father SAP. The DSP conducting the SAP did not implement it as written.

Attempts to observe additional SAPs were made for seven other individuals, however some individuals refused to participate during multiple attempts (i.e., Individual #245, Individual #297, Individual #233), or were unavailable to participate in their SAPs (i.e., Individual #331 was asleep during two attempts, Individual #335 could not be located during two attempts). Finally, Individual #272's DSP could not find the SAP materials necessary to conduct the SAP. This difficulty in conducting SAPs might be a function of infrequent implementation of SAPs.

Ensuring that SAPs are consistently implemented should be a priority for San Angelo SSLC.

15. Eighty-four percent of all SAPs had integrity assessments. This was an improvement over the last review when 40% of SAPs had integrity measures. San Angelo SSLC established a schedule of SAP integrity that would ensure that each SAP was observed within three months after it was developed, and once every six months thereafter. These integrity measures should consist of observations of DSPs conducting SAPs, rather than role-playing the implementation of SAPs.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.											
Summary: The quality of SAP graphs did not maintain from the last two reviews. Moreover, about one-third of SAPs were reviewed each month. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
16	There is evidence that SAPs are reviewed monthly.	32% 6/19	1/3	0/1	1/3	0/1	0/1	0/1	2/3	2/3	0/3
17	SAP outcomes are graphed.	58% 11/19	2/3	1/1	2/3	0/1	1/1	0/1	2/3	0/3	3/3
Comments: 16. Several SAPs were not included in the monthly review (e.g., Individual #233's write her address SAP). 17. All SAP data were graphed. Some SAPs (e.g., Individual #331's state her personal boundaries SAP), however, represented multiple steps that were not clearly indicated in the graph and, therefore, limited the usefulness of the graph to reflect overall progress.											

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
Summary: The Center regularly measured engagement and set goals for individuals. This has been the case for this and the past two reviews, too, for all individuals. Therefore, indicators 19 and 20 will be moved to the category of requiring less oversight. That being said, most individuals were not observed engaged in activities when observed by the Monitoring Team. Likewise, the Center's own data showed that less than half of the individuals met their Center-set goals for engagement. Indicators 18 and 21 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
18	The individual is meaningfully engaged in residential and treatment sites.	22% 2/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and	44%	1/1	0/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1

	treatment sites are achieved.	4/9									

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 #335 and Individual #272 consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

Group counseling sessions were one aspect of many individuals' weekly schedule. Attendance was very low. The Monitoring Team attended a relationships session, attendance was two of six; an anger management session, attendance was zero out of five; and a sexual offender group therapy session, attendance was two of seven. Thus, Monitoring Team observations found overall four out of 18 (22%). The Center's own data showed group sessions attendance to be 29% and sexual offender group therapy to be 62% over the past nine months.

There were some examples of good engagement and opportunities for engagement. In one home (510), individuals were engaged in Richard Simmons Jazzercise. Most individuals were actively participating and seemed to be enjoying themselves. There were several job postings and opportunities for engagement displayed at the coffeehouse. People who were working were being paid minimum wage and seemed to value the positions they held. Working at the greenhouse and the woodshop appeared to be preferred employment for some individuals, and a great opportunity to develop organizational and interpersonal skills.

19-20. San Angelo SSLC regularly assessed engagement across treatment and residential sites. Additionally, they established individual engagement goals for each site.

21. Individual #272, Individual #335, Individual #297, and Individual #337's residential sites achieved the facility's engagement goals.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: These scores remained low and will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	335	245	337	331	402	297	241	272	233
22	For the individual, goal frequencies of community recreational activities 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
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. None of the individual's achieved their community recreational goals. 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. Absence of community activities, outings, and training may have been impacted by the direct care staffing crisis at the Center.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
Summary:			Individuals:								
#	Indicator	Overall Score									
25	The student receives educational services that are integrated with the ISP.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments:											

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals, nor was it clear the Center maintained reliable data in this area. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	367
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/3	N/A	N/A	0/1	N/A	N/A	N/A	N/A	0/2	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/3			0/1					0/2	
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/3			0/1					0/2	
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/3			0/1					0/2	
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/3			0/1					0/2	
Comments: a. through d. Prior to the Monitoring Team's onsite review, the Center submitted documentation that indicated on 9/10/18, Individual #270 had one dental refusal, and that on 7/12/18, 8/3/18 and 9/25/18, Individual #150 had three refusals, two of which occurred within the document request period. The Monitoring Team could only locate documentation for one of these instances (i.e., for Individual #150 on 9/25/18.) This called into question whether the Center had an adequate system for maintaining reliable data with regard to dental refusals.											

Due to the lack of documentation, the Monitoring Team could not fully evaluate whether the IDTs had addressed two of the three refusals identified by the Center for which the Center should have submitted documentation. For Individual #150, his IDT had not developed a specific goal or objective related to the 9/25/18 refusal to cooperate with dental cleanings. Documentation did indicate he had participated in weekly tooth brushing visits from July 2018 through 11/19/18, which was positive, but without a measurable goal/objective, it was not possible to determine if he had made the progress needed by the time the weekly tooth brushing visits ended.

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: As with previous reviews, overall, IDTs did not have a way to measure clinically relevant communication outcomes for individuals reviewed. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	331	241	270	185	248	343	237	150	364
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/8	0/1	0/1	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% 0/8	0/1	0/1	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% 0/8	0/1	0/1	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% 0/8	0/1	0/1	0/1	0/1	0/1	0/1		0/1	0/1
Comments: a. through e. Individual #237 had functional communication skills, so supports were not indicated. None of the other eight individuals had clinically relevant or measurable goals to address their communication needs. As noted above, Individual #237 had functional communication skills, but since he was part of the core group, a complete review was conducted related to communication. For the remaining eight individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals.											

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.	
Summary: Individuals ISPs did not include plans to address their communication needs. These indicators will remain in active oversight.	Individuals:

#	Indicator	Overall Score	331	241	270	185	248	343	237	150	364
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	N/A									
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									

Comments: a. None of these individuals had measurable strategies and action plans related to communication included in their ISPs/ISPAs, although eight of the nine individuals had communication needs for which the IDTs should have developed plans. For example:

- Two individuals (i.e., Individual #241 and Individual #150) had AAC devices, but their ISPs/ISPAs did not provide measurable strategies and action plans for their use.
- Another two individuals (i.e., Individual #331 and Individual #183) communicated verbally, but had identified issues with intelligibility for which the ISPs/ISPAs did not provide any measurable strategies and action plans

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 continue to focus on ensuring individuals have their AAC devices with them and that they are in functioning condition. Most importantly, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner. These indicators will remain in active monitoring.

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

			Individuals:								
#	Indicator	Overall Score	287	130	40	25	98	211	202	183	Shared switch 502
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	86% 12/14	1/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	36% 5/14	1/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1	1/1
			Individuals:								
#	Indicator		241	323	144	150					
a.	The individual's AAC/EC device(s) is present in each observed setting		1/1	2/2	1/1	1/1					

	and readily available to the individual.										
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		1/1	0/2	0/1	0/1					
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	100% 7/7									
Comments: a. through c. Individuals' AAC devices were usually present or readily accessible, with the exception of devices for two individuals whose equipment was not operable (i.e., Individual #25's headphones were not charged and staff did not take the initiative to charge them, and Individual # 98's switch was broken), and, therefore, could not be considered "readily available" for use. The Monitoring Team further observed that individuals were often not using their devices or supports in a functional manner and that when opportunities for using the devices presented themselves, staff did not consistently prompt individuals to use them. It was positive, though, that when staff were specifically questioned about the use of seven individuals' devices, they were generally knowledgeable about how those devices were to be used.											

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 the time of the last review, two indicators were moved to the category of requiring less oversight due to sustained high performance. At this time, one additional category 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.

There were seven transitions since the last review. The new admissions and placement coordinator and her staff were extremely receptive to feedback and commentary from the Monitoring Team. They continued to make progress in developing a comprehensive list of supports that were written in measurable terminology. The department staff were extremely receptive to feedback and commentary from the Monitoring Team.

All the pre-move inservice supports referenced didactic/classroom training as the inservice methodology. The IDTs needed to consider whether didactic learning was appropriate for all needs. Pre-move training supports included a reference to how competency would be determined. This was good to see. Each relied upon written tests, requiring a score of 100%. Overall, however, the written exams still did not test competency as needed for either individual.

The IDTs developed more than 40 post-move supports for each individual. Most post-move supports were measurable, which was positive. As at the time of the last monitoring visit, the primary exceptions related to measurability were the post-move supports for training of any new community provider staff.

The CLDPs did not include supports that comprehensively addressed past history, and recent and current behavioral and psychiatric problems. The IDTs did develop some detailed post-move supports related to current behavioral needs. This was a positive step forward.

The IDTs developed supports in some areas related to safety, medical, healthcare, therapeutic, and risk needs, such as for scheduling of health care appointments. But, the IDTs still needed to develop clear and comprehensive supports in these areas. While both individuals in the review group were young and relatively healthy, they still had some important health care concerns that the IDTs did not address as needed.

Post move monitoring was occurring at required intervals and documented in the required format. Overall, the Center continued to move forward regarding post move monitoring activities. The PMM Checklists provided some good examples of documenting valid and reliable data, but this was not yet consistent.

Based on information the Post Move Monitor collected, both individuals had frequently received supports as listed and/or described in the CLDP, but this was not yet consistent. Sometimes, it was impossible to confirm whether individuals had received supports due to the lack clarity and measurability in the supports as written in the CLDP. It was good to see, however, that the PMM was able to identify when supports were not in place as required.

Overall, the PMM took action toward resolution when she identified supports were not in place. This was positive, however, there were times when problems had not yet been resolved, but were closed out.

Both individuals had multiple PDCT events that involved law enforcement contact and psychiatric hospitalizations. More thorough supports (including provider staff training and competence) and deeper IDT/Center action when problems were emerging are areas for improvement for the Center's transition department.

The transition department involved IDT members, individuals, and LARs. Along the same lines, there was some progress regarding some of the other transition planning activities. Transition assessments, however, did not show much improvement.

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: The San Angelo SSLC transition department continued to make progress in developing a comprehensive list of supports that were written in measurable terminology. The department staff were extremely receptive to feedback and commentary from the Monitoring Team. A focus on the supports around the training of community provider staff, and ensuring that all important needs end up as pre- and/or post-move supports, were two areas for improvement regarding these two indicators. Both indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	267	406								
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1								
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1								
Comments: Seven individuals transitioned from the Center to the community since the last review. Two were included in this review (Individual #267, Individual #406). Individual #267 transitioned to a community home operated under the State's HCS program, while												

Individual #406's family decided to serve as a host home for her, also under the HCS program. The Monitoring Team reviewed these two transitions and discussed them in detail with the San Angelo SSLC Admissions and Placement staff.

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 individuals' needs and preferences will 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. Examples of supports that both met and did not meet criterion are described below:

- Pre-move supports: The respective IDTs developed six pre-move supports for Individual #267 and four pre-move supports for Individual #406.
  - For Individual #267, two of the pre-move supports addressed the type of home (e.g., all male home with no more than three other individuals and his own private bedroom) and the level of supervision required (e.g., 24-hour awake staff to provide prompts to use the restroom at night and to monitor for possible elopement). A third pre-move support addressed the need to have journaling materials available. These three supports met criterion for measurability.
  - For Individual #406, one of four pre-move supports addressed the availability of a weight scale and was measurable.
  - The remaining pre-move supports for these two individuals were for provider staff training. At the previous site visit, the Monitoring Team found the Center had made some progress in the development of pre-move training supports, having included a summary of topics to be covered in pre-move training and specified the staff to be trained, but found that neither CLDP consistently indicated the provider staff knowledge or competence required to provide the needed supports. This continued to be the case for these two CLDPs. To continue to move toward compliance, the Center should continue to focus on defining specific competency criteria and ensuring the tools for measuring those competencies are thorough and appropriate to the need. Findings included:
    - Pre-move training supports provided a list of topics to be covered under each broad area of training, which was positive, but the topics rarely indicated the specific knowledge provider staff would be required to know by the time of the transition. Examples included:
      - For the QIDP training for Individual #267, topics included social history, previous placement history, family involvement, preferences and strengths, and guardian-imposed restrictions. A support for the latter topic (i.e., guardian-imposed restrictions) indicated the specific knowledge provider staff needed to have, but the supports for the other topics did not. The pre-move training for behavioral supports listed topics, including self-injurious and replacement behaviors, but did not provide specific criteria about the nature of his self-injurious behavior or how staff would be expected to implement the replacement behavior.
      - For Individual #406, the QIDP training did not include specific competency criteria that defined what provider staff needed to know or know how to do. In some cases, the training topics for medical risks described what staff needed to do, such as take bi-weekly weights and provide an 1800 calorie diet. Others, such as training related to her risk for seizures, did not provide such clear information. For example, that support indicated staff would be trained on signs and symptoms, but did not define what her specific signs and symptoms would be. The behavioral training listed topics, with some specific criteria, such as for replacement behaviors, but this was not consistent. For example, the training included a topic for instructions for prompting and reinforcing, but it didn't indicate what

staff needed to know about those strategies. The pre-move support also included a topic for relevant behavioral history, but indicated only that it would be as determined by the behavioral health specialist (BHS.)

- All the pre-move inservice supports referenced didactic/classroom training as the inservice methodology. The IDTs needed to consider whether didactic learning was appropriate for all needs, and whether other methodologies, such as demonstration or hands-on modeling, might be better suited to some. As the IDTs continue to make improvements in identifying specific competency criteria, those should form the basis for determining how competency could best be measured. For example, a written test may not always be sufficient to demonstrate provider staff know how to correctly implement behavioral strategies.
- Pre-move training supports included a reference to how competency would be determined. Each relied upon written tests, requiring a score of 100%. Overall, however, the written exams still did not test competency as needed for either individual. As described above, testing needed to be constructed to measure the specific criteria that would demonstrate staff were competent to provide supports as required. The written tests reviewed for these two CLDPs did not include questions for many of the topics and/or competencies listed as needed under each support, so there was no corresponding measurable evidence of related staff knowledge. Examples included:
  - For Individual #267, the pre-move behavioral training described topics, but rarely provided the competency criteria. Overall, the competency exam also did not address all needed supports in this area in a thorough manner. For example, one question asked provider staff to identify his target behavior and further indicated the correct answer was broadly self-injurious behavior, rather than the specific self-injurious behaviors staff would need to know. Another question listed psychiatric diagnoses, including for auto-erotic asphyxiation. The test did not probe to ensure provider staff knew what this meant, what to watch for or what actions to take.
  - For Individual #406, the nursing training had 10 questions, but many did not fully address what staff needed to know. For example, one question asked what staff should encourage her to do to reduce her risk of falls, for which the answer key indicated the correct response was to wear her glasses. This was correct as far as it went, but per her Integrated Risk Rating Form (IRRF), staff also needed to ensure she wore her left knee brace when she not sitting to reduce the risk of falls. Another question asked how often she should be weighed, for which the correct answer was to be twice per month. While this was technically correct, the test did not further probe whether staff knew the weight parameters that would require them to take action, or what action to take.

- Post-Move: The respective IDTs developed 45 post-move supports for Individual #267 and 50 post-move supports for Individual #406. Most post-move supports were measurable, which was positive. As also reported at the time of the last monitoring visit, the primary exceptions related to measurability for both individuals were the post-move supports for training of any new staff. These supports were structured identically to the pre-move training supports described above that were not measurable. In addition, some post-move supports indicated the PMM should interview provider staff, but did not specify the staff to which this referred. This was an important consideration to ensure that the PMM interviewed the appropriate staff (i.e., those who would have primary responsibility for implementation of supports and therefore needed to be knowledgeable.)

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for the indicator to be scored as meeting criterion. The Center had identified many supports for these two individuals and it was positive they had made a diligent effort to address their needs. Still, neither of these CLDPs fully and comprehensively addressed support needs and did not meet criterion, as described below.

- Past history, and recent and current behavioral and psychiatric problems: The CLDPs did not include supports that comprehensively addressed past history, and recent and current behavioral and psychiatric problems. To meet criterion, the IDTs should continue to make improvement toward developing comprehensive supports that address behavioral and psychiatric history and needs. Findings included:
  - For both individuals, the IDT did develop some detailed post-move supports related to current behavioral needs. This was a positive step forward. Still, neither IDT developed pre-or post-move supports that ensured provider staff had knowledge to meet their needs.
  - Individual #267's CLDP did not address his significant behavioral history. For example, several assessments noted a diagnosis of autoerotic asphyxiation. The behavioral assessment indicated his most recent episodes occurred in 2016, and further indicated those resulted in ligature marks on his neck on one occasion and peri-orbital discoloration and petechiae on his face on another. The assessment further stated "these behaviors can have serious health consequences for him. Deaths often occur when the loss of consciousness caused by partial asphyxiation leads to a loss of control over the means of strangulation, resulting in continued asphyxia and death." Given the relative recency of these episodes and the severity of the potential consequences, it would have been important to ensure that provider staff were aware. Similarly, the behavioral assessment described a history of placing various items in his rectum and had required anesthesia for surgical removal of some of the items, but the CLDP supports did not address this significant history.
  - While the CLDP for Individual #406 included many detailed behavioral supports based on the Center's positive behavior support plan (PBSP), that plan was designed for staff implementation in an SSLC rather than a family home setting. While these may have been appropriate for the day program staff, Center staff should have considered how to modify these staff-centric actions for the family home.
  - The CLDP for Individual #406 lacked clarity about supervision requirements. Documentation prior to the transition indicated the parents stated they would never leave her unsupervised. The IDT did not formalize this expectation in a support that could be monitored, nor did the CLDP describe the level of supervision required in the day program or in any anticipated employment setting.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The respective IDTs developed supports in some areas related to safety, medical, healthcare, therapeutic, and risk needs, such as for scheduling of health care appointments. To meet criteria, the IDTs still needed to develop clear and comprehensive supports in these areas. While both individuals were young and relatively healthy, they still had some important health care concerns the respective IDTs did not address as needed. Findings included:
  - For Individual #267:
    - Per the CLDP narrative, the IDT did not agree he needed weekly vital signs as recommended in the medical assessment, stating rather that the community provider nurses do that quarterly. This was a significant

difference that required a more complete justification based upon his individual needs rather than simply citing the provider's usual practices.
        - Individual #267 had elevated weight and cardiac risks. Per the CLDP narrative, the Placement Coordinator recommended adding a specific support for exercise. The IDT disagreed, saying weight monitoring would be sufficient to address his weight gain, but this did not address his identified need for exercise to address his cardiovascular health.
    - For Individual #406, in addition to the incomplete supervision support as described under Indicator 1 above, examples included:
        - Per her nursing assessment, she had missed a neurology appointment on 6/18/18 that needed to be rescheduled. The CLDP included only a post move support for an annual neurology appointment by February 2019.
        - Individual #406 had a history of falls and had been fitted with a left knee brace by Center habilitation staff on 5/29/18. The nursing assessment noted that she had missed appointments for a recommended magnetic resonance imaging (MRI) of her left knee, which needed to be rescheduled. The CLDP did not include a specific post move support for this need, nor did it address a related need for a follow-up appointment with the orthopedist.

- What was important to the individual: The Monitoring Team reviewed various documents to identify what was important to these individuals, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. While both CLDPs did address some important outcomes, neither did so fully and assertively. Examples included:
    - For Individual #267, the IDT identified his important outcomes as finding a part-time job and learning how to play golf. As described further below, the CLDP did not define an outcome expectation that he would have a part time job. Supports were limited to obtaining and completing an application for referral to the Texas Workforce Commission (TWC). The CLDP also did not define an assertive outcome for learning to play golf. Instead, a support called for him to participate three times a month in a preferred community activity such as, but not limited to, miniature golf, riding bikes, playing basketball, taking walks, going to the movies, bowling, hockey game, or picking out a restaurant. This support did assertively address learning to play golf by including miniature golf as one of numerous options. First, he had not expressed a desire to play miniature golf, but to learn the actual sport of golf. Second, the support could have been met without ever even playing miniature golf. If this was one of his two important outcomes, the IDT needed to address it in a manner that reflected its importance.
    - For Individual #406, the IDT defined her important outcomes as part time paid employment and learning to sew. As for Individual #267, the IDT failed to develop a set of assertive employment outcomes or supports for her. The IDT also did not develop any supports for learning to sew.

- Need/desire for employment, and/or other meaningful day activities: Both had goals for paid community employment in their ISPs. Neither CLDP included supports for seeking employment that defined any outcome expectation:
    - For Individual #267, employment supports were very limited, including only that provider staff should assist him to obtain an application for a referral to the TWC, and then to assist him to complete the application. In effect, his

employment supports could be considered to be met once an application was completed.
    - Individual #406's family declined a referral to TWC, indicating they would take care of assisting her to find employment. The CLDP did not included any specific support for an employment outcome or even to monitor for related assistance having been provided.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success. For both individuals, the IDTs defined supports that included some elements of positive reinforcement and other motivating components. Individual #267's CLDP addressed this in an assertive manner, but Individual #406's did not.
    - For Individual #267, it was positive the CLDP provided several specific supports in this area, including the following:
        - When there was no scheduled programming, encourage to assist with chores, provider staff should give him attention, ask him what he would like to do and encourage him to draw, doodle or journal on paper or his laptop.
        - On Fridays and Sundays after his phone call with family, provider staff needed to be aware he might be upset and want to talk. In such circumstances, provider staff could implement one or more of several supports, such as to remind him he could talk to staff when upset, to show interest in what he says, and/or to help him journal his feelings, thoughts and concerns.
        - When preferred staff were not available, provider staff present could encourage him to make a note or a drawing for the preferred staff and/or encourage him to journal his feelings.
    - For Individual #406, the behavioral assessment included many good recommendations for prevention strategies and interventions, but did not address reinforcement with same attention or within the context of living at home with her parents. Instead, it focused on instructions for staff. It was notable that post-move monitoring documented the mother's lack of understanding of reinforcement procedures at the time of the 90-day PMM visit.

- Teaching, maintenance, participation, and acquisition of specific skills:
    - Individual #267's functional skills assessment (FSA), dated 9/6/18, indicated he might need more detailed instruction and experience in cooking. The CLDP included a post-move support to assist with preparing meal of choice once per month, but did not identify any specific related skill acquisition, nor would a once-monthly activity be likely to lead to acquiring any new skills. The FSA also suggested areas of need, such as learning how to manage a bank account and reminders to apply deodorant, but the IDT did not develop any related supports.
    - For Individual #406, several assessments recommended she be encouraged to shower daily due to history of boils and it was positive the CLDP included this as a post-move support. The FSA documented several areas of need, however, that were not addressed. For example, that assessment identified using the bus for transportation as an area of need, which would have been a very appropriate support for community living, but the IDT did not address it with CLDP supports.

- All recommendations from assessments are included, or if not, there is a rationale provided: San Angelo SSLC had a process in place for documenting in the CLDP discussion of assessments and recommendations, including the IDT's rationale for any changes to, or additional, recommendations. The Monitoring Team noted this process was often used very effectively to identify and rectify issues related to clarity, measurability and comprehensiveness. Still for this review, the IDTs did not yet

address all recommendations with supports or otherwise provide a justification, as described above.

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

Summary: Post move monitoring was occurring at required intervals and documented in the required format. This has sustained across three consecutive reviews at 100%. Therefore, indicator 3 will be moved to the category of requiring less oversight. For indicators 4-9, there were examples of the Center meeting criteria as well as examples where more thorough post move monitoring was required. Overall, the Center continued to move forward regarding post move monitoring activities. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 267	406							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	100% 2/2	1/1	1/1							
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1							
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1							
6	The PMM's assessment is correct based on the evidence.	0% 0/2	0/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	0% 0/2	0/1	0/1							
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	Not avail -able									
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	Not avail -able									

Comments:

3. Post-move monitoring was completed at required intervals for both individuals. Each of these post-move monitoring visits were within the required timeframes, were done in the proper format, and occurred at all locations where the individual lived or worked.

4. The PMM Checklists provided some good examples of documenting valid and reliable data, but this was not yet consistent. To

continue to move toward compliance, the Center should continue to focus on improving overall clarity and measurability of supports that provide guidance to the PMM as to what criteria would constitute the presence of various supports. Some comments about obtaining valid and reliable data included the following:

- As described above under Indicator #1, the language for staff knowledge supports did not specify the competency criteria the PMM needed to be able to accurately collect valid data.
- The PMM often relied on interview with the provider supervisory/management staff rather than with the direct support staff responsible for implementing the supports. The CLDP typically did not say what staff needed to be interviewed, so the IDTs may need to focus on being more specific in this area.
- At the 45-day PMM visit for Individual #267, the PMM Checklist indicated he had experienced a 20-pound weight gain, but the provider explained the scale was not weighing correctly, so a referral to the dietitian was not required. The PMM did not document obtaining a corrected weight at that time, nor did she document his weight at the time of the 90-day PMM visit.
- Individual #406's CLDP included a support for making healthy meals. At the time of the seven-day PMM visit, the PMM documented Individual #406 was preparing wings, so it was unclear that the healthy component of this had been addressed. The PMM marked this support as being in place. The PMM continued to mark this support as being in place at the time of the 45-day and 90-day PMM visits, without ever providing any comments that documented any evidence that addressed the healthiness of the meals, even though Individual #406 continued to gain weight.

5. Based on information the Post Move Monitor collected, both individuals had frequently received supports as listed and/or described in the CLDP, but this was not yet consistent. As described above, the Monitoring Team sometimes could not evaluate or confirm whether individuals had received supports due to the lack clarity and measurability in the supports as written and/or a lack of reliable and valid evidence that demonstrated a support was in place as required. It was good to see, however, that the PMM was able to identify when supports were not in place as required, including the following:

- For Individual #267, the PMM identified the following supports as not being in place:
  - At the time of the 45-day PMM visit, he did not have his state identification card. Per the 90-day PMM documentation, the IDT had met and agreed to extend this due date by three months, but this impacted the timeliness of his work supports as well.
  - At the time of the 90-day PMM visit, the provider had not documented prompting him to use the restroom.
  - At the time of the 90-day PMM visit, the blood pressure log had gaps. The data available noted some instances that should have prompted provider staff to call the nurse, but the nurse indicated she had received no notifications.
- For Individual #406, the PMM identified the following examples of supports as not being in place:
  - At the time of the 45-day PMM visit, her exercise program was not in place.
  - Also at the time of the 45-day PMM visit, the provider had not obtained the initial consult with the board-certified behavior analyst (BCBA) as required.
  - At the time of the 90-day PMM visit, the community PCP had declined to make the necessary referrals to establish care with a podiatrist, hematologist, or endocrinologist, as Individual #406's post-move supports required.

6. Based on the supports defined in the CLDP, the Post-Move Monitor's scoring was frequently correct, but there were still some exceptions in which the evidence provided did not clearly substantiate the finding. For example:

- For Individual #267, the PMM marked all of his behavioral supports as not applicable because a new PBSP had been implemented. The presence of a new plan would not render the existing supports inapplicable; instead, the PMM should have

reviewed, or better yet, had the IDT review, the new PBSP to determine if all of the requirements of the CLDP behavioral had been addressed. If the requirements had not been addressed, the IDT would have needed to review the provider's rationale for modifications to ensure the new supports met his needs and/or to identify any concerns for follow-up.

- At Individual #406's seven-day PMM visit, the PMM marked all behavioral supports as not applicable because no behaviors had been displayed. The PMM still needed to probe whether Individual #406's mother had knowledge about what she should do for behavioral prevention and intervention.

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. Whether follow-up is completed as needed relies heavily on the accuracy of the PMM's assessment of whether supports were, or were not, in place. This, in turn, relies on the accuracy, completeness, and measurability of the supports. Overall, the PMM took action toward resolution when she identified supports were not in place. This was positive, however, the Monitoring Team did not always find the PMM's determination that problems had been resolved to be supported by the evidence. Findings included:

- At the time of the 90-day PMM visit, Individual #267 had not participated in cooking any meals. The provider indicated this was because he refused to participate. For Individual #267's part, he acknowledged his refusals, stating he was unhappy with the provider. This statement of dissatisfaction should have prompted IDT follow-up.
- Individual #406 had a post-move support for participating in exercise that was not in place at the time of the seven-day PMM visit, per the available documentation. The documentation further indicated the PMM met with the IDT on 12/3/18 to discuss the issue and that the IDT had no concerns because the provider was working to develop a tracking sheet. The PMM then documented this as resolved, but should not have done so until confirming the tracking sheet was in place. At the time of the 45-day PMM visit, the tracking sheet still had not been put into place.
- The provider had not obtained consultation by a board-certified behavior analyst (BCBA) or licensed professional counselor (LPC) for Individual #406 at either the 45- or 90-day PMM visits. Per the documentation, the provider contracted with a BCBA who had been hard to contact. The IDT met on 1/31/19, and the ISPA indicated the IDT had no concerns because the provider was working on it. The PMM documented this issue as resolved based on the ISPA, but the support was not yet in place. The PMM should not confirm resolution based upon a stated plan for the future, but rather on the achievement of the support as required or a decision by the IDT to change the support. This set of circumstances did not indicate the support was no longer required and, in fact, Individual #406's behavioral needs were worsening.
- In other instances, the PMM documented other issues for Individual #406 that were not specific to any support that still required follow-up action. These included:
    - At the time of the 90-day PMM visit, the PMM documented observing damage to a wall in the home that Individual #406's mother indicated was caused her son who was "on drugs again" and got angry. The mother further stated she called police and got a protective order. The PMM documented a plan to follow-up with an IDT meeting to address this, but the Center provided no evidence this meeting was held.
    - At the time of the 90-day PMM visit, Individual #406 had experienced two episodes in which she fell out of her chair. On 1/8/19, an incident report documented she experienced a two-minute seizure and fell from the chair, hitting the left side of her head. It resulted in bruising above her left eyebrow. The documentation indicated the bruising was iced, but no medical attention was required. Another incident report, on 1/31/19, indicated only that she got dizzy and fell out of her chair to the floor with no injuries visible at this time. Given her history of seizures, and her missed

neurology appointment, the IDT needed to re-consider the lack of assertive supports in this area.

9 - 10. Post-move monitoring did not occur during this monitoring visit, so these indicators were not rated.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.											
Summary: Both individuals had multiple PDCT events that involved law enforcement contact and psychiatric hospitalizations. More thorough supports (including provider staff training and competence) and deeper IDT/Center action when problems were emerging are areas for improvement for the Center's transition department. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	267	406							
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.	0% 0/2	0/1	0/1							

Comments:

11. Both individuals had multiple PDCT events, as described below:

- For Individual #267:
  - He experienced four events on 10/ 17/18 that included law-enforcement contact, an emergency department (ED) visit, a medical hospitalization, and a psychiatric hospitalization. The IDT met on 10/30/18 to review. The PDCT documentation was limited, but indicated he left the home after becoming upset by the absence of preferred staff and another peer getting too much attention. The documentation did not provide any detail about how law enforcement came to be involved or how long he was hospitalized. It noted he would have one-to-one supervision until a door alarm was installed. In discussing efforts made to address these items prior to the move and whether anything could have been done differently, the IDT indicated that provider staff had been trained on his behavioral supports. However, they did not document any critical discussion as to whether the training was adequate or whether sufficient evidence of provider staff competence in that area had been obtained.
  - Individual #267 again experienced a psychiatric hospitalization on 2/10/19, but the IDT did not meet to review this event until 3/28/19. Per the documentation provided, he was having dinner at a restaurant with family when he reported hearing voices and believed his brother and father were threatening to hurt him. He ran out of the restaurant and sought help from an employee of a nearby business, asking that person to call police. The police came and eventually took Individual #267 to the psychiatric hospital.
  - At the 3/28/19 PDCT ISPA meeting, the IDT also discussed another psychiatric hospitalization that occurred on 3/19/19. The documentation indicated Individual #267 became upset because his favorite staff was not working that day. Individual #267 left the group home to go to another home operated by his provider agency to see if the preferred

staff was there. When staff at the second home tried to redirect him to his own home, he stated he was suicidal. The staff called police who transported him to the hospital. The ISPA did not indicate whether he was admitted or how long he may have stayed for this hospitalization or the previous one on 2/10/19.

- In addressing these latter two events, the IDT, provider, and LIDDA discussed continuing Individual #267's ongoing counseling support. They also proposed a plan for him to attend a LIDDA-sponsored program three times a week to assist with coping skills and to allow for time away from the group and day program. His guardian agreed, but sent an email the following day withdrawing her permission. The final recommendations included that he should attend the LIDDA program at least one day a week and continue with his current therapist. It was not clear if this meant that Individual #267 would attend the program in opposition to the guardian's decision. Further, the documentation did not reflect any information about the course and/or outcomes of the psychiatric hospitalizations or plans to address the psychiatric symptoms with his community psychiatrist. Moreover, the ISPA indicated the IDT believed provider staff could have better utilized the behavioral strategies included in his CLDP supports, such as reminding him that he could speak with staff when upset, that staff should spend time with him discussing areas of concern and problem-solving, and/or that he could have been encouraged to write to staff and make a note or drawing. The IDT should also have probed this issue further and taken a more critical look at whether the Center had ensured provider staff had adequate preparation to implement these supports. As described above under Indicator 1, the Center did not clearly identify the competency criteria or test provider staff knowledge in this area in a comprehensive manner.

- For Individual #406:
  - The IDT met on 12/3/19 to discuss an ED visit after she had a fall from a parked car. On 1/15/19, the IDT met to review another PDCT event, in which Individual #406 became upset with her mother and struck a window, injuring her finger. This resulted in an ambulance being called, which also prompted law enforcement to respond. She was again treated in the ED. The IDT met with the host home provider agency and agreed she should visit a group home as an alternative setting, noting that Individual #406 was "getting by with having a lot of aggression and behaviors at home." At that time, the IDT did not discuss the adequacy of Individual #406's behavioral supports or whether pre-move training in that area had been sufficient.
  - The 90-day PMM Checklist also documented an event on 12/26/19 that met PDCT criteria, noting that service delivery log from the provider LVN indicated Individual #406 was taken to the ED for suicidal ideation and "not being calm." The discharge paperwork stated the ED diagnosed conduct disorder and suicidal ideation and administered Ativan and Benadryl. The Center did not provide an ISPA indicating this PDCT had been reviewed by the IDT.
  - The IDT met again on 2/28/19 to discuss an additional ED visit within 90 days, resulting from an unauthorized departure from the day program. The documentation indicated she ran into traffic, engaged in self-injurious behavior, and then ran back inside the day program and locked staff out. Once staff were able to gain entry, she became physically aggressive and staff called police. The police restrained her and Individual #406 was given "sedative shots in both arms." Per the documentation, she stated her behaviors occurred because she was hearing voices, having nightmares, and didn't want to go bowling. The police took her to the hospital. She was not admitted, but the ED physician increased her Haldol dosage and also prescribed Seroquel. The IDT determined that looking for a group home or employment should not be pursued at that time due to her aggressive behaviors, but also noted she could not return to the current day program. This ISPA did not document a clear plan to resolve these various concerns.

- The IDT met a third time on 3/13/19 to discuss another psychiatric hospitalization. It was unclear when the event took place, but it included physical aggression toward her mother and threatening her mother and law enforcement personnel with a knife. The documentation also indicated she had three seizures during the course of these events, although staff were unsure if these were pseudo-seizures or not. Individual #406 reported she heard voices in her head telling her to hurt herself and her mother. Law enforcement personnel reported they did not believe the jail was suitable for her needs and took her to a psychiatric hospital. The ISPA documented provider staff had been actively looking for a group home and for a new day program, although it did not make clear how long she had been without a day program and/or if that meant she had been staying at home with her parents throughout that period. The IDT recommended that another appropriate setting be found to minimize contact with her mother. Per the provider, Individual #406 was no longer able to move to their available group home due to repeated aggressive behaviors; instead they suggested the IDT consider changing providers to one that could more immediately accommodate her needs.
  - The PDCT ISPA did not lay out a clear plan for resolution of these issues. In discussing what could have been done differently, the IDT indicated Individual #406's behavior support plan was not appropriately followed, but again did not critically examine the adequacy or appropriateness of that plan. The IDT also did not discuss whether they should have provided some additional post-move training once it became clear that her behavioral needs were not being successfully addressed. Without first having more carefully examined what they could have done, or could still yet do, the IDT suggested that one alternative could have been for someone to press charges against Individual #406.

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: The transition department involved IDT members, individuals, and LARs. This is evidenced by the high score for indicator 13. Along the same lines, there was some progress regarding indicators 15-17, as seen in two of those three indicators scoring at 50%. Transition assessments (indicator 12) did not show much improvement. This set of indicators will remain in active monitoring (except 18 which will remain in less oversight).			Individuals:								
#	Indicator	Overall Score	267	406							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are	100% 2/2	1/1	1/1							

	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.										
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	50% 1/2	1/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	50% 1/2	1/1	0/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/1	0/1							
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

Comments:

12. Assessments did not consistently meet criterion for this indicator. Discipline assessments to support successful transitions continued to need improvement as reported at the time of the last monitoring visit. Per interview with the transition staff, little progress had been made in this area, an assessment with which the Monitoring Team agreed. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated with 45 Days of transition: Most assessments provided for review met criterion for timeliness. Assessments that did not meet criterion included:
  - Individual #267 did not have a transition communication assessment or update, but should have. Per his AMA, he seemed to have a receptive communication delay. This had been further substantiated by his stepmother, who cautioned that he needed to be told an entire task before breaking down into small steps, to be implemented one at a time without moving to the next until the current was one complete.
  - For Individual #406, the Center did not provide an OT/PT assessment or update, but should have based on her risks and supports. She was at risk of falls and was supposed to wear a knee brace that had been fitted by the Center habilitation staff. She also had a PNMP.
  - The IDTs also documented a review of the Quarterly Drug Regimen Review (QDRR) in the CLDP, but it consisted only of a statement that it was reviewed and did not provide any detail or recommendations.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Many discipline assessments provided

a summary of relevant facts in the available assessments, but this was not consistent. For example, neither of the vocational assessments provided a clear understanding of employment needs and strengths.

- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: In addition to the missing assessments described above, the vocational assessments provided little in the way of recommendations.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not fully address/focus on the new community home and day/work settings. Currently, assessments did not consistently meet criterion in this area.

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: For both individuals, the Center maintained detailed Transition Logs. These were helpful in understanding how the Centers transition processes ensured necessary participation. Section IV of the CLDP document, entitled Community Living, also provided details of transition activities that described the involvement of the individual and LAR/ family, the LIDDA and Center staff.

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: Training provided to community provider staff did not yet meet criterion for these two CLDPs, as described in Indicator # 1 above. Overall, the IDTs did not yet consistently identify the expected provider staff knowledge or competencies that needed to be demonstrated. The Center also needed to improve its processes for ensuring provider staff competency to deliver supports as required. For example, written exams need to be constructed to cover all essential knowledge. The testing materials the Monitoring Team reviewed fell short of this mark. Competency testing did not clearly document provider staff had knowledge of all essential supports based on each individual's needs.

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. Both CLDPs included a relevant statement, but evidence did not indicate whether the required collaboration had been completed.

- For Individual #267, the IDT indicated it would be beneficial to his progress if the Center psychiatrist reached out to the community psychiatrist to provide additional historic information regarding his care. The IDT did not develop a specific pre-move or post-move support, but did provide documentation that the Center psychiatrist prepared a letter.
- For Individual #406, the IDT made a similar statement that psychiatry should write a letter describing her medication history and needs. The Center did not provide documentation this had been completed.

16. SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs: 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. The CLDP for Individual #267 met criterion. The Community Living summary for Individual #406 stated no settings

assessment was needed because she did not receive OT/PT services. The IDT did not provide evidence it considered that a settings assessment might be appropriate based on other needs. In addition, Individual #406 had a risk for falls and had been fitted for a knee brace by OT/PT, in part to reduce her risk for falls, so it was not clear the IDT's assessment was correct in this regard, either.

17. Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual: The CLDP should include a specific statement of 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 met criterion by providing this statement.

18. The APC and transition department staff collaborate with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition: This indicator was in the category of requiring less oversight.

19. The pre-move site reviews (PMSRs) for both individuals were completed prior to the transition date. It is essential the Center can directly affirm provider staff competency to ensure an individual's health and safety prior to relinquishing day-to-day responsibility, but the neither of these two PMSRs accomplished this. For both individuals, the PMM documented receiving the signed competency quizzes after the completion of the training, but the quizzes did not cover many of their important needs and were insufficient evidence that provider staff were competent. In addition, Center staff who completed the PMSR sometimes did not provide comments that explained the basis for affirmative decisions. For example, for Individual #406, Center staff indicated the provider had procedures in place to address any injury/illness that may occur or to address behavioral incidents. Center staff based this determination on interview with the provider program manager, but provided no evidence the procedures were viewed or discussed.

Outcome 5 – Individuals have timely transition planning and implementation.											
Summary:			Individuals:								
#	Indicator	Overall Score									
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments:											

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.
  - HHSC PI 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 within past two years, 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 HHSC PI 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
HHSC PI	Health and Human Services Commission Provider Investigations
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
PNA	Psychiatric nurse assistant
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
SUR	Safe Use of Restraint
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone
UTI	Urinary Tract Infection
VZV	Varicella-zoster virus